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
Mr Martin Dixon
Mr Khalil Eideh
Ms Fiona Patten
Ms Natalie Suleyman
Mr Murray Thompson

Witness

Dr Kate Seear, senior lecturer in law, Monash University.

Necessary corrections to be notified to executive officer of committee

The CHAIR — We reconvene this public hearing of the Law Reform, Road and Community Safety Committee meeting and our inquiry into drug law reform, and I welcome Dr Kate Seear, a senior lecturer in law from Monash University. Welcome, Kate. In terms of formalities, you might be aware Hansard is recording everything that is being shared this afternoon, and after a couple of weeks you will get a draft of the report. Once you have approved it as technically correct it will be part of the public record. You would also be aware that you are covered by parliamentary privilege when you are in here. I am not sure whether that is relevant today, but otherwise we are in a public meeting. First of all, thank you for your submission to the inquiry. If we first hear a general overview of the key issues as you see them, Kate, then we will have some questions and discussion to follow on from that.

Visual presentation.

Dr SEEAR — Thank you all very much. I did prepare a statement that I think speaks to some of the key issues that I want to emphasise today. I would just like to begin first of all, before I say anything else, by acknowledging the traditional owners of the land on which we meet today, to acknowledge elders past and present, and to extend that respect to other Aboriginal and Torres Strait Islander peoples. I do want to thank the committee sincerely for the opportunity to speak with you today. It is a great privilege.

I would also like to acknowledge the Australian Research Council, who have awarded me a fellowship and that has enabled me to conduct research into drugs, addiction and the law in Australia and Canada, and that fellowship has informed much of my written submission and the statement that I want to make today. I also want to acknowledge of course that I think the committee has a very challenging task ahead, and I want to commend you all very much on the work you are doing. It is a very complex and important area.

I want to second comments from the Penington Institute's written submission, which I have had the opportunity to read, where they note that this is an opportunity to improve a system that is not performing optimally and that change is required, and I agree with that. Clearly it is a matter for the committee as to what kind of reform or change would be appropriate, if any.

The committee may remember that I made a written submission that contained nine recommendations, many of these overlap with recommendations made by other people who have made submissions to the inquiry. This includes things like the need for a supervised injecting facility in Victoria, the introduction of needle and syringe programs in Victorian prisons, decriminalisation, reforms to drug-driving laws and the removal of what is called the prohibition on peer distribution. I am very pleased to say that, based in part on research that myself and some colleagues — Dr Kari Lancaster and Professor Carla Treloar — conducted, the ACT government lifted their prohibition on peer distribution last year. It has also happened in Tasmania, and there are compelling reasons I think for Victoria to follow suit and for other actions and reforms. But in the time that I have available to me today I want to emphasise what I think are two overarching principles that provide the foundation for reform if you consider it appropriate.

In my view, I think reform is not only justifiable but necessary based on human rights principles on the one hand and because of links between stigma and the law on the other, and those are the two points that I just want to emphasise briefly today. As I have argued in my written submission, reforms to Victoria's drug laws would be consistent with human rights principles. In recent years a number of international figures and organisations have expressed concern that existing drug laws and policies around the world enable human rights breaches. Last year, for example, the former United Nations Secretary-General, Kofi Annan, called for a range of reforms stating that drug laws needed to be grounded in what he called a deep concern for health and human rights. I do not need to tell you all of course that human rights considerations are particularly relevant here in Victoria, as Victoria is one of only two jurisdictions in Australia to have a human rights charter. The 2006 charter, as the committee will be well aware, recognises 20 rights for Victorians, including crucially in section 9, the right to life.

There is a substantial body of jurisprudence from around the world which suggests that some protected rights place positive obligations on governments. In this sense, the charter both enables and I think necessitates drug law reforms, including wherever it is possible to make reforms that may reduce harms, improve health and preserve life. Importantly as well the Victorian charter, as the committee well knows, requires every bill introduced into Parliament to be assessed for its compatibility with human rights.

