T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 21 August 2017

Members

Mr Geoff Howard — Chair
Mr Bill Tilley — Deputy Chair
Mr Martin Dixon
Mr Khalil Eideh
Ms Fiona Patten
Ms Natalie Suleyman
Mr Murray Thompson

Witnesses

Mr Greg Chipp, CEO and director, and
Dr John Sherman, director, Drug Policy Australia.

Necessary corrections to be notified to executive officer of committee

The CHAIR — We are about to hear from Drug Policy Australia — from Greg Chipp, the CEO and director, and Dr John Sherman, who is also a director of Drug Policy Australia. We thank you for the submissions you have provided to the committee, and we look forward to hearing from both of you this morning. As you are aware, we have been open to submissions for some time. We have received something over 200 written submissions, and we have been hearing from a range of those submittees and others over the last four months. It is good that you have come in today. Hansard is recording the conversation we are having, and a draft transcript will come to you in the next couple of weeks to ensure that it is factually correct in terms of what you believe you said. It will then be part of the public record.

Greg is going to speak first and then there will be an opportunity for John for up to 10 minutes, and then we will have some questions and some discussions from then on. Over to you, Greg, for your opening comments.

Mr CHIPP — Thank you for the invitation to appear before this committee inquiring into what I consider to be one of the great social justice issues of our time. You may think that is a little bit of a stretch, but I ask you to look at the number of people dying in Victoria from overdoses and from tainted batches of drugs and the number of people incarcerated due to crimes against the drug laws.

To be honest, I really want to raise with the committee, as our submission did, the very basis of the prohibition, the persecution, the vilification of people who use drugs. Unfortunately that is what it has come to after 50 years of repressive laws that ultimately determine that a citizen of this country, of this state, can be jailed for doing an action in the privacy of their own home that in actual fact affects no other citizen except through perhaps the actor themselves.

I am talking to politicians here, so I am sure you can relate to the reference here to the philosophies of John Stuart Mill, who espoused in the 17th century the thought that there are limits upon what areas a government can legislate in. That was the primary thesis that he put forward: that actions that do not directly affect another individual in society — such as theft, such as murder, such as assault — should not be considered illegal. The prohibition that we — your families and your constituents — suffer from daily, the criminalisation that occurs because of the prohibition, is ill founded.

I am making an appeal to you good people to genuinely look from the ground up at what these laws are doing to Australian society. It is a time for a rethink. I mentioned in our submission that there was an inquiry very much like this in Portugal in 2001 that came to the conclusion that the criminalisation of drug users does more harm than good. It is killing people, and you have got to admit this. You have travelled the world. You have seen the best evidence around, and I have faith in your processes to come to a conclusion outside of the political system. The political system says that the war on drugs is the status quo. We have had it for 50 years. We need to think outside the box that we are given, otherwise we are just like a frog in slowly boiling water, unaware of the consequences.

Fifty years ago, when I had discussions with my father about the prohibition, the evidence was not out. It might have been worth a shot 50 years ago to see if we could prohibit drug use and criminalise drug users with the aim of reducing the health impacts. That is the clear logic of prohibition: if you prohibit something, less people will use these dangerous substances. I am certainly not contesting that drug use — alcohol or drugs — can be dangerous, but the assumption is that by prohibiting these substances we are reducing the health consequences. The evidence that I am sure you have seen around the world is quite the contrary. We have increased not only the health consequences but the societal attitudes.

Victoria is an interesting state where we have had, through party politics, the ratcheting up of the criminal law and penalties for drug use to the point now that it is a crime in this state to possess information about how to grow cannabis — laws that are based on the terrorist laws, which are quite reasonable. Possessing information about how to make a bomb should certainly be a crime. But here is the thing about the war on drugs: it is getting militarised. It is getting worse. Where do you go? Increased penalties, more harm, more mayhem. We now have roadside drug testing for cannabis that can detect cannabis taken seven days after the event. There has been a 20 per cent increase in the number of cannabis arrests in Victoria. You might go, 'Okay, look, that's just part and parcel', but the social cost of a father living in a country area unable to drive his children to school the next day or even go into town for shopping, losing employment because of a cannabis bust for a mere trace of cannabis in his system — I just implore you to rethink this from the ground up. We think this was done in 1981 with the Penington report, which was referred to in the previous session — that the legalisation, the

decriminalisation of drugs, allows the government and the authorities to regulate and control quality and quantity and to bring people into treatment.

