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MR D. HOWARD SC, Commissioner

SYDNEY ROUNDTABLE ON DECRIMINALISATION

SYDNEY

10.03 AM, THURSDAY, 18 SEPTEMBER 2019

Continued from 16.9.19

DAY 34

MS S. DOWLING SC appears as counsel assisting the Commission
MS J. HEWETT, facilitator

FULL PARTICIPANT LIST TO BE FOUND AT END OF TRANSCRIPT

THE COMMISSIONER: All right. Well, I think everyone is here. So, I can indicate that we're going to have a public hearing today of the Special Commission Inquiring into the Drug Crystal Methamphetamine. And we have today a number of very distinguished persons who have very kindly offered up their time today. And I would perhaps just like to indicate to the IT people that we're ready for the live stream. So, first of all, can I welcome you all to this very important discussion on the pros and cons, I suppose we would call it, of decriminalisation.

I would, firstly, like to acknowledge the traditional owners of the land, the Gadigal people of the Eora Nation and also their Elders past, present and emerging. And could I just also indicate that I do have an apology from Dr Elizabeth McEntyre, a Worimi and Wonnarua woman who is a mental health social worker, and she's also the Aboriginal Official Visitor to New South Wales prisons and a member of the New South Wales Mental Health Review Tribunal. Very sadly, she rang in unwell today. And I am very sorry that she can't be here today. And – now, I have a list of matters in my terms of reference for this Special Commission of Inquiry.

And, briefly, the first is to inquire into the nature, prevalence and impact of crystal methamphetamine, commonly known as ice, and other illicit amphetamine-type stimulants. So, the whole range of amphetamines, from MDMA and other amphetamine-type stimulants to ice or crystal methamphetamine. I'm also to look into the adequacy of existing measures to target ice and illicit ATSs, amphetamine-type stimulants, in New South Wales, and also to strengthen New South Wales's response to ice and illicit amphetamine-type stimulants, including law enforcement, education, treatment and rehabilitation.

Now, decriminalisation is an issue that we felt it was very important to look at, particularly given that it touches on so many of those issues that I've just raised. Some decriminalisation programs have an emphasis on treatment and bringing people into health and treatment alternatives. It also is relevant in the context of law enforcement, whether we're doing that the right way, whether we should be changing that, and also to existing measures to target ice and illicit amphetamine-type stimulants. Within the last few months, the United Nations Chief Executives Board, which is the board for chief executives of the many agencies within the United Nations, issued a communique which was supportive of decriminalising the use and possession of illicit drugs. That's a very recent development that is one – it's appropriate that we are aware of and take note of.

Much academic literature has been written on this subject, and I can say that this Inquiry has received many submissions in response to the issues papers that we prepared some months ago from many stakeholders, which largely – or many of them certainly – seem to support the notion of decriminalisation for a variety of reasons that they refer to in their submissions.

There is also the issue of stigma that is a major issue in the entire question of how as a state we should be approaching the issue of illicit drug use. Decriminalisation

plays into that whole issue of perhaps lessening the stigma that surrounds those who use drugs to the extent that they are, because of criminalisation, concerned about coming forward to help their drug addiction or issues treated. They're afraid of coming forward for other reasons, such as fear of having children removed from their care. And a large question which is relevant to this whole issue of decriminalisation is whether it would be a positive way of reducing those aspects of stigma that are causing perhaps a worsening of the problem of illicit drugs in New South Wales.

So, with those introductory remarks, I'm very delighted that we have Jennifer Hewett here today, who is a very seasoned professional as you will all find out by the way she will be facilitating this roundtable hearing. And I've asked Jennifer to take that role so that I can perhaps take a slightly one step backward role and listen in and also ask questions of my own while she very carefully steers us through the agenda that we have today. So, firstly, can I thank you, Jennifer, for being here. We're very grateful for your expertise. And, that said, I hand the meeting over to you.

MS HEWETT: All right. Well, thank you, Commissioner, and welcome to everybody. It's – my name is Jennifer Hewett. I work for the Australian Financial Review as a columnist specialising in politics and business. This is, obviously – the ability to have a look at this round table is one of the, you know, huge issues I think, obviously, affecting all of our societies in the west, but also in New South Wales and how we deal with this.

So, it's great to have everybody at this round table to discuss this over a period of time, a period of a day. And what we're going to start by doing, I think, is going to have all of you go around and give opening statements. Now, we know that the roundtable is open to the public, but it's also being live streamed on the website. And an audio recording is also being made of the discussions and a transcript will be prepared and placed on the website. And there will also be some coverage by the media.

So, as the Commissioner said, the purpose of this roundtable is to focus on whether New South Wales should respond to the problem of crystal methamphetamine and other amphetamine-type stimulants by de-penalising or decriminalising the use and possession of those substance, and also to discuss what model of depenalisation or decriminalisation should be implemented. So, you've, obviously, got a briefing pack in advance of this round table, including the discussion paper, topics and questions to be discussed, other reference material. So, for the public, that pack is also available on the inquiry's website. We're going to go through each of the topics that the Commissioner has outlined in a methodical way.

Now, the first session concerns whether New South Wales should depenalise or decriminalise the use and possession for personal use of crystal methamphetamine and other amphetamine-type stimulants, which from now I will now refer to ATS by the acronym. Otherwise, I'm going to get myself tongue-tied all day. And that's going to involve, obviously, a discussion of the strengths and weaknesses of the current framework and existing schemes and a discussion about the strengths and

weaknesses of depenalisation and decriminalisation generally. And that will also include reference to the experience in other jurisdictions.

We're going to break for lunch, and then the second session of the round table we will discuss in more detail what depenalisation or decriminalisation might look like, including whether criminal sanctions should be removed, what should take the place of criminal sanctions, if they are to be removed or otherwise not enforced, and whether depenalisation and decriminalisation are consistent with international law. My role as facilitator is to guide us through this discussion. Obviously, we want to have an open discussion as much as possible about this.

So – but I would also – particularly in terms of the public discussion, I think it's important for many members of the public to realise that the terms "depenalisation" and "decriminalisation" do kind of get confused a little and often used interchangeably when they're not really. And, as I understand it now, depenalisation retains the use or possession as a – of illicit drugs as a criminal offence, but it introduces a mix of civil administrative measures to deal with it. But the difference is that it gives the police relatively wide discretion whether to charge a person or impose a civil penalty, as opposed to depenalisation – sorry – decriminalisation, removing it as a criminal offence, so it, really, becomes a civil or administrative offence not exactly akin to parking offences, but similar.

So, for that I would now like to ask participants in the round table to introduce themselves and to provide some opening remarks before we go to a general discussion. And I would – I know anybody who is speaking, I'd ask them to repeat their name and experience for the benefit of the transcription service.

Now, Geoff Gallop is an empty chair here. He is unable to attend this morning, but he'll be joining us for the afternoon session. So, I will introduce him in his absence. He is – Professor Gallop was a Premier of Western Australia from 2001 to 2006, and he's director – and then director of the Sydney University Graduate School of Government 2015. He is chair of the New Democracy Foundation's research committee and a member of the Global Commission on Drug Policy based in Geneva. So, Mr Gallop will – Professor Gallop will give his opening remarks when he arrives this afternoon. Now, so what I would like to do now, though, is to ask everyone around the table, starting with my left, and Caitlin Hughes, Associate Professor of the Centre for Crime Policy and Research at Flinders University, to start with her opening remarks. Thank you, Caitlin.

PROF HUGHES: So, thank you very much. My name is Caitlin Hughes, and I'm an Associate Professor of criminology and drug policy at Flinders University, also visiting fellow at the National Drug and Alcohol Research Centre, and Vice President of the International Society for the Study of Drug Policy. So, my background very much is a drug policy researcher. I've been in the field for over 17 years now. I'm also the lead author of the Irish Review on Alternatives to Arrest that has been put into the briefing pack, as well as a number of other reports.

So, I think what's important to note is that, looking across the world, we can see, we're at a time of considerable change in relation to drug policy. A lot of debate about the issues that we're raising here today, looking at the use and possession of illicit drugs.

This is spurred in part by the evidence that, in spite of best intentions, criminalisation of simple possession leads to considerable economic, health and social harms, that often far outweigh the harms from the use of drugs themselves, as well as the wealth of knowledge that has been borne from the more than 30 countries that have adopted alternatives to arrest for simple use or possession offences.

But, I think, another key motivator, as noted by the Commissioner, is the recent statement at the UN that has called on all member states to promote alternatives to conviction and punishment in appropriate cases, including by decriminalisation. And this, I think, really sets the scene for today.

But before we begin, I think it's also important to recognise the huge wealth of knowledge and experience that has been borne within Australia. So I've just returned from Norway, from their decriminalisation deliberations, and many people commented on how lucky we are, in Australia, to have had a federated system, with so many different policy experiments going on, different states and territories, different types of responses, both to the use and possession of cannabis, as well as use and possession of other illicit drugs.

And I think this is really true, because the reality is, there's a lot of challenges with the language, but whether you call it "diversion" or "depenalisation", Australia has amassed a huge amount of knowledge about the benefits, as well as, in some cases, the challenges or potential side effects of alternatives to arrest. And we've seen the emergence of a remarkable consensus, really, across Australia.

Nowhere was this more evident than in a recent national review that I conducted with Alison Ritter and Kate Seear and Lorraine Mazerolle, for the Commonwealth Department of Health, where we assessed the reach of our current drug diversion responses in relation to use and possession offences, and then consulted police and health and non-government stakeholders. And we found, very much, all the stakeholders were in agreement that in Australia, we need to be expanding the use of alternatives to arrest for use and possession offences.

The key question is how. And our work, particularly for the Irish government, has shown, there are many models, as was noted by the Commissioner, whether using civil penalties, or treatment responses, hybrid responses, whether you're targeting different types of drugs. All of that, I think, will be gotten into later today. And each of these has advantages and disadvantages.

But, I think, one of the key opening lessons that we learnt from our review is that there's no evidence that any alternative significantly increases the use of drugs in society.

Another key thing that we have learnt is that how you operationalise models really does matter. And so that's things like whether you use threshold quantities, where you set those threshold quantities. That all matters on the ground. And so that's why I'm delighted to be here today, to take part in this important deliberation.

And finally, just I'd like to close on two quick clarifications from the briefing material, as well. I'm asked to raise any clarifications. So, Portugal was not the first country to decriminalise low-level drug use. The Czech Republic actually did this in 1990, and some other countries, like Spain, have never criminalised the use and possession of drugs in the first place. It's also noted in the briefing statement that no Australian states criminalise use of drugs themselves, but the reality is that seven states and territories, that is, all states and territories except in Queensland, criminalise the use itself. I've got copies of the law for anyone who's interested. Thank you very much.

THE COMMISSIONER: Thank you.

MS HEWETT: Thank you. And now I would like to call on Andrew Scipione, former Commissioner of New South Wales Police.

MR SCIPIONE: Yes, thank you, Jennifer. Andrew Scipione, 37 years with the New South Wales Police Force, the last 10 serving as the 21st Commissioner in the history of the organisation. My time and my contribution today will be formed around – based around my experience, clearly. That's why I'm here.

In 37 years, I've seen drug trends come and go, and certainly I've seen them impact, not only on those that would be consuming the drugs, but those supplying the drugs, those that are living in families where drug use is a problem, right through to communities that are just trying to get on with their business and that have been the subject of horrible crimes. So, my view is going to be very law-enforcement-centric, as you would expect, Commissioner.

But I think it's important that a person like myself has a view around this table, because you need to hear it from the other side. Much of what I will take away from this day will be the wealth of experience that comes from research; it comes from policy consideration; it will come from dealing with matters related to the use of ice in courts, and through tribunals. But no one else will bring a law enforcement perspective from the – through the eyes of a police officer. And I would extend that through into – from – from, also, the views of an ambulance officer, from those that are out on the ground dealing with this first-hand.

You can't go anywhere and talk to anyone that is working in this area and not have them express some concern over the use, misuse and the abuse of ice in today's society. So much so that on walking into the room today, and talking to Jennifer, she relates a story of a young man she knows who has just joined the police force, who is working in western Sydney, and says, the vast majority of domestic violence cases that he attends, ice is a factor. And – and when I hear that story, it makes me

shudder, because domestic violence, when I was a young officer, was very different to the domestic violence situations we find ourselves dealing with now.

Now, I'm retired; I've been out two years. Things could well have changed even more so. But I can assure you that when I finished as Commissioner, we were seeing horrific crimes, that would – that would bring us to the point where we would be almost saying, "Well, if we don't do something soon, this is going to overcome us," particularly around some of the damage that was being done to family members, where the level of violence was extreme, where people weren't being assaulted by a physical punch; they were being stabbed, or shot, or run over, or set on fire.

And then there was the officers that had to engage and deal with those situations; the ambulance officers, that were simply there trying to support and help people that were in times of crisis. The mental health impacts, that the police were having to try and deal with people that – that were not capable of being dealt with by a police officer at that time.

So, there is much to be considered. There is no single solution, I'm sure; otherwise we would have cracked this egg a long time ago. I can say that there is a view out there, generally, in police, that we do need to look at change. Things have to change, because, necessarily, what's happening at the moment isn't working. And so, I think the environment is right, the time is right, prevailing conditions are right, to look at how we might best go forward from this point.

But we do know, and it's clear, that whatever we do, if we look at this more as a health problem, then we need to make sure that we have additional investment in health, and social services, because without it, this will be an unmitigated catastrophe – in my mind at least. With nowhere to refer somebody to, it becomes nightmarish, for the officer that has to deal with the case, for the person that's in the grip of a terrible situation.

And then you have the complexity of moving from a city like Sydney to some of the far remote western parts of this state, and you realise that there are no medical services, let alone any other specialist services, dealing with this type of problem. I have many friends that are GPs, that will talk to me regularly about some of the enormous problems they face here in Sydney. They only shake their hands when they think about how tough it must be out in the west. I can only agree with them.

So, you know, that's without even touching on some of the – the other, wider problems, which I'm sure we will get a chance to talk through today. The notion of depenalisation versus decriminalisation – the impact that a decision like that might have on our international treaty obligations is significant. We can't discount them. We are part of a global response. And so, the notion that to decriminalise, based on the advice that I've received in my pack, may be entirely problematic. Do we need to look at a depenalisation model? So, there are so many variants to a theme on – that we will need to talk through.

But, I guess, I would finish simply by saying that we are ready for some sort of change. We do need to make this better. And I say that not only from the user's perspective, for the decision for somebody to use a drug is one that's entirely their business. Until they decide to get on the road and drive, or decide to assault somebody, or rob somebody, or commit a crime that impacts us; then it's our business. Then it's your police force's business, to actually go about trying to bring to an end the crime spree. Not necessarily the use; we're not medical workers. But we certainly are in the business of bringing safety to community. And so, it's something that will impact law enforcement, and I would ask that whatever comes from this inquiry takes that well into consideration. That's one of the very, very important things that we need to deal with, going forward. So, thank you.

MS HEWETT: Thank you very much, Andrew.

THE COMMISSIONER: Thank you.

MS HEWETT: And now I'd like to call on Alison Ritter, who's the director of the Drug Policy Modelling Program at the Social Policy Research Centre at the University of New South Wales. Thank you.

PROF RITTER: Thank you very much. Thank you, Commissioner. It's a pleasure to be here. I, along with my colleague, Associate Professor Caitlin Hughes, have been working and studying drug policy, and various forms of decriminalisation, for many years. And I echo Andrew Scipione's comments that we need to do something different, and the time is right. I'd like to make four key points as part of this opening statement.

The first is the confusion of terms. It's very unhelpful to have so many different terms: "depenalisation", "decriminalisation", "de jure/de facto", "diversion". I think what's really clear is that the goal is the removal of criminal responses to people who are using drugs for their personal use. And if we focus our goal on developing a different response, other than a criminal response, however we might choose to call that, then I think we're focused on the right goal, particularly because of the evidence that Caitlin has already outlined in relation to it not increasing use and the significant health and social benefits associated with the removal of criminal penalties for the personal use of drugs.

The second point I would make is that much of the discussion, internationally and nationally, is in relation to cannabis; here we are concerned with amphetamine-type stimulants, in particular crystal methamphetamine and ecstasy, or MDMA. And when you think about those two drug types within the class of ATS, removing criminal responses is absolutely perfect for these two drugs. In the first instance, in relation to MDMA, or ecstasy, this is more often used in a non-harmful way; therefore, a criminal response is disproportionate. Crystal methamphetamine, on the other hand, is often used in a harmful way, I think as outlined by Andrew Scipione, and that also makes a criminal response inappropriate; what we need is a health and social response. So criminal penalties for the use of crystal methamphetamine are

completely misplaced, as they are for MDMA, and these two substances are perfect for this kind of policy change.

My third comment is in relation to impediments. It has already been highlighted that our obligations under the international treaties do not prevent us from moving forward with the removal of criminal penalties for the personal use of drugs. I would also make note that New South Wales is a laggard state: no other state in Australia bar Queensland has the kind of repressive approach to personal drug use as New South Wales. Every other state bar Queensland has de facto depenalisation for crystal methamphetamine and for ecstasy. So, we are a long way behind the eight-ball nationally.

My last comment is in relation to public opinion. There has been a lot of use of various statistics around whether the public do support an approach that removes criminal penalties from personal use. This morning, I reviewed the latest data, which is from the National Drug Strategy Household Survey, which is a representative sample of Australians, collected in 2006. Of course, we don't ask the public, "Do you support decriminalisation?" because they don't know what that is, just like most of us can't agree on what it is. What's asked is what should happen to someone if they are caught in the possession of a small quantity of methamphetamine, or if they are caught in possession of a small quantity of ecstasy.

65.2 percent of Australians believe that for crystal methamphetamine, people caught with that should not be subject to criminal penalties; the vast majority, 45.7 percent, think referral to education and treatment is appropriate, echoing the greater concerns about the importance of support, treatment and care for people who are experiencing problems. For ecstasy, of course, the public support is even higher, as 76.5 percent of the Australian public support responses that do not include a criminal response. So, the Australian public is clearly in support of the removal of criminal responses for both crystal methamphetamine and for ecstasy. Thank you very much.

MS HEWETT: Thanks very much, Alison. And I'd now like to call on Don Weatherburn, whose official title at the moment is Adjunct Professor, University of Sydney Law School, but of course is better known to all of us as the former director of the New South Wales Bureau of Crime Statistics and Research.

DR WEATHERBURN: It's probably more appropriate to point out that I'm at the National Drug and Alcohol Research Centre at the moment, so I'll let that pass. I just want to correct a few factual things. I don't want to declare a position for or against decriminalisation or depenalisation yet.

The first point to make is that, reading the papers, it appears that there are substantial benefits claimed in terms of decriminalisation for the workload of the courts. I should point out, that's not true, because a very large proportion of people who turn up for amphetamine use and possession are turning up for other non-drug offences as well, and when you remove those cases, when you remove the people that have got the concurrent non-drug-related offence – when I say "non-drug-related offence", I

mean any kind of drug-related – any non-drug offence – you're down to about 1.2 percent. So, there wouldn't be a substantial reduction in the workload of the court if you decriminalise the offence.

The second thing is that the avoidance of criminal convictions – a big proportion, about 60 percent, of people who turn up for use and possession of amphetamine have a prior non-drug offence, so they will already have a conviction, and decriminalising is not going to reduce, in large measure, the number who end up with a criminal conviction. And it's also worth pointing out that about 19 percent of them, within the next four years, pick up a conviction for another non-drug offence. So, the avoidance of criminal convictions is not a great benefit that would flow from this.

And likewise, the avoidance of prison, because, when you look at people who are arrested and convicted for use and possession of amphetamine and have no prior record, only a very, very small number go to prison. Having said that, I agree with Alison; I think prison is a wholly disproportionate response to someone whose only offence is use and possession of a drug.

I have to take issue with my colleague Caitlin on the issue of whether or not the evidence on decriminalisation uniformly shows no effect. In my paper, which I think the Commission has, on the pros and cons of prohibiting drugs, there is split evidence on the question of whether or not decriminalisation increases consumption. I should point out that the question of whether or not decriminalisation has an effect depends, or arguably depends, on the state of the epidemic you're in. If you're at the point where drug use is now maximised, or stabilised, say, for example, such as we are or have been with cannabis, you're not likely to see too much effect. If you're in the middle of an epidemic – I'd call it an epidemic. If you're in the middle of a rapidly rising drug consumption, I suspect the effects of decriminalisation are likely to be quite different. In any event, I'd refer you to the evidence that I cited in that paper, Uses and Abuses – sorry – Pros and Cons of Prohibition.