The majority of existing laws that pertain to drug use were introduced long before the charter came into operation in this state and therefore those laws have never had the benefit of being assessed against the charter. In all likelihood, Victoria has many laws on its books that affect the lives of people who use drugs, but that are not compliant with the charter. Of course, as you all know, if reforms were to be proposed as a result of this inquiry, those proposals would also themselves need to be assessed against the charter.

What this means is that there are compelling reasons for the committee to examine the relationship between drug law and human rights. I think this inquiry offers you all both a long overdue and unparalleled opportunity to consider afresh what a human rights compliant drug law framework could look like in this state. The committee has a unique opportunity to help Victoria, in this sense, to become a national and even international leader in this space as momentum for drug law reform in line with human rights principles gathers pace all around the world.

The second point I wanted to emphasise was around stigma. As I have argued in my written submission, reforming laws might help to reduce the stigma that is often experienced by people who use alcohol and other drugs, and this is highly likely to generate many important social, health and economic benefits. In recent years several major international stakeholders and organisations have begun to turn their minds to the relationship between law and policy, stigma and discrimination.

It is well known that stigma is the key driver of health inequalities. In their 2008 World Drug Report, for example, the United Nations Office on Drugs and Crime described stigma as one of the unintended consequences of the international drug control system and its application, and this is what they said:

> A system appears to have been created in which those who fall into the web of addiction find themselves excluded and marginalized from the social mainstream, tainted with a moral stigma, and often unable to find treatment even when motivated to seek it.

Stigma was also addressed in the 2016 World Drug Report, where they noted among many other things that efforts to address drug issues around the world must include a focus on overcoming stigma.

Many other international bodies, and I reference some of them in my written submission, including the World Health Organization and the World Health Assembly, have raised similar concerns and called for a review of policies and law. What this means, I think, is that there is an emerging consensus, nationally and internationally, that laws matter and that law plays a very important role in generating and exacerbating stigma. Ambitious statements calling for the elimination of stigma, however, are rarely accompanied by details on precisely how governments might do this. So it is not always clear what a committee such as yours might do to address it.

Together with colleagues Professor Alison Ritter and Dr Kari Lancaster I have recently conducted a major study for the Queensland Mental Health Commission which focuses on precisely this question. We have recently developed a world first framework for assessing the relationship between law and drug-related stigma. This framework allows one to assess individual provisions and determine the potential of each provision to generate drug-related stigma.

It is my view that this work can and should be replicated in Victoria. If a map of Victorian law of this kind were to be developed, it then becomes possible to identify each and every law that is potentially stigmatising and in need of reform. Importantly, this is not to suggest that this work should stand in the way of other more urgent reforms. Rather, work should be undertaken to capture the many laws that deal with alcohol and other drugs, beyond the most obvious ones, and to consider all of the ways that laws might generate or exacerbate stigma and other forms of harm.

The committee will note some discussion of these issues in my longer written submission, such as the existing situation with section 54 of the Victims of Crime Assistance Act. That is a provision that allows victims of crime in this state — people who are in need of the state's care and support — to be denied compensation or to have their compensation reduced where they have a past history of drug use. This is precisely the kind of less well-known provision that has the potential to generate stigma and to be counterproductive to the health, welfare and wellbeing of Victorians, and this I submit should be our focus. I welcome the opportunity to answer questions.

The CHAIR — Thanks, Kate. I was just going to ask: in terms of your experience in Canada — you mentioned you had a look at their legislation extensively — what are the main differences that you observed between the legislation in Canada and here?

Dr SEEAR — I would say that the main difference is that Canada has a charter of rights and freedoms, which is similar to but has more teeth, if you like, than the Victorian charter. You are probably aware of those discussions after the recent review of the charter conducted by Michael Brett Young. What that means is that one of the things that can happen in Canada is that an individual can bring a standalone cause of action if they allege a breach of human rights, and there have been a number of those cases that have argued in effect that governments have obligations to provide health services and certain other social services to people who might have problems with alcohol or drugs, and that they have that obligation as a consequence of the charter.

