# 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
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Mr Murray Thompson

Witness

Mr Demos Krouskos, chief executive officer, North Richmond Community Health.

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

**The CHAIR** — We are now to hear from Demos Krouskos of North Richmond Community Health. Welcome. Just to start with the formalities, you would be aware that everything you share with us is being recorded by Hansard, and a draft of the discussion will come back to you within a couple of weeks for you to check for any technical errors, but after that it will go on the public record. You are covered by parliamentary privilege when you speak to us; I trust you understand that circumstance too.

We are pleased to have received your submission. Clearly a lot of interest has been directed, even from the previous witness, in regard to Richmond and issues, as we have heard from many others, associated with concern in your neighbourhood. We will be pleased to hear you give a summary of some of the issues that you have experienced at the community health centre, and then we will be interested to ask you a couple of follow-up questions.

**Mr KROUSKOS** — Good morning, everyone, and thank you very much for the opportunity to give this evidence to the committee. First of all, I would just like to start by saying that it is one of the most complex issues that we have dealt with in my 25 years as CEO of North Richmond Community Health centre. Some of you are aware, of course, that the North Richmond area has undergone very significant social and demographic change over the past 20 years, sometimes referred to anecdotally as gentrification. But one of the things that has not changed about that area is this incredibly entrenched use of what we sometimes call illicit drugs, specifically heroin. Certainly that has been a feature of the community that I work in for more than 20 years, so it is a generational issue, not just recent. It is entrenched.

Another feature of the area that I work in is that the North Richmond Community Health centre, which has been providing services for the past 42 years on its current site in Lennox Street, is located on Victoria's largest public housing estate and has about 6000 residents — a very significant community. This is the equivalent of two moderately sized country towns. It is the impact on that community that we are most concerned with and of course the impact on people that inject drugs and their families.

Let me just start very quickly by giving you a brief summary of our submission and also why we support these particular approaches. North Richmond Community Health supports a very carefully considered and pragmatic evidence-based approach to decriminalisation or legislation of so-called illicit drugs. We believe decriminalisation could improve the health and wellbeing of people who inject drugs. Furthermore, we advocate and support decriminalisation, which would increase access to health and social services, and we believe that the negative effects of criminalisation both increase disadvantage and marginalisation and have a stronger impact on people who are already disadvantaged.

Your previous witness presenting here made a comment which I thought was quite illuminating — a throwaway line — that his court does not deal a lot with people coming from Camberwell but many more people from the west, illustrating that social and economic divide and where this drug issue is located. We believe that the current drug laws add to this stigma and increase incarceration rates unnecessarily, which further compounds the disadvantage suffered by people who inject drugs.

So what potentially could be the benefits? There was a question asked about the Portuguese experience and other experiences in Europe and other jurisdictions. We believe these are very important learnings that we might reflect on, because that is quite extensive experience — in Portugal more than 15 years, and in other parts of Europe more than 10 or 20 — and significant legislative change in drug laws which I believe has had a very positive effect on people who inject drugs and just as importantly on the community. It is a very important issue to think about — the nature of those decisions, what the evidence is that comes from the experience and what relevance it might have for our situation in Victoria.

So what are the benefits? We believe it would reduce incarceration rates of people who inject drugs who are not otherwise involved in crime or the drug trade. It would reduce the stigma and disadvantage experienced by already disadvantaged communities and potentially reduce the incidence of new blood-borne virus transmissions and lead to safer injecting practices. It would allow for more efficient use of resources that are currently spent on law enforcement. For example, these resources could be directed to other socially beneficial policies such as housing, treatment and social services.

Of course the experience in America is through regulation of certain types of drugs. Regulation of the drug market means we are now in a much more controlled environment with social, political and also legal control.

These are very, very important issues in a way of managing these issues, and that is the experience that we obviously have in overseas jurisdictions.

The legalisation of drugs would allow for regulation of drug markets and would make it more difficult, we believe, for young people to access these drugs, because access to illicit drugs is seen as easier to obtain than alcohol or cigarettes. In numerous examples of research, both those drugs are very harmful, much more harmful in terms of the impact on individuals and the community, particularly alcohol or legal regulated drugs.

Regulation of the drug market through legalisation would mean the drug use would be safer as the people using them would know the strength, purity and the contents of what they are using, and harmful additives would not be in them. So legalisation would allow government, also obviously in regulation, to potentially tax drugs — as in the experience of being in the United States — and to use those taxation revenues for more socially useful purposes, particularly in harm reduction and in the treatment of people that use drugs.