If I could just finish on a thought that we put in our submission, it is a tragedy that 100 years ago we had the persecution of homosexuals in this country — people locked up for an action that was considered a self-regarding action, an action that affected nobody except through the actors themselves. The current Premier in Parliament apologised. He was embarrassed, and he said, 'There was a time in our history when we turned thousands of ordinary young men into criminals, but I look back at those statutes and I cannot possibly explain why we made these laws and clung to them and fought for them'. I have no doubt that this failed prohibition will in future be rolled back, and when it is rolled back we will be able to save lives and have an environment that is conducive to controlling the negative impacts of drug use in an environment where people can seek help. The state will save literally hundreds of millions of dollars that could be turned into helping people rehabilitate and for other services. I thank you for your time.

The CHAIR — Thanks, Greg. We will come back to you with some questions in a moment.

Dr SHERMAN — Thanks for the opportunity to come and talk to you about something that is pretty dear to my heart in that I have been treating heroin addicts, mainly, for over 30 years. There are 15 000 being treated in Victoria on pharmacotherapy — that is, methadone or suboxone — and I treat 1000 of those.

I want to make some practical recommendations, and I submitted them to the committee. The first one that flashes up, of course, is the ice problem. Remember, ice is methamphetamine. The other street name is speed. The difference between the two is that ice is four times the strength of speed, so we are really looking at, say, beer compared with whiskey. Back 25 years ago I ran a program to treat methamphetamine addiction with a drug called dexamphetamine, which is like a cousin to methamphetamine and is used in the treatment of attention deficit disorder in children and adults with great safety. I used that drug to treat people with methamphetamine addiction, and it was highly successful. It was stopped by the state government health department because there was a fear that I might send people psychotic, although these people, of course, had been heavy intravenous speed users for years. Anyway, that program has been used in the UK for decades with success, and I would have thought from a pragmatic point of view we should revisit this to offer treatment immediately for ice-addicted people.

In the program I ran, the tablets were crushed and mixed with orange juice and it was drunk in front of the chemist each day, so diversion was virtually impossible. People stayed on that program for months and weaned down, or they stayed on it, weaned down and went into rehab. So that is the first recommendation I would make, and I believe that in New South Wales there are two programs — two trials — with dexamphetamine. It is something we could do immediately and allow the specialists in addiction medicine to start prescribing immediately.

The second recommendation I make is a very practical one with regards to pharmacotherapy. The commonest reason people drop off the program is money. The federal government supplies methadone and suboxone to pharmacists free of charge, but it is not on the pharmaceutical benefits scheme; therefore the pharmacists charge a fee of between $30 and $40 a week, which is a lot of money for someone on sickness benefits or on the disability support pension or on the dole. People drop off, and what happens? They get back into drugs. They get back into dealing. They get back into crime and prostitution. So my suggestion is that it be put on the pharmaceutical benefits scheme, but better still it should be paid for by this state government.

There is a precedent for this in that if you are under 18 and you are on the pharmacotherapy, the state government will pay the pharmacists the 30 bucks a week. Also if you come out of jail, the state government will pay for the first month or so for your pharmacotherapy at $30 a week. Now the costing I have worked out for 15 000 people for $30 a week is $22 million per year that the state government would have to fork out. However, if we have a look at, say, 250 places in jail, the cost per year to the state government is $30 million. So we have got 15 000 people on treatment for $22 million, or we have got 250 in jail for $30 million. I think there is a strong argument for that free treatment. It is a life-saving treatment, by the way, and the benefits of it have been researched and found since 1965, when that program was begun in America by two psychologists called Dole and Nyswander. The advantages I will tell you in question time if you are interested.

The next matter that I wish to draw your attention to is the fact that we need more doctors in this game, and at present they are an ageing group of grey-headed old people like myself — almost 72.

The CHAIR — Not so much grey hair left either.

Mr DIXON — That was nice!

The CHAIR — I can say that.

Dr SHERMAN — The other major players in Victoria are all getting older — Dr Chikoda and Dr Cooper and the like. Now how do we attract doctors into this field, where we have some people who can act out pretty badly in the waiting room and quite a number who have antisocial personality disorder and even psychosis? I think there should be a new item number arranged whereby these doctors are paid, and that will attract anyone into anything — money. I cannot see any other way to attract doctors, so that would be another recommendation.

