T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 8 May 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 John Ryan, chief executive officer, and
Mr Tom Lyons, senior policy and research officer, Penington Institute.

Necessary corrections to be notified to executive officer of committee

Mr HOWARD — Welcome to the first public hearing of the Law Reform, Road and Community Safety Committee inquiry into drug law reform. This being the first public hearing, we did open for submissions a number of months ago, and we have received over 220 submissions. Obviously today is a chance to hear from people who have made submissions that we wish to tease out some of the information from and follow up on. As you are aware, Hansard is here to record today's proceedings. Within a fortnight after today we will send proofs out to you with what was said for you to correct any typographical or factual errors, and then the corrected transcripts will become part of the public record after that. While we usually hold these public hearings in public, there is the opportunity if anybody wishing to present to us believes their evidence should be heard confidentially for us to consider that and to then have a confidential section of the meeting if we agree to that. We welcome observers and trust that anybody who is here has turned their mobile phones to silent.

To the witnesses, Tom and John from the Penington Institute, we welcome you as the first people to speak to us today. We have received a very lengthy submission from you that in the next 45 minutes we will try and tease out, which will be a bit of a challenge given the size of the submission, but obviously there is an opportunity to follow up with you at a later date too if required. Given that we have seen the submission, the opportunity is now here for you to speak to us for perhaps 20 minutes or whatever you think is appropriate to highlight the key issues that you have presented in your submission or other issues that you think are pertinent. Then we as the committee might like to enter into a discussion and ask you some follow-up questions. I do not know who is starting, whether it is John or Tom.

Mr RYAN — I will. Thank you very much for the opportunity to present to you today. It is a very important subject matter that you are looking into. I think it is fair to say that it is something that the community is very concerned about, from a crime perspective but also from a human safety and dignity perspective. The Penington Institute is interested basically in advancing safety and human dignity in relation to drug use issues. Obviously the legal regime is part of that, but so too are the policies and procedures, and in fact our culture is actually part of that. We are very concerned that we have not yet achieved in Australia a sensible approach to the way that we handle drug-use issues. There are increasing numbers of overdose deaths.

Obviously the issue with methamphetamine — ice — in Victoria and the rest of Australia and in fact globally has taken policymakers by surprise; it took many communities by surprise. The harms were are considerable and mostly undocumented, and that is one of the issues that we raise in our submission — that is, that the data in relation to drug use problems is very soft, whether it is at the policing level, at the prison level or in fact at the community level. It is very difficult for the health system to identify when a problem is drug related because of the stigma relating to drugs. Many patients will not actually acknowledge that they are consumers of illicit drugs or are consuming pharmaceutical drugs illicitly. So I think one of the great opportunities that this committee provides is to really put a spotlight on these issues.

I think you will discover as you work through the numerous submissions, including the long ones, that the exact nature of the scale of our drug problem is unknown, but in fact families and communities will be, I am sure, very vocal in pointing out that they do have drug problems in regional and rural Victoria as well as in the city. That is a change that has happened in the last 10 years. We did not have the ice problem in country Victoria 10 years ago. In fact country Victoria had cannabis consumption but not much more in the illicit space, and now it is often the case in small country towns that is easier to procure ice than it is to procure cannabis, a much less dangerous drug.

The volatility of the drug market is something that I think we need to keep in mind. We have seen significant and rapid changes in the drug market over the years from the heroin crisis of the 90s to the ice problems of recent years, and it does suggest that the drug market typically moves more quickly than the government and policy responses. I think the lesson from that is that we need to have a system that is able to adapt and adopt changes in the drug market, so we need an overarching system.

We have had a harm minimisation model in Australia since the mid-80s. It has had bipartisan support. Some people criticise it for going soft on drugs; it does not. The majority of expenditure is still mostly on supply reduction; that is, law enforcement and the courts and prisons. By far the largest part of the expenditure is in that area. At the other end of the scale, the harm reduction sliver of that harm minimisation trilogy, is 2 or 3 per cent of drug expenditure. So we put some money into treatment and prevention, most money into supply control and very little into trying to reduce the harm from ongoing drug use. We hear from some people that that 2 per cent

expenditure signifies an excess of funding. I think that is a fairly ridiculous perspective considering the scale of the problem and the fact that most people become addicted without even knowing the signs of addiction.