Just to be clear, our position is that the legalisation and/or regulation of drugs does not mean that we condone drug use. It is does not mean that we think drug use is a good thing. It is not a good thing, neither is the use of alcohol or any of those sorts of things. However, how can we improve the current situation that we are currently experiencing? How can we reduce the incidence and impact of illicit drug use or the current illicit drug use in the community? That is our position. We do not condone drug use. Quite the opposite, we recognise that it is a phenomenon. It is overwhelmingly an issue that affects the poor and disadvantaged.

The current drug laws significantly increase stigma of people that use drugs. Regarding the effects of stigma and discrimination, if you think about it in other ways or other times we refer to this issue, let me take the example of racism and the impact of racism and racial vilification. We have seen this on the football field. We do not accept it anymore. It used to be quite common to racially vilify people. No longer is that the case. The impact is very significant on individuals. The same would apply to other individuals that are stigmatised and highly marginalised via having the label of using illicit drugs.

We know that people that use drugs have significant underlying mental health issues, and they have been refused mental health services because of their drug use. We do not have a good system which comes to an understanding. We did have a little bit more in previous times, but the combination and the impact of drug use and mental health are interrelated in our experience. More than 80 per cent of our clients that use drugs have an underlying mental health issue but have refused treatment in mental health facilities because their drug use has not been dealt with, and sometimes vice versa. That is a very significant issue.

There have been very dramatic examples of occupational violence in our healthcare facilities by people who use drugs. I noticed that recently, particularly with the use of drugs such as ice, New South Wales opened the first treatment centre for people that use ice. It will be very interesting to see how they go with that. It is a highly problematic area, but other drugs also contribute to occupational violence in our healthcare facilities.

These are opportunities, if you like, for us to think about a very different approach to how we deal with this. In the past I believe that there has been greater interest in social policy reform, but in these times we seem to struggle with coming to grips with what is the evidence around us. Incarceration of people that use drugs is really unnecessary. I understand the people that trade in drugs, and there are laws against that. That is an issue that I think is well handled in Victoria, and we hear the evidence from the drug courts. These are people committing serious criminal offences. I have no problem with that position. I am more concerned with the people that use drugs.

There are significant benefits in terms of morbidity and mortality in our community. You would have perhaps seen the evidence of the coroner in a recent case that we also presented to, where we had 172 overdose deaths last year. That is a huge impact on a community and on those individuals. About 22 of those deaths occurred in Richmond in 2015 and 2016. I attended three of those deaths myself. They were terribly distressing events to attend. Yes, I work in a healthcare facility. Yes, people do die in healthcare facilities, but these people have died unnecessarily.

What we are talking about are people with families and children. Often they are young people, and their lives have been taken away at such an early age. It is such a tragic event, and it has an enormous impact on our staff as well, attending these regularly. Richmond has the highest rate of ambulance call-outs for overdose in the

state. Fortunately most people are revived through the use of naloxone. That is a very fortunate occurrence, but unfortunately others do die.

Let me give you a little bit of information about our client group. Who are they? In 2014–15 a study by the Burnet Institute of our client group noted the following: 30 per cent of our clients are from Aboriginal backgrounds. This is quite a new phenomenon for North Richmond. This has got to do with a displacement effect that has occurred in our inner city — again, largely through gentrification to our north — and certain groups in our populations being pushed into our area. It is quite new. In the past Richmond has been known as a multicultural area — an area of recent arrivals, refugees, asylum seekers, migrants and the like. This group is very significant, and 30 per cent is a big number.

Ninety per cent of our clients are unemployed. The drugs they prefer to use are opiates and other types of drugs — heroin and other opiates. Less than 20 per cent have completed year 12. That is significantly lower than the Victorian population. Thirty-seven per cent are in unstable accommodation or have no accommodation at all. The average age of people first injecting drugs was 17 years, and the youngest age at which anyone in this survey started injecting drugs was seven years old.

These are stark facts, and they have shaped the way in which we have tried to respond to this situation. It should be noted, of course, that we are a primary health care service; we are not an emergency department of a hospital, and we do not have the resources of a hospital. We have nurses and we have some doctors, but we are a tiny service, and it has a huge impact. Therefore the capacity to respond to this situation is very circumscribed.