The second thing is that if we did go for a less punitive model, I'd be wary of going for fines. And the reason I say that is there's a long history in this state and other states of seeing people turn up in prison for, first, not paying their fines; second, having their licence disqualified and then being picked up for driving while disqualified. So, I think if you were going to go for a less punitive approach, it would be better to go down the caution track than the fines track, for that reason.

Another couple of comments. Firstly, this constant contrast between a health approach and a law enforcement approach is a bit staged, in the sense that when you interview people, as we did back when the heroin epidemic was on, a very large proportion of people entering treatment say they're entering treatment because of contact with the police and the justice system. So, I'm not suggesting for a moment that it's a better result all round if we just for the health side. All I'm saying is that one of the reasons people seek treatment is to avoid further contact with the police. So, it's not the case of going down one track or the other.

There's no questioning that prohibition generates a stigma. That's what every criminal offence does. And that's what it claims to operate by, creating a stigma. Whether that's worth the pain that it inflicts, whether the benefits – is a very difficult to question to answer. I think the question is clear in relation to imprisonment for drug use and possession. I think that's highly disproportionate, that we do know that having a prison record substantially reduces a person's employment prospects and substantially reduces their earnings prospects. That's probably way out of proportion to the harm done by being picked up for use and possession.

It's less clear for me in relation to decriminalisation, but if you were to go down the decriminalisation route or the depenalisation route, I'd urge for a cannabis caution approach, rather than a fines approach, just because of the unintended consequences associated with fines. That's it from me.

MS HEWETT: Thank you. And now I'd like to call on Eddie Lloyd, who is a scholar at the Centre for Social Research and Health –

MS LLOYD: No. That's not me.

MS HEWETT: Sorry. Apologies. Sorry. Of course, it's not. The councillor at the Lismore City Council with plenty of other experience, as well.

MS LLOYD: Thank you very much. Yes. I'm a councillor at Lismore City Council, and I'm also a trial advocate with the Aboriginal Legal Service for the northern region of New South Wales. In our region, we've got about six to seven percent of our population from the Aboriginal community. And they are experiencing, like most Aboriginal people across the country, transgenerational trauma, which is a result of the impacts of colonisation and the impact of state-sanctioned policies that have seen their land removed, their children stolen, their dignity and their liberty for many of them taken away.

And many of them deal with that trauma by self-medicating with substances. And particularly crystal methamphetamine is prevalent in the Aboriginal communities in my area. And there's a great amount of trauma, which means there's a great amount of self-medication. And that has led to disproportionate incarceration of Aboriginal people in our region. In the state the average is about 25 percent of people incarcerated are Aboriginal. Well, in our region Aboriginal incarceration in some parts of the region are double that of non-indigenous people. And there's a woeful lack of treatment facilities in our region and a lack of culturally appropriate ways to deliver justice.

So these social issues led me to establish the Social Justice and Crime Prevention Committee on Lismore City Council. And that is a group of people from across the divide. We've got people from the DPP, Community Corrections, Legal Aid, Aboriginal Legal Service, Housing, lawyers, Health, the Aboriginal liaison officers with the court. We have been meeting for about a year and have been gathering on-the-ground statistics and experiences from people and have produced a paper that has

been sent to our politicians to try to convince them, show them the evidence, that we have a lot of needs in our region and here is the evidence for that, in the hope that we'll see some change and services delivered.

A core belief of the committee and also for the Aboriginal Legal Service is that, as long as substances are criminalised, people using them will be stigmatised, alienated and they'll suffer more harm. For many people, though, using substances does not lead to experiencing substance use disorder and they're not actually harming anyone, yet arresting and charging, convicting, we're causing more harm, we're reducing their employment prospects, we're disrupting their lives, their relationships, alienating them, stigmatising them and separating them from community.

For others, including many Aboriginal people using substances to self-medicate, the social issues that they face in their lives, this does lead to substance use disorder. And even if treatment facilities were adequate in our region and across Australia, the stigma of being a drug addict is a significant barrier in asking for help. And I know this because that's actually what happened to me. I spent many years living in shame experiencing substance use disorder. And I was too embarrassed to ask for help. I felt like a bad person, I felt like a criminal. And now I know I was experiencing a chronic health issue. And I'm one of the lucky ones who was able to make it out the other side to tell the tale.

So today I speak for the Aboriginal Legal Service, I speak for our regional community, like many communities in New South Wales that are facing this crisis, and all those people who have experienced and are experiencing substance use disorder who desperately need drug law reform, who need decriminalisation of substances and who need our political leaders to accept the war on drugs is over and to put down their weapons and treat this as a health and social issue. The laws are doing more harm. The only people benefiting from the war of drugs are those that are controlling the market, with criminal syndicates there.

So the Aboriginal Legal Service, the council committee and my personal view is that I'm not a supporter of depenalisation. For Aboriginal people, that does lead to secondary offending, where they are unable to pay a fine; this leads to suspension of license. They often don't get the letter in the mail, because they live transient lives, they don't have stable housing. So, then they're brought before the court for drive whilst disqualified. And that leads to, for many of them, incarceration. Also, the cannabis cautioning scheme in our region is not working for Aboriginal people. There are strict eligibility requirements, that if we went down that road, I would support those eligibility requirements being less strict, to enable unlimited cautions to be available.

We have seen that decriminalisation has got some really significant social benefits. We've seen what's happened in Portugal. And to me it's obvious that this is the way forward. And I just don't think that we can continue to accept the criminalisation of substances. And, also, I would note I know that we're talking about personal use and the small amounts, but many, many people before the courts are also charged with

supply, because many of them are feeding their habits. So, I think that that's an issue that we should talk about, as well.

But, of course, I think today I'm talking to mainly a room of sycophants, where most of us are on the same page, and many of you have been sitting around roundtables and expert committees and inquiries for decades discussing exactly this and still nothing has happened. So, nothing is going to change unless we deal with the biggest barrier here. And that's the politicisation of the issue. That is the biggest barrier here. So, I think that I would hope that one of the key messages that comes out of today is that we let our – you know, the law makers know that there needs to be a bipartisan approach to this issue if we're going to move forward at all.

MS HEWETT: Thank you very much. And I will now call on Annie Madden, who's from the Centre for Social Research and Health at the University of New South Wales.

MS MADDEN: Thank you. Thank you for inviting me here today, and thank you, Commissioner. Yes. I am currently a PhD scholar at the Centre for Social Research in Health at the University of New South Wales. But – and I am also a founding member and current board member of Harm Reduction Australia. I suspect my large presence here today is to do with the fact that I have for almost 30 years now represented people who use drugs, people with a history of drug use, people in drug treatment as my day job.

As a person with lived-experience myself, I have – until 2016 I was the CEO of AIVL, which is the Australian Injecting and Illicit Drug Users League, the national peak body, representing people who use drugs in Australia, and have also been the CEO of the New South Wales Users and AIDS Association prior to that. So, I have a personal history, as I say. I'm currently on methadone. I have had a long history of both injecting and other illicit drug use, both with the substances we're specifically talking about today and many others. So that's where I'm coming from in my comments.

Just before I make a couple of comments, speaking of perspectives, some colleagues of mine from Harm Reduction Australia, which is Family Drug Support, have asked me to briefly state that they are not present here today. We have talked about families and the importance of families. Family Drug Support is an organisation that has over 30,000 contacts with family members every year and largely through their national telephone support line and 40 programs they run every month. So, they have a very unique perspective and understanding to bring. And they are very disappointed that they aren't here today to be part of this. And they do request that they be part of future discussions. I think that's very important.

To my own views on things, I think it's really important to say upfront that drug use – you know, it's not just about problems and disaster and violence. And I think that needs to be very clearly said and put on the record. In fact, it is largely about people

enjoyment – people enhancing their experiences and, dare I say it, even about pleasure. So, I think that needs to actually be said upfront.

My view on penalisation is that I think it's the least amount of reform possible. I wouldn't oppose it, because I think an any positive change approach in this case would be good. But I think we can do better. And I think that depenalisation, as a number of other people have already said, also has risks associated with it, not the least of which are the fines that have already been mentioned, and the risks with those approaches, but also there are big risks, I think, in police discretion for such a highly stigmatised and marginalised community.

So, decriminalisation, in my opinion, is the minimum amount of reform that we should be considering. And I think there are some points to note, though, about that. And I agree with – and that the model really matters, if we are to go down that road. Threshold amounts, as she has said, really matter. And Portugal has shown us that. If they are too low, they simply will not do. We won't reap the benefits of this kind of reform. They have to match the reality of drug use for people and the issue of user-dealers that has already been raised.

And I think we also have to really think about this issue of selective approaches to drugs. While I note the points Alison has made about why these particular substances might be suitable, I think really you could make that argument for any currently illicit substance if you think about most of the harms that we experience from these drugs are because of their illegality and their criminalisation, rather than the substances themselves. So, I think – and I include dependent drug use in that. I do not believe it has to have the toll it has for people. I don't believe it has to cause the harms it causes for people. And I do believe that it is possible for people to live productive, meaningful lives as dependent drug users, as well as people who use drugs occasionally. That's a more complex matter, but I'm happy to discuss it further.

I think, also, in terms of moving from a criminal to a health approach, absolutely, yay, 100 percent, but I also think in doing that we have to be really careful about overpathologising people. It happens very easily, in my view. And you end up giving us a choice between being criminals or being victims and sick people without agency and who don't know our own minds and can't make decisions for ourselves. So, I think that's really – really important factor, I think, to consider in the detail of things.

And it links for me to the issue of stigma and discrimination, which is profound, entrenched, absolutely, completely, utterly, you know – is part of this issue from top to bottom. And if we were to go down a decriminalisation pathway, then I think stigma reduction/elimination has to be part of any approach. And that's with police, with health services, and also with the general community, frankly, because just because you decriminalise things, it's not magically going to take away stigma and discrimination overnight. We've spent a long time building that story. So, it's going to take some deconstruction.

I think the final issue with decriminalisation is the black market. And I think that is its biggest limitation, because it remains despite decriminalisation. And it is the biggest problem, in my view. You can decriminalise, but people will still have to buy their drugs in a black market and of unknown purity and unknown content, and often going into environments that can be risky. So, I think there are some issues to consider there.

Finally, I would just say that I know – I got the message, got the memo, it's legalisation and regulation is not on the table, so I understand that. But I wouldn't be representing people who use drugs adequately if I didn't put on the record that I think what we do need actually is legalisation and regulation in this space. We need to secure a safe, affordable supply of drugs. We know all the reasons for that. They've been stated here. And we can also see it through what is happening in Canada as we speak. So, I think these are really important issues. I think it needs to be on the record. I think decriminalisation is fine, but it is not enough. It would be a first step, not the final step.

MS HEWETT: Okay. Thank you, Annie. And now I'd like to call on Stephen Odgers, a barrister.

MR ODGERS: Thank you. Yep, I'm a barrister. I've been a criminal barrister for 30 years, so I've seen my fair share of criminal cases involving drugs, drug use, drug supply, more particularly. But I'm here, really, representing the Bar Association. I've been chair of the Criminal Law Committee of the Bar Association for 17 years. And I can say that the Bar Association's position has been for many years in support of decriminalisation of all drugs, in relation to, of course, possession and use. It's not – we're not supporting any decriminalisation of supply or trafficking or manufacturing or cultivating. We're focused on, as I know this round table is focused on, possession and use.

The Bar Association has always appreciated that drugs can cause harm. I mean, no one doubts that. We can disagree about the extent of the harm, but for some people it can be terrible harm and it can cause harm for them individually, but also to society. But – and it's the but – our view is that there are real doubts about the effectiveness of the current law enforcement focus, a punitive focus, which we believe is ineffective and inappropriate and both wrong in principle and at a practical level.

We're also concerned in that context with the harms that result from criminalisation. They've been discussed already, but those harms are real, both to users themselves individually, but also to society. The consequences of criminalisation affects how people deal with drugs, how they use them and how the community deals with this problem. The Bar Association has been impressed by the Portuguese experience. It's been mentioned. That, of course, most of you would be aware, involve the complete decriminalisation of all drugs, not just ATS drugs. And a reliance on civil orders imposed by community tribunals in cases where – particularly where there was a perception that a person's problems needed to be addressed. The focus is on

dependent users, not people who use occasionally and for whom there is no apparent harm resulting for problematic users.

And it's dealt with at a community level with non-punitive sanctions, civil approach, not necessarily fines, but encouraging people into treatment where it's necessary. And, importantly – and I hear what Don Weatherburn said a moment ago, but my understanding – our understanding is that it has not resulted in a significant increase in drug user. That's critical. It seems to me that the critical argument – the strongest argument that's always has been advanced against decriminalisation is that that will result in an increase in drug use and, therefore, an increase in drug harm.

So, our understanding of the Portuguese experience and indeed for decriminalisation in other jurisdictions is that it has not resulted in an increase in drug use. And, indeed, in some areas it's led to reductions in certain kinds of drug use and certainly the harm that results from drug use. So, looking at it from that perspective, the Bar Association's position is, as it has been for some years, there should be decriminalisation; depenalisation is not sufficient. It should not be a criminal offence to possess or use small amounts of drugs – any drug. Thank you.

THE COMMISSIONER: Thank you.

MS HEWETT: Thanks very much. As I said, so Professor Gallop will be with us later. So, I'd like to now move on to Kate Seear, who's an Associate Professor in Law at Monash University.

PROF SEEAR: Thanks, Jennifer. Yes, so my name is Kate Seear. I'm an Associate Professor in Law at Monash University, in Melbourne. I'm also an adjunct research fellow at the National Drug Research Institute at Curtin University. I'm a practising lawyer as well, and I'm the academic director of Springvale Monash Legal Service, which is a large community legal centre in Victoria.

So, I'd like to begin by thanking the Commissioner and everybody involved in this Special Commission for the great opportunity and honour to be involved in this roundtable today. I realise that we're going to talk about a lot of these issues in much more depth, so I'll keep my remarks brief, and they do very much overlap with many of the things that have been said already. So, there's a risk of repetition here, but I will – I will repeat a few things that have been said already.

So, in general terms, my position is that reform is very much needed in this space. And I agree with Annie Madden that depenalisation and/or decriminalisation are worth considering, particularly decriminalisation, but this should be seen as a first step only. If we can get to that place, I think that would be terrific, but I don't think it should be the end of the conversation. I'm very much in favour of legalisation of drug use more broadly. And I just note, in that respect – I'm sure that, in the agenda, there's going to be a conversation about this in more detail today – I note counsel's advice that decriminalisation could be problematic from an international law point of

view, but, that issue aside, I think it is well worth considering decriminalisation and legalisation, as I said.

Alison Ritter mentioned that New South Wales is very much lagging behind other jurisdictions in this space. And I wanted to just restate that, and also mention some other things that haven't yet been mentioned. As the Commission is no doubt aware, a number of other jurisdictions in Australia have been and are considering at the moment reform in this space, and so it's great to see New South Wales having this conversation. But in recent years Victoria has held a major inquiry into drug law reform, and I'm sure the Commission is – I know the Commission is well and truly familiar with that report. Western Australia has been looking at these issues over the last couple of months. The ACT, of course, has been doing work in this space. And in that sense, New South Wales is not alone, but it has a long way to go in terms of catching up to what's happening in some other jurisdictions.

In this respect, I did want to mention briefly that options for reforming New South Wales's approach have been canvassed in depth in the recent report that Caitlin Hughes mentioned, that Caitlin, Alison Ritter, Lorraine Mazerolle and I wrote on diversion across Australia. I was going to speak to that report in depth, and I know that Caitlin has submitted a more detailed statement which does a wonderful job of summarising that research, but what I would just reiterate from that report is a key finding, which is that New South Wales diverts just 46.8 percent of its offenders for use and possession offences, and this puts it at the third-lowest jurisdiction in Australia. Only Western Australia and Queensland do worse. And when we compare that to a jurisdiction like South Australia, that diverts 98 percent of its offenders, we see that New South Wales really does have a very long way to come. And there are a range of measures that can be introduced that would rapidly expand New South Wales's approach to diversion or depenalisation, for example, which we've documented in that report, and I'm sure we'll get some time to talk more about that today.

There are otherwise just four brief points I want to underscore. The first is that, although I know it's not been a specific focus of the materials produced and distributed for this roundtable, I think it is relevant that the Commission of Inquiry consider the relevance of human rights to its deliberations in this inquiry. Numerous calls have been made at both the international and domestic level for drug policy to be shaped or informed by a human rights-based framework.

The Commissioner mentioned the recent communiqué by the heads of the 31 United Nations agencies calling for decriminalisation, but also, importantly, in that communiqué, there was a reference for the need for drug policy to be framed based on human rights considerations. And in this respect, I would point the Commission to another recently released document, released by the UNDP, which is a set of international guidelines on drug policy and human rights, that talks about some of the many considerations that need to be taken into account for a drug policy to be human rights compliant.

The second point I just briefly wanted to make is that I realise that the focus of this Commission and today is very much on decriminalisation/depenalisation, and I'm aware that the Commission has very specific terms of reference, but it would be remiss of me not to mention one, I think, very important point, and that is that illicit drugs figure in the criminal law, of course, but they also figure in a range of different areas of law outside the criminal law, and it's essential that if any reforms are contemplated in relation to the criminal law, we contemplate reform to those other areas of law, too.

Professor Suzanne Fraser, from the Australian Research Centre for Sex, Health and Society, and I have written about this, as have Alison Ritter, Kari Lancaster and I. And I think it's important to undertake work that maps all of those areas of law where drugs figure, because, if we reform the criminal law and we don't look at those other areas of law, that kind of de facto criminalisation and punitive approach will remain.

And so, in work done by Alison Ritter, Kari Lancaster and I in Queensland, as just one example, we mapped provisions that dealt with alcohol or other drugs, and we found more than 200 legislative provisions that deal with alcohol or other drugs in Queensland alone. As far as I'm aware, a similar mapping exercise has not been undertaken in New South Wales, but there are many provisions here in New South Wales that do deal with drugs: one example is section 49PA of the Anti-Discrimination Act, which essentially excludes drug addiction from anti-discrimination law protections. And it's those kinds of provisions that would need to be looked at as well.

Two final quick points. Third, like Annie Madden, I would very much caution against any assumption that drug use should be seen generally as a medical problem. That's – people use drugs for a wide range of reasons, and to see drug use in binary terms, as either a criminal problem or a medical problem, is both inaccurate and stigmatising in and of itself, and it can often lead to other harms, particularly where it becomes a logic to support compulsory or mandated drug treatment. And on that point, I should note that the United Nations Special Rapporteur on Torture, and also the United Nations Special Rapporteur on the Right to the Highest Attainable Standard of Health, have both expressed concerns about compulsory drug treatment, and many others have as well.

My final point is just to reiterate the importance of addressing and removing stigma, both inside and outside the criminal law, as an overarching principle or framework for this discussion. I would respectfully disagree, perhaps, with Don Weatherburn that stigma in this respect can sometimes be positive. I may have misunderstood or misrepresented your comments, Don, so I apologise if I have. But, in my view, there is very little or, I would say, no benefit to stigmatising drug use in this respect. And I note that the Commission has included some reference to some of our recent work, again with Alison Ritter and Kari Lancaster, which looks at ways to evaluate the relationship between drug law and stigma. I'm happy to discuss that research in

more depth today, but I think it has to be a driving consideration and concern for reform. So, thank you.

THE COMMISSIONER: Thank you.

MS HEWETT: Okay, thank you. And now, for our final contribution of prepared remarks, Alex Wodak, President of the Australian Drug Law Reform Foundation.

DR WODAK: Thank you very much. My journey to come to this gathering today began on June the 5th 1981, in London, when I read about the epidemic that we now call HIV. And a few years later, I was working as the director of the alcohol and drug service at St Vincent's Hospital, and I learned of a study in which 3000 to 4000 men who have sex with men had – were thought to have HIV infection in the Taylor Square–Kings Cross area. And I deduced from that that several hundred of them presumably also injected drugs, and that we would – if we weren't smart about it – we would see a cascade of HIV infections moving through to the general community. And I remind you that at that time, and for another – until 1996, HIV was an almost always fatal infection.