The CHAIR — Although I would note that those who are there at the moment are doing it because they see the social benefit or they have the conscience to do so, so they do not all do it for money obviously.

Dr SHERMAN — I agree. I think there is a lot of altruism in the group who treat heroin addicts, but also there are lots of rewards — but that is hard to convince a young doctor of where the patient has a wheelbarrow full of problems as compared with someone with a sore throat. My other quick recommendation is with regards to the obvious ones such as a heroin program, which nearly came off back in Keating's time and was revisited in Howard's time. If you read the chapter in my book called *Drug Addiction in Australia*, you will see where Penington had all of the health ministers throughout Australia agreeing with a heroin trial but then he got a phone call from Mr Howard, who knocked it on the head. Back in 1984 of course we were the leaders in the world with a pragmatic approach that stopped HIV in Australia cold, and that was with methadone programs and with needle exchange. The rest of the world slowly caught up, but since then we have not done much and we have slipped right back as compared with other places. So the last point I wish to make is about prevention.

One-third of my patients, and this group is mainly Caucasian, have had a daily commitment to intoxication from very early teenage years — from 12 or 13. They are intoxicated every day, and this group want heroin. That is their drug of choice, and when that is not available they will use any other sort of drugs, which are often more dangerous. That group often fail treatment up to a point, and that is the group I am saying should be on the heroin program which has been so successful in Switzerland. So it is not everybody. There are lots of other groups of heroin-addicted people who will never use heroin, such as my 80 young Indian men from the Punjab who smoke heroin — like 70 per cent of young men in the Punjab do at the present time — or the 30 per cent of my patients who are Vietnamese. The Vietnamese, of course, are the traffickers and dealers of heroin in Melbourne, so they have got drug availability. There might be a father and two sons. It is there in the community, and where there is drug availability there is an increase in addiction.

My last point is with regards to prevention for that group who make up over a third of my patients, those who have psychiatric problems which can be picked up very early with school psychologists, and I think we should be aiming to have psychologists in every school to pick up all these children who have behavioural issues or who have mental illness, anxiety, depression, obsessive behaviour, bipolar disorder. I have got them all in my clinic. They find self-medication with drugs, and as such they are the group who are daily committed to addiction. Thank you.

The CHAIR — Thank you, John, for the very practical suggestions to put to us. Could I just follow up? You would have heard the comments made by the last people we interviewed, where Gary talked about naltrexone as being an appropriate replacement or encouraged us to look at it as a replacement for methadone or suboxone treatment. I wonder about your comments on naltrexone.

Dr SHERMAN — Twenty-five years ago I ran the first trial of naltrexone in Australia, with the tablet. We had 10 people on the program. One person did well, and the other nine all relapsed after treatment. Indeed the research on naltrexone has shown that the tablet form of treatment has been a failure, and that is why it is not on the national health in Australia. The only success were a group of addicted doctors in America, and if you got a positive urine, you lost your job. The rest has been a disappointment.

It is used, as you know, to help alcoholism. It is on the national health for that, so in relation to the tablet form research for decades now shows it has been a failure. With regards to the implant, it has had a mixed reception throughout Australia. For some reason in the west they seem to do well, whereas in the east it has not worked

out well at all. There are a number of problems. The first thing is the choice of patient, and if you have got those patients with a daily commitment to addiction, you can use all the implants you wish — they are still going to be addicted and will probably get into more trouble.

The product itself has been problematic in that it has given out the naltrexone in different concentrations, so it has not been a 24-hour blockade. Also there has been a problem with infections and allergic reactions to the implant. I agree with the people who spoke over the phone — who I thought were on the phone from the Middle Ages at one stage — that research possibly needs to be done further. The group I think who will do well are those under the age of 23 without a history of psychiatric illness, without a history of criminality, who have not got a drug-using partner, who do not have a psychiatric illness and who are not polydrug users, and that is about 5 to 7 per cent of people with a heroin problem. For that group, yes, I would certainly think that there is a place for implants. For the rest, I think a lot of research has to be done before I would be buying into that, and indeed the patients I have seen go over to Western Australia have come back and relapsed when the product has worn out of their system — but yes, research.

The CHAIR — Good. I will move to others on that.