One very high profile example of that is Insite, which is the supervised injecting facility in Vancouver, for a long time the only supervised injecting facility in North America, although that is changing now. A number of years ago that facility had been in place for several years, but there was talk of closing it down. An action was brought in the Canadian Supreme Court using the charter, arguing that government had an obligation to keep that service open because it saved lives and because of the right-to-life provision it needed to remain open.

So in a sense what I would say generally is that with cases like Insite, there is a significant culture of human rights in Canada and a legal framework that enables arguments to be made in Canada that differs a bit from here, that very much emphasises the connection between human rights, particularly the right to life, and government's obligation to provide services where they can.

Mr THOMPSON — In terms of destigmatising drug use, how would that operate where, if it is a drug such as, for example, heroin and the cost of it sometimes involves criminal offending in the realm of theft? How would you destigmatise drug use whilst at the same time work ways forward with the magistrates court convictions for the theft?

Dr SEEAR — Yes, it is a very good question. I think the starting point must be, as I was arguing in my written submission, first of all to identify whether laws have the potential to stigmatise people, and I think that is a first step that has not yet been undertaken in this state.

As I said earlier, work is underway in Queensland to this effect, and my colleagues and I have recently conducted a major study for them, but that is not yet public so I cannot talk about the findings. What I can say is that our research has located links between a number of provisions in Queensland law and stigma, including in some instances the criminal law.

The question then becomes one for government. What do we do? How do we balance those competing public policy objectives that you are talking about — perhaps the need to punish or even to rehabilitate a person who might have a problem with drug use on the one hand with the fact that some criminal sanctions or other kinds of sanctions can stigmatise people on the other?

Many organisations around the world have said that the solution here is to think more often about drug use as a health problem rather than a criminal one, and obviously we have a model in Victoria that seeks to address this in part through the Drug Court system. That is one option.

I think another is to consider ways to divert people out of the criminal justice system where that is appropriate. That obviously already happens, but perhaps not quite as much as it could. But I think the very important point that I would like to emphasise is that as a first step we need to have a sense of the broad suite of laws that do impact upon people in this way, not just the criminal law. Look at also how they overlap and interact with one another, how the criminal law might interact with employment law for instance, and what the effect of a criminal record for a minor drug use or possession offence might have on a person later in life, and see whether there is a way to perhaps balance those competing public policy objectives more effectively.

Ms PATTEN — I read your submission with great interest. Turning to the Road Safety Act and the issues around that, you are suggesting that we have a working party to consider this. Are there any jurisdictions that are doing this well? With the legalisation of cannabis in many jurisdictions, whether it is medicinal or personal, this is going to raise that issue — I am just wondering if you are aware of any jurisdictions that are working on this well.

Dr SEEAR — Yes, there are certainly a lot of jurisdictions that are working on it. I would say one of the reasons in my submission I pulled up short of making very strong recommendations about what should happen with drug driving laws is because I do not have a background as a scientist and I think it is the kind of issue that requires scientific expertise. There has been a lot of work done in the UK most recently.

The Woolf report, which you might have heard other people speak about — I am not sure — looks precisely at this question. A panel made up of a number of experts from different backgrounds made some recommendations about the need for thresholds for different kinds of drugs, including prescription medications, and the need for different thresholds if there is also alcohol present in a person's system. If you look at that report, that is one reference, and I think I may have referenced it in my submission; I hope I have included it in there.

Ms PATTEN — Yes, you did.

Dr SEEAR — That is something that could be looked at. I think they have a table that suggests what the threshold might be, depending on whether we are talking about methamphetamine, cocaine or whatever it might be.

Ms PATTEN — Fantastic. We will look into that.

Dr SEEAR — I would say that the Wolff report is the most significant major report internationally in recent years that would provide some guidance to this committee, if that were of interest.