Also we have carried out a second wave of research, again by the Burnet Institute, and of course one of the biggest issues there that we were trying to deal with was the prevalence of blood-borne viruses, particularly hepatitis C and HIV. It should be clear that both of these now are entirely treatable conditions and preventable to some degree. But in our community, particularly amongst the Aboriginal community, support required to get them into treatment and to maintain them in treatment is incredibly limited. It takes a lot of resources and dealing with complex issues to ensure that these people have an equal opportunity to others in the community to avail themselves of the benefit of this type of treatment.

It is not acceptable to us that we have such a high prevalence of these diseases. They are quite serious and, in some cases, life-threatening illnesses. Therefore we believe that through decriminalisation and through legalisation we would be able to provide much more significant support to those groups rather than have that energy, time and resource directed to managing a situation in the highly unregulated environment that it is at the moment.

That is probably all I would like to say in terms of my introduction. I am very happy to answer any questions. Hopefully everybody has had a chance to look at our submission.

**Mr THOMPSON** — Demos, you gave some statistics in relation to the cohort of people you have dealt with, and I just wanted to ascertain how many of them were within the City of Yarra, so to speak, and how many might have had residential addresses outside that had come into the City of Yarra.

**Mr KROUSKOS** — That is a very important issue. Probably only about 20 per cent of our clients would reside in the City of Yarra — those that actually have a residence. More than 80 per cent come from outside of the City of Yarra, and this is a pattern — an inner-city pattern, if you like — owing to the confluence of a number of public transport routes. It is quite easy to get to the City of Yarra. People go to the City of Yarra for various reasons. It is an entertainment precinct, particularly Victoria Street, and there is a restaurant precinct, and people enjoy that street. It is quite an easy place to get to. That sort of pattern has been there for many years. People are coming into the city. They do not come for the syringes, by the way. They come to purchase drugs — that's 80 per cent of our clients.

**Mr THOMPSON** — In relation to syringes, do you have a view on what more can be done to advance the syringe program?

**Mr KROUSKOS** — Yes, we believe that in order for that program to be more effective — and we are very fortunate because we have received a little bit of funding to install a vending machine — that service should really be available 24 hours a day, seven days a week, because it is not a 9-to-5 phenomenon. We have installed that, and now over 30 per cent of our syringes — we distribute more than 80 000 syringes per month — come

from the vending machine at the front of our centre. We only switch that on when our over-the-counter exchange is not operating.

**The CHAIR** — So it is available in the other components of the 24 hours that your centre is not open.

**Mr KROUSKOS** — Yes, but as a service that misses out on the opportunity to build relationships with our clients and to provide information and support. That is a valuable component. It is not just a handing out of syringes; it is understanding and supporting people to get into treatment.

**Mr THOMPSON** — Is there responsible disposal of syringes so that they do not end up in Port Phillip Bay?

**Mr KROUSKOS** — We believe that we have made quite a lot of advances in that area through our education programs, but of course there will always be inappropriate disposing, unfortunately. It is not just a matter of education or of the installation of collection bins. It is really about having a much stronger engagement with our clients to support them and to understand the phenomenon of inappropriate disposal. Obviously it poses a danger to the community — a certain risk to the community — and what we have found is that it is not just that phenomenon; it is often dictated by the activities of others. When we ask our clients, 'Why do you throw away the syringe and not take it to a bin?', the major reason is fear that the police might find those syringes on them and, therefore, that the police will take a very dim view of them carrying syringes. That is their view. They worry that it will stigmatise them as injecting drug users and that other consequences may follow. That is one of the major reasons that people do dispose inappropriately.

**Mr DIXON** — You are a community health service, and there are lots of services similar to yours around the state. I imagine that the bulk of your work seems to be drug related. Do you try to provide other services, or are they just squeezed out so that your community, perhaps those who do not have drug issues, do not get the opportunity to have their other primary health concerns met?

**Mr KROUSKOS** — Fortunately, although it is very prominent in the media — the issue of drug use in Richmond — and it is our busiest single program, we provide support to more than 200 people per day. But we actually have 12 GPs. Our biggest program is our dental program. We have seven dental chairs at North Richmond; it is one of the biggest in the state. We have got a couple of chairs in Fitzroy and a chair for the Aboriginal community up in Robinvale, for example.

**The CHAIR** — So clients are not dissuaded from using other services because they are concerned that there might be druggies about?

**Mr KROUSKOS** — No, not at all. However, elderly people and more isolated people are particularly concerned, because they do sometimes have some anxieties, and we provide a different type of service for them — a home-based service. By the way, most of our services can be provided in the home, including our dental services. The biggest part of our dental service is actually nursing homes and in schools. It is not just the chairs; it is a very different model. Yes, there is always that risk, but we have got very big nursing, allied health, medical and the like — maternal and child health.