Mr DIXON — I am a little confused — you were talking about the Middle Ages before. In your statement, John, when you were talking about your patients and your clinic, of those who have got drugs that are more available to them, they have got therefore increased addiction. Am I paraphrasing you correctly there? Is that what you were saying?

Dr SHERMAN — Yes. The more available the drug and the cheaper it is and the higher its concentration, the more addiction you will see. We saw that in the late 1990s in Victoria when there was a switch of traffickers from European to Asian. How do you get into the market? You sell the product at a greater concentration and at a cheaper price, and we saw many more — hundreds of new players as a result of this marketplace pressure, including a lot of schoolkids who came to me. There is also the greater risk of death from overdose. We are having a death a day in Victoria. So yes, drug availability is a big issue.

Mr DIXON — Therefore if drugs are legalised, does that mean that more people will use them? Is that the same argument?

Dr SHERMAN — I think that we have to take each drug one at a time. For instance, if we are talking about heroin, we are looking at a pretty strict program for those who have failed all other treatments —

Mr DIXON — Yes, I understand that.

Dr SHERMAN — where they go to a heroin program and they inject the drug once or twice a day. If we are looking at cannabis, I think it is pretty much a given that it will be legalised for recreational use at some point in the future, as it is in America and in various other countries in Europe.

Mr DIXON — And therefore if it is more available, more will use it?

Dr SHERMAN — It could be. We would have to wait and see. I thought the research from Portugal, where you can have whatever drugs you want — two weeks supply — in your pocket, showed there has been a drop in youth drug use by 50 per cent. That is what I have read. I am not a researcher in this area; it is just what I read in the press. So each drug is individual.

With regard to the ice thing, if you get people on dexamphetamine, you are going to put stress on that market and you might decrease the black market.

Mr CHIPP — Could I buy in just to elaborate a fraction on that point?

The CHAIR — The legalisation as opposed to decriminalisation issue?

Mr CHIPP — Yes. When you say 'legalisation' you mean access — increased access, increased harm. That is the old argument of prohibition that to be perfectly honest is not borne out by the facts, as in Portugal. Colorado might be a better example. I will admit that the facts are out. But when we talk legalisation we are talking with regulation. It is not a blunt sword. You can regulate to limit supply, and alcohol is a classic example here. If we have more bottle shops in a particular area, there is heavier drinking. There are dry areas in

Melbourne — Doncaster and out in the east. Access can be controlled through regulation. It does not have to be controlled through criminalisation, with all of the negative consequences that that criminalisation involves.

California is going through the process, and I am sure in your travels you have come across this. How do we regulate to make these drugs as safe as possible? I will be frank with you. If we legalise cannabis, let us say that there is a small increase in the total number of people using cannabis. But those using cannabis have more access to the dangers. There is an open market where information about the health implications, whether it be lungs or psychological impacts, is available in a free market, and those mechanisms themselves will help to regulate excessive usage. At the moment in a black market all of that market information is hidden, which effectively makes cannabis and other drugs more dangerous, not less.

Ms PATTEN — Just following on from that, the EMCDDA in their 2017 country snapshots actually showed that looking at 18 to 24-years-olds Portugal had a rate of 5.1 per cent of those young who had used cannabis in the last 12 months, as opposed to Sweden, which has got a very different approach to drug use and had 7.3 per cent over the last 12 months. So I think certainly availability with the education, as you say, Greg, has got positive outcomes. John, you mentioned that you have 1000 patients on methadone. Two things: one, how do you manage that many? And two, we heard from Drug Free Australia that methadone does not help, that it does not stop people going back into crime, that it does not stop people from using drugs. I know you are not a researcher so I wonder: with 1000 patients you must have got a lot of anecdotal information there.

Dr SHERMAN — I think, firstly, the research since 1965 suggests strongly that there are five things about methadone programs. There are less deaths from overdose; there is less intravenous drug use, but it is not cessation-less; there is less HIV; there is less criminality; and there is a greater chance of work. That is repeated time and time again in the research, particularly if it is a well-run program and the dose is adequate enough.

As to my 1000 patients, some of them have been on the program with me for 30 years, so I only see them every couple of months. I am not taking any new patients so it will slowly subside. I am getting into my eighties, you know.

Ms PATTEN — And as your patients get into their eighties.

Dr SHERMAN — I work five days a week, just from 10.00 a.m. to 4.00 p.m., and I see a maximum of 40 patients a day, so I can cope.