And so, a group of us worked very hard to try and establish needle-syringe programs in Australia, advocating them to Government, with no success. And finally we resorted to civil disobedience to speed up that process, on November the 12th 1986, and ultimately HIV was kept under control among people who inject drugs, and also in the general community.

In 1987, I was sitting in my office one day, and I was trying to understand this process that I and my colleagues had been through. Why had we had to resort to civil disobedience to get needle-syringe programs established, when it was clear that this was necessary to stem the epidemic? And I realised that – thinking it through – that the main reason was drug prohibition. And I have devoted, really, the rest of my life to trying to understand why we adopted our drug laws. Did they work? Were there better ways of managing the situation?

And that's really why I'm here today. I'm not really here because I think our drug laws are ineffective, although I think they are ineffective. I'm not really here because I think there are better ways to manage this problem, although I'm sure there are less worse ways to manage the problem. I'm really here because I think the drug laws punish people who have minority drug preferences, and absent harm to others I think that's unfair and unjust. And I've been very much influenced by the writings of Professor Douglas Husak, a professor of the philosophy of the law, in New Jersey.

So, let me begin. What is the aim of drug policy? Regrettably, though critical, the aim of drug policy is rarely made explicit. The resulting confusion is one of the reasons drug policy discussions are so often disappointing. Drug policy, in my view, should aim to reduce harm: specifically, reduce death, disease, property crime, corruption and violence. Though quite inappropriate, reducing drug consumption is

usually the tacit primary objective. Reducing drug consumption should only ever be, in my view, a possible means to an end.

Global drug prohibition was introduced gradually about a century ago. Australia followed international developments. It cannot be said too often that drug prohibition has been an abject failure. Any company failing as badly as drug prohibition would have been declared bankrupt long ago.

Why do I say drug prohibition has failed? First, over many decades, the drug market has expanded, and become much more dangerous. There has been an increase in drug production, consumption, the number of different drugs available, the hazardousness of newer drugs, and often in the availability of drugs. Meanwhile, drug prices have dropped substantially, and purity has often increased. Second, and more importantly, where data are available, death, disease, property crime, corruption and violence have often increased. Some of these parameters, such as corruption, are hard or impossible to measure. Third, growing numbers of political and law enforcement leaders, initially only retired but now also serving leaders, have acknowledged not only the failure but also the futility of drug prohibition. Many political elite figures have known for decades that drug prohibition has been an expensive way to make a bad problem even worse. The then Prime Minister Tony Abbott said on the 29th of April 2014 that:

The War on Drugs is a war you can lose. You may not ever win it.

Fourth, the shrinking numbers of prohibition defenders are unable to explain critical questions. How can drugs be kept out of Kings Cross when they cannot be kept out of our maximum-security prisons? How can law enforcement reduce drug supply when the price of drugs increases several hundredfold when transported from countries of origin to countries of destination? How can law enforcement succeed in – how can law enforcement succeed in reducing supply when drug traffickers are much better resourced and equipped than they are? How can drugs be kept out of Australia with its coastline of 27,000 kilometres and with 8 million containers, including frozen containers, and 9 million international air passengers arriving every year and with 4 billion letters and parcels delivered every year? What is to be done?

First, the threshold step is redefining drugs as primarily a health and social issue rather than primarily a law enforcement issue. Second, drug treatment has to be expanded and improved until it reaches the same level as other health services. Third, all penalties for personal drug use and possession have to be scrapped. Fourth, as much of the drug market as possible has to be regulated while recognising that part of the drug market is already regulated, such a methadone treatment, needle and syringe programs, medically supervised injecting centres. It will, of course, never be possible to regulate the entire drug market. We have regulated parts of the drug market before. Edible opium was taxed and regulated in Australia until 1906 and in the United States Coca-Cola contained cocaine until 1903.

Fifth, efforts to reduce the demand for powerful psychoactive drugs in Australia have had limited benefit and require a new focus. Unless and until young Australians feel optimistic about their future, demand for drugs will remain strong. Young people, understandably, want more certainty about their future prospects, including climate, education, jobs and housing affordability. Change will be slow and incremental, like all social policy reform. As Herb Stein, as adviser to President Nixon said:

Things that cannot go on forever don't.

Drug prohibition cannot go on forever and will be replaced by libertarian paternalism. Thank you.

MS HEWETT: Okay. Thanks very much, Alex. Well, obviously, there's a lot of different points of view there which we're now going to try and unpack, and I take Eddie's point that a lot of people have sat around similar tables and discussed these issues, and some – but I don't think, actually, there's any consensus on the details of how you go around the practical consequences of these things. And I think it's very clear that we all – that there's maybe a consensus that some changes are needed, but there's also the counterfactual of, you know, what are the possible unintended consequences of changes. So I think what we'll try and do now is have a discussion in slightly more detail about the weakness as well as the strengths of the current system.

And so, I would like to start with you, Andrew. We obviously have heard from, you know, many people saying this should never be, you know, seen through the eyes really of law enforcement or the criminal justice system. And we've had Don say, "Well, actually, that's a bit of a fake framework, really. You know, often it involves both." So, you said you thought change was required because the current system is threatening, or has already, overwhelmed us. Now, what types of changes do you think are going to work best in this area?

MR SCIPIONE: Well, I guess that's the $64 million question. Look, I don't know that I bring any answers to the table. What I know is that my observations over many years would tell us that perhaps what we're doing at the moment isn't stopping people from actually starting to experiment with drugs and then going on to have lives that are significantly impacted by drug use over many, many years. The whole notion of changing the current arrangements is something that law enforcement has been part of for a number of years. And I know, Commissioner, you're going to talk about the cannabis cautioning scheme, and that in itself, for us, was a significant shift.

Again, I've got to preface all that I say by saying I'm no longer a policeman. I don't serve a government in terms of, you know – as a sworn officer. My experience is only my experience, but, you know, I thought it important that I come and talk here because there needs to be a voice for every police officer in this country, for everyone that gets involved. And I'm sure that many of my colleagues from around Australia would say something needs to change. That's why we're happy to come

around the table and to talk to experts, particularly those that come from fields where there has been some significant shift and change.

Cannabis cautioning, I think, has been a useful thing. I know that not that long ago the commissioner in New South Wales actually sought and was given the authority so that police could deal with minor amounts of drugs that are found in the possession of people by way of a criminal infringement notice. Now, I know that there's a whole lot of work that's gone into does that make it better or does that make it worse: the fact that somebody has a fine and they can't pay it, then starts to spiral for some – to the point where that becomes more of a problem to them than the initial use of the drug or the possession of the drug.

So, I'm not sure that I can bring to you, you know, the golden solution, but what I can say is there's willingness, I think, amongst law enforcers to look at options, to look at what we can do together. And I'm mindful there's been some discussion about, you know, you can't necessary differentiate or push between the two current approaches, that is, a law enforcement approach or a health approach. I don't know what sits in the middle. Perhaps it's more about getting the social setting right. The issue that perhaps sits around this is the reason why people decide that they would look to self-medicate. Perhaps they're the important factors that really need to be approached and dealt with, and dealt with appropriately. That's why we used to say to so many – in so many forums and to so many people, "The best thing you can do is sit down with your child and talk to them about drug use."

MS HEWETT: Okay. In terms of the decriminalisation and depenalisation, obviously a lot of people at this table would think that depenalisation is – you know, is not a good idea. Others think it's the minimum required in a possible first step. But one of the issues is that depenalisation would give police quite a degree of discretion. And I know we're kind of at the beginning of this discussion, but there's kind of pros and cons to that. So what do you think about that idea of the cautioning which gives – does give police discretion on the depenalisation model?

MR SCIPIONE: Well, I think that that's worked well. I think police have - - -

MS HEWETT: And would work well beyond the cannabis cautioning?

MR SCIPIONE: Well, again, you know, you really don't know until you actually get to the point where you trial it. Having said that, I know that criminal infringement notices were trialled – I think it was over the last summer period in New South Wales, and the results, from what I've heard, were quite promising in terms of being able to stop people being forced into being part of the criminal justice process by having to appear in a court. It's always important that you have that discretion as an officer. Most officers will act appropriately and, as Don Weatherburn said, you know, most of the people that we're dealing with that are in this situation that we've been talking about, that is, that have appeared in a court, haven't appeared because they've used or they had in their possession, you know, a street deal of ice.

And I, for the life of me, couldn't think of a court that would be dealing too harshly with somebody that was before them for a first offence with a street deal of ice in their possession or have used. It would be unheard of for a person to go to prison for that single offence.

DR WEATHERBURN: I just should - - -

MR SCIPIONE: You might tell me otherwise, Don.

DR WEATHERBURN: I just should clarify. I didn't suggest that – my point was really that there are a large proportion of people who are picked up – turn up in court for cannabis use and possession who have other non-drug offices.

MR SCIPIONE: That's right.

DR WEATHERBURN: That's really a point about how much saving in the amount of court workload there would be. I think the thing with a criminal conviction is there's good reason to suspect it has an adverse effect on a person's earnings and employment prospect and that's a bad outcome. You wouldn't want that, especially for somebody for whom this is their only offence and only ever will be their only offence. That's the attraction of the caution. I'm less confident than Alex has always been – we've talked about this over the better part of 25 years – less confident than he is that prohibition doesn't exert a constraint on consumption.

Sorry if you've heard this before, Alex, but a few years ago we conducted – it's a survey of a general population about whether they'd use cannabis if it were legal, and the intriguing thing to me was, not a very large proportion of those who'd never used cannabis said yes, but those who were regular users – I think it was weekly users – of cannabis said yes. 90 percent said they'd use more. And the thing about that is that most of the harm comes from the regular users, not from those who use once a year, or once a month, or so. So, although it's not certain to me that decriminalisation would increase consumption, it's possible.

And, you know, it's not like cannabis. We've got people turning up in emergency departments of hospitals with ATS-related psychosis, going through the roof. So for me, it's – it's a risky jump, you know? I'm not saying we wouldn't get away with it, but I'm not so sure as everybody else that "Ah, don't worry, Don. It's okay, you know. You look at Portugal." Everybody wants to look at Portugal. But the thing is that you really need to study the controls or other factors that might influence consumption, not – not just a simple before/after study. Anyway, I'm starting to raise my - - -

MR SCIPIONE: I think – and, Jennifer, that's my concern. And – and so, into – even the Justice Action submission here said that there is a possibility that decriminalisation could increase the rates of drug use and worsen an existing pattern of drug consumption. That's an incredible risk to actually manage, if you're trying to introduce that. So that's why I say it's important that we sit down at roundtables

like these and talk about how we – we do deal with it. And, look, Don, your point is right, that is, in terms of why people appear in court. But clearly, most people that we would deal with through the cannabis cautioning scheme escaped having that conviction.

DR WEATHERBURN: Yes.

MR SCIPIONE: So if it was a one-off, they weren't tainted with a criminal record - - -

PROF HUGHES: Yes.

MR SCIPIONE: - - - which didn't impact on their prospects for employment and, you know, the future.

PROF HUGHES: And - - -

DR WEATHERBURN: The only other thing I'd have to rush in and say is that – there's no offence meant to your past, but it's very dangerous to give police too much discretion. Whenever you give people in a position of authority a large amount of discretion, you increase the risk for corruption.

PROF HUGHES: Yes.

MS HEWETT: Right.

DR WEATHERBURN: So I'd want to see clear guidelines - - -

MS HEWETT: Okay. I think that's a very, kind of, good point. And I'll come to you in a second, Caitlin. I just wanted to ask one question, which is, we've talked – there's different arguments, which we'll go into, about saving the courts time, but what about saving police officers' time? Has that saved – I mean, the cannabis caution – does that actually make much difference? Does it - - -

MR SCIPIONE: Oh, it does.

MS HEWETT: And - - -

MR SCIPIONE: It does. Just the time of charging somebody, the process of taking somebody to a police station, charging them – that takes - - -

MS HEWETT: Right.

MR SCIPIONE: - - - considerable time. If you can deal with it on the street, it's a much better process. However, we think that there could have been more time saved, particularly around – and in fact there could have been more – better outcome from some of the schemes. In a cannabis cautioning scheme, you have to have somebody

who will admit the offence before you can exercise it. And in certain circumstances, certain groups of people were getting legal advice that said, "No matter what you've done, you never admit the offence." And, of course, if you don't, that immediately excludes you from a caution, which seemed counterintuitive to us. We were trying to reduce the number of people with criminal records, and, in fact, based on the advice they were receiving, they were getting criminal records, because we had no option but to charge, particularly younger people.

DR WEATHERBURN: Yes, but about 90 percent of them, maybe more, plead guilty.

MR SCIPIONE: That's right. They would go to court and plead guilty.

MS HEWETT: Right.

MR SCIPIONE: So they had the criminal record. We're saying, you know, let's put some – this is just the common-sense discussion that needs to be had.

MS HEWETT: Okay.

THE COMMISSIONER: Can I - - -

MS HEWETT: Can I - - -

THE COMMISSIONER: - - - just pipe in there, Andrew. You mentioned earlier, in your opening statement, that there would need – if there were more facilities and more resources - - -

MR SCIPIONE: Yes, health and social services.

THE COMMISSIONER: Yes – for police to take people to. For example, I think you said, there's nowhere to refer to people to at times; it was a "nightmare" at times, I think, was a word you used. And the lack of medical services in remote areas was something that you also highlighted. Could you just expand on those issues a bit for me?

MR SCIPIONE: Well, I mean, it's – particularly if somebody is presenting at a crime scene, and they're in possession of a particular drug, and there's a notion of psychosis, dealing with the person, it then is clearly a mental health issue that we're dealing with in the first instance. In many places, there's nowhere we can refer them to. There – there's – there is – you know, it's often very difficult to actually get them the help that they need. And that's what it's about: it's about helping those people. I don't think that's – and there'd be experts in the room that could tell me what the density of, you know, drug support services would be in some of the far, far remote parts of New South Wales. But in fact, we know that drug use in some of those communities, you know, per capita, was much higher than what we were experiencing here in Sydney.

DR WEATHERBURN: Alex used to have a lovely phrase on this: "It should be easier to find treatment than a drug dealer."

MR SCIPIONE: And that's a really important statement.

MS HEWETT: Now, Caitlin, we did raise this a little bit. I'd like your, kind of, comments on what Andrew and Don said, but the other thing – one of the things that Don said was, "Everybody raises Portugal." And it does seem to me – and you did, obviously, as well, Stephen. But it seems to me that the comparison with Portugal is slightly misleading, in the sense that you're not dealing with the same circumstances. So you had Portugal, who went from absolutely no treatment available, and an extremely punitive session, to then, you know, almost the opposite. So – I mean, I think that would be very different to a situation like Australia, surely, where you've actually got a whole lot of treatment programs and things. So I'm curious in your views on that, as well.

PROF HUGHES: Yes. I might just start off by the New South Wales context, with the criminal justice system, because we've had a lot of comments about, you know, whether people who go before the courts are only going there if they've committed a use/possess offence and another offence. The review that we conducted – that I conducted with Kate Seear, Alison Ritter and Lorraine Mazerolle – was looking only at responses to people with a principal offence of use and possession. So that is an offence for which this was their most serious offence, so they had no other concurrent offences for which, you know, other sorts of actions could have been taken. And in the New South Wales context, we found that, on average, in any one year, there's close to – it was just under 11,400 people who were being detected in New South Wales for a use/possession offence which was their most serious offence; six - - -

MS HEWETT: Sorry; did you say 400?

PROF HUGHES: Sorry; 11,400; 6146 of those are then going before the courts. So this is on average, in any one year. Most of them are then found guilty. So, you know, as Kate Seear said, what this data shows is, when you look at how New South Wales is doing in this regard versus other states and territories, that only 46.8 percent of people are being diverted from the court for this particular offence - - -

MS HEWETT: And is that - - -

PROF HUGHES: - - - it's much higher in states like South Australia or Victoria.

MS HEWETT: Are those figures for cannabis as well, or are you just talking illicit - - -

PROF HUGHES: This includes all illicit drugs, yes, but the majority of people who are – based on our discussions with expert stakeholders – who are going before the

courts would be for drugs other than cannabis, because there is the cannabis caution scheme, as Andrew has talked about.

In regards to Portugal, yes, the context for that particular reform is different to the context that we find ourselves in here in New South Wales, or in Australia more generally, not only because New South Wales has got more, you know, particularly harm reduction services, as well as more treatment, but it's also had these existing diversionary schemes, like the cannabis caution scheme, and the more recent criminal infringement scheme, that was trialled at the festivals over the last six months for particularly, the data would suggest, mainly MDMA. But at the same time, there still remain some underlying, you know, similarities in the – and as you see in many parts of the world that are looking at this issue – about, how do we respond to use and possession of other illicit drugs in a way that can really, you know, be more effective and reduce harms?

Because, at the end of the day, we're seeing people for whom – people who either go to the courts or people who receive criminal convictions – it is often disproportionate to the harms from the use of the drug itself. And if you provide alternative responses, whether that's through removing the criminal penalties by law and/or some other means, then the evidence suggests that there is significant reductions in health, economic and social harms.

MS HEWETT: Okay. Now, I'm just aware, it's now half past 11. I'd leave it up to the Commissioner to decide if you want to break for 10 minutes, to have a quick tea or coffee, or would you rather just go through to lunch?

THE COMMISSIONER: Well, look, I'll leave that to the participants. If people would like a stop for five or 10 minutes, we can do that.

MR ODGERS: Do we have coffee available?

MS HEWETT: Yes, we do, over in the room just over there. So why don't we just have a very quick break, and – it's now half past 11 – and be back here, you know, hopefully within about - - -

THE COMMISSIONER: Just 10 minutes.

MS HEWETT: Yes, at – 10 minutes at the latest, ready to go. Thank you.

ADJOURNED **[11.30 am]**

RESUMED **[11.41 am]**

MS HEWETT: All right. Well, welcome back, everyone. Now, I hope everybody just has a bit of a break. Obviously, some very intense discussions we've had and we're going to continue, and I just wanted to come back on the point that there will obviously become disagreements. I'm very happy to have a kind of free-flowing discussion, but it's important not to interrupt everybody at – you know, at every minute. But if you – you know, if you have a response to somebody and you want to say something, you don't always have to direct it through me. And on that point, I think Alison just wanted to make a couple of rebuttals, I suppose would be the way of putting it, to something – a few things that Don had said.

PROF RITTER: Well, it was actually a conversation that was going on and – so the question about how much court time or policing time would be saved through alternatives to a criminal justice response, that question has some answers to it from an evidentiary basis. In the first instance, the report that Caitlin referred to demonstrates that there is court time being used for people with simple use/possess offences in the absence of any other criminal offending behaviour, so there would be savings to the courts. That is evidenced in the data that's being presented to the Commission. The second - - -

MS HEWETT: Sorry, can I just ask one point on that?

PROF RITTER: Yes.

MS HEWETT: That data, is that referring to cannabis again mainly?

PROF RITTER: It's referring to all drugs.

MS HEWETT: But is it – but the majority of that would be the cautions or – a thing on cannabis.

DR WEATHERBURN: Yes.

PROF RITTER: We might assume that – they're not cautions. They're going before the courts.

MS HEWETT: Well, sorry. Sorry. Going before the court.

PROF RITTER: We might assume that - - -

MS HEWETT: Would most of that be cannabis?

PROF RITTER: - - - the majority is likely to be cannabis but we do not know.

DR WEATHERBURN: Well, I do know. I spent 31 years looking it and I can tell you the vast majority of use/possession charges in the court relate to cannabis - - -

MS HEWETT: Right. So that would be - - -

DR WEATHERBURN: - - - in New South Wales. Absolutely.

MS HEWETT: And that would be a very different issue, I think, given in the context of this when we're talking about ice and other ATS.