**Mr DIXON** — Do you see many people with prescription drug issues as well?

**Mr KROUSKOS** — Yes, and the combination of that is the most dangerous aspect.

**Mr DIXON** — Combination with what?

**Mr KROUSKOS** — With heroin use and prescription drugs. Prescription drugs are very easy to purchase, and people use them in combination, and that is when naloxone is less effective. Naloxone used against heroin is quite effective. When you have a base such as prescription drugs — I am not a medical person, but I have been advised by our medical staff — that is at times very dangerous, and that is when it is less effective, and people have died through the combination of those drugs.

**The CHAIR** — Can I ask in terms of your proposals about decriminalisation or legalisation — I notice you have got an 'or' there — in terms of legalisation, if you were looking down that path, would you propose legalising all illicit drugs?

**Mr KROUSKOS** — Not necessarily. As I said, we need to have an evidence-based approach to this, and we need to think about what will be the impact of that on individuals and specifically on our community — on the Victorian community, I am talking about now. We do not condone the current use of drugs; however, we are completely opposed to the criminalisation of drugs. So we would have to go through a very careful process in weighing up the evidence and to think about those competing priorities in our community before making that decision, but I would certainly be in favour of decriminalisation of heroin. That is for sure; I think that is a given, and probably — —

**The CHAIR** — Sorry, did you say legalisation or decriminalisation?

**Mr KROUSKOS** — Decriminalisation of heroin and decriminalisation of cannabis use. We do not believe that they should be criminal offences, to use those drugs.

**The CHAIR** — So would you create the step then of legalisation?

**Mr KROUSKOS** — That is to provide the drugs through some legal process, yes. You would have to have at least some regulated process, because if you decriminalised it, you would still have illicit drug markets. Illicit drug markets are unregulated markets, and therefore you need to have forms of regulation. I am not a legal expert, but I would imagine that we would need to look at what would happen through various forms of legislation to reduce the negative impacts. If you look at what we are trying to achieve through this, that is to reduce the harm of illicit drug use on individuals, families and our community.

**Mr THOMPSON** — Just on that, would you see any unintended consequences arising from legalisation?

**Mr KROUSKOS** — I believe there are always unintended consequences, unfortunately, and at the moment if you think about what the experience is, as I said, overseas where there has been decriminalisation or legalisation of certain drugs, it is possible that perhaps this leads to a normalisation of drug use. That would be unintended. It is not a good thing to normalise these sorts of activities. But that could be a risk, that somehow it seemed to be acceptable or socially acceptable to do this, and that would be of concern. So how you would do this, I am not certain, but that might be a very significant risk.

**The CHAIR** — I would also like to get a sense of the practical cases of where decriminalisation has had a negative impact on your clients. In other words, I am wanting to assess whether police are actually charging people just for personal use of many drugs — whether it be cannabis, whether it be heroin — and therefore they have gone to court, and it has clearly had a negative impact on them, whereas in most cases perhaps the police are arresting people for violence or for other acts that are associated with their drug use, as opposed to the drug use itself. So I am interested to get any practical advice about how that affects your clients or what the impact is on your clients.

**Mr KROUSKOS** — The police take a very pragmatic approach, in my view, to personal use. Usually people with small amounts of illicit drugs are given a warning and the drugs are confiscated, and they have been very helpful in that regard. That has been my experience. It might not be exactly the right thing to do, but that — —

**Mr THOMPSON** — That has been your observation?

**Mr KROUSKOS** — Yes, it has been my observation that that does happen, whereas of course obviously they take a much more dim view of people in possession of very significant drugs and are dealing in drugs and the like. This is again a question about: what should our law enforcement agencies be doing? What is the priority in our community? Think about the very significant numbers of people that are incarcerated for drug-related crime. Is this the priority that we want to have?

**The CHAIR** — I guess my point is, in asking the question: are they being incarcerated for possession, or is it for crime or other activities that go with the drugs? And how do we separate those out?

**Mr KROUSKOS** — Usually, in my experience, they are incarcerated for other activities associated with drug use: theft, burglaries and the like, to get money to buy drugs; and violence at times, associated with drug use — all of those very serious offences. That is usually the case, in my experience, anecdotally. So if you have an unregulated market for drugs, if you have an unregulated environment, that will be a consequence; of course it will be. It is brutal. It is a brutal environment. I do not know if you have been down there in Richmond. It is a

very nasty environment that the drug market operates in. There is lots of personal violence and polydrug use, which leads to a lot of personal violence. So there is not just heroin use but alcohol, pills, heroin, ice — the whole lot — and it is a very, very nasty sort of thing to be involved in. So yes, that is what people are incarcerated for, and we believe that by supporting people more, increasing the resources that are available for the treatment of drugs, that will take away some of those criminal offences, or reduce them.