Mr CHIPP — Can I comment as a recovered addict myself, having been on a methadone program, on the bottom line here? It allows hapless individuals, which I was as an addict or as any addict is, to stabilise a lifestyle and to seek treatment, to withdraw from the need to associate with criminals and the black market and to find money for a daily hit. The benefits to society are enormous in terms of reducing the total use of heroin and the money and the crime required to finance it. That argument translates into HAT — heroin assisted treatment — as well.

Look, guys, this is just a no-brainer, and I use that in the generic American sense. You have got addicts buying and sustaining a heroin market. If they are spending $100 or $500 a day on feeding their habit, dealing to support their habit and using crime, and you can put them into treatment with heroin-assisted treatment, you are snuffing out the black market, about 80 per cent of the demand in the black market. But more importantly there is also a contagious nature of the social circles and drug use, where one heroin addict can influence a peer group. This has been shown in England and other places that have had heroin-assisted treatment. These people are in treatment, and they are seen now not as glorified drug users, counterculture figures, but as poor hapless addicts, which they are.

I guess I am saying that for society with methadone and the extension of that heroin-assisted treatment there are massive benefits. The benefits to the individual, allowing them to stabilise and seek treatment and possibly stay alive, are enormous. John is credited with saving thousands of lives over the years with his treatment of methadone, but it is only one course of treatment.

The thing I will speak to anecdotally as a user of the methadone service is about those fees that John is talking about of $30 a week for an addict. Let us say that you are down on your luck, you are on the dole, you had a good job, you have lost that and you have spent your superannuation money on feeding your heroin habit. Paying $30 a week for the dispensing fee is a lot of money — 10 to 15 per cent. You are probably still smoking

cigarettes; I know you should not, but whatever. Your budget is going to be very limited. So you may miss your methadone dose because of that $30 fee, where if it could be subsidised there would be more people in treatment and being maintained in treatment. And again the societal benefits of that would be enormous, as they would be for the addicts themselves.

Ms SULEYMAN — Thank you for your passionate submission. My question is in relation to the real-time prescription monitoring system. As you are probably aware, the government has introduced this system that will take place in the future. What is your view in relation to the misuse of prescription medication?

Dr SHERMAN — It is a huge problem, and many of my sort of problematic Caucasians would be on prescription drugs — bought on the street often — and sometimes they find a doctor who will do a private script so it does not go through the pharmaceutical benefits scheme, so when we ring the hotline it is not recorded that this patient is a doctor shopper. So there are issues about that. Of course with regard to OxyContin, it is a powerful opiate. We saw the risk of death from overdose rise in America to surpass heroin overdose deaths. Now that OxyContin is presented in a product that is harder to milk and inject we have seen the OxyContin go down and, in America, the heroin go up. That is happening also in Victoria, I believe, although in Victoria we are not seeing an increase in the people going on pharmacotherapy because the new people on the block are using ice. Yes, some changes there would be good, but it is not going to stop the problem. That group who are daily committed to intoxication will be looking at any drug they can get their hands on, but they would be happy with the heroin program. That would stop it cold.

Ms SULEYMAN — I just have one final question. I was just curious in relation to the allowing of home cultivation of up to four plants following the model of the US and Canada. Why four and not, let us say, two — or none?

Mr CHIPP — I actually did the research on that particular point. It is a random figure, but the point being made is that if you are going to legalise cannabis, homegrown needs to be part of the mix. We have got the current pretend cannabis laws being passed in Victoria, which would legalise authorised big pharmaceutical companies to produce extensively a synthetic product or a refined chemical product from the cannabis plant and sell that at enormous cost and profit. If the herb, which is what it is, is going to be legalised for recreation, it needs to be allowed to be grown domestically as well for people who want to use it for medical or for recreational purposes.

Ms SULEYMAN — So how would you monitor — it is very fascinating how —

Mr THOMPSON — Look, if someone has got 10 plants, you know, a massive bloody green, police do a fairly substantial job now of monitoring. Is it going to be a massive area of enforcement? Not necessarily, because you have got to understand you have now eradicated the black market. You probably can go down to a tobacco shop or a smoking shop and buy cannabis, as they can in Colorado, as you people have seen. So it is a question of regulation — sensible regulation. It is just a simple matter. Okay, you are over the odds. There could be an administrative fine or many ways to enforce it, but the difference with this approach of legalisation and regulation — they go hand in hand — is that the market is controlled without sending people to jail.