PROF RITTER: Yes, potentially. And it would be important to source the data in relation to court presentations for simple use/possess in the absence of any other criminal offending, and that piece of data would inform the relative costs and benefits of removing the criminal office and use/possess. A second question was asked about whether the cannabis cautioning is – saves police time. Andrew Scipione clearly knows the answer from his experience in policing. The answer is yes. I would also comment that we also have research evidence from Caitlin, Dr Marian Shanahan and myself, a cost effectiveness analysis of the cannabis cautioning scheme, which demonstrates that it is highly cost effective in a number of factors, including saving police time.

The third piece of discussion that's been going around this morning has been the conversation about whether versions of decriminalisation or depenalisation will reduce drug use and the extent to which it will reduce drug use, or increase drug use, or make no change to drug use. And I think this is an important topic that needs to be discussed because there is a lot of careful wording, I think, and I think the comment was made earlier, reading out from one of the submissions, that, you know, the grave fear is the substantial increase in drug use that would be associated with this, and Don's comment in relation to cannabis compared to ATS, which I think is an interesting point for potential discussion. So I think that's an important conversation.

MS HEWETT: Yes.

PROF RITTER: Will it increase drug use?

MS HUGHES: Can I add just one further comment?

MS HEWETT: Yes.

MS HUGHES: One other thing we found in our Commonwealth Department of Health review was that, when you look across Australia, the diversion rates as a whole have been reducing year on year and in large part, when we spoke to the stakeholders, particularly police, they said the reason that this is occurring is because of methamphetamine. So they're picking up more people for use and possession of methamphetamine or like substance and, in the absence of alternatives to arrest, particularly in New South Wales and Queensland, the two biggest states for which people are being detected and for which there has not traditionally been these alternative measures, this has driven this overall national reduction in diversion.

MS HEWETT: Right. Okay.

PROF SEEAR: Jennifer, could I add – could I just jump in and add something if that's okay?

MS HEWETT: Yes.

PROF SEEAR: I just wanted to make a sort of separate comment but which relates to the discussion that we're having and it's about this question of what might – what the future might hold and what risks might appear if we make any changes. And I just wanted to make the point that, in my view, I think these kind of speculative deliberations about the future aren't unimportant – I recognise that questions about whether drug use might increase and so on are important to many people, but I also think it's just as important to – and perhaps – or actually more important that we focus on the people that are currently impacted by the existing regime rather than being sort of too focused on a speculative future that hasn't yet arisen.

And I say that knowing that I realise that those issues are still important, but I don't think that they should hijack or fully shape the conversation that we're having. And in that sense I just want to raise two related points, and that is that the question of how much we should speculate about a potential future that doesn't yet exist, as opposed to the existing status quo, which I think is hugely problematic, comes back to the question that Alex Wodak opened with, and that is the question of what is the goal of drug policy. And I'm not sure that we're having a kind of explicit conversation about that specific question here, but I think it is something that we do need to focus on.

And in a related sense, what it is that we choose to problematise – and there is quite a lot of work in recent years about what we problematise in the alcohol and other drug field and what it is that we assume is problematic, and on that point I would just like to reiterate and underscore Annie Madden's point which I think is extremely valuable and not often said in these circles, and that is that we often proceed, I think, from a starting point that any drug use is a problem and that drug use itself is problematic. And I recognise that it can be associated with harm and so on, but people also do use drugs for a wide range of reasons, including pleasure, as Annie pointed out. And so if we proceed from the assumption that increasing drug use – or the risk of increased drug use is always already a huge problem, I think we skip over some of the nuance and subtlety that the conversation does need to retain.

MS HEWETT: Alex.

DR WODAK: Thank you. I'd like to make some comments about what's been discussed about drug consumption. Firstly, the – firstly to reiterate the views that others have already expressed, that the literature is fairly clear that not only does more liberal approaches or less restrictive approaches to drug policy not lead to drug consumption – there may be exceptions to that but generally that is the case – and many people have found this, many people have commented on it. Secondly, I think it's important to realise that – or to have a discussion about the trade-offs. If we had, let's say, a five percent – a policy change which resulted in a five percent reduction

in deaths but a five percent increase in consumption, well, I would enthusiastically support that.

And most policy change involves trade-offs. And we discuss this as if the only issue that matters is whether drug consumption increases. It may be important, but I'm much more interested in those other things: death, disease, crime, corruption, violence.

Also, I think it's important to recognise that the – that illicit drug consumption is very different from legal drug consumption, in the sense that there is a very tight correlation between consumption of legal drugs and harm. If people go from smoking 10 cigarettes a day to 20 cigarettes a day to 30 cigarettes a day to 40 cigarettes a day, you can plot on a graph what's going to happen to the number of heart attacks, lung cancers, and all the other harms from smoking. Ditto for alcohol.

It's much more complicated with illicit drugs. We don't really know what the relationship is with illicit drugs consumption and harm, because, as Annie quite rightly pointed out, the important variable here is the drug distribution system, the black market. The black market imposes a great deal of the harm that is attributed to drugs. Let's take a couple of examples quickly on that. One is acetylmorphine, more commonly known as heroin. Prescribed by doctors, dispensed by nurses and pharmacists, it causes serious constipation. And that's about it. Rarely does it cause death. It does cause death occasionally when people aren't paying attention. But it's pretty harmless, apart from constipation.

MS HEWETT: Yes. I don't think you would say that about ice.

DR WODAK: And when it is distributed – we'll come to that. When it's distributed through the black market, there's often a lot of harm to the person who uses the drug, also a lot of pleasure, also a lot of harm to the families and the wider community. With ice, the drug methamphetamine is prescribed by doctors in the United States, not in Australia. And we have to also recognise not just the quantitative effect of drug policy on the drug market, but also the qualitative effect.

And what we see with many different kinds of drugs, opiates, amphetamines, cocaine, what we see with each of those drugs is the drug market has encouraged the emergence of more dangerous forms of those drugs – more risky forms of those drugs than originally applied. So with cocaine we've gone from cocoa leaf to basico to cocaine hydrochloride powder to crack. And in each step the harmfulness, the riskiness, of the drug has increased. We've seen the same progression with amphetamines. We've seen the same progression with opiates, now going to opiates laced with fentanyl produced in China. So black markets are inherently dangerous and they make a bad situation a much worse situation.

MS HEWETT: All right. But that, again, it refers to the – I mean, I think it goes to the point of legalisation, which we're not really discussing at the moment. So I understand what you're saying, but just in the interests of time, I'll - - -

DR WODAK: No. With respect - - -

MS HEWETT: - - - leave - - -

DR WODAK: - - - I think this applies whatever policy prescription you apply. First come the observations, then come the recommendations. And this is an observation that can be made regardless of what recommendations we come to.

MS HEWETT: Okay.

DR WEATHERBURN: Well, I'd just make the point that the harms associated with methamphetamine have been raising rapidly with consumption. There's no surprise in that. It's also possible, of course, that you could reduce the harms without reducing consumption, as we did with needle exchange in relation to heroin. But I don't think it's possible to avoid the question of where we're going to end up, because that's what we're here to discuss.

MR SCIPIONE: That's right.

DR WEATHERBURN: What would happen if we were to decriminalise or depenalise. And, you know, I don't think it's certain either way, but to avoid discussing it, I think, is impossible.

PROF RITTER: Can I just check. You're not talking about the population prevalence of consumption. You're - - -

DR WEATHERBURN: No, I'm not.

PROF RITTER: - - - talking about – thank you. Can you - - -

DR WEATHERBURN: No.

PROF RITTER: - - - just clarify what you're talking about.

DR WEATHERBURN: So what I'm talking about here is the tendency is to focus on whether decriminalisation will result in an increase in prevalence, being the percentage of the population who uses a drug. I don't think that's the relevant point to focus on if you're concerned about harm, as Alex is. The relevant concern should be about aggregate consumption. And the reason I say aggregate consumption, Alex, is because that's as close as we can get to a proxy for harm. It's not the only determinate of harm. Obviously, other things affect it, but consumption, as you gave the example in tobacco, when consumption of tobacco dropped, we saw a drop in lung cancer. So consumption and harm are pretty closely related, if not, you know, uniquely determinative.

MS HEWETT: Yes. Sorry, Don. So can you just – yes. Can you just explain that a little bit further?

DR WEATHERBURN: So – okay. Well, maybe the simplest way of putting it is that most of the drugs that are consumed legal and illegal are consumed by a small proportion of the users. So when you're talking about consumption, you're talking about the total quantity consumed, knowing full well that the total quantity consumed is largely accounted for by a small percentage of the consumers. Is that clear?

MS HEWETT: Yes. But it - - -

DR WEATHERBURN: So it's not frequency; it's frequency times percentage using, if you like.

MS HEWETT: Right. But what you're – what I'm trying to understand is you're saying that there is a risk of increased - - -

DR WEATHERBURN: Consumption.

MS HEWETT: - - - consumption by just – by more people than that group or is - - -

DR WEATHERBURN: No. The people who currently - - -

MS HEWETT: Already using.

DR WEATHERBURN: - - - use even more.

PROF RITTER: No.

MS HEWETT: Right. Who – that - - -

PROF RITTER: That's the problem with your argument.

MS HEWETT: So that is – so you're not saying that you think it would actually expand the number of people using?

DR WEATHERBURN: Well, it may or it may not. The evidence, as I said, is - - -

MS HEWETT: Is mixed.

DR WEATHERBURN: - - - split down the middle. No one has actually done the work of seeing whether it affects consumption, because consumption is extremely hard to estimate.

MS HEWETT: Yes.

DR WEATHERBURN: My point is that if you're going to base the argument around whether there's a change in prevalence, the evidence points is inconsistent.

MS HEWETT: Right.

DR WEATHERBURN: Some studies find no effect in prevalence. Some studies find an effect.

MS HEWETT: Okay.

DR WEATHERBURN: Do you want me to cite the studies?

MS HEWETT: Okay. Caitlin. Caitlin.

PROF RITTER: Caitlin can.

PROF HUGHES: Can I draw the Commission's attention to one particular piece of evidence. It does pertain to cannabis use.

MS HEWETT: But that's the problem, you see? I don't want to go – to have too much discussion about – I mean, obviously, we'll look about cannabis, but I think in many ways the cannabis – the cannabis cautioning scheme is useful in some ways, but it can be misleading if you're trying to then equate it to ice, which seems to me a very different type of drug.

PROF HUGHES: Yes. But this is not about the cannabis cautioning scheme. Just to say that there was a recent cross-national study conducted by Professor Alex Stevens of the University of Kent, published in the International Journal of Drug Policy that compared the use of cannabis in 36 countries – sorry – 38 countries, including countries that liberalised drugs as drug laws, as well as those that had not, and found that living in a country that had liberalised drugs led to no significant difference in the odds ratio of using cannabis either in the lifetime or in the last 12 months.

MS HEWETT: All right.

PROF RITTER: The important point about this conversation is the difference between the population prevalence, that is, the number of people who are using a drug versus the quantity frequency or consumption, to use Don's word, of the drug. Consumption is absolutely associated with harm. Population, prevalence, the number of people using drugs, is not associated with harm. Under decriminalisation, the removal of criminal penalties, the question is will it increase harm and consumption amongst the people who are already consuming, or will it increase or decrease or change population prevalence? If it changes population prevalence, it probably doesn't matter, because that's not where the harm is. How then is the – what's the mechanism for the removal of criminal penalties one which increases consumption?

MS HEWETT: I don't - - -

DR WEATHERBURN: Can I just say it's not true to say that prevalence doesn't matter. When the prevalence of smoking dropped, so did lung cancer. Now, it may

not be the best proxy for harm, but it's simply not true to say there's no relationship between population prevalence of a particular drug consumption and the harm associated with it.

MS HEWETT: I must say, also, I didn't understand that point either. I mean, obviously, there's been a huge increase in the prevalence, if you like, in the population - - -

PROF RITTER: There hasn't.

MS HEWETT: No. In - - -

PROF RITTER: In amphetamine-type stimulants - - -

MS HEWETT: No. No.

PROF RITTER: - - - there has been no population prevalence increase.

MS HEWETT: No. For example - - -

PROF RITTER: That is the point.

MS HEWETT: - - - in some regional towns, I mean, people talk about how much - - -

PROF RITTER: Yes. That's not population prevalence. That's not - - -

MS HEWETT: All right. Okay.

PROF RITTER: - - - what we're talking about. The National Drug Strategy Household Study has shown that there has been no increase in the population prevalence of ATS use - - -

MS HEWETT: Except - - -

PROF RITTER: - - - and crystal methamphetamine use.

MS HEWETT: - - - there's a lot of questions about that particular study, that particular - - -

PROF RITTER: Well - - -

MS HEWETT: - - - survey, surely.

PROF RITTER: I mean, arguably, represent sample of Australians, it's the one we've relied on.

MS HEWETT: Yes. Isn't it the wastewater thing has shown a completely different picture?

PROF RITTER: Well, that's a whole other argument that we could get into about wastewater, but the point is that in thinking about where the harms reside, there is a difference between the number of Australians who are consuming crystal methamphetamine and the frequency and quantity of that consumption amongst that population that's associated with harm, and then what is the connection between those two things and the criminal response? That's what we're here to talk about, the connection between giving a criminal response to this.

MS HEWETT: All right. Stephen, you wanted to say something?

MR OGDERS: Yes. I hesitate. I'm not going to get into the debate about the probabilities of increased use and harm, but to say this. My understanding is that no one can say that decriminalisation will result in a substantially increased level of consumption/harm. All that can be said is we don't know. There's a possibility. That's – I think Mr Scipione said that. What I'd say in response to that is that that can't be a sufficient basis for declining to go down the path of decriminalisation, given the benefits from decriminalisation and given at least the argument that we should find out what will happen in our jurisdiction, whether that's a pilot project or adopting some mechanism to actually find out. If there is a real chance of avoiding the harms that flow from decriminalisation and a real chance that it will not significantly increase consumption and harm from usage, then we should adopt that strategy.

MS HEWETT: Well, I'm struck by, you know, the comments about people talking about New South Wales as a lagger, and also other states which are clearly looking at these issues. But it's my understanding that no other state in Australia has decriminalised the use of - - -

MR ODGERS: I'm talking about Portugal.

MS HEWETT: Right.

PROF RITTER: De facto depenalisation for crystal methamphetamine is in South Australia, Tasmania - - -

MS HEWETT: Yes.

PROF RITTER: - - - Victoria - - -

MS HEWETT: But not decriminalisation. That's what I was – yes.

PROF RITTER: Not decriminalisation as defined by the Commission, no.

MS HEWETT: All right. And, now, Eddie, one of the things that really struck me when you were talking about both the – two issues, the stigma and also the trauma. Right? And I think Andrew made, you know, in many ways the same point. You've got all these underlying issues that can be, you know, described as the root cause of many of these problems – or problematic use. But we've been struggling with this for, you know, how many – forever. It's not as though those underlying issues are actually going to be resolved. So the point, I guess, is now, given their intersection, you can't say, "Well, we need to fix those first", because they're not actually going to be fixed.

MS LLOYD: Well, we might not be able to – I had hoped that we will be able to fix the social issues, particularly facing Aboriginal communities. I have some optimism that we will, but we certainly need to provide opportunities for healing for people. And we're not going to provide those opportunities through the current laws that we have prohibiting the substances that they're using to self-medicate the trauma that they're experiencing.

I think if I just could go to what we're discussing here and some of the comments that I've heard and the concerns I've got in regards to the current scheme of cannabis cautioning and the discretion, is that discretion is not working for the Aboriginal community. It's not being used. With the cannabis cautioning scheme, that's probably because of the threshold limits, as well. And I've already commented on the fact that many of our clients – well, none of them will be before the court with just a possession offence. None of them. So I don't know how relevant those statistics are, because most of them are there also with concurrent offences, mainly property-related offences that they're committing because they need to get more substances to self-medicate their trauma; and also supply offences, low level. So many of them are user/dealers.

So in a way this discussion about decriminalising small amounts and – or possession is not really going to assist or address the issues that people in the Aboriginal community and wider are facing. And it's not going to facilitate access to treatment for them, and it's going to see them continually to be criminalised and continually to be stigmatised and continually to be incarcerated.

So, from the ALS point of view, discretion is very dangerous. And I just don't see how it's going to – I mean, you could change the eligibility requirements. But, still, I mean, I had someone in court the other day, an Aboriginal person, facing a charge of possession alongside other things of one gram of cannabis; and another person with 12 seeds, 12 cannabis seeds. That should just never be before the court. And I think the issue there is maybe one of them couldn't get a caution, or it just wasn't offered to them.

THE COMMISSIONER: It's interesting, that there's quite a variety, too, between local area commands - - -

MR SCIPIONE: Yes.

MS HEWETT: Yes.

THE COMMISSIONER: - - - as to - - -

MS HEWETT: Huge.

THE COMMISSIONER: - - - you know, what the percentages of people who are given a caution are. And that's a concern. That's a concern. I just want to make an intervention here, in light of what Eddie has just said. It seems to me that one of the real potential weaknesses of the current system is, people aren't getting into therapeutic interventions as much as they need them. And that seems to me also to be very much tied to the issue Andrew raised earlier, and one that I have certainly heard a lot of evidence about in the course of this inquiry, which is the inadequacy of resources being put into that space.

So I'm just wondering, in terms of the weaknesses of the current system, whether another aspect of that is – for example, with the cannabis cautioning scheme – the very low percentage of people who take up the invitation to go to the drug assistance – now, I forget its acronym. And even for the second caution, the statistics are very slow; it's less – low – it's less than, I think, 40 percent. And it's meant to be compulsory, or mandatory, for them to do that, and have that education – that education session. So I see these as weaknesses of the current system of cautioning. I just wonder if I could throw that out there and see if anybody has a comment about those issues.

MS HEWETT: Annie.

MS MADDEN: I'd like to make two comments, first, to go to the point the Commissioner has just made, and then also to follow up with something Eddie has raised. Firstly, I think, to go to your question about why people might not take up the opportunities available for education and treatment, I think, often that will go to the fact that what's available to people doesn't meet their needs, and doesn't suit what - - -

THE COMMISSIONER: Yes.

MS MADDEN: - - - they want, and perhaps they don't believe that they need treatment. And that's their choice to make. So I think that it's really important to not – I think it's a very slippery slope to get into mandated treatment. The evidence is clear that that's not an effective way to go; it's not an effective buy, for Government to mandate treatment, by and large. And there are some very specific exceptions around mandated treatment, but by and large it is not a strategy that, I believe, is an effective or cost-effective one.

So I think that whether or not people take up options for education and treatment will largely go to what is available and what people see as their needs in the situation, and what their drug use is about, for them, in their lives. And I don't think we should be

making assumptions that everyone's drug use is problematic in that regard. So I think that's part of it.

To go further to what Eddie has raised, one of – there's a sort of little known piece of work that actually has been done in relation to the Portugal question, that the International Network of People Who Use Drugs have worked with their sister organisation on the ground in Portugal, the Drug Users Organisation in Portugal, who have been living with this decriminalisation system for some time.

And while there are some clear benefits that have also been shown in the research, around HIV infections and overdose reductions and those sorts of things, to go to Eddie's point around, sort of, discretion, one of the big problems, coupled with the low threshold amounts in Portugal, is that users are reporting, because they still have to engage with the black market to buy the drugs they're buying, they are often forced to go into environments where the police target; they are then targeted by police not only to give up who they're buying their drugs from, but also have their drugs confiscated, the drugs they are apparently legally allowed to possess, because – under the system. So those drugs are confiscated even if they are within the thresholds, which then drives people to have to have to find more money, to buy more drugs, etcetera, etcetera.

So, you know, there are lots of – the model really matters. As both Caitlin and I have said, we've got to be really careful around this issue of thresholds, the issue of discretion, and how it kind of works with highly marginalised populations and populations that are forced to deal with the black market, because there is no other option for them. It's a particular environment, and it's not – you know, it's not, sort of – well, not – the same rules as a legal environment do not apply, and – yes.

DR WEATHERBURN: Could I comment on Annie's - - -

MS HEWETT: Yes.

DR WEATHERBURN: - - - point. I totally agree with Annie that the vast majority of people who don't seek treatment don't need it and don't want it, and I don't think I'd be too depressed about the two percent, although it's probably lower than I'd like. What I'd like to see is those who needed treatment - - -

THE COMMISSIONER: Yes.