**The CHAIR** — So another way of asking the question that I have been working around is: although we talk about decriminalisation, do we in fact almost in Victoria take that approach that, while it is there on the statutes, people are not actually being charged or put through the courts just for possession, and in fact if they are charged and taken through the courts, it is actually for other acts? So in fact do we have a sort of decriminalised approach in regard to possession already in the state?

**Mr KROUSKOS** — That is my observation. I do not have any evidence for that, but that is my observation — that certainly the clients report to us that usually they are given a warning by police, told to move out of the area, that type of thing. I do not have any evidence for how often that happens. I am sure not even the police would probably have a lot of evidence for that. So you say: yes, de facto, that is in fact the case. But that would need to be researched a bit more carefully to find out, and that is not an area — —

**The CHAIR** — Indeed. But the direction you would want us to take is certainly to look at the health and wellbeing aspects of the people who are under the effects of drugs or using drugs.

**Mr KROUSKOS** — Absolutely. Our policy is very much reduce the harm associated with drug use and reduce the social harms — not just the health-related impacts on individuals and families but also reduce the social harms. The impact on our community is terrible to have this entrenched more than 20 years. These are people who have often come from very traumatic experiences — they are refugees, they are asylum seekers, they are that type of people — and they have come here for sanctuary. To be confronted daily by police sirens and ambulance call-outs is a very disturbing thing to happen to them. They find people collapsed in the street. The social harms are probably the most significant harms, and therefore that is why we advocate for decriminalisation, because if that aspect is not there, if we are operating in a regulated environment, we can remove a lot of that social harm associated with illicit drug use.

**The CHAIR** — If you had five things that you would want to do in a practical sense to improve opportunities or deal with some of the things you see, is a safe injecting facility clearly on your list?

**Mr KROUSKOS** — Absolutely. That would be top of our agenda.

**The CHAIR** — In terms of health support for clients, what are the other things on the list?

**Mr KROUSKOS** — We do not believe a standalone supervised injecting facility is the ideal model. I know there is one in Sydney; it has been very, very successful for more than 15 years. We believe that model needs to be improved upon. It cannot be just a standalone facility. It actually needs to be integrated into a suite of services that provide comprehensive support, a bit like the drug courts — the Drug Court is not a standalone facility; the Neighbourhood Justice Centre, another model, is not a standalone facility — where it takes a comprehensive approach dealing with all of the social harms, as well as the harms of this issue on individuals. A safe or supervised injecting facility should always be co-located within a generalist health and welfare-type service, with the resources that are available to actually have an impact and an effect. You have seen in other jurisdictions the significant benefit that can be gained. That would be number one.

The second issue is we have a situation at the moment where we do not have a clear view in terms of social policy about issues such as drug use. Is it an issue where we have a recovery model in Victoria? In 2014 we recommissioned our alcohol and drug services, our mental health services, towards a recovery model. Other people say to you that this is actually an enduring disability, particularly mental health, for example, under the NDIS model, and that is why people are given support. So it is very complex to think about what is the right philosophy, if you like, for this recovery — is it a combination of both? — and we are very cognisant of that.

By the way, in 2014 unfortunately we lost all of our mental health and alcohol and drug services in Richmond through the recommissioning process. We lost seven staff — very experienced staff. However, what we do know is that we believe, yes, sometimes recovery is the right approach, and we would advocate that in the first

instance, but others need very, very long-term support for us to actually have any impact whatsoever, and we need to be clear about how we address that issue.

**Mr THOMPSON** — In terms of your firsthand observations of drugs on the street, are you able to just briefly outline what the prevalent drugs being used on the streets of the City of Yarra might be?

**Mr KROUSKOS** — Obviously heroin is the most prominent illicit drug that is used in Richmond. It is probably the last big street-based heroin market in Victoria in fact. There is obviously an open drug market down in St Kilda and the like, but most of them have disappeared. So heroin would be the number one drug, but also virtually every other drug is available, particularly prescription drugs. They are very easy to purchase in the City of Yarra. Increasingly ice — that is, amphetamines — is also very easy to purchase. It is not so prevalent there, probably more prevalent in outer suburban and regional Victorian locations. So there is a geographic divide, if you like, or a geographic distribution for some of these drugs, but heroin would be the number one.