So we have a lot more to do in terms of community education and particularly education for people who are experimenting with drug use before they actually become addicted. The tension, I guess, in the community is that we have an expectation that governments can solve this problem, and I think the lesson from the last century is that governments cannot solve this problem on their own. The responsibility must be shared and more equally shared between government and the community. That means an end to the Nancy Reagan 'Just say no' mentality or the war on drugs approach that we have seen in America. America has got an absolutely dreadful drug problem. It had 52 000 overdose deaths in the last year of recording. The chance that we will end up with an increase in opioid use following the American trend is very high. We have seen an increase in the last 10 years in overdoses due to opioids — mostly driven by pharmaceutical opioids, not heroin. So I think the lesson from that is that we need to be much more expecting shared responsibility between government and community, and that actually requires government to let go, I guess, of its own expectation of itself that it can solve the drug problem with an emphasis on law enforcement and supply control — that we do need a balanced approach, that that balanced approach should include a balanced budget allocation between the different pillars of our bipartisan harm minimisation approach and that really to have that shared responsibility we need to be supporting local communities to be facing up to their drug problems.

The stigma in relation to drug use and drug addiction is one of the great barriers for people who are experiencing problems, whether they are family members or individuals with a drug problem. That stigma prevents them from seeking assistance. The stigma also applies to some people in the healthcare profession. There are many excellent healthcare providers, but there is also a significant taboo in relation to drug use issues. So we see a great opportunity, for example, in relation to general practice in small country towns. GPs are pillars of the community. There is a great opportunity in small country towns for GPs to be playing a leading role in relation to drug use issues. They have not traditionally been recognised to be doing that. They could be doing that with the collaboration of local police, the local hospital.

We have developed a model that would actually support such an innovation. It would be an early intervention in relation to drug use issues: catching people before their drug use escalates to become extremely problematic and therefore involving serious criminal offences. But moving that approach to that level of local community is something that would be new for Australia and something that is actually long overdue. There are many excellent GPs that are doing work in this area already that is often unrecognised.

We see a great role for the medical profession and the health profession in relation to drug use issues. That means an end to the bouncing of people with drug use issues between the mental health sector and the drug treatment sector. It means acknowledging that drug use is endemic in our community at the moment. I think the statistic for cannabis consumption in Australia is that more than 40 per cent at least at some time in their life have consumed cannabis. That means that we have basically a disconnect between our legal framework and the way we are behaving as a community. That creates enormous problems in terms of respect for the law, but it also creates enormous problems in the sense that people do not want to acknowledge that consumption and seek help when they need it.

When it comes to the specifics of that drug expenditure and the allocation of resources in relation to drugs, we have never had a national review of expenditure in relation to drug use issues, so we do not know, for example, compared to many other areas of importance to the community, where the Productivity Commission has investigated the best expenditure of taxpayer money on social issues — we have never had a Productivity Commission review, and we have never had any other significant review of expenditure in relation to drugs, so we do not really know how much drug use is costing us economically, and we certainly do not know with any great accuracy how much drug use is costing us socially and within our families.

I would just like to say a couple of quick things about our current legal arrangements and policy arrangements in relation to the needle and syringe program. It has been an absolute triumph — the needle and syringe program — in terms of return on investment. The economic return is $4 to $1. If other economic costs are included, it is $27 to $1, so it has been a terrific success. However, the level of hepatitis C infection in the community of people who inject drugs is still more than 50 per cent.

We still have inadequacies in the law in relation to our needle and syringe program. We do not provide adequate legal protection for people who distribute injecting equipment within their community. That is actually one of

the most effective ways of providing injecting equipment to hard-to-reach, hidden populations. The importance of that is that whilst we have got very low HIV generally in Australia amongst injecting drug users because of the early introduction of the needle and syringe program, we are always vulnerable to quick changes in the drug market — for example, in relation to injecting ice. Unsafe injecting practices and communities that are particularly vulnerable, including Aboriginal and Torres Strait Islander communities, are therefore at risk of an outbreak of HIV. That has happened in Canada in First Nation communities, and we are at risk of that in Australia. One of the barriers to providing adequate access to sterile injecting equipment for people who inject drugs is in fact the ambiguities in the enabling legislation for the needle and syringe program. It has not been changed since it was introduced in the 1980s.

Of course there is a lot of attention around supervised injecting facilities, or consumption rooms, in the media, particularly in relation to Richmond, which has got an intractable, open drug market. The Penington Institute is a supporter of evidenced-based policy in relation to drug use. The evidence around injecting facilities is incontrovertible — they save lives. For us that is a key driver of any drug policy. It should be about saving lives.