Dr SHERMAN — If I could just say something on that, I have worked in Footscray for nine years. I am back in St Kilda now, for six months. The street worker who worked with me in Footscray has worked there for over 30 years. I said, 'What is the estimate of the number of people who are growing cannabis?', and he said, 'Without a doubt, 1400'. That is in the Footscray area. So it looks like it has already been growing, pretty much. I cannot grow maidenhair, so I have not tried to do that.

Mr THOMPSON — The notion that the government should be aiming for a drug-free society, I think, is a constructive one and, in a provocative sense, should not be dispatched to the Middle Ages as an objective. I note in provocative terms that Peter Hitchens in his book *The War We Never Fought* took issue with the view that Mill supported individual liberty. The view that the taking of drugs creates no victims and therefore cannot be a crime he strongly challenged. He even noted:

> Some actually assert that the liberty to damage one's own brain and confuse one's senses is a freedom to be defended alongside the freedom of speech and thought.

In deconstructing the arguments in relation to Mill, he noted that Mill conceded that there are limitations to the maxim of leaving people to themselves and that society does have an inherent right to ward off crimes against itself by antecedent precautions. There was dialogue in relation to alcohol.

I just note further, and I quote Hitchens:

> But the most severe effects of all drugs are not public, but private. The family of the drunkard or the drug abuser are often deeply wounded, and are among the … victims of preventable wrong in our society.

The effect on the part of the drug user affects attainment in study and work, and it can lead to a loss of prospects. Drug use can capriciously and unpredictably destroy their lives and the users' mental health, and the more available a drug is, the more addiction it could lead to. So do you have any feedback in relation to the prevalence of drug use in society, the availability of drugs in society and the focus of government in being to develop a drug-free society, as opposed to cultivating its use by expanding access?

Mr CHIPP — A drug-free society — what the hell is that? The United Nations, and with respect, in 1999 had a report of the UNGASS session. The United Nations session on drugs in 1998 had as its primary goal a drug-free world. A drug-free society — I assume if that is an aim, an admirable aim, you would be including in that alcohol, tobacco, coffee and a number of other drugs.

Mr THOMPSON — I would just prefer to focus on those drugs that are currently illicit drugs rather than being a progression towards alcohol and tobacco. We are dealing with the expansion —

Mr CHIPP — But that is a circular argument to try and say that we should free ourselves of illicit drugs, which is an arbitrary category, but not licit drugs. For God's sake, this is what your committee — the essence of what you are inquiring into is, 'Should these illicit drugs remain to be illegal, or are there arguments in terms of the social good where we should bite the bullet and admit that a drug-free world is' — I hate to be rude — 'just a foolish, impossible dream?'. A drug-free world? A drug-free Australia — sorry, an illicit drug-free Australia, apart from the classic circular logic of that statement, is just not possible.

Here is another factor in this prohibition that I think you need to take into account and I hope you will take into account: okay, access and availability may lead to an increase in use, but so does prohibiting a substance. From my own experience, when I was 16 and attracted to the philosophies of John Stuart Mill and was speaking to my father, the minister for customs in charge of drug policy, I just saw the injustice of my friends having police raid a party or have a little bag of cannabis being taken off them. I was interested in morals and the questions of right and wrong. That encouraged me to use drugs and experiment perhaps more than I should. So I say quite clearly: prohibiting drugs can increase demand.

The other fact I just want to leave this with in terms of this crazy drug-free Victoria, free of illicit drugs — we can fix that by one stroke of the legislative pen of course and make them licit. Is the number of arrests that occurs for cannabis itself — I alluded to before that 10 000 of your constituents in Victoria are arrested for cannabis every year. Ten thousand is a big number. What does that mean? It means a line of young people from here to Geelong, 10 000 kilometres — well, probably not quite Geelong. Let us say from here to Frankston, about 10 kilometres, standing as we did in primary school, arm in front of the person in front of us. You people picture this: 10 000 Australians, being Victorians — the number is 80 000 as far as Australia is concerned. Ninety per cent of those 10 000 Victorians, and these are the figures from the Australian Criminal Intelligence Commission — 90 per cent for consumer-only offences.