DR WEATHERBURN: - - - getting treatment. I don't think there's any point forcing people who don't think they need treatment to get treatment. I think that would just add insult to injury. But the crucial issue is, are the treatment resources there? And all the evidence points to the fact that the treatment resources are appalling, and nowhere near the right number of people are getting access to treatment who would like it. And if there's money to be spent, it ought to be spent on the treatment domain, not in the additional law enforcement domain.

MS MADDEN: Or the type of treatment, either. It's not just the amount.

DR WEATHERBURN: Yes.

MS MADDEN: It's the - - -

DR WEATHERBURN: No, I totally agree with you, and what's appropriate for an Indigenous person may be completely inappropriate for a non-Indigenous person. But the crucial issue is, are the right people getting into treatment? The answer is obviously no. I would never expect success to be 100 percent of people who've been arrested for drug use and possession to be climbing into treatment.

THE COMMISSIONER: Can I - - -

MS HEWETT: However, one – sorry.

THE COMMISSIONER: - - - just say, one of the – one of the interesting things about the Portuguese model is that it triages.

DR WEATHERBURN: Yes.

THE COMMISSIONER: So it does distinguish between people who - - -

DR WEATHERBURN: Yes.

THE COMMISSIONER: - - - don't have a serious problem – it just will suspend the hearing and let them go – but it's the more serious ones - - -

DR WEATHERBURN: Yes.

THE COMMISSIONER: - - - that they will recommend into treatment, and encourage into treatment. And failing that, there is a civil penalty, which - - -

DR WEATHERBURN: Sounds good.

THE COMMISSIONER: I mean, that does seem to have some - - -

DR WEATHERBURN: Yes.

THE COMMISSIONER: - - - merit to me. So I'm just interested in what other people would - - -

MS LLOYD: Can I just - - -

THE COMMISSIONER: - - - think of that.

MS LLOYD: Can I just add one thing. My view is that decriminalisation of small amounts is not going to assist people getting treatment, because they aren't the type of people that are needing treatment. It's the people like my clients, who are committing other crimes so that they can fuel their – get more substances: they're the ones that we need to be targeting. Decriminalisation is not going to target that. I have to agree with everyone else – at this end of the table anyway, and some up there – that the only way to deal with that is legalisation, regulating the market. And I think that New South Wales is in a prime position to be doing that. And I draw the Commissioner's attention to the Home Affairs submission, which says that:

> *Between –*

there's a month missing:

> *Between 2018 and March 2019, the weight of amphetamine-type stimulants detected by the Australian Border Force at the Australian border was 4258 kilograms. Of this, ice comprised 4178 kilograms, with 94 percent intended for importation in New South Wales.*

And that's just what's detected. There's a whole lot of drugs coming into the country that is completely out of law enforcement's control, and out of your view. And I think that, if we're going to really address people who need treatment, such as many Aboriginal clients, who are committing crimes to get money or property to sell to fuel their substance use disorder, then the market should be legalised, and that would mean that they would not need to commit those property crimes, because they could then go to a doctor, and then hopefully be, you know, facilitated into the treatment that they need, and not into custody, where obviously they're getting no treatment at all.

MS HEWETT: But in the absence of legalisation, are you saying that decriminalisation would actually not be effective?

MS LLOYD: I don't see how, and I'm not sure - - -

MS HEWETT: So it would be no better than the current system?

MS LLOYD: Well, it's not going to target people who have got substance use disorder, I don't think. The people coming before the court with a real problematic – drug problem have got other crimes associated with them, and long, long criminal records that would not allow them a cannabis caution, for example, under depenalisation.

MS HEWETT: But, to Don's point – accepting that the treatment facilities may be completely inadequate, particularly in regional Australia, or regional New South Wales – I think you made the point earlier, Don, that in some ways, the interaction with the criminal justice system does – is the way to actually get into treatment, and that that - - -

DR WEATHERBURN: If it's there, yes.

MS HEWETT: - - - kind of provides a – if it's there – provides a trigger for treatment that would otherwise not occur.

MS LLOYD: Yes, that's true, but there's no – there's no adequate facilities.

MS HEWETT: Sure, but I'm – if there were adequate facilities - - -

MS LLOYD: Yes.

MS HEWETT: - - - would you agree or – that, in that sense, the idea that it is actually an offence, or you're going to run into – because of your other issues, or other offences – you're going to run into the criminal justice system, you are more likely to actually be in a – where you want to seek treatment?

MS LLOYD: No, I don't think so, because I think, as long as it's still criminalised, there's still going to be the stigma, and that's still going to prevent people from wanting to access that treatment. I think that's a big issue.

MS MADDEN: I think it goes back to the model issue again, you know. The model is really important, about the detail of what it does and doesn't do, how people – threshold amounts; what might include you in the system or exclude you from the system – all those sorts of things are really important.

MS HEWETT: Yes.

DR WODAK: Beginning of this century, a heroin shortage became established, initially in this part of Sydney and then spreading throughout the country, and soon after that there was a spike in cocaine availability, and then there was a steady increase in amphetamine use and – availability and use. And, working at St Vincent's Hospital Alcohol and Drug Service, we saw all that, and we wanted to respond to that, and we were disappointed that people on our doorstep were obviously having serious problems, some of them, and weren't coming to us.

So we sent somebody out to interview 20 or 30 people with serious cocaine use or amphetamine use, and asked them whether they were interested in treatment, and if not why not. And the answer was – for us – was very disappointing, very depressing. And they said that "We didn't come to you for help, because we don't think any alcohol and drug service really understands our issues. We don't think you've got anything to offer us. We don't think you could do anything that would help us." I regret to say, I'm sure they were right.

We turned our service around, and got some funding, and we started a separate psychostimulant section, which was separate from the rest, and we had people took a particular interest in the literature and all of that. And we also started prescribing, lawfully prescribing, to very carefully selected people, dexamphetamine, controlled

availability, under supervision. And – with the hope that we would be able to do something more than that in the future. And part of that was also looking at the effectiveness, adverse effects, cost-effectiveness of that. With great difficulty – every obstacle that anybody could put in our path, in my path, was certainly put there, and new ones were added as time went by. We got – we published two papers, and – but they were pilot studies. We wanted to go on and do larger studies, and that was just impossible. And this is not just a national experience. I know that other people internationally, like in the United States, had similar problems.

MS HEWETT: Yes.

DR WODAK: Now, it turns out, in retrospect, that the agent we wanted to prescribe – and part of the reason for prescribing was a carrot to draw more people in. Part of the reason that didn't work as well as we would have liked it to work is, the replacement drug, dexamphetamine, is – has characteristics which make it unsuitable for this kind of treatment.

MS HEWETT: Yes.

DR WODAK: There are better drugs now that are available, and that are being trialled.

MS HEWETT: Well, but bringing you back to ice – so what is - - -

DR WODAK: This is all about ice.

UNIDENTIFIED FEMALE: This is the treatment for ice.

MS HEWETT: Right, but so in terms of the - - -

DR WODAK: This is a hundred - - -

MS HEWETT: - - - treatment of ice now - - -

DR WODAK: - - - percent about ice.

MS HEWETT: Yes, right.

DR WODAK: And this is really about getting more people in Lismore, getting more people wherever, who have serious problems but don't want to come – and who are willing to push their stigma problem aside for the time being to get treatment. One of the people who we prescribed dexamphetamine to is now at university, not using any drugs – stopped smoking; doesn't drink alcohol – and is doing a university course.

MS HEWETT: So if we go – I'm kind of – I know the Commissioner was interested in this issue of – of stigma, as well. Kate, if I could ask you – I guess that

one of the community senses would be to say, actually, it's perfectly reasonable to have a stigma against ice, because the effect is, it's not – you know, and obviously there may be some people who just use it for pleasure, and who don't impact on the rest of the community, or, you know, whatever, but in fact, there's a lot of evidence that ice in particular has all sorts of social harms and effects. So what's wrong with the idea of stigma if – are you saying it's because it doesn't stop people doing it? Are we so convinced that it does?

PROF SEEAR: Well, I mean, I could say a lot in relation to your question, Jennifer. You know, much of the evidence and literature on this has been canvassed in the briefing documents and I'm not going to repeat much of what has been said. What I would say is two things. First of all, the question of whether stigma sometimes – you know, sometimes referred to in the literature as sort of positive and negative stigma. This distinction is sometimes drawn. The question of whether or not stigma is valuable or productive depends on what you think the problem is and what your goal is, to state something potentially pretty obvious.

But I think that that's important, and my idea about what the goals of drug policy should be perhaps differs from people who would say that stigma is productive and valuable in and of itself. The other thing I would say is that we mentioned earlier that Alison Ritter, Kari Lancaster and I have done some research on this in recent years. We did a large study for the Queensland Mental Health Commission. The report is publicly available and we can send it to the Commission if they don't have that report. Part of what we did for that research was interview people in Queensland who had – were experiencing what we call problematic or what the Commission referred to as problematic use – substance use, and we interviewed a bunch of people in Queensland about their experiences with stigma and discrimination.

And what we found – perhaps unsurprisingly, our findings very much aligned with the international literature on stigma and – drug-related stigma – was that people had experienced significant and sustained stigma in a wide range of settings – in healthcare setting, in particular, that was a very strong theme, also in employment contexts and other stigma from family members and so on – that was severe and that, you know, the international literature suggests that, when people do experience stigma, stigma can last a lifetime and can impact for a lifetime.

One of the reasons why I think that research is especially significant is because a very strong theme of the discussion today and in the briefing document is that people should be encouraged to move into healthcare settings or treatment if they feel that they need it, or to receive education and support if they need it. And we can't do that – we can't even contemplate that if we don't address stigma because of that strong relationship between stigma and healthcare and people's reticence to engage with services because of this history of stigma and discrimination.

The only other observation that I would make in relation to that is that – just to reiterate something I think I said in my opening statement, that often we see in both national and international documents a commitment to reducing stigma. It has been

in the National Drug Strategy in the past, in the National Hepatitis C Strategy, in international documentation produced by the WHO and others calls to produce an enabling environment that reduces stigma and discrimination, and also there is very little detail in those strategies or policy documents or guidelines about what that actually means and what that would look like.

And so Alison Ritter, Kari Lancaster and I did try to look at those questions about how we can actually reduce stigma, given these international and domestic calls to do so, for all of the reasons the Commission has identified. And, in my view, we can't do it while retaining criminalisation of use and possession because – and also while retaining punitive approaches to drug use in all of the other areas of law that I mentioned earlier because it continues to separate drug use and possession out from other kinds of behaviours and will continue to be counterproductive for all of the reasons we've mentioned.

MS MADDEN: Can I just respond, just really briefly?

MS HEWETT: Yes.

MS MADDEN: I just really – I really have to say this at this point, given my personal background and experience. And I'm sorry to kind of depart for a moment from the evidence and the research and all of that which is what we've mostly been talking about, but when we talk about stigma and whether it can be beneficial, I just ask all of you to just stop, for one second, and imagine what it is like to live your entire life as if you are a piece of dirt on the ground, something on the bottom of people's shoes. You are evil. You are social evil.

This is what people who use drugs live with every day of their life. It is incredibly disempowering. It is – you have no sense of self-worth. Anything that – small value of self-worth you have is crushed out of you by, you know, not only something like police or courts and the criminal justice system, but by the healthcare system. I mean, the only reason you access – someone accesses the healthcare system is because they need help, and the best our healthcare system can do is to say, "You're a piece of rubbish. Go away. We are not interested." And worse, stigma kills people. It is not only a lifelong, you know, affliction that people live with, you know, that they find very hard to engage as a member of society. It's – it kills – people die in a room next to someone else from drug-related overdoses because they're too ashamed to tell someone who loves them that they've got an issue because of this very useful stigma that goes on.

I'm sorry to get so – it's just – this is not an abstract thing. This is real people, real human beings, just like you and I, the same feelings. They are cared for, they are loved by people and we have to really stop for a minute and think if we seriously think that treating people like rubbish for any reason is a good thing to do, I mean, really? I mean, that is just beyond anything I can get my head around for anything.

THE COMMISSIONER: Annie, can I – can I just say this.

MS MADDEN: Sorry.

THE COMMISSIONER: No, not at all. Thank you for that intervention. The Commission has been around to a number of regional towns that have significant issues with this drug – with these drugs and we've heard a lot of evidence in private from users and people with limited experience, including family members, and I can, I think, fairly say that what you have just said I have heard many times, and it's a message that's getting through very loud and clear to this inquiry.

MS MADDEN: Thank you.

THE COMMISSIONER: And I'm not, for a moment, wanting you to think that it's something we're not aware of. It's a huge issue. It's an enormous, vital issue to this whole inquiry.

MS MADDEN: It really is.

THE COMMISSIONER: I think the sense in which Don was using stigma was – he will correct me if I'm wrong – was that – not that it was good that people are suffering as people who are stigmatised in the way you suggested, but rather that the stink of a penalty can sometimes be a deterrent and a useful weapon in the armoury of law enforcement. Am I - - -

DR WEATHERBURN: Look, the only point I was trying to make is that the law works by stigma.

THE COMMISSIONER: Yes.

DR WEATHERBURN: So it's not surprising that people who get convictions are stigmatised. Whether it's a good thing or a bad thing – I mean, it's a great thing in relation to domestic violence, if you don't mind me saying so. I think that should be stigmatised. When it comes to drug use and possession, as I've been saying, I just think that the sanctions, the consequences on employment and the rest of it, far outweigh the benefits associated with it. So I certainly am happy with the proposition that it ought to be dealt with less punitively than it currently is. Whether it will be better – whether the world will be a better place if there were no sanctions whatsoever or if there was no – complete decriminalisation, I'm just less sure, for the reasons that I've given already.

MS MADDEN: I guess it goes to more than just the laws and the models and the – it's about sort of the work this Commission could do, just to make some statements about the – the basic humanity of people and their right to basic dignity and respect in all things, and that using drugs, legal or illegal, should not put you outside of that. And then when you layer on top of that all of the intersectionalities with this issue around poverty, race, you know, they're the people who bear the brunt of this. So it's, I think, on us all sitting here, and in every place we sit, to really have this front of mind as really one of the most pressing social issues of our time, in my view.

MS HEWETT: Well, it is, except that I would have thought the intersectionalities – you also can't avoid the intersectionalities of other offences, including violence, often against family members. So it's not just – in that sense, I can't see, as a – in the terms of the community or, you know, a broader – by the police or kind of social response to this, people saying that's – as Andrew said, if you then, because of your drug use, abuse your family members or resort to violence or have all sorts of other impacts, that does affect everyone, doesn't it?

PROF RITTER: Yes. I think one of the biggest reasons that countries or sort of country states choose to go down the road of decriminalisation as opposed to depenalisation is about this issue to do with human rights and treating people who use drugs like, you know, citizens who are fully deserving of the same sorts of opportunities that other citizens receive. And certainly that's very, very explicit in the Portuguese model, that this was about introducing a more humanitarian and pragmatic approach and recognising that the traditional approach has been very much excluding people from other sorts of systems. People were not prepared to go to treatment, even if the services were available, because of the stigma. Same with the harm reduction services.

But you also see similar rationales in Germany, which through a Constitutional Court ruling they said, you know, it's – they changed the laws. And what's interesting with their particular model is they didn't introduce any alternate sanction. So that's kind of not one of the models that's raised in the briefing paper, but they, basically, removed the criminal penalties for use and possession by law, but then didn't place any additional requirements on people who use drugs. But they said – but they – they've, nevertheless, seen many more people accessing treatment and harm reduction services through voluntary means. And this is largely because you're reducing the stigma.

DR WEATHERBURN: Well, they did massively increase expenditure on treatment, though, didn't they? So that could also - - -

PROF HUGHES: Well - - -

DR WEATHERBURN: - - - have been a reason.

PROF HUGHES: - - - Czech Republic is another example. In all of these contexts – well, I think one of the really important messages is, you know, changing the law, if you're going to do that with use and possession, is a really important means to sort of be reducing stigma, as well as other effects. But changing a law in and of itself is barely going to be sufficient. It's a good – but if you really want to see the benefits from changing the response, is increasing investment in treatment, harm reduction responses is really important, as well as new messaging about – to address the stigma and discrimination that has been occurring in society.

And I think, you know, these models, Portugal, Czech Republic and Germany, are particularly important, because all of them pertain to models that have changed

responses for use and possession of all illicit drugs. So it's not just cannabis. And you see very similar effects in terms of reductions in drug-related harms and increased, you know, service access for the people who are wanting it. So it's not everyone going; it's people, but it's very much creating a more enabling environment.

MS HEWETT: Well, I would imagine that there will be no one around the table who would disagree with the idea that the current treatment is, you know, not adequate and there needs to be a lot more investment in that and a lot more skills in that. So I don't think – in a sense we can, basically, all say that it would be a good outcome for society. It's a question of then how you best kind of access that. So I would like to then talk to Andrew in terms of his views of that intersection with treatment and law enforcement. You said you came at it from a law enforcement view. And how you would see something like the decriminalisation or the depenalisation affecting that ability to access treatment, on the basis that they're – you know, that there should be more? I mean, obviously, there is that issue.

MR SCIPIONE: I mean, the whole issue of decriminalisation, the papers have touched on the impasse that – the Commonwealth would set out in the Homeland Security paper of our international treaty obligations, and says that it would be inconsistent, I think they talked about, with international law if we were to decriminalise. Now, I noticed that we talked about decriminalisation in other states, but in fact it's not true decriminalisation, consistent – as Alison said.

PROF RITTER: It's depenalisation. It's de facto depenalisation.

MR SCIPIONE: So – de facto penalisation we have done. That's the de facto with the cannabis cautioning scheme.

PROF RITTER: But only with cannabis.

MR SCIPIONE: That's right. So we've done it in the past, but no one in Australia has gone the full nine yards to decriminalise, because of our international law obligations. It then sets out – if we did do that, it sets up a conundrum for police. You have somebody in possession of a substance that at Commonwealth level is prohibited – prohibited to import it, prohibited to possess it, prohibited to use it – but at a state level, if we propose that we would have a decriminalised model, it would say, well, it's not prohibited.

DR WEATHERBURN: Can I just check something, Andrew. I'm right, am I not, in thinking that a criminal infringement notice doesn't result in a conviction.

MR SCIPIONE: No. That's right. So that's penalisation, effectively.

DR WEATHERBURN: Yes. So - - -

MR SCIPIONE: So - - -

DR WEATHERBURN: - - - it's not just in relation to cannabis that we've, effectively, got de facto - - -

MR SCIPIONE: No. And we in fact did something specifically around crystal meth through – and MDMA through the - - -

PROF RITTER: The festivals.

MR SCIPIONE: - - - festival period. Yes.

DR WEATHERBURN: Yes. That's the point I'm making.

MR SCIPIONE: So – but that's not decriminalisation.

DR WEATHERBURN: No. No. I know. It's - - -

MR SCIPIONE: So the whole notion of decriminalisation is one that, I think, consistent even with the legal advice that we've taken from counsel, that there could be some real troubled water there. So if you then went back to the depenalisation process, well, right now it's one thing to give somebody a caution, a CIN – sorry – a criminal infringement notice, which is known as a CIN, but not offer them anything else. I mean, before police are police they're humans. They see that there is a screaming need. This could be my brother. This could be my father. They want to have a solution. And the solution isn't just, "Here's a traffic – here's the equivalent of a parking fine or a traffic fine"; it's about so then what? What now?

And if there's inadequate resources – and, look, I will give you an example. Forget the fact that I was ever a police officer, but I had a friend whose son was a 30-something year old businessman, very successful, never had a problem with drugs, married, three beautiful children, and got caught. And his life spiralled out of control within six months. He ended up selling all of his father's business assets without his father even knowing. Subsequently was arrested for some serious, serious violence against his wife and children.

MS HEWETT: So are you saying, because he got caught, that he spiralled out of control?

MR SCIPIONE: No. He spiralled - - -

MS HEWETT: He spiralled out of control before.

MR SCIPIONE: - - - out of control because of his addiction. Right. Okay. Then got caught, though, in the spiral – the downward spiral of addiction. And, you know, I saw this man, who was a good man, change overnight. And let's not demonise him. My compassion levels went through the roof, because I couldn't – I was then making phone calls. He was at this stage in serious trouble running from the police, but we were trying through his father to get him into an adequate, appropriate facility

to get him help. Couldn't get him one. I couldn't get it. I'm the Commissioner of Police. I couldn't get it. Well, what does that say for others? Because there was just no room. And we would talk to him. He would say, "Yes. I need help. I want help." That's an indictment.