Ms PATTEN — That is great. Thank you. You also mentioned that you were looking at getting your head around intoxication. I think from memory you were looking at stigma as well, so looking at the use of the term 'intoxication' in our legislation. You noted, I think, 500 mentions of it. Can you give us some examples of where that confounded you? The use of 'intoxication' in so many pieces of legislation was surprising to me.

Dr SEEAR — It was surprising to us as well when we conducted that research. It was far more complicated than we had anticipated. I thought somebody on the committee might ask me about this. Just to go back a step, what we did in that research was look at all pieces of legislation in Australia that attached significance to intoxication in some way. We looked initially just at the criminal law.

There are 500 individual provisions in Australia that attach significance to intoxication in criminal law only. There are separate provisions in, say, the civil law — things like the Wrongs Act and equivalence in other jurisdictions in Australia. Forty seven of those provisions are here in Victoria, so there are 47 individual criminal law provisions in Victoria. They include things like provisions that you would be well familiar with, like those in the Road Safety Act pertaining to drink-driving or drug driving. But they also include things like the possibility for criminal action to be taken in association with work — maybe driving a train, for example, while intoxicated.

The most striking finding of our research is that there are these 500 provisions right across the country and very little unity in terms of how intoxication is defined or understood.

Ms PATTEN — Right, or measured.

Dr SEEAR — Exactly. I am not sure if I included it in my written submission; I think I may not have, but in our research what we found is that different terminology is used in legislation. So sometimes legislation will attach significance to intoxication, sometimes it is to being severely intoxicated, sometimes it is being drunk or adversely affected by drugs, or adversely drunk, or significantly drunk or substantially drunk. In many instances the legislation makes no attempt to define any of these terms.

The view we took in our research, and one of the conclusions we reached, was that this was problematic — this lack of definition or definitional certainty — and also the fact in many cases that legislation attaches significance to intoxication but does not define it in any particular way. Yet powers, including coercive powers, can sometimes be exercised in circumstances where the central object of that legislation, for example, being substantially affected by alcohol, is not defined at all. I think that creates a number of problems for how we then consider effective law enforcement and so on.

Ms PATTEN — Absolutely. I will leave it, but it does take me on to the new psychoactive substances legislation.

Dr SEEAR — Yes, sure.

The CHAIR — Which is sort of where I was looking at going anyway, and how we might respond to some new synthetic drugs coming onto the scene and what is the best way of legally getting around dealing with that.

Dr SEEAR — Well, it is interesting. Some colleagues and I have recently done some research, not based on Victoria but looking at new psychoactive substances. There is a paper which I think I may not have referenced in my written submission, it may not have been completed at that stage, with colleagues Monica Barrett and Kari Lancaster. What we were concerned about there was the tendency, and I know it is a very challenging area for Parliament to grapple with, at times in those frameworks to define the problem as one of drug affects and just how nebulous the concept of drug effects is and can be.

I fully understand why the legislation has landed where it has, because of the shifting nature of what is a very complex area and trying to catch up, but I do think that that is particularly problematic in that there is a substantial body of literature emerging in the social sciences about the complexity of the notion that drugs have certain predictable effects. As you would be well aware, there are a range of factors that can shape how people consume and experience drugs and what kind of affects the experience from those affects. That was our principal concern with that legislation. But I recognise that it is a very challenging issue, as is any circumstance where Parliament or legislators are trying to define or deal with a problem that is nebulous and changing.

The CHAIR — Have you seen any more effective alternatives?

Dr SEEAR — Not at this stage. I know there have been some recent developments overseas, but I am not fully up to speed with them, to be honest.

Mr DIXON — In your submission you talk about removing the prohibition on peer distribution.

Dr SEEAR — Yes.

Mr DIXON — First of all, that was the first time I knew that there was a prohibition. How would that prohibition improve the health aspects of people taking substances? Can you just tease that out for me?

Dr SEEAR — I can, yes. This is in my mind one of the most significant areas that would benefit from reform. As I mentioned earlier there are a couple of jurisdictions in Australia that have acted on this recently: Tasmania and the ACT — and also the Northern Territory, I think.