Those people carry the legacy of that conviction. It limits their ability to travel, to be employed, for the rest of their lives. They have experimented with cannabis, as I daresay the majority of members of the committee have themselves, or if you have not, your children and your family members certainly have. So this idea of a drug-free Victoria as an admirable goal — sorry, an illicit drug-free Victoria as an admirable goal — is a phantom. It does more harm than good, and I would just ask you from the bottom of my heart, having experienced the pleasures of drug use and the despair and the pain of abusing drugs, to really get down to basics. I refer to John Stuart Mill. I know we can argue — there are critiques of his philosophies — but just weigh it up on a balance of harm versus good, criminalisation versus regulation and controlling this market. Is the criminalisation reducing drug use? Is the aim of a drug-free world plausible? Surely you people are smart enough to answer that.

Mr TILLEY — Just in relation to the treatment of amphetamine — methamphetamine, and you made mention of dexamphetamine — how many pharmaceutical companies are producing it?

Dr SHERMAN — Producing what?

Mr TILLEY — Dexamphetamine.

Dr SHERMAN — I think it is just one company. It is a cheap drug for the government to pay for attention deficit disorder.

Mr TILLEY — You are not aware of the one company that is producing dexamphetamine particularly?

Dr SHERMAN — No.

Mr TILLEY — Or under what brand name it comes under?

Dr SHERMAN — I think it is just called dexamphetamine, and there is a long-acting dexamphetamine that is on the market as well which is used for attention deficit called lisdexamfetamine, which I do not know much about.

Mr TILLEY — You were talking about sensible regulation and human nature, so outside the safety of our own homes or out in public. At this stage Victoria has brought in legislation for being affected while in control of a motor vehicle. The state is seeing a significant number of deaths, so how would sensible regulation look? At this stage we cannot quantify impairment, but as legislators — to take the politicians out of it, all of us here around this table are legislators — what sensible legislation or regulation can the state of Victoria bring in to stop people driving a motor vehicle whilst impaired?

Mr CHIPP — It is not hard. There are difficulties in determining the level of impairment and intoxication with cannabis, which is why the current roadside drug test will test for a minute trace of cannabis in the system, sometimes a week-old depending on how much consumption.

Mr TILLEY — I appreciate that. I was one of the state's first drug testers in Victoria Police. I have been around all this and I have seen lots of it, all right? So I do not need convincing on that.

The CHAIR — He wants something better.

Mr TILLEY — Something a bit more technical if I can. What jurisdiction in the world might have a testing regime that actually tests for impairment?

Mr CHIPP — There are tests that can give some indication of the concentration. The trouble with cannabis is it has various reactions depending on metabolism, as does alcohol. It affects different people differently.

Mr TILLEY — We have got standards for alcohol.

Mr CHIPP — Let me say this to you: the assumptions of prohibition are really what need to be rethought here. Talking about cannabis causing schizophrenia again is a misnomer, one of the exaggerated claims and myths of prohibition.

Mr TILLEY — I disagree. I have seen young men climbing up the walls of police jails with psychosis.

Mr CHIPP — But, with respect, that is anecdotal evidence. You have seen somebody who has consumed cannabis that has a mental issue.

Mr TILLEY — Not just somebody, quite a number of young Victorians.

Mr CHIPP — But it is not evidence of a causal relationship. We are going into a different area here. Just to deal with this quickly, this idea that cannabis causes schizophrenia was one of the main arguments for justifying in the latter years the banning of cannabis.

Mr TILLEY — I am not saying that.

Mr CHIPP — The fact is if cannabis did cause schizophrenia, we would know demographically, but since the 1970s while cannabis use has tripled and four or five times increased in Western society, there would have been an increase in schizophrenia diagnosis. That has not occurred. It has flatlined since the 1950s. So it is this idea of causation. All I am talking about is the myth of prohibition. The myth of prohibition here is that people who have had a joint are the same danger on the roads as people who are using alcohol. They are two completely different drugs. And I am not encouraging people to drive.

Mr TILLEY — But we can test for impairment. When you have got somebody in control of a motor vehicle, with all due respect, you can tell impairment because they cannot properly control a motor vehicle.

Mr CHIPP — If they are on alcohol, it is their coordination and there is physical impairment. Cannabis does not do that. It is a perception drug, so it slows down one's perception. There certainly would be driving implications, but the research, the testing needs to be done is the bottom-line answer to your question, and we would need to have a test that was accurately testing impairment. This has been a very live issue, as I am sure you have looked at, in Colorado. The science is increasingly catching up, but I would be the first to say there needs to be some objective yardstick of impairment. I do not know what that is, but it is plausible to look at the science and determine impairment and obviously to limit and stop those people with very heavy penalties if they are impaired and driving and a danger to the community. That is where your John Stuart Mill argument comes in. Driving intoxicated is clearly an element of not a self-regarding action but one that affects the whole society.