MS HEWETT: Alison.

MR SCIPIONE: And, just to finish that, Alex, this comes back to your very point. You know, it should be easier to get help than it is to find a drug dealer.

MS HEWETT: Well - - -

PROF RITTER: So just on the treatment things, just a few things for the record that I know the Commission is well aware of, in an analysis that we've conducted, we're treating about the half the number of people who are wanting and seeking treatment. That estimate includes alcohol, as well as other drugs, heroin, crystal methamphetamine and so on. And, importantly, that estimate is driven by an expectation that we only treat of 35 percent of people who meet diagnostic criteria. So it's a low estimate. So we need to double our investment in treatment in New South Wales, throughout the whole of New South Wales, including in regional areas to meet the current demand for treatment.

MS HEWETT: Just on Alex's point, you said half the people.

PROF RITTER: Yes.

MS HEWETT: But that includes alcohol. Have you broken it down any further?

PROF RITTER: We don't have more detailed figures, but it's probably about – it's probably slightly less than that for crystal methamphetamine. And we're actually treating more people with opioid dependence than that. So there's smaller unmet demand for opioid dependence, higher for alcohol dependence, and probably – I don't know. I'd need to go away and look at the model and do some remodelling to get a specific figure for amphetamine – for crystal methamphetamine. For MDMA, we don't need treatment. This is not a drug that people need treatment for. So we also need to be clear about putting ecstasy to one side for the moment.

The second thing is we need better treatment responses. Alex has alluded to them. We need better pharmacotherapies for crystal methamphetamine. Lisdex is being trialled at the moment. We need to increase and ramp up our research, our piloting efforts in relation to new treatment options, including pharmacotherapies, as well as other treatment options. So contingency management is a treatment option that's been well demonstrated in the international literature that's rarely provided here in Australia, and it would, by – based on all of the theory and the research evidence, be a good response for people who are dependent on crystal methamphetamine.

The next thing is that not everyone who's charged with – or caught, under a decriminalisation program – needs or wants treatment. The problem with the Portuguese model is, everyone has to go to the Commissions of Dissuasion. Around five percent of them end up being treated. Caitlin is nodding, so I've got my numbers right; thank you. So we're wasting, in a sense, 95 percent of resources if we set up a model similar to Portugal. It's expensive, and it's probably unnecessary, if we can detect those five percent, 10 percent, better.

And, just on compulsory treatment, we have a lot of research evidence around compulsory treatment. There are two different types of compulsory treatment. The first type is civil commitment, where someone is at serious risk of harm to themselves or others. There is absolutely a role for civil commitment. It's not about criminal offending; it is about protecting the person from dying or from killing someone else. Those civil commitment programs are important, and part of the system here in New South Wales. The IDAT program is one example – is the example, actually.

The other form of compulsory treatment is mandatory treatment associated with a criminal conviction. The research evidence for that is that these programs do not work. So if we want to set up compulsory treatment, we need to think about civil commitment, which is not associated with criminal penalties, and we shouldn't go down the line of mandatory treatment associated with criminal responses, if we're following the evidence. If we're not following the evidence, we can do whatever we like.

MS S. DOWLING: Is an exception to that the compulsory drug treatment centre that's in – the prison-based one associated with the Drug Court, which is compulsory?

PROF RITTER: Yes, but the evidence for effectiveness is not strong; that's my point.

MS DOWLING: Of the CDTCC?

PROF RITTER: That's right.

DR WEATHERBURN: Well, I have a different - - -

MS HEWETT: Don, what do you think?

DR WEATHERBURN: Oh, look, I think the – it's not gold standard, but there's certainly plenty of evidence that drug courts are effective.

PROF RITTER: But drug courts are not - - -

DR WEATHERBURN: But I'm not – I just want to – can I just – in saying that, I'm not suggesting for a second that we should coerce people into treatment. The key difference with the Drug Court is that they have committed other serious offences.

MS HEWETT: Yes, yes.

DR WEATHERBURN: So I'm – I would not be inclined to send people – coerce people into treatment whose only offence was use and possession of a drug. I think that would be a great waste of resources. On the triage issue, I don't know how long it takes to make a judgment about whether someone has got a serious problem of dependence, but I would imagine, even if you had some false positives, the gain would be worth the investment, in terms of offering treatment to people who you might subsequently discover – you know, I'm talking here about a totally voluntary scheme, so they've all put their hands up and said, "Yes, I'm interested in treatment," and you're doing a triage to make a judgment about whether or not your available resources can allow you to take that person. I would have thought that would be – could well be cost-effective, notwithstanding the false positive issue, as long as it's not being coerced, in which case you would have dozens of people who don't want to be there.

MS HEWETT: Yes.

THE COMMISSIONER: Can I just pick that up.

PROF RITTER: Thank you for correcting the Drug Courts.

DR WEATHERBURN: That's all right.

PROF RITTER: Don is right about the Drug Courts.

THE COMMISSIONER: Yes. Can I just pick up from what Don has just said. It's interesting, because I've just had, sort of – as the discussion has been ranging, I've jotted down a few words – it's more a thought bubble, really, but I'd be interested to know what people's reaction is to this: a sort of – is there a midway, with a scheme that might be something like a voluntary or cooperative depenalisation, where people, perhaps after a second or possibly third infringement for drug use, were then referred to something like the Dissuasion Board, but it could be a tribunal or – adequately staffed with an addiction specialist, and a lawyer, and a community member, for example, who could then triage and decide.

If there were people that were at a high level, who might have a substance use disorder, that actually warranted treatment, they could assist them into treatment, not make it mandatory, but – it's voluntary, but if the person doesn't want to do it, after going through that process, and just wants to go back into the criminal justice system, then they can. So it's a time-out opportunity for a person to be offered treatment, that would be well resourced, if that could be done. They could get assessed, and know that, in fact, they had a problem, that perhaps they didn't realise

they had before, and then offered an alternative to a criminal conviction by cooperating with the recommendation of such a body.

DR WEATHERBURN: So there's sort of coercion there.

THE COMMISSIONER: There's – it's a - - -

PROF RITTER: But you've retained the criminal offence in that model.

THE COMMISSIONER: That's why it's depenalisation and not decriminalisation. But if one – if one accepts that there's – the stick of going back before the courts is some incentive to engage with treatment, I wonder if that isn't – being respective of human rights - - -

MR ODGERS: Sorry; can I just ask a question, related to that.

THE COMMISSIONER: Yes.

MR ODGERS: What is the experience in Portugal, where it is – there is some element of compulsion; they triage, as you say; they find people who they consider problematic.

THE COMMISSIONER: Yes.

MR ODGERS: Well, they're either dependent users or - - -

THE COMMISSIONER: Yes.

MR ODGERS: - - - there's some problem. And they do adopt various strategies to "encourage" - - -

THE COMMISSIONER: Yes.

MR ODGERS: - - - the person into dealing with their problem.

THE COMMISSIONER: Yes.

MR ODGERS: What's the success rate? That's my question. Do we know? Because, if – I mean, I hear people say, around the table, it doesn't work if you're not willing to do it. I'm just curious about that. Well, it seems to be an important question, because it is an – if you go down this path, you do have to decide, are we going to adopt a strategy where we're going to try to push people into treatment where - - -

THE COMMISSIONER: "Encourage".

MR ODGERS: Encourage – encourage by, well, sticks and carrots? I mean – so are we going to have sticks and what are they going to be?

THE COMMISSIONER: Yes.

MR ODGERS: So I'm curious to know what – if there is data from Portugal about that.

MS HEWETT: Well, Annie, you seemed to suggest that there was data, didn't you? Sorry, Alison. Alison, you did seem to suggest there was data on the Portugal thing and - - -

PROF RITTER: So what I quoted was the five percent of people who go from the Commission of Dissuasion who are then referred on to treatment.

MR ODGERS: Yes.

PROF RITTER: But you're asking about outcomes, Stephen.

MR ODGERS: Yes, I am.

PROF RITTER: And I'll refer that to Caitlin.

PROF HUGHES: So if you're interested in the Portuguese model, I suggest you have a look at, in the briefing pack, the report called the Irish Review. It's page 40 to 42 – outlines kind of the context, the mechanisms and the outcome from that particular reform. So it's absolutely correct that this is very much a triaging system and so it's very much a minority of people who are deemed to be dependent who are referred on for treatment through the system. But I should just note that something that's often not recognised is that the Commissions for the Dissuasion of Drug Addiction also involves social workers and have a broad network of social – sort of other networks attached to the commission, including people – it's mental health services, employment services, education. Yes. And it's a very big wraparound.

And so from my perspective, as well as Alex Stevens', one of the biggest kind of benefits of that approach is that it is this kind of targeted social health option. It's not doing it for everyone but it's enabling those services for those people who may need it. So in the case of, say, a young 18 year old who – or 17 year old who goes before the commission, if they are not attending school but they're an occasional drug user, then the commission can look at what are the circumstances about why that is occurring and look at other sorts of options for – that are more social in orientation, whereas someone for whom it's dependent, it's more about encouraging the treatment access.

So just to raise that because I think sometimes we do get focused on it's either got to be, you know, criminal justice or health or fine based, and I think the social element can be really important as well.

THE COMMISSIONER: It's the advantage of triaging, too.

PROF RITTER: Yes.

THE COMMISSIONER: You can tailor it to the individual - - -

PROF RITTER: Yes.

THE COMMISSIONER: - - - rather than just have a - - -

DR WEATHERBURN: So your model with the triage, can I just check something?

THE COMMISSIONER: Yes.

DR WEATHERBURN: Would there be triaging at each appearance or only after the – right at the end, whatever your end may be?

THE COMMISSIONER: I would think at each.

DR WEATHERBURN: At each?

THE COMMISSIONER: Yes.

DR WEATHERBURN: That would make a lot of more sense to me because the thing is that you're trying to – you're trying to draw anyone who wants treatment into treatment, and you don't want to be waiting till the third appearance or the second or the nth or whatever it is, until you make that offer.

THE COMMISSIONER: Yes.

DR WEATHERBURN: The only concern I would have – and I'm not sure it's an overwhelming concern – is that they're going to end up getting a criminal conviction if it's the end of the third one and that criminal conviction is going to do damage to their employment and earnings prospects. But the flipside of that is how many people are going to turn up two times or three times or four times without any other allied offence, no prior criminal history, no risk of committing another non-drug offence. So that sort of makes me think, well, maybe it's worth a go.

MS HEWETT: Now, on that point, we're due to break for lunch for an hour. So unless anybody has got any objections. Or, Commissioner, are you happy to break for lunch now?

THE COMMISSIONER: Yes, I think we should.

MS HEWETT: Yes. Okay. So we will break for lunch now and come back at 1.45. And what I – I'm going to work on some things over the lunch break about some of the practical kind of measures. You know, we've had a very general discussion

about lots of principles, lots of things this morning, and I think we'll try and pin down a few – kind of some concrete steps – or thoughts on concrete steps this afternoon, including that whole issue, for example, that you – you know, you raised about, you know, the barrier – or the blurring of the lines between use and possession and supplying and, you know, all sorts of – and the depenalisation, the idea that Don talked about, about the prospect of police discretion also gives the prospect for corruption, you know, all of those practical issues. So thanks very much for a great discussion.

ADJOURNED **[12.52 pm]**

RESUMED **[1.44 pm]**

MS HEWETT: Okay. Well, we're getting close to starting. And we have, of course, been joined by the eminent Dr Gallop here. So I will – what I'll first do is get Geoff to have the opportunity, that the others had earlier this morning, just to make some opening remarks, and then we'll go on from there. I'm just saying, Geoff, that we're probably – I wouldn't mind starting and talking about the consistency with international law about your opening remarks. But then after that, I also want to get down into some specifics about how something like this would work in practice. So thank you very much for your - - -

PROF GALLOP: Thank you very much. I come to this not as an expert in all of the evidence that we can pull together in relation to proposals for – either the current system or changing the system, but I come as someone who was involved in the issue as a Member of Parliament and then as a Premier, and we took legislation through the Parliament based on the recommendation of the Drug Summit, which we promised to do before the election, to decriminalise users of cannabis – personal consumption of cannabis.

And, I must say, I found that process pretty easy, actually. I'm trying to find out where the real obstacles were in the path of that, and I can't think of any. The police were relaxed about what we were doing. The previous government had moved a bit to cautioning, so there was already a bit of a move that way. There were lobby groups out there that were opposed, but it went through both Houses of Parliament. So, you know, in a way, that was easy. The one thing we didn't do, of course, is lock in the Opposition. So when there was a change of government, the policy went out the door. So, I think, in terms of sustainability of things, that's an issue we might think about as well.

Just a quick point: when I look at a public policy proposal, I always had three ideas in my head. And you might have discussed these this morning, so I apologise if you have. One, is it suitable? Is therefore evidence that that policy can deliver the things

that you want it to deliver? In other words, is it a suitable response to the issue you're wanting to address?

The second question is a feasibility one: you know, do you have the capacity to do that with the resources and the capabilities in the public service? And in relation to some of the issues I'm sure that you discussed this morning, and Andrew would know well, that if the police are going to be involved in some sort of diversion, obviously, their training in relation to these issues becomes a question.

Acceptability gap: now, this is one that I think we underplay. Is it acceptable? Now, I think, the acceptability of something has two elements to it. One is the general public acceptability of an issue. And particularly in a contentious area, when you move, it is important to have a good layer of public support. But also potential people affected by the policy, so users in particular. If they're not part of the team, you know, the policy may not turn out as you may want it to.

So when I look at an issue, is it suitable? Is it feasible? Is it acceptable? And I think just – I'll just throw that on the table for a framework that we could look at. My own philosophy on the subject, I guess, is drawn from Karl Popper, the great philosopher, who incidentally wrote a lot of his Open Society and Its Enemies in New Zealand, where he was a professor. They called him back to Europe – unfortunately lost him – but he was a brilliant man. He said:

> *The role of the State is not to make people happy, but to avoid avoidable suffering.*

And I very strongly support the view that if you're looking at issues, the question of human suffering has to be foremost in your thinking. So when I would assess a law, the criteria that I would bring to it – or a policy – would have two segments to it. I would ask the question, does it lead to a reduction in unnecessary death and clearly identifiable suffering? And I think a lot of the harm reduction initiatives that have been taken have been put to that test and have come out, I think, very well in terms of the results. If – the second question I would ask, though, is another one which too often we avoid, and that is, if yes, does it have other consequences which need to be taken into account when considering the details of implementation and delivery?

So you make the philosophical case that you should have a policy that reduces unnecessary death and suffering, and I think that's very much part and parcel of what I – how I would look at the issue. But then you'd have to add to that and say, well, when implemented, there might be other consequences that need to be taken into account when considering the details of implementation and delivery. So, in a way, there's policy as it relates to individual people and the way our society looks upon their rights and their interests, the way our society looks at their health and wellbeing; and on the other side, there's the greater community that are part of the whole operation. And, of course, we've seen that a bit with the arguments about amenity in Kings Cross; you know, that's been an issue raised vis-à-vis the injecting centre. So they would be the two questions that I would, you know, think that we

should have foremost in our mind when we look at what sort of policy we would want to take.

My observation, as a person sitting in a helicopter, looking down on policy in New South Wales today, is that all of the – all of the drive for change has been coming from the harm reduction side, and the harm reduction side has been able to show pretty clearly, I think, that in many respects, they are on the side of reduced suffering; they're on the side of supporting people in their life's journey; and, given human nature being what it is, that's the best way to look at the issue.

And so, when it comes to drug policy generally, I would certainly advocate for decriminalisation. In terms of what it would mean for the individual people concerned, we know the debate about harms there, what harms there are in terms of having criminal convictions, the harms there in terms of the stigma and – difficult for people to access services, and whatever.

But, as you pointed out in your excellent paper, there are different ways of doing that. And I think that, in many ways, the detail of doing it becomes just as important as the doing it, given that you had four models – I think you had depenalisation before decriminalisation, then decriminalisation without penalties, decriminalisation with sort of administrative fines and whatever, and then decriminalisation with referral to other services. So there are different models that come up.

So that's my general position. I personally believe – and I think we can marshal evidence to that effect – it's – by the way, there's no nirvanas here. This is not an area of nirvana. You know, I'm reminded – I picked out this lovely quote you might be interested in from Machiavelli:

> *Men are so thoughtless they will opt for a diet that tastes good without realising there's a hidden poison in it.*

I mean, he – his view was, human nature is human nature. We cannot assume rationality; we cannot assume that people are going to be perfect; we cannot assume – we have to just assume the world as it is. And the world as it is is that people will take drugs. And, as a result of that, we've got to work out how we – you know – how we position ourselves as a community in relation to that issue. So my first instinct is, decriminalise. And in and around that, you know, what are the details? The details become everything, in a sense – just as important as the philosophy.

My second point would be in favour that, from a community point of view, I think, it just sets a framework within which we can better deal with all of these issues, if we have a decriminalised – I'm talking about use here, by the way; I think you understood that – users. If we have a decriminalised situation, the world changes. The way the users would look on their position, the way the community could intervene to help, the way that the whole society looks at this thing – it'll be taken from a more normalised approach, rather than building in moral, you know,

fundamentalist-type issues that never work well in human society. We – you know – we try it and we try it.

I don't know whether any of you have visited the Piazza della Signoria, in Florence, but if you go there, there's a little plaque right in the middle that says, "This is where Savonarola the radical priest was hanged and then burnt at the stake." And then you look around, and there's the government building where Machiavelli had his office. And the fact is, Savonarola wanted a perfect people. He wanted to have virtue reigning on this earth, and he had gangs of young people checking up on behaviour, and he had bonfires of the vanities, as the book came to be known. And it didn't work. It cannot – you cannot expect human nature to do what it can't do. You can expect it to allow for change, but you can't expect it to create perfection. So I come in at that level. And for that reason, I think, it's much better to have a decrim framework.

So I'll leave it at that. Is it suitable? Is it feasible? Is it acceptable? are the three frames I use for public policy. Secondly, my criterion for analysis are, does it reduce avoidable suffering, and death for that matter, and then, if it does, what are the consequences that we need to take into account to make it work effectively? And then, finally, I would favour a decriminalised approach to all drugs, but the key issue then becomes, what is the detail that goes with that? And the detail could vary dramatically in terms of its impact. So really that's just the first step; there are a bunch of many other issues that you would have to raise if you went down a decriminalisation path. So I don't know how I've gone there, Jennifer, but - - -

MS HEWETT: You got a bit of dispensation. Okay. Well, just on that point, we are going to go - - -

PROF GALLOP: Yes.

MS HEWETT: - - - to a lot of those details this afternoon, because, you know, obviously, it is true that the philosophy is important, but so is exactly how you do it. But on that – but, before we do that, I would kind of quite like to just deal initially with this idea of the consistency with one international law in terms of decriminalisation if that matters, and also the consistency with Federal law. We don't, obviously – you would have seen, probably, the submissions from the Department of Home Affairs and their arguments on that, so I won't go over them. But, obviously, you know, they think this would be a very big negative.

So you don't – anybody who wants to, you know – maybe only a few of you want to contribute on this, but I thought we should at least address it. And I would like to start with you, Andrew, on that point, (1) if you've got any views on the international law, but (2), obviously, given your background, how you think that plays into the police enforcing state laws that may be in conflict with Federal laws.

MR SCIPIONE: Yes. Okay. Thanks, Jennifer. Look, we talked at length about the whole notion of international law and the international obligations – treaty

obligations that we have. And I think they're well covered off. In fact, you've got some specific independent legal advice that says that, you know, if there's a problem, potentially - - -

THE COMMISSIONER: For decriminalisation.

MR SCIPIONE: For the decriminalisation. Correct. Ironically, what would be interesting, if you did manage to go down the path of decriminalisation in New South Wales for ice, but you still had cannabis criminalised, effectively, it would be laughable. Thank you, Don. Perfect.

DR WEATHERBURN: That's all right.