We had an American academic visit us as part of the Australian Drugs Conference that we hosted, and she said in her American way, in language that is not appropriate in Australia, 'Dead addicts don't recover'. I think that is absolutely, in a nutshell, what injecting facilities are about. It is about providing not just a place for people to consume their drugs rather than in an alleyway or in a car park or at the back of a school area; it is actually about providing access to healthcare providers who can assist those people on their recovery journey back into the mainstream community. We do not do nearly enough for those extremely vulnerable people who are injecting in public. Most injecting happens in people's lounge rooms, but for some people their lounge room actually becomes the street. It is disturbing for other members of the community, but it is particularly dehumanising for those people who are in that situation; in which case, we support consumption rooms, properly supervised, and see them as an opportunity not just for Richmond but actually for other areas where there is street-based drug use.

In relation to one of the great triumphs of medical interventions in relation to addiction — the pharmacotherapy program — opioid substitution treatment is gold-class treatment internationally recognised on the WHO's essential medicines list. Unfortunately in Australia, due to a very unfortunate classification, opioid substitution treatment, as evidenced based as it is, is the most expensive treatment available for people. It is cheaper to be on illegally prescribed pharmaceuticals than it is to be on medically assisted treatment. People who access methadone or buprenorphine, protective of their health, preventative of blood-borne viruses and preventative of overdose, are expected to pay $5, $7 or $10 a day in dispensing fees to pharmacists. That is a cost barrier on people who are socio-economically disadvantaged to begin with. That generates an enormous amount of grief for those people who are trying to get on top of their drug addiction. It also generates an enormous amount of churn in and out of the treatment system. So we see people dropping out of treatment because they cannot afford their dispensing fees, going back to the illicit consumption of drugs because it is actually cheaper to hoodwink GPs and others into accessing those pharmaceuticals than it is to be on medically supervised treatment. That is an anomaly that has traditionally been left as a state versus Australian government problem, but in my mind if we are going to take responsibility for drug issues, one of the great opportunities is actually to address the dispensing fees at pharmacy for people who are addicted to opioids seeking medically assisted treatment but unable to do so because of the prohibitive fees. That is an opportunity that the state government could step up to in relation to subsidising that medication.

The other great challenge, I guess, in this area is assuring the community that prison is an appropriate place for people who have committed offences, but it is a missed opportunity in terms of providing rehabilitation. It is a difficult environment for rehabilitation, but if we continue to just warehouse people that are often extremely vulnerable socio-economically, often have co-occurring mental health and drug addiction issues — warehousing them in prisons and then letting them back into the community often more traumatised than when they went to prison — we are going to continue to fail to address: the crime problem related to drug use; and those people's lives in relation to whether or not they would ever be able to flourish in the community having being dependent on drugs and committing crimes typically to finance their drug addiction.

The challenge, to my mind, for those that operate the prison system is to exploit opportunities for diversion that are effective; that is, to be more interventionist in relation to those people who have committed offences — to intervene earlier in that regard — but also to provide much better access to rehabilitation and transition back into the community for those that do end up going to prison.

We can actually get on top of these problems; we have failed to do so thus far, but I think the community is far ahead of where we were 10 years ago, which is to say that most people know someone that has been personally affected by drug use in their family network, most people know that it is a combination of vulnerabilities — especially including mental health vulnerabilities — and most people want us to do more to solve this problem.

The CHAIR — Is Tom adding anything at the moment or just as questions come along?

Mr LYONS — Yes.

The CHAIR — Thank you, John, for that pretty thorough overview of your submission and of the issues. Clearly with an inquiry such as this there are such a broad range of areas that come into the issue of trying to support or deal with people who are on drugs and how they get onto drugs. In terms of the range of recommendations that you have just discussed, if the state government — in our case we are looking at advising the state — has an additional bucket of money to put into drug reform or better treatment in the area of drugs, where might your priorities lie?

Mr RYAN — To my mind the disconnect between the scale of the problem — that is, that it is endemic in our suburbs; it is endemic now in our regional and rural towns — and the way that we fund the response suggests that the biggest opportunity is to actually invest in a health approach. The police have said that we cannot arrest our way out of this problem; they have said it repeatedly. I think that that suggests that it is time that the health sector actually stepped up to start better managing this issue. That actually takes funding. It takes significant practice change at the health system level. It means at emergency departments better responses to identifying people with drug use issues and better linkages to drug treatment. It means at the GP-primary care level nurses that can support GPs in private practice to better manage drug use. I think it absolutely means addressing the terrible anomaly of dispensing fees for medication-assisted treatment, and it actually requires, I think, a much more proactive approach to reaching out to people who are currently using.