In short there has been some research conducted in Australia around the extent of what we call coverage from needle and syringe programs — that is, essentially how many people who inject drugs have access to clean needles and syringes. Consistently that research shows that coverage is not optimum; it is not at 100 per cent. As a consequence of that and a range of other factors, people who inject drugs who cannot access clean needles, whether they be people in remote areas, country areas, people with disabilities who cannot physically get to services, whatever it might be, share needles. Where that happens, of course, the likelihood of a person acquiring a bloodborne virus, like hepatitis C or even HIV, increases. Something like 90 per cent of new transmissions of hepatitis C in this country every year come from people who share needles in that way.

What we also know, though, from research is that people who inject drugs often go to needle and syringe programs and collect needles for people who they know need them and take them home and illegally distribute them. That is a very important harm reduction measure that has long been underway in this country, although it is happening unlawfully in most jurisdictions at the moment.

Mr DIXON — So there are two types of distribution. One is the good one, where they are getting them from a reputable source. The bad one is that you are sharing your own used needles.

Dr SEEAR — No, sorry, perhaps I did not explain the properly. What it is that happens is that people who inject drugs might give to a needle and syringe program and collect clean needles —

Ms PATTEN — To share.

Dr SEEAR — take those clean needles away and give them to — —

Mr DIXON — Yes.

Dr SEEAR — Yes, without having used them.

Mr DIXON — I can see why that is a good thing, but then you have got people who are sharing dirty needles, have you not? That is not helpful.

Dr SEEAR — The present situation is that there certainly are people who share dirty needles; that is correct. What would be ideal in this country is that, for those people who do inject drugs, clean needles are made more readily available to them. Established needle and syringe programs is one way that already happens. Another way is through this unlawful underground network where people get clean needles for their friends and get them to their friends where they can. Lifting the criminal prohibition on that practice would be very important for a number of reasons: one, it would send a clear signal to those people who already engage in that practice that harm reduction practices like that are valued; also I think there is some anecdotal evidence, and certainly perhaps those of us who work in the field know, that the prohibition certainly has some effect on people's willingness to distribute clean needles in that way.

There was also a case a number of years ago now — I think in 1999 in New South Wales — where there was a prosecution in association with this practice, and my understanding from the sector is that that prosecution has had a ripple effect for many years. People are still frightened to collect clean needles and distribute them to other people where they know they need them, and what that means is that those people may well not get access to clean needles and they share.

I think I mentioned this in my submission, and I think this is a very important point, that in the last couple of years direct-acting antiviral drugs have come onto the market, and there is a real excitement in the sector that there is a possible cure for hepatitis C on the horizon. But I think if we continue to have a law like this one on our books, that prohibits people from engaging in other harm-reduction practices that would be helpful and in fact complementary to the rollout of direct-acting antivirals, that there is a risk that that essentially acts as an obstacle to this medication being rolled out.

Mr EIDEH — Can you can explain to us in a sense or give us some details about the problem, especially with the infringement system as it relates to AOD issues.

Dr SEEAR — Yes, I can. Thank you for your question. You may have seen in my submission one of the hats that I wear in my job. My main one is that I am a senior lecturer at the law faculty at Monash, but I am also the academic director of Springvale Monash Legal Service, so I am a practising lawyer there. We deal with many hundreds of clients, at the very least, each year who have infringement problems. What we find under the current system, under the infringements act, is that, as you would be aware, there is a provision that allows a person to apply to have their infringements waived if one of three special circumstances are met. Those special circumstances are homelessness, mental illness or alcohol or other drug addiction.

Of course if someone makes an application of that kind, they have to be able to prove that one of those circumstances has been met. What we find in practice is that it is often very challenging for us to be able to prove that a person has or had — most often had — a drug or alcohol addiction in the past. The reason for that is that they come to our legal service seeking help, sometimes years after they have recovered from their drug or alcohol problem. They are now trying to deal with infringements that may have been incurred many years ago. The stigma associated with their problem meant that they never saw anybody or perhaps even talked to anybody about that problem in years gone by, and so there is no doctor or expert that we can go to to help collect that evidence, and that is often the kind of evidence that we need. This is an especially important phenomenon when we are talking about drug or alcohol addiction, which is a highly stigmatised issue and where many people cannot get help, or will not get help, and cannot talk about it.