MR SCIPIONE: So we will let the international law stand and I'm sure that that's something that will be for discussion elsewhere. I was talking to Jennifer a bit earlier about – it's really important that we send clear messages to our police. And when you have inconsistencies like – potentially, we could decriminalise amphetamine in New South Wales, but they would still be a prohibited import under the Commonwealth legislation. You get a lot of confusion. There's a lot of – any messaging, there's a lot around what it is that we need to do. What are we trying to do here?

Particularly you can imagine – and I was trying to think about it. Imagine if you had somebody that walked off a plane from another state that had been in the air at Mascot Airport, stopped out the front and they're in the terminal building, and they're arrested and when they're searched they're found – they're spoken to, searched. When they're searched, they're found to be in possession of crystal meth. The cops are going to be saying, "Well, where has the offence been committed? Are we on Commonwealth property or are we on state property? Is this a Commonwealth offence or is it a state offence?" Well, the Commonwealth says that, you know, we need to take certain action, because it's a crime. It's that sort of confusion you do not want in your police force. You want clear, concise directions, so that they can work to the letter of what's required under the law.

MS HEWETT: So, just on that, is there any advice from the ACT, given they're policed by the AFP, in relation to their laws surrounding cannabis? So the cannabis laws in the ACT differ from the Commonwealth cannabis laws and it's the same police force. So this might actually be the same officer.

MR SCIPIONE: Yes, but they're a contracted – they're a contracted police force.

MS HEWETT: Okay.

MR SCIPIONE: So, effectively, they've been leased out from the Federal Police. They have their own administration, they have their own administer, they have a - - -

MS HEWETT: Okay.

MR SCIPIONE: - - - commissioner.

MS HEWETT: But they would still be in the same situation.

MR SCIPIONE: Accepting that, too – I'm not sure. Have they decriminalised - - -

MR SCIPIONE: - - - cannabis? Full decriminalisation?

PROF HUGHES: No.

MR SCIPIONE: It's - - -

PROF HUGHES: Effectively.

MR SCIPIONE: Sorry?

PROF HUGHES: Effectively, but it's depenalisation.

MR SCIPIONE: Depenalisation. And that's the point. So this is where it gets really confusing. If a group like us are sitting around a table and are confused, depenalisation, decriminalisation, where does it sit, can you imagine what it's like for an officer on the ground trying to deal with, you know, information overload. There's risk, there's threat, there are people there. It's just not good practice, particularly if, and as is the case with a cannabis cautioning scheme, the infringement notice scheme, we leave them with some discretion.

Now, if you separate out the corruption potential – let's take that to one side, because that should be dealt with by other practices. There should be strong management control around the corruption practices. And if this is an issue, that should be dealt with by others. But if you think about that environment where they are going to and they are daily exercising their discretion, it's nice for them to have really clear, you know, unambiguous rules around what's actually happening. "What are we trying to do here? Why are we doing this?" And I think that that's something that does need to be considered.

MS HEWETT: Okay. Thank you. I just wondered, Geoff, if you had, because of your position on the Global Commission on Drug Policy – have you given any thought to or have any particular views on that inconsistency with international law?

PROF GALLOP: Well, I'd make two. First of all, the Commission's currently doing a whole lot of work on the implications of current policy around the world on - - -

MS HEWETT: Yes.

PROF GALLOP: - - - incarceration and human rights and all that. So that's currently being looked at very, very carefully. So all of those… you can put that to

one side. I've just joined this, so I'm not, you know, clear on all of their positions on everything and the work they've done I'm going through. But on the general issue I'd like to make a couple of points. One is there is the law and then there is the politics. For example, at the national level at the moment, it was always interesting to watch how the Federal Government approached the injecting centre. Now, obviously, initially, it was a pilot, so that wasn't such a big issue.

But one wonders whether they could have taken a hard line on it. I mean, just to give other examples, Gough Whitlam used to always argue and argue to me that the Australian Government should go to the International Tribunal in Geneva to rule on our electoral law, but no one ever did it. You know, would a national government try to overthrow a state that introduced policies that could be seen as inconsistent? There are politics in this. And John Howard was a pragmatist. He never intervened on the injecting centre, which I found quite interesting. As a pilot, obviously, they might not have had a position to do so, but once it's up and running.

They did it in Canada. They tried to knock off the one in Vancouver. So I take Andrew's point that he would know that there's a lot of – sometimes we – someone says, "This could be against the law", you might still do it, because the other side who would take it up might not deem it politically. And in our society, everything is not clear. Democracy has fuzzy edges attached to it. It makes it work. Without the fuzzy edges – there's a huge fuzzy edge at the moment in terms of abortion law in New South Wales, for example, that parliament is trying to fix up. But you can see the point, that it doesn't necessarily follow that if there is a case it will happen. So I don't think New South Wales should necessarily not do it because of that. And I know there's probably other legal views on that question, but there is the politics. On the, you know, the general – well, I will leave it at that.

MS HEWETT: Okay. Now - - -

THE COMMISSIONER: I might just make an intervention there. Thanks for that, Geoff. The medical safe injecting centre in King's Cross, of course, is a statutory exception de jure, not de facto, to the criminalisation of possession of those drugs that people take in there. So while they're in that space it's lawful for them to be in possession. So that actually is an example of decriminalisation.

PROF GALLOP: It is.

THE COMMISSIONER: It's also interesting that at the time the UN objected to it, and now we see safe injecting centres all around the world, and it's interesting that as the international conventions stand, the word, that injecting centre is in breach.

PROF GALLOP: Yes.

THE COMMISSIONER: And the state has made an exception despite those conventions, because it was seen as being the right thing to do, in effect, as a matter of policy. So I just make that point, that we already have a decriminalised operation

in the medical self-injecting centre that technically would be, arguably, in breach of those conventions.

PROF GALLOP: But I don't think the Federal Government would do that. That's my judgment call. They may try, but I think - - -

THE COMMISSIONER: Well, you may be right. I'm just saying it's existed - - -

PROF GALLOP: No.

THE COMMISSIONER: - - - for about 20 years now, I think, and it's still there.

MS MADDEN: It goes to Kate's point, too, though, earlier about human rights frameworks, as well, human rights law, because the case you raise about Canada and the Federal Government in Canada, the reason they failed in that attempt to close the self-injecting room was predominately came down to human – on human rights grounds. That's how the court – I mean, Kate studied - - -

PROF SEEAR: Yeah.

MS MADDEN: - - - this. She knows more about it than I do.

PROF SEEAR: Yeah. Thanks, Annie. I was keen to intervene when Geoff was saying that, because that's absolutely right, but, also, too, the important thing is that that was because of the Canadian Charter of Rights or Freedoms, which is absolutely different to any protection that we have here in Australia, unfortunately. But, nevertheless, as I mentioned at the outset today, there is this increasing rhetoric at the international level about the need for human rights-compliant approaches, which – which is, obviously, off to the side of the international law question about whether decriminalisation might be in breach of those treaties. But I think is something that can potentially be leveraged or needs to be thought through, in any event.

THE COMMISSIONER: Can I just add one other thing Jennifer, thank you. This Chief Executives of the United Nations' agencies, their communique which was issued in January this year indicates in annexure 1 that that Board, which are the head of the 30-odd different agencies under the UN umbrella, including the United Nations Office on Drug and Crime, resolved to promote alternatives for conviction and punishment in appropriate cases, including the decriminalisation of drug possession for - - -

UNIDENTIFIED MALE: Sorry.

THE COMMISSIONER: The decriminalisation of drug possession and use and to promote the principle of proportionality. And they go on with some other things, as well. So it's interesting that despite these international conventions, the chief officers of all the UN agencies have made that communique. So I just put that out there as another thing that might soften this issue.

PROF HUGHES: Can I add one thing to that, which is that in 2015 the International Narcotics Control Board actually came out with a statement that the Portuguese decriminalisation was a model of best practice that member states should be following. And so if the international Narcotic Control Board has been saying that since 2015 and we now have the 30-odd member states, including the United Nations Office on Drugs and Crime, which was kind of the most recent to adopt this position, stating this, I think it's a very important statement that has been put out to member states including Australia. Another final comment is that another sort of international law expert, Brendan Hughes, who's actually no relation of mine, from the European Monitoring Centre on Drugs and Addiction, has recently stated that decriminalisation is very much in the mandate of member states. So - - -

MS HEWETT: Now, does anybody else want to talk on the - - -

PROF GALLOP: Could I just push Andrew a little bit on the discretion issue. As a principle, absolutely agree with you. And I had a case study of this when the Federal Government wanted to change the right to kill laws, you know, when police are confronted with a potential terrorist. I was the one person who didn't agree with the changes, because I thought – I was advised by our police service that they had clear directions, they knew what to do. This was loosening it up.

And the poor Brazilian guy in London, as you know, was shot even though he wasn't a terrorist. So good point, I agree. How difficult would it be in this case, though, really, do you think? I mean, all the time our police officers are in complex situations, you know? I've seen them at football games dealing with very tricky situations where they're very wise in the way they deal with it. And it's all discretion. How seriously difficult would it be, really, to - - -

MR SCIPIONE: Give them discretion - - -

PROF GALLOP: In this area.

MR SCIPIONE: Well, look, they do it every day, Geoff. They do it - - -

PROF GALLOP: That's my point.

MR SCIPIONE: - - - with cannabis cautioning, they do it with criminal infringement notices.

PROF GALLOP: Yeah.

MR SCIPIONE: There are some criteria that have to be there, around the individual and the particular - - -

PROF GALLOP: Yeah.

MR SCIPIONE: - - - case. And if they aren't there, then they don't have the choice to exercise their discretion. But if they comply, then they're in a position to say, "Well, we're not going to put you before a court on this occasion. You know, we need to give you a break. We need to help you." My point is that if you give them that clear guidance, they'll exercise their discretion well. Some might suggest it could open up potential in terms of corruption. Well, that's another issue, as I've said.

But the thing is it's about making sure that, you know, you give those people – and they're predominately younger people that they're dealing with in these circumstances, where they sort of say, "We realise that if you end up with a criminal history, it's going to be very difficult for you to get work. And if you can't get work, you're not going to probably go as well in life as you potentially could or should. So we need to give you a break. We all make mistakes." And, as I said before, these people, before their cops, they're people.

They don't have a problem exercising discretion but they need to have very clear guidelines. They don't like confusion because that's when it all goes wrong. "You know, I thought I could do that, but maybe I couldn't," you know.

MR ODGERS: When the United States was considering – a number of states were considering legalising cannabis, as a number have done, one of the arguments advanced against that was that it would be inconsistent with federal law and, indeed, you know, there's no doubt that under federal law dealing in cannabis remains an offence. But in practice it has not proved to be a major problem. My understanding is the FBI and federal bodies in the United States generally don't enforce laws where it's a situation where the law has been legalised in the state.

MR SCIPIONE: I tell you where it's been a bit of an issue, Steve, it's been around one state to another where there's inconsistency in adjoining states - - -

MR ODGERS: Yes.

MR SCIPIONE: - - - where they're crossing over borders and they say, "Hang on a minute. 100 yards down the road I was okay, but now I've come in here and you've arrested me."

MR ODGERS: It's plainly desirable that there be consistency.

MR SCIPIONE: Consistency.

MR ODGERS: Plainly. But the question is: does the fact that there might be some inconsistency, that some police may have some confusion about how they're to act, is that sufficient reason not to take the step of whatever it is, decriminalisation or the legalisation? And my view is that it's unlikely to be a sufficiently serious practical problem that it would discourage reform of the type that we're discussing.

MS HEWETT: Yes. Alex.

DR WODAK: Well, Geoff has reminded us of the importance of looking at not just the legal aspects of this but also the politics of it. And I don't think it's a secret that the United States has been a prime – the prime instigator and prime enforcer of the International Drug Control System over the last century. In recent decades, the most senior US official spokesperson on drug policy, Brownfield, used to say that the interpretation of drug treaties was inflexible. He then changed his mind and a few years ago started saying, no, actually the interpretation of the drug treaties was flexible. He has since retired and I don't know what his replacement says.

But it's clear now that the situation of the instigator and enforcer is very different when 10 of the 50 states have in fact – are now regulating cannabis, but the states of course, the 50 states are not parties to the convention, only the federal government is, so there's some wiggle room there.

MR ODGERS: As there would be here if New South Wales decriminalised.

DR WODAK: Indeed. So I think the other point I want to make is that the – that's relevant to the medically supervised injecting centre and also this debate is that in about 2006 the UNODC, under a different name at the time – sorry, the INCB commissioned a review from the legal section of the UNODC, which was called something else at the time, about the legality under international law of harm reduction measures. And they didn't like the report, presumably, because the report was shelved – was kept under wraps, but some noble citizen leaked it and it's now readily available, and it has been acknowledged to be the official report.

Anyway, the conclusion was that all of the things that we discuss in relation to harm reduction, and they specified the needle/syringe programs, methadone treatment, medically supervised injecting centres, all of them do not breach the international treaties, but they made an exception in the case of pill testing and said that they're not sure about pill testing. They didn't say it was definitely in or definitely out. That was almost 15 years ago. So in terms of this discussion, I think that's encouraging.

MS HEWETT: Okay. Now, if – unless anybody else wants to talk - - -

PROF SEEAR: Can I make one – just one quick point, Jennifer?

MS HEWETT: Yes.

PROF SEEAR: Just to pick up on Andrew's comments. Obviously I defer to Andrew, not being a police officer, certainly never the Commissioner of the Police Force myself, so – but I make just one quick additional observation. In the diversion report that we've mentioned a couple of times already that Caitlin, Alison, Lorraine Mazerolle and I conducted, we did interview people, as Caitlin mentioned earlier, from across Australia, including people in policing, and questions about the kind of observation that Andrew makes about police confusion or other bureaucratic and

administrative minutiae was raised repeatedly as something that does shape how willing police are to offer diversion to people.

But we also heard ways in which diversion, or depenalisation, as this Commission would have it, can be facilitated, and we listed a number of those facilitators in our report, and one of those was police – putting it into police performance monitoring systems. If police – we were told repeatedly that if police knew that diversion or these kind of administrative alternatives were required and were required to report accordingly, that they would be more willing to take it up. And, as I said, Andrew, I defer to you if you – if that's wrong, but we heard that repeatedly.

MR SCIPIONE: Absolutely the case. As I said, they like clarity. They don't want any misunderstanding. They – simply, "If that's required, that's what we'll do." And so that whole – then this comes down to the crunch point. If it is to be a diversion process that we go through, you've got have somewhere to divert them to, and the services are just not there.

MS HEWETT: Okay.

PROF HUGHES: Can I just add briefly. The other thing that was noted is probably even more important than putting things into police performance targets or measures would be making schemes de jure, so it's in law. So South Australia is a real exception. You saw 98 percent of people being diverted there for a principal offence of use and possession, and the number 1 reason we were told that state is such a standout is because both of their schemes have been in law whereas – as opposed to just discretionary. And the Victorian Parliamentary inquiry for drug law perform also recommended that the diversion schemes in Victoria be, again, put into law as a mean of clarifying – just making it very clear, and that would be one means of reducing the differences that you see between local area commends.

DR WEATHERBURN: Doesn't the cannabis caution scheme - - -

PROF RITTER: And protecting the police.

PROF HUGHES: And protecting the police.

DR WEATHERBURN: - - - have a legislative base?

MR SCIPIONE: It does.

DR WEATHERBURN: So that's not really - - -

MR SCIPIONE: But it's not a direction. There's still - - -

DR WEATHERBURN: No, no. But there's never going to be a direction - - -

MR SCIPIONE: Well you will not get - - -

DR WEATHERBURN: - - - in law, "You must divert."

MR SCIPIONE: Exactly, because, at the end of the day, the oath of office, they take the role that they perform as the office of constable. You can't – the commissioner could never direct an officer to go and arrest somebody. It just - - -

PROF SEEAR: But can I just say, Don, I think, again at the risk of stating the obvious, there's a very big distinction between legislation that says you shall divert and you may divert.

DR WEATHERBURN: Yes.

PROF SEEAR: And that's the kind of – I know we're going to talk about the kind of detail minutiae of any system, and system design is very important, but that's one example of how one word in a provision could have a hugely divergent impact on what happens.

DR WEATHERBURN: I know the difference between "must" and "shall".

PROF SEEAR: I know you do. I'm just making – I'm just putting that on the record.

DR WEATHERBURN: I remember my Latin from first year, you know. The man who cried out, "I will drown – I shall drown," and everybody let him drown. That's what he wanted to do.

MS HEWETT: All right. Well, I think I shall change the topic slightly, and that is to go –although segueing in from this whole thing – is to go to this question of, you know, as Geoff said, you know, about the details, and I do think this is very important. Now, I don't want to verbalise everyone – anyone, but I would kind of like to get, just around the table, some views on this because we come down, I think – I understand that some people obviously would prefer legislation, but I'm – but in the context of this particular debate, we seem to be coming down, I think, to whether there should be any change in terms of decriminalisation or depenalisation.

And I wouldn't mind getting, you know, an assessment on that from around the table, what's the kind of – I think we've agreed there's obviously no perfect solution and, again, in some ways it's kind of the least worst option. So if we could kind of, like, start on that, just as a kind of outline, and then we'll go into exactly how that should work, if it should be different for different drugs. And on this basis, that's – because we are kind of talking so much about, you know, ice and ATS, I understand the reference – you know, it's kind of useful to have cannabis there, but I don't really want to get into cannabis very much or just – you know, because it's a very different – I think it is very different drug, but also we really want to kind of get specific on methamphetamine. So, Caitlin.

PROF HUGHES: So, to answer the question that's posed here, "Should drug use/possession remain a criminal offence?" I would say, on the basis of the available evidence, the answer is no. So there should be – expanding depenalisation would be beneficial in New South Wales, but decriminalisation, removal of the criminal penalties for use and possession by law, would be more effective and a better and more just approach.

MS HEWETT: Okay. Andrew.

MR SCIPIONE: Well, as you probably imagine, I'd have a – probably a bit more conservative view. The whole notion of – of decriminalisation still, in my mind, hasn't been finalised. We are signatories to international conventions, and certainly the – you know – the paperwork that we were provided with makes that really clear. We got an obligation to ensure that domestic law complies with international convention to which we're a signatory. The Commonwealth Government has made the – the point. Geoff's point that in – you won't be challenged – that could well be the case. But from my perspective, I still think that we need to look at some of the systems and processes that are working, like the cannabis cautioning scheme – not talking about cannabis – like the – the criminal infringement notice scheme, and the scheme that was used over the last dance festival period, that New South Wales Police were able to issue infringements.

MS HEWETT: So that was effectively - - -

MR SCIPIONE: I - - -

MS HEWETT: - - - depenalisation.

MR SCIPIONE: That was depenalisation.

MS HEWETT: And you think that's a better option - - -

MR SCIPIONE: Well, I - - -

MS HEWETT: - - - than decriminalisation?

MR SCIPIONE: Well, I think it would be, from my perspective, in light of what I've read, and – and even the independent advice – I still think that there is some – it's not a good look to start, sort of, I think, turning down your obligations that you signed up for - - -

MR ODGERS: Can I interrupt; I'm sorry.

MR SCIPIONE: - - - internationally.

MR ODGERS: I think you're misstating the position. The advice is that it may be inconsistent - - -

MR SCIPIONE: Correct.

MR ODGERS: "May be". It's not saying it is; it may be. I'm not aware of – even the federal department didn't say it would be; it may be. So there's uncertainty about it. We have numerous international bodies saying it won't be. So I'm just correcting your proposition - - -

MR SCIPIONE: Sure, sure.

MR ODGERS: - - - that it will be. I think that that's misstating it.

MR SCIPIONE: But in the light of "it may be", that's again – this is a – this is all about, in my mind, getting certain clarity around these things.

MS HEWETT: And also just – and then – and then – there's clarity, but then there's also this idea that depenalisation – the use of police discretion, as well. So just - - -

MR SCIPIONE: Well - - -

MS HEWETT: - - - in terms of the practice of that, do you think that's the - - -

MR SCIPIONE: Depenalisation - - -

MS HEWETT: - - - better option?

MR SCIPIONE: - - - ensures that there is discretion, based - - -

MS HEWETT: Yes.