We have tried to get funding from government in relation to ice use to do community education for people who are currently using ice. We were unsuccessful. We were very fortunate to have the support of the Lord Mayor's Charitable Fund and the William Buckland Foundation to develop a digital resource to actually reach out to current ice users. There was nothing that spoke to people who currently use drugs in language that they would understand and being respectful of the fact that they are actually using but providing alarm bell opportunities for the risks that they are taking, but also being respectful of the fact that they are actually using and that they need help to understand the risk that they are taking.

We do not do nearly enough fair and factual information outreach to people who are currently using drugs. That is a great failure, and it means that many people become addicted not actually knowing the signs of addiction and not actually knowing the risks that they are taking and that even with one use of a drug you can obviously have fatal consequences. But basically we are stuck in this idea that it is either a law enforcement or a treatment approach, and we do not do anything in that sliver of space called harm reduction, which is about improving community understanding and capacity to manage drug use issues.

Ms PATTEN — Thanks very much, and thanks for a really substantial submission that was great and, I think, recognised the broad scope of the terms of reference, which was wonderful. I have actually got some more specific questions. You raised the issue around our drug use data and that it is really hard to actually know the level of drug use in our community. Most of it, I think you noted, was self-reporting, so it is the household drug surveys and it is the ecstasy one. What would a better collection of data look like? How could we do that?

Mr RYAN — We introduced wastewater analysis to Victoria a few years ago in relation to the ice problem because we were being told that there is no ice problem. The wastewater analysis debunked that myth. Now the Australian government is funding that, but I do not think it is being done at the scale that it could be done. More regional and rural towns for sure should be included in that. There are not enough sites. There needs to be a much more concerted effort, I think, which requires significant money. It just actually requires scaling up. We are always going to be relying on self-reports for drug use. I think that is fine, but we could be doing it more frequently and more broadly.

When it comes to the health system and the criminal justice system, there is drug use monitoring of police detainees that happens occasionally in a couple of sites. We could actually ramp that up considerably. We do

not know adequately how many people in the criminal justice system are there for crimes driven by drug use related offending, so asking the question — —

Ms PATTEN — How do we not know that?

Mr RYAN — Because we do not adequately ask the questions.

Ms PATTEN — But that would not cost much to ask that question, would it?

Mr RYAN — No, it would not, but you have got to ask it sensitively. There is some complexity to it. But being more transparent about drug use, I think, is an easy win, and the same thing goes for the hospital system. We could be much more accurately recording drug use as long as we dealt with people's fear and anxiety around the stigma that results from self-disclosure.

Mr THOMPSON — One question, just to clarify: your understanding is that there is over a 50 per cent re-use of syringes currently in Victoria.

Mr RYAN — No, my comment, I hope, was that the prevalence of people with hepatitis C is over 50 per cent amongst injecting drug users in Victoria. In Victoria, off the top of my head, about 18 per cent in the last month have used somebody else's needle. It is about 18 per cent. The reason I mentioned Aboriginal and Torres Strait Islanders is that if you look at their data specifically, the sharing rates are actually higher, in which case they are much more vulnerable to infection with hepatitis C and HIV.

Mr THOMPSON — Thank you. The inquiry's terms of reference require the committee to examine drug law reform from other jurisdictions, including overseas jurisdictions. What are some of the significant practices of other jurisdictions that the committee should consider?

Mr RYAN — I hate to say it, but I think we have got a lot to learn from America. I have got a love-hate relationship with America.

The CHAIR — It is a big place. Which part?

Mr RYAN — Exactly. It is many, many countries. Texas, for example, has changed its approach to incarceration. Obviously the American war on drugs was much more extreme than our war on drugs in Australia. Their incarceration was extraordinary and was sending them broke, basically. The Republicans have driven a group called Right on Crime. That is actually all about decarceration, and I think we have a lot to learn from the Americans in that regard. Rather than repeating their mistakes of forever increasing incarceration, they have actually gone through that cycle. They are coming out the end of it. It is Republican-driven, and what they are interested in doing is actually rehabilitating people, hopefully and preferably in the community so that they do not end up with these extraordinary bills for taxpayers, which is the more expensive incarceration cost, and what it does to treat people in the community. I think that is one of the great lessons of the last 10 years. I think Right on Crime is an extraordinary organisation, supported by members of the Bush family and George Schultz and all sorts of high-profile Republicans.