This is, I think, one area where a very practical, pragmatic change could be made, where if we allowed people to rely upon other sources of evidence, including a statutory declaration where they themselves swear an oath, perhaps, that they have experienced a problem in the past but did not get help for it, we would recognise that that is valid evidence in and of itself, rather than requiring evidence from an expert, which is most often what we need to have to get over that hurdle. I think, again, this is another example of an area of law where stigma is

very much at the forefront of my thinking, in that for somebody who may have had a drug or alcohol problem in the past, we sometimes see clients who may have $10 000, $30 000, $50 000 or even $100 000 worth of infringements that they have accumulated. So being able to deal with that debt in that way is very important to enabling that person to get on with their life. The legislation recognises that there might be a nexus between addiction and infringing but just does not quite give us enough help to assist those people to move on.

Mr THOMPSON — Dr Seear, I am interested in the issue of unintended consequences. We heard from an earlier witness of a number of examples where there were unintended consequences from decriminalisation. In the case of Holland there were entertainment precincts, and so it was seen that visitors to Amsterdam may experiment and binge. In Portugal there was not a large increase; there was some increase but no harms that have been defined on criteria presented to date. In the case of alcohol and tobacco, it was suggested that more licences and later trading hours had led to an increase in domestic violence. There was clear data that said that the hours of operation had led to harms. Then in relation to cannabis in some American jurisdictions there had been a view that there might be a new source of revenue to support worthy causes, but it had led to perhaps profit-making, that it was more available to minors and that there was a cash economy that had developed so that the product did not go through formal channels. Is that something you have had a chance to turn your mind to at all — in relation to unintended consequences of the relaxation of law?

Dr SEEAR — Yes, it is certainly something that I have read quite a lot about, and I have followed some of those developments and debates as reforms have unfolded around the world. I suppose what I would say to that is that it is well recognised that the existing system also has a number of unintended consequences. Some of them I think are catastrophic, particularly if we think back to the example of the prohibition on peer distribution and what happens when people share needles or perhaps even inject drugs in public settings, and I understand that the committee has already received some evidence about the particular problems we are facing in the North Richmond area with overdose deaths. I think that is a particularly stark example of the unintended consequences that we are seeing from the existing system.

There is certainly some evidence, and you have pointed to some of it, of other consequences from around the world, but my view is that those unintended consequences perhaps need to be balanced against existing consequences which are themselves unintended and often catastrophic. So I said at the outset that I think as a committee you have a very difficult task of deciding how to balance those various consequences, weigh them up and decide what reforms, if any, are needed. But my strong view is that there are a number of reforms that could be introduced that would reduce existing unintended consequences, including very catastrophic ones like public overdose deaths, and that those reforms should be considered for that reason.

Ms PATTEN — I just want to quickly turn back to this notion of significantly drunk, substantially drunk or, as we are seeing with some of the legislation around new psychoactive substances, that it is around significant psychoactive effect. Now, again, it is very difficult to define any of these. I guess that leads us on to, when we are looking at reviewing road safety legislation, how do we define when someone is impaired to the point that they are not safe on our roads or someone is significantly intoxicated that they are not safe to be in a public place? Do you think there is a way that we can do that — that we can find a definition and a measurement for that?

Dr SEEAR — For new psychoactive substances or for drug driving or both?

Ms PATTEN — I think it actually goes across all of them because, apart from the fact that alcohol causes a psychoactive effect — and in the argument we are having at the moment we are saying, 'Well, is the effect of two glasses of wine a significant psychoactive effect insofar as it changes your mood or whatever, or does it need to be eight glasses of wine to be considered significant?'. So I think in those areas where we cannot say .05, we are going to have to rely on some other measurement.