**The CHAIR** — If there are no more questions, is there anything we have missed that you want to say as a final — —

**Mr KROUSKOS** — No, not at all. I just want to thank the committee for the opportunity to present. I think it would probably be fair to say that North Richmond has quite a different view to perhaps some of the other people who are presenting to you. We do not resile from our position at all — quite the opposite. We believe that there are very significant benefits to thinking very differently. We need to think differently if we are going to have an impact. That has been my personal experience of more than 25 years. Nothing much has changed in that time. People have continued to suffer. Families have suffered and people have died. So unless we are prepared to be courageous and to think very, very differently, I cannot see any change occurring by just tinkering at the edges of this issue.

**Mr THOMPSON** — Chair, just one postscript question, if I may. There has been an uplift in the number of Indigenous Victorians being looked after by the services that you provide. Are they from regional Victoria or regional Victorian centres who have gathered in Melbourne? Do you have any thoughts in relation to this particular Victorian committee for ways forward that might address their needs more than some of the other people who have been drawn to the North Richmond service?

**Mr KROUSKOS** — Yes, our Aboriginal clients come from all over Victoria and interstate, so they are not just from the Melbourne area, but some are from Melbourne. Again, as you know, it is a very diverse community actually, the Aboriginal community. These are people with strong family relationships, and we need to be very, very cognisant and aware of the nature of those relationships and what the impact of this is in terms of providing support to them. I do not think we have a very good understanding of those issues, and that is because we do not have a consumer-focused approach where we engage directly and we hear the voices of our Aboriginal community and ask them what it is that would be beneficial in providing support.

We have been working closely with VACCHO and the Victorian Aboriginal Health Service to support that group, but that does not necessarily mean that they actually have a relationship either with those services or the communities that those services support. So without an understanding of the history of colonisation and dispossession, the history of the Stolen Generations and all of those very complex factors that come into play, I do not think we will have an effective model, and that was clearly brought home to us on Sorry Day last week, when we celebrated — celebrate is not the right word, but when we —

**Mr THOMPSON** — Marked.

**Mr KROUSKOS** — marked Sorry Day for that community, where we heard directly from them their account that what might be useful in their community was very different to our understanding, and unless mainstream health services learn those lessons, we are going to have inadequate models. At the moment I do not believe there is enough attention. Thirty per cent of our clients are from that sort of background. They are the ones suffering the greatest amount of disadvantage, so unless we hear directly from them, get them to shape the services themselves, I do not think we are going to have much success.

**The CHAIR** — But then I guess the follow-on question is: with that number of clients you are in a position to talk with those clients on an ongoing basis. Do you get any sense of any particular change of direction or requirement that you could be more specific about?

**Mr KROUSKOS** — Yes, and particularly in discussions with Aboriginal workers that we employ ourselves. Essentially what they are saying is that simply to treat the drug issue or the manifestation of drug use, if you like, or the impact of drug use by itself will be very ineffective; it will not produce much change. But to acknowledge the issues of harm, historical harm, to acknowledge the issues of dispossession and colonisation and the Stolen Generations, the impact of people being taken, without that acknowledgement and a deeper understanding of that, we are not going to get much further.

What are the practical consequences of that, you say? What is the program, if you like? Well, it actually does help a lot to say sorry, I have found. It is quite a big thing in the community. We are trying to, in fact, change our service to be much more responsive to diversity in general. Is the service designed for our benefit — I am talking about the physical buildings — or is it designed for their benefit? What are the visible manifestations that show and demonstrate that support and understanding of those historical issues? Because that is what they are saying to us. They want that first, in a sense. I think a lot of health services simply treat it as just a health issue, just a disease or something of that nature. We can change things.

It is interesting, the biggest thing that we hear when we try to refer our Aboriginal clients is that they have run away from the service. You send them to a hospital, and they run away. Everybody says, 'They are non-compliant'. No, they are not; they are trying to protect themselves. They do not get very good treatment. Why is that? We all have a very benign view of our health services, but for them it is a very negative view. That is why we believe that you need to do much more than simply provide a mainstream type of approach.

**The CHAIR** — Demos, thank you very much for your time.

**Mr KROUSKOS** — Thank you very much, everyone, for the opportunity to present to you. I wish you all the best for the future of this very important inquiry.

**The CHAIR** — Thank you.

**Witness withdrew.**