Mr THOMPSON — You have used the name Right on Crime. Is that the name of the program?

Mr RYAN — Yes. The advocacy organisation that has been driving it is Republican-based and it is called Right on Crime, but it is actually the Texas government and others that have taken on the Right on Crime agenda, which is about smarter, more cost-effective ways of dealing with crime driven by addiction issues.

Obviously the Portuguese model gets a lot of attention in Australia. I think it is very interesting, and it is actually much more complex than it is purported to be in Australia. Decriminalising drugs is not a simple solution. The fact that pharmaceutical misuse is such a growing problem suggests that it is not just a matter of the laws that will solve our drug problem; it is actually the laws, the policies, the culture and the way that we approach drugs. But the most important lesson, I think, from the Portuguese approach has been that they have significantly invested in therapeutic interventions for people who are detected as using drugs. So their therapeutic interventions include the traditional needle exchange-methadone pharmacotherapy services, but also an emphasis on wraparound services dealing with people's employment, their housing and their psychosocial skills. That is actually a great lesson for us. We do not do nearly enough psychosocial education of people who are currently using, particularly in the extreme consumption pattern of injecting drug use that suggests

significant risks in relation to drug use. We do very little psychosocial education for those people compared to what we should be doing.

Mr TILLEY — In the early part of your contribution you made mention of early intervention. If you can, can you just direct me to exactly which part of the submission refers to those sections?

Mr LYONS — Sure. So we are talking about towards the end, starting at page 48 going through to the top of 52.

Mr TILLEY — I will just have to pay a little bit more attention to those specific sections. Thanks for that, Tom. I will quickly go back to my notes here. You referred in your contribution to and were talking about injecting rooms and consumption rooms. If we are talking specifically about illicit drugs coming off the streets, so they are cut, they are filthy; how would you ensure in that program, with consumption rooms or injecting rooms or whatever label you want to put on them, that as it is ingested it is not cut with the filthy stuff that comes off the street?

Mr RYAN — You cannot guarantee that what is consumed is not filthy. That is the nature of the illicit drug market.

Mr TILLEY — Why can't the cut be not filthy — the stuff that it is cut with?

Mr RYAN — Exactly, so you do not know what you are getting, basically. That is the gamble that people are willing to take, which is that they buy drugs from the illicit market and they do not actually know what is in it.

One of the reasons that ice use caused so much trouble is that the purity went from 20 to 80 per cent, and the end consumer does not know what the purity is when they buy it. One of the risks with opioid overdose is changes in the purity of the drug. So in an illicit drug market you can never guarantee what is going to be consumed.

However, the opportunity in a consumption room is that health staff are there on hand to intervene in an emergency. That is much better than leaving somebody in an alleyway to die on their own in the gutter. So there is an opportunity to save somebody's life, and once you have built that relationship with them, knowing that that is where they are at in their life, that they are willing to take those risks, then there is the opportunity to actually talk to them about what sort of dream they do have for their life, what sorts of opportunities they would like to pursue, whether it is to access secure housing, whether it is to rehabilitate their relationship with their family or — most often — whether it is to actually control their drug addiction, to better manage their drug use. They are the opportunities that a consumption room provides that are just as important, I think, as the supervised ingestion; it is actually about providing an opportunity to deal with people's complex health and social issues and a pathway for them away from that extremely vulnerable and dangerous lifestyle.

Mr TILLEY — Sure. So on a public policy level, in regard to this committee's findings and recommendations, you speak of sensitivities of people's use, consumption and those types of things, and significant amounts and parts of public policy are about abrogating and apportioning risk, so when we talk about the sensitivities of people ingesting whatever type of drug, whether it be illicit or pharm or whatever the case may be, what sort of data gathering would you anticipate or could expect that a consumption room might be able to get together? Would you agree that you did say the datasets are fairly soft historically, and where can we pick up on that?

Mr RYAN — The police actually collect a fair bit of drugs from the street and can accurately identify what drugs are out there, what they are mixed with et cetera. But the opportunity, to my mind, with a consumption room is to collect better data in relation to the psychosocial issues of those individuals and the more effective ways of intervening.