Dr SEEAR — Yes. So there are a few things to say in relation to that. The first is in relation to drug driving. As I said, there have been some attempts in the UK and the Wolff report —

Ms PATTEN — Yes, I look forward to reading that.

Dr SEEAR — to do something much more specific and to have a series of thresholds introduced. In other areas of law, and this is what we have argued in our work both on stigma, for the Queensland Mental Health

Commission, and intoxication, those are two separate research projects that I have undertaken. In both senses I think it depends in part upon the various powers that attach to the object in question.

I will give you an example. In many jurisdictions in Australia there is provision for police not to question a person who they may have arrested who appears to be — and forgive me if I get the wording incorrect, but wording to the effect of: a person who appears to be adversely affected by alcohol or drugs. That is a situation where in some jurisdictions that terminology, that phrase 'adversely affected by alcohol or drugs' is not defined, but I would say that there is good public policy reason for there to be no definition, because what it encourages police to do by and large is err on the side of caution and protect the rights of the person who might be drunk and perhaps should not be interviewed by police in those circumstances. So the context within which the legislation or the provision sits is crucial, as is the question of what power attaches and how coercive the power is and what the flow-on effects or purpose of that legislation might be.

In Queensland, as I mentioned earlier, my colleagues and I have just developed this world-first framework for looking at stigma and law. What it does is encourage you to go through a series of questions like this — a kind of test, if you like: what does the legislation say? Is the intoxication, or whatever it might be, defined? What is the purpose of the legislation? What powers attach? Who has those powers? What are the potential implications of that power? That is why I do believe that this kind of mapping exercise is crucial; otherwise you do not really know what you are dealing with. Then that gives you a sense of whether the legislation is potentially stigmatising and also whether it enables or might enable exercises of power that impact adversely upon people without sufficient protections in place. That is the best answer that I can give to your question because it is I think a provision-by-provision equation.

The CHAIR — So it is clear, then?

Ms PATTEN — It is clear, that is right, absolutely; as clear as it is right now. Did I see in your submission that you felt that a pilot of a supervised injecting centre did not require legislative change?

Dr SEEAR — No, you did not see that from me.

Ms PATTEN — You just said there is no legal barrier to the implementation?

Dr SEEAR — That is right, and I think — —

Ms PATTEN — Except the law?

Dr SEEAR — Yes, that is right. I may in this submission have referenced your bill, which I know has been before Parliament earlier this year — —

Ms PATTEN — Yes, you did.

Dr SEEAR — Legislation of that kind, that mirrors the MSIC approach, I think, is what is needed, and I think there are very sound health and public policy reasons why that should be considered, yes. I am sure many other people have spoken to you about that, though, so I will not go on unless you need me to.

Mr THOMPSON — Forgive me if this question has already been raised, but I just noted roadside drug testing and the use of biological detection methods and thresholds. Are you able to explain a little bit of that to the committee?

Dr SEEAR — Yes, I can. The general position, as you may be aware, is that in Victoria there is no threshold in the legislation at the moment, so that for drug driving a person can be charged under the Road Safety Act if they have any presence of a particular substance in their system. What that means in effect is that a person may have, say, consumed cannabis some days before they are in charge of a vehicle, and if that drug is still in their system, they can be charged under the act. I think the problem with that — and this has been recognised in recent months in New South Wales; there is a magistrate who has made a couple of findings in New South Wales in this respect — is that I think that provision offends on public policy grounds, primarily because it does not necessarily capture impairment. My view is that the legislation is most likely to be effective if we are targeting people who are actually impaired at the time of driving.

The Wolff report in the UK that I mentioned earlier has looked comprehensively at this issue in recent years and made a number of suggestions about how legislation might be reformed to capture actual impairment with a series of biological detection methods or thresholds for people who have consumed drugs.

The CHAIR — Thanks, Kate.

Dr SEEAR — Thank you; it is a pleasure. Good luck with your work. As I said, I know it is very challenging, and there is much to be done.

Witness withdrew.