Dr SHERMAN — If I can make the point about cannabis — and I used to treat cannabis-dependents until I found that my results were so poor that I got out of the game — it will not cause schizophrenia but it will trigger schizophrenia. If you have got the hereditary genetic make-up to get that illness, like asthma or diabetes, it will trigger it. If you want to find out whether you have got that genetic predisposition, go and smoke cannabis because soon after you will go psychotic.

The CHAIR — That is not a very good way of testing then, is it?

Dr SHERMAN — No.

Mr THOMPSON — It is not a good recommendation for my colleagues either.

Dr SHERMAN — The other thing is if you wish to have treatment and to be brought into remission with psychiatric antipsychotic drugs, they will not work because you will continue to smoke cannabis, which seems to be something about schizophrenia with smoking, with alcohol, with nicotine. So unfortunately it is a tragic state when a young man comes in who is psychotic and then you realise this is going to go on.

Mr TILLEY — And it is not only cannabis. It is pharmaceuticals, impairment with pharmaceuticals or speed.

Mr CHIPP — Yes, the ice.

Mr TILLEY — Absolutely, you know, off their nut. There is no way you could possibly be in control of a motor vehicle — the nystagmus test, all that, walking lines, all that sort of stuff.

Mr CHIPP — Here is John's point: bringing those people into treatment with dexamphetamine — a stable dose and keeping them tethered to a doctor or in support services — makes all the difference. So this is again the decriminalised model that Portugal has instigated. You know, not a free-for-all. Here is the other thing on legalisation —

The CHAIR — We are trying to wind up now.

Mr CHIPP — It is not necessarily a supermarket and buying drugs. It is a controlled, regulated environment with decriminalisation for personal use and possession.

Dr SHERMAN — Can I make one more point? Working in Footscray I could offer methadone or suboxone. Now I am working in St Kilda in a clinic called First Step, which maybe someone might like to visit, because we offer two psychologists, a social worker, two psych nurses, a legal service, two nurses to take blood tests or whatever, a liver specialist, a hepatitis nurse all on site — so what a difference that makes. We are not

just offering pharmacotherapy; we are offering a whole service. What is the point of giving methadone to someone who is homeless or sick? I think that is something also to realise — that treatment must be a package.

Mr TILLEY — Are they on-site?

Dr SHERMAN — All on-site in the one building.

Mr THOMPSON — Dr Sherman, there is a Black Rock family in my constituency whose son is seriously into synthetic cannabis. They have spent thousands of dollars in trying to access private rehab. They have spent much time liaising with government in trying to access services. You noted that you no longer treat cannabis addicts because of great difficulties. Is there any advice I could convey from you to my constituent family who are seriously concerned about the availability of synthetic cannabis and a son who, to use their words, has fried his mind through his dependence upon the drug? What can I advise them?

Dr SHERMAN — It is going to have to be an abstinence program. There is no point in decreasing to get to a non-toxic level. Home detoxification has a success rate of zero, so one would be looking at some inpatient setting, either public or private, and then probably a stint in a rehab. We have only got 200 rehab public beds in Victoria compared with 800 in New South Wales, so he would be on the waiting list. But then again does he want to do this? There is no involuntary treatment in Victoria. These parents would love to have involuntary treatment, but it is not available. He just has to make that decision to go into a drug withdrawal house and then to rehab, maybe for six months. It is going to take six weeks for the marijuana levels to drop down to zero in his bloodstream, so there is six weeks of healing.

Mr CHIPP — This is synthetic cannabis specifically, which is not cannabis of course, and much, much more dangerous. I need to make the point that he would be better off using cannabis, a drug of known effects and which has been used for thousands of years. I am not recommending it, but that would be our solution.

Dr SHERMAN — The lesser of two evils.

The CHAIR — We appreciate the time you have spent with us, Greg and John. It is terrific to have you here, among the others we are listening to today.

Dr SHERMAN — I have left some books there.

The CHAIR — You have left some reading material for us. Thank you very much.

Witnesses withdrew.