That to my mind is the great opportunity of an injecting facility. One, it provides a supervised place for people to consume dangerous illicit drugs — no doubt about it — preventing, therefore, fatal overdoses particularly, and also preventing bloodborne virus transmission and lots of other related harms. But the biggest opportunity of an injecting facility after that I think is around pathways to care, pathways to treatment and pathways to a different lifestyle.

There are stories from the Sydney medically supervised injecting facility of people who were there who thought that they were worthless, who thought that no-one cared about them, who met a nurse who did actually care about them, who met that nurse again and again as they visited the service again and again, and then three or four years later wrote a letter back saying, 'I'm now reconciled with my family. I've moved back to Dubbo' — or wherever they came from — 'and I just want to thank you because at the lowest point in my life you cared about me'. You cannot put a price on that. That is about saving lives.

Ms SULEYMAN — I have a quick question. I think you have effectively discussed the effective prevention and early intervention, and in your submission you have stated that efforts to date have not worked equally well for all groups in relation to prevention. Can you elaborate on particularly the GP-led model of early intervention and the pilot project being developed in Mansfield?

Mr RYAN — The problem is that we have thought of drug use traditionally as an inner city problem when in actual fact it was throughout suburbia, and then it changed and it became a country problem as well. What has not happened is that we have not adequately changed our system to reflect the changes in the drug market. So, for example, in small country towns there is generally no access to dedicated expertise in relation to drug treatment. People have got to go out of their local community, often very long distances, if they want to participate in a drug treatment program. We saw the need, listening to local communities as we travelled throughout the state, that GPs were in a pivotal position and were actually dealing with families talking about drug use within their family and also individuals talking about their own drug use with the GP.

Also police in those towns were aware of the diversion opportunities that currently exist but did not see them as necessarily adequate to deal with that person's problem. So you have an enormous opportunity in a small country town, where everyone knows everyone and everyone knows everyone's business, to be actually more proactively engaging in drug use issues. That means that GPs, in our view, are a pivotal component but would be working in collaboration with a nursing support and other social supports and also with the police, so that if there is somebody who is developing a drug problem, whether that is through disclosure with the GP or whether that is through disclosure to police, there is actually a referral pathway within the town to manage their drug use issues from a health perspective. So it is the GP working in collaboration with allied health, who would then be providing the intervention for that person. It is an opportunity, therefore, to intervene earlier in somebody's drug use trajectory.

Obviously most people who use drugs do not become addicted, but for those who do become addicted their problems become extremely severe and so we see this as a crucial missing link in the way that we deal with drug use problems. We generally have a 'Prevention first; don't use drugs' approach, and then we deal with people when they are extremely addicted and come to the attention of law enforcement. In between those two extremes there needs to be much more effort. That early intervention through the health system is a great opportunity.

Ms SULEYMAN — I understand the GPs, but what about the ones who are not in contact with GPs and are not part of that link? Where is the early intervention for those types of people?

Mr RYAN — There are lots of different opportunities for early intervention, whether it is through workplaces and work colleagues talking openly about drug use issues and talking with their colleagues about their drug use, whether it is through sporting clubs et cetera. So there is lots of social infrastructure where drug use issues should be spoken about more honestly and openly, providing the opportunity for people to call out escalating drug problems.

Our tendency culturally is to look the other way when we see that somebody's drug use is escalating, partly because of fear and partly because we do not actually as a community adequately understand the signs of a growing drug problem. That is why that community education is so important to understand better addiction, to understand better the signs of addiction, and also why that destigmatisation is so important that we need to talk about these issues in a similar way that we have had a journey as a community in relation to mental health issues.

There are very few people with drug addiction issues who are willing to speak publicly about their personal story compared to the number of people who have got personal stories. It is highly taboo, and breaking that taboo is very important in terms of early intervention because it means that, A, we have got a more honest approach to drug use problems but, B, that honesty prevents people from successfully hiding their drug use

because they can be called out for it. So there are many points where drug use problems can actually be identified and addressed, but the key pivot, I think, in a local community, in a small country town community, is actually GP-led care.

Mr DIXON — I have a couple of points. I was blown away by the fact that the data is soft, and I think: how do you solve the problem if you do not know what the problem is and the extent of it? So I think that is a massive issue we have got to deal with. Then Natalie asked about the GPs. People are out of the system, and I can understand now it is the context of the whole countryside and community.

I am learning all the titles and jargon. You talk about the dispensing fees and those who take that medical, pharmaceutical sort of option; what percentage of users? Is that a very small group of users, or is it a growing group of users that take that option and is affected by those dispensing and associated fees?

Mr RYAN — The numbers off the top of my head in Victoria of people who are on opioid substitution treatment is about 15 000, just less than 15 000. The number of people who are registered to participate in the program is about 22 000 or 23 000, which means that there is a big gap between those that are currently being dosed — being medicated — and those that are entitled to be medicated. Some of those entitled might have become abstinent and ceased treatment for that reason, but we do not know because the data is too soft. It is likely that the churn in the system is that they have dropped out of drug treatment and back into illegal drug use. That pharmacotherapy system is an enormous opportunity for much more rigorous data, because we just do not know where that 7000-odd are. But that is the scale of the problem, and I think that is a very big problem.

Mr DIXON — I had no idea it was that big, so thank you for that.

The CHAIR — Fiona does have another burning question.

Ms PATTEN — I think it is an overall question, and I have lots of questions. But it was a really fulsome report. Looking at that Bureau of Crime Statistics and Research — the New South Wales research — it says that:

> The authors concluded there was 'little in our results that would support increased investment in supply control policy as a means of reducing drug consumption …

So what they are saying is that despite all the work we are doing in seizing drugs, we are not reducing drug consumption. I guess that leads me to the question: why? Why is that not working?

Mr LYONS — Yes. I think that study tries to test whether when we seize more drugs that indicates that we are reducing the supply. But all kinds of indicators — price, purity and availability — suggest that we are not, and that actually the more you seize the indication is the more is being consumed. So it is an indication of increased demand rather than a reduction. As to why, I suppose early intervention and educational approaches that do try to address demand and try to educate people early about how they can not get into those problems and consume large amounts of drugs further down the track I guess would be the answer.

Mr RYAN — It is amazing how ingenious drug traffickers are, and they are ingenious because the profit incentive is so high. The cost of cocaine in Columbia or ice in China is absolutely minute compared to what end users are willing to pay here. So every time the police or border control figure out a way to detect shipments, the drug traffickers just change their technique. So it is a continual catch-up game. The real opportunity is actually to flip our approach I think and to actually concentrate on demand.

In terms of the social costs of drug use, the biggest costs are not the occasional user or whatever. Many people will try ecstasy once a twice in their life or cocaine once or twice in their life or cannabis once or twice. They are not our biggest problem. Our biggest problem is those people who end up in addiction. Obviously they start with something, but they never plan to get into addiction. So just as with gambling or other social problems, the biggest contributor to the problem at large in our community is actually those people who are highly dependent. So the drug traffickers will manage to outfox police. They always get caught sooner or later via an old technique, and then they will switch to a new technique. What we have not done is actually try and drive down the demand of those people who are addicted, but we incentivise those drug traffickers to innovate their importation methodologies.

As an island nation we will never be able to afford a border control regime that actually eliminates the importation of drugs. It is just impossible because of global trade and the amount of commerce, imports, that we have coming in for other matters. But if we did actually manage to control our borders perfectly well, drug production would shift to domestic production and we would still be having the problem, which is that the drug market is actually being driven by people who are addicted. So we have got to concentrate on reducing the chance of people becoming addicted, and when they are addicted we have got to get them out of their addiction. That is the solution.

Mr LYONS — Just to add to that I do think that one of the big changes over the last 10 years or so is that all drugs have become more potent, so they are purer — it is more bang for your buck, if you like — so in terms of smuggling them, getting them through borders, they are more easily concealed —

Ms PATTEN — It is reducing the size.

Mr LYONS — Yes. So the profits are extremely wide, and that is only becoming more so, whether it is ice or synthetic opioids replacing heroin or novel psychoactive substances which are potent at incredibly minuscule doses. So the law enforcement challenge is only becoming more difficult.

The CHAIR — John and Tom, they have put me here so I can see the clock up there, so I am aware that we have already exceeded the time, although I am sure we have more questions that we would have liked to have asked. There might be an opportunity further down the track to perhaps invite you back or perhaps other witnesses might be able to assist us with some of the other questions that we still have. Thank you very much for your very detailed submission and for your time today. As I said, you will get the transcript of the discussion in a couple of weeks, and then we will be able to follow up later.

Mr RYAN — Thank you very much.

Witnesses withdrew.