MR SCIPIONE: - - - on what we've seen. But again, I don't think any of it should be adopted. We shouldn't go anywhere near changing anything, unless there are services sitting behind such a decision that we could make sure we could refer to the people that can deal with this. Because, you know, at the end of the day, for us to do anything – if we were to change the mix, and then throw people like this out in this – this whole process whereby we might divert them to nowhere, would be terrible.

MS HEWETT: So you think that it'd actually be worse than the system we've got now?

MR SCIPIONE: Oh, well, if we had nowhere to divert them to – if we started to put massive numbers through – and if you look – Don, you could tell me, how many people have been through the cannabis cautioning?

DR WEATHERBURN: Sorry, can't tell you, actually. I - - -

MR SCIPIONE: Thousands?

DR WEATHERBURN: I don't work in the Bureau of Crime Statistics - - -

MR SCIPIONE: No, no, no, and I don't work in the Police Force any more.

THE COMMISSIONER: But tens of thousands - - -

MR SCIPIONE: Tens of thousands - - -

DR WEATHERBURN: Tens of thousands.

MR SCIPIONE: If you put them through a scheme, and you sort of – you didn't give them anything that sat behind that scheme, then you're setting – you know, I mean - - -

DR WEATHERBURN: Pointless.

MR SCIPIONE: It's – sorry?

DR WEATHERBURN: Pointless. It'd be - - -

MR SCIPIONE: Pointless. Absolutely pointless. So, you know – and I look at a number of the recommendations and a number of the presentations that are here, and they're all saying, you must have that back of house, you must have that support, that medical support, that social services support, in order to make a difference that's going to be positive. Because it could be far worse.

MS HEWETT: Okay, great. Thank you.

THE COMMISSIONER: Sorry – sorry. Andrew, I'm just wondering, coming back to this idea I was talking about before lunch, with – if police are – well, if it was a guided discretion, to the point that if somebody had used up, say, two cautions – and I'm just snatching this out of the air; this isn't a formal model, but – and then comes before the police on a third occasion, and if the statute then said they must fall into a tribunal, which could then triage the extent of their problem, decide whether or not they needed to be "encouraged" into treatment or perhaps allowed just back in the system, that would be something that wouldn't be too complicated - - -

MR SCIPIONE: I think that'd have merit.

THE COMMISSIONER: Yes. And there would – that would be – I mean, there could be clarity in a scheme like that.

MR SCIPIONE: Of course. Of course.

THE COMMISSIONER: Yes.

MR SCIPIONE: I mean, and it – you know – it's going to be that type of an outcome - - -

THE COMMISSIONER: Yes.

MR SCIPIONE: - - - that, I think, will change much of what we're doing today. Because, as I said when I first spoke, what we're doing is not working.

COMMISSIONER: Yes.

MR SCIPIONE: So we do need to look for options. That would make sense.

MS HEWETT: Thank you. Alison.

PROF RITTER: I absolutely agree with Andrew's call for treatment for crystal methamphetamine.

MR SCIPIONE: Yes.

PROF RITTER: That call obviously is misplaced in relation to MDMA. And you can see the numbers under the current infringement notice scheme: it's predominantly MDMA. So a – more treatment for people with problems with crystal methamphetamine, but that's not required for a change to the criminal penalties in relation to MDMA.

Secondly, I – I mean, I think the discussion is really concerned with depenalisation versus decriminalisation. And I'm not sure, Commissioner, but I think the model you were describing is a depenalisation model - - -

THE COMMISSIONER: I think that's probably right, you know.

PROF RITTER: - - - as you keep referencing back to the courts. You know, based on many years of considering these issues, and the evidence that's before us, I support decriminalisation – de jure decriminalisation – as the most appropriate and, on balance, most likely to produce the outcomes that are desired. There will always be trade-offs with any of these policy options that we choose, but on balance, that would be the one that I would support.

THE COMMISSIONER: Could I ask you, Alison, if decriminalisation were going to happen - - -

PROF RITTER: Sure.

COMMISSIONER: - - - for whatever reason - - -

PROF RITTER: Yes.

THE COMMISSIONER: - - - would a depenalisation expansion, such as the very rough idea I've floated, be better than the current situation?

PROF RITTER: Yes. So in other jurisdictions, there is a informal or, you know, de facto depenalisation of all drugs. So if I have a quantity of crystal methamphetamine on me for my own use, and I'm in the city of Melbourne, I will not be charged with a criminal offence. That is true in all of the other capital cities of Australia bar Brisbane and Sydney, and we don't need a commission, and we don't need to bring people before it; we could simply have de facto depenalisation tomorrow, in New South Wales, and it would bring us in line with the other states and territories in Australia. That would be the absolute minimum. Then you would step it up to the kind of model that you're talking about, with some notion of the drug types, I think, is important. Putting everyone with MDMA - - -

THE COMMISSIONER: Yes.

PROF RITTER: - - - before that scheme - - -

THE COMMISSIONER: Sure.

PROF RITTER: - - - is not a good use of resources; crystal methamphetamine arguably is.

THE COMMISSIONER: Thank you.

MS HEWETT: Yes, Don.

DR WEATHERBURN: So you're just asking for statements, not reasons, so I'll just keep myself – so - - -

MS HEWETT: You can give some reasons as well, if you want.

DR WEATHERBURN: So, yes, I certainly think – no one's mentioned it; it's hardly ever used – but I think it'd be good to get rid of prison as a sanction for use and possession simpliciter. I think that does very substantial harm, to very limited effect. It'd be good to caution rather than convict, because conviction also does significant harm, but only up to a point. I'd be worried about a situation – and this goes with my issue of decriminalisation – I'm still very nervous about the potential consequences of decriminalisation, notwithstanding the confidence of my colleagues around this room about its benign effect.

MS HEWETT: Now, on the depenalisation, though, but you're also rather dubious about the effect of that, though, aren't you? I mean, if you're asked to choose between one of those options - - -

DR WEATHERBURN: Well, I'm – I'm very happy with what we were discussing before, which is that you massively expand treatment options, and you do your best to siphon people who are dependent users into treatment. Did I miss that bit?

MS HEWETT: No, no. I'm talking about when you were talking about that giving police discretion is not a good option - - -

DR WEATHERBURN: Oh, no, I think that my point there was about unfettered or unguided discretion. Andrew dealt with that adequately when he - - -

MS HEWETT: Right.

DR WEATHERBURN: - - - pointed out that there would be guidance. The extent to which you put it in law or you just put Commissioner – Police Commissioners' instructions – he's absolutely right, that if you're a police officer on the beat – and I've talked a lot to them – if they're in any doubt about what's right and what's wrong for them to do, you get all sorts of problems. So I don't mind the discretion, as long as the circumstances of its exercise are clearly spelt out.

MS HEWETT: Okay. And so you don't have the issue with corruption, either, that you'd mentioned this morning?

DR WEATHERBURN: Only if it's unfettered and unguided.

MS HEWETT: Right, okay. Okay. And in practice you don't think that would be an issue?

DR WEATHERBURN: Well, no. Well - - -

MS HEWETT: It was very - - -

DR WEATHERBURN: Well, we can't be sure about these - - -

MS HEWETT: Right.

DR WEATHERBURN: - - - sorts of things. But – but, you know, if he's – if he or his successors are able to say, "You exercised your discretion that way, and that violated the Commissioner's Circular 345B," then there's a way - - -

MR SCIPIONE: It can be dealt with.

DR WEATHERBURN: - - - dealing with it.

MS HEWETT: Okay.

MR SCIPIONE: That's right.

MS HEWETT: Okay. Great. Eddie.

MS LLOYD: So I don't think it should be a criminal offence to possess small amounts of drugs, and I think the threshold needs to be increased. I do not – and the ALS position is that we don't – agree with depenalisation, for all the risks, and the evidence that we've seen of secondary offending for many Aboriginal clients, and also the issue of discretion. Police discretion, in my experience, hasn't been operating well within Aboriginal communities. And in many communities, including in our region, in certain sectors, there's quite a big division in between the police and the Aboriginal community. So also that affects whether or not people are willing to admit to an offence, as well; that could be a barrier.

And I think we just need to acknowledge, in this roundtable and in the broader inquiry, just keep – I need to keep reminding everyone of the overrepresentation of Aboriginal people in custody, and the now 30-year-old Commission into Aboriginal Deaths in Custody report, with deaths still happening. And any discussion on the models, we need to really have that at the forefront of our minds, the overrepresentation of Aboriginal people in the criminal justice system.

And depenalisation is not working. Decriminalisation is preferable, although I'd go with legalisation, but I would agree it needs to be de jure, in legislation. I think we definitely need to look at increasing the thresholds of possession, because so many people who are using, particularly crystal methamphetamine, are user/dealers, and quite often they've got certain – or they're not dealing, and they've got quite a bit in their personal supply; that is, because it's over the threshold, they're deemed to be supplying, so then they get charged with supply. I think it's only three grams of methamphetamine; over that, then they can be deemed supply. So, I think, definitely the threshold needs to be increased, and maybe then you'd see savings of cost to the system, because you'd be capturing those people as well.

And then any cautioning scheme, really – I've got the concerns around the discretion, but if there was going to be one, that treatment shouldn't be mandated, because, of course, there are so many people that won't need treatment. And there shouldn't be any limit on how many cautions somebody gets.

And I'll just comment on the international law question. I don't think it's a significant barrier. I think it's important to remember that the conventions that we've signed are from 1988 and 1961, and that the communiqué from the UN has come this year, and that's the kind of guiding, overarching recommendation to all member states, to decriminalise. And that – well, let's face it, there are plenty of international conventions we've signed that have been breached over time: The International Convention for the children, the Refugee Convention. So I don't think that's a huge barrier at all. Any model that we agree with has to come with an expansion of treatment services.

MS HEWETT: Thanks. Annie.

MS MADDEN: Yes. Well, so, as I said before, I support legalisation and regulation. Outside of that, in this context, I think, it needs to be decriminalisation de jure, no sanctions attached; realistic thresholds for possession. I think it needs to be all – for all currently illicit substances; I think there's real problems with taking a selective approach. There has to be more quantity and quality of services, and they need to be health and social services, not just treatment services, and culturally appropriate frameworks and approaches within that, and not mandated. I think there also needs to be a comprehensive stigma reduction and elimination type program or strategy that would accompany something like this, that targets everyone involved, including the general community. That'll do for now.

MS HEWETT: Thanks, Annie. Stephen.

MR ODGERS: Well, as I said at the beginning, our association favours decriminalisation of all drugs. That position hasn't – my views on that haven't changed. Just apropos of the issue the Commissioner raised about the possibility of a depenalisation model with greater levels of discretion and triaging and all of that, my fundamental concern about that, apart from the principled one which is, it should not be a crime to use a drug per se – that's a principled approach – my fundamental concern pragmatically is a cultural one, which is that if you retain it as a criminal offence, that will inevitably feed through to the whole approach that various governmental bodies, institutions, health services – the way they approach the drug user, even subtle, changing the way that that approach occurs. And it seems to me that, as in Portugal, whereas the Commissioner pointed out, the whole premise of it was to move away from a prohibitionist criminal justice framework to a therapeutic, socially-focused mechanism designed to help users where they needed it, of course they didn't. Then you need to decriminalise to encourage that. And so that seems to me a pragmatic reason why simply going to depenalisation doesn't – won't be as practically successful as is what is likely to be the case with decriminalisation.

DR WEATHERBURN: That'd be speculation, though. Is there any evidence of that?

MR ODGERS: No. I'm talking at a level of principle, really. I can't – I mean, I'm saying – the evidence, as I keep saying, let's look at what's happening in Portugal. The fact is Portugal decriminalised. Right? They did not retain a criminal offence. They are able to – still able to have carrots and sticks, which I think is sensible, but they don't need – they haven't - - -

MS HEWETT: Yes.

MR ODGERS: - - - retained the option of a conviction.

MS HEWETT: Yes, but to Don's point, a lot of the discussion we have about the use and possession of ice, as opposed to, say, MDMA or cannabis is often accompanied with other offences.

MR ODGERS: But they'll be dealt with by the criminal justice system.

MS HEWETT: All right. So it's not - - -

MR ODGERS: It's not changing any of that.

MS HEWETT: Right. Okay.

PROF GALLOP: Look, I think in terms of my criteria, which was, you know, to deal with avoidable suffering – and in respect of ice, clearly there are elements of the consumption of that that have suffering attached to them. And I think they're avoidable. My view would be that if you don't decriminalise, the difficulty you're going to have is you're not going to encourage – you're not going to create an environment in which those people that use this drug would feel confident about, you know, trying to deal with it. You'll leave it in the hands of the police.

And, as Andrew says, if I might use a quote against his position, if you like, that they're in that discretion business, you know, they're having to make these decisions. If you decriminalise, I think it's a much clearer framework within which for the user to exist, within which the police to exist and within which the overall community, I think, can talk about what it needs to do. And Andrew's right, the lack of services at the moment is a major issue. I don't know whether you've seen the Uniting Church film From Dubbo to Sydney, you know, it's horrific, you know, the lack of services for people who want to get them in regional, but also the waiting lists here in – so, in a sense, you'd have to tackle that on – tack that on to your issue, as well.

So decriminalisation is the cleaner solution administratively, if linked with targeted diversion as indicated here in 3.4 of the paper. I think it's – it would have good health effects. I think it's easier for the police if that was the framework. And just if I can conclude by saying yes, there's going to be inconsistencies in the way that our society operates. We've already made cannabis into a different category. And it's already a different category and it's treated differently. We've got the injecting centre with that little, you know, framework around it. Things that happen there can't happen in the rest of society.

This is the way we develop our society. If we stick rigidly, you never change anything. And I think the ice question is raised, there's a lot of families interested in, there were a lot of people concerned about it. A decrim would add, I think, a positive element to our society, just as the injecting centre does, the methadone programs have. You know, adding a little bit more of the harm reduction.

But I just say one thing in conclusion. If I was, you know, the Premier, I can understand, you know, where she's at at the moment. You know, I mean – and I think we can't avoid that issue. I mean, you know, she's surrounded by people who will not accept decriminalisation. I'm not making a judgment call there. I think it's probably correct, and she's just gone through a battle, or she's going through one at

the moment. She might be wanting to say, "Look, I'm sorry. It's just too hard. I'm not going to go through this again."

So I think it would be useful to make the case for decriminalisation, but then perhaps, you know, to say, "If was to be – if it was to be – this is the things you would have to do to make it at least half acceptable", because, you know, the politics for her are very tough at the moment. And I can see – you know, we want something to happen, and we've got to be realistic about her position.

DR WEATHERBURN: Well - - -

PROF GALLOP: I think decrim's a much better way to go.

DR WEATHERBURN: - - - I've got no intention of stating a position for a political purpose in order to enhance the likelihood of my chosen preference. This is – we're supposed to be here to discuss what's an appropriate response to the problem - - -

PROF GALLOP: Well - - -

DR WEATHERBURN: - - - not to second-guess what a politician might do with the advice.

PROF GALLOP: Well, I'm afraid I'm advocating for decriminalisation.

DR WEATHERBURN: Yes. I don't, I don't have a problem with that.

PROF GALLOP: Yes.

DR WEATHERBURN: I just don't think the deliberations of this group should be guided by what the premier will or will not accept.

PROF GALLOP: No, but that's not the point. The point is if you – if the Commission wants to have depenalisation, it's got to explain very clearly in it - - -

DR WEATHERBURN: Sure.

PROF GALLOP: - - - how it's going – that's what I'm saying.

DR WEATHERBURN: Sure.

PROF GALLOP: And that to me is a sort of a political issue.

DR WEATHERBURN: Can I say something about prohibition and treatment seeking. We're right in the middle of prohibition at the moment, and people are charging into treatment. The number of people turning up in the emergency departments of hospitals and turning up as inpatients with psychiatric symptoms is going up like a rocket. Now, it may be true that if we decriminalised, more people

would go in. On the other hand, maybe fewer would. We don't know. So I don't think it's fair to assume that decriminalisation is going to result in a big increase in the number of people seeking treatment. I think it's a possibility, as is the possibility that if you remove the sanctions, there'll be less incentive to seek treatment and it'll go down. I think it's – you can argue the case either way.

PROF GALLOP: But, Don, surely the current system isn't working.

DR WEATHERBURN: No, look, in my view, the biggest problem with the current system is the lack of treatment options for people who are seeking treatment. I agree with that. The second-biggest problem is that people whose only offence is use and possession of a drug are getting a criminal conviction and in the odd case going to gaol. And that's an unacceptable outcome. I agree with all of that. What I'm not clear about, and you missed the earlier discussion this morning, is whether or not it's true to say we can be sure that if we decriminalise there'll be no increase in consumption or prevalence of use. That I'm not so sure about.

THE COMMISSIONER: Can I just make an observation here that certainly the whole process of this inquiry is an independent one of politics. From day one, that is the way a Special Commission Inquiry is established. I hear what Geoff is saying, but I also pretty much hear what Don is saying. And politics is not a consideration. We will decide – I will make my recommendations based on the evidence that I hear. And this has been a fabulous exercise in gathering evidence, which is what today is about. I just make that point clear lest anybody misunderstand the Commission's position.

MS HEWETT: Okay. Thank you. Kate.

PROF SEEAR: Thank you. Well, my position is very similar to Annie's, in that, as I said earlier this morning, that I'd prefer legalisation and regulation and, in the absence of that, I think decriminalisation is the best option. And de jure decriminalisation preferably. I think we need to have a suite of options available to people, for the reasons that we've discussing today. And, as I mentioned earlier this morning, I have grave concerns about positioning all people who use drugs as suffering from a medical problem that demands treatment. I think that inaccurate, stigmatising and the like.

A couple of other things that I would just flag. There's just been some mention of threshold quantities in this discussion. I think Eddie mentioned it earlier. Of course, some years ago Caitlin Hughes and others – maybe, Alison, you were involved in that, too, so sorry if I've forgotten that – did some work on threshold quantities and the inadequacies of threshold quantities in relation to peoples' patterns of consumption. Obviously, patterns of consumption change and evolve quite rapidly. And, as far as I understand, that research hasn't been updated for five years or so, so my strong recommendation to the Commission would be that threshold quantities not only need to be looked at again, but that Caitlin and others might be invited to update that research again, because I think it's very important and valuable.

I just wanted to make one other comment wearing a slightly separate hat. I mentioned earlier this morning that one of my roles is as a practising lawyer and an academic director of Springvale Monash Legal Service. And one thing that we've talked a lot about the impacts on policing and courts and the economic implications of any reform for police and courts. What we haven't talked about is the implications for Legal Aid and community legal centres more broadly. And I have some concerns about that.

And what I mean by that is that we already exist in a climate of significant unmet legal need in this country, and that gulf is widening. Increasingly, numbers of people who come from marginalised backgrounds are unable to access Legal Aid and unable to access legal advice. Legal Aid Commissions around the country, including in Victoria, where I'm based, have tightened their legal aid criteria over time. I'm not fully familiar with the New South Wales position, but Stephen and Eddie - - -

MR ODGERS: It's the same.

MS LLOYD: Yes.

PROF SEEAR: - - - can no doubt fill us in. So, effectively, for instance, in Victoria, if you're charged with a criminal offence or you find yourself in contact with the criminal justice system, you are not entitled to Legal Aid unless there is a reasonable prospect of imprisonment. And what that means is that people who are charged with sort of more minor offences who don't have a criminal record and who aren't facing gaol really can't get legal aid, and they have to come to community legal centres like the one that I run. And we are overrun with people who – and we have to turn people away all the time.

I understand that this might seem an intuitively strange point to make, because if we move towards decriminalisation, I know the assumption would be that we would need fewer lawyers, but if we use a model like the one, Commissioner, that you've flagged where people might find themselves detected and offered diversion and/or flipped across back into the criminal justice system if they're on their third detection, etcetera, I actually think people need more legal advice in those contexts, because it's an entirely new system, in two senses, both when people are initially detected, if they're offered diversion, they might need legal advice about what that means.

Those needs are more acute or they are different for Aboriginal populations, as Eddie's reminded us. And that to me means that we would have potentially a risk of an even greater number of very marginalised people who couldn't get legal advice and need it under this new quite complex system, where they need to decide whether to accept responsibility, go into treatment or risk being flipped across into the criminal justice system. It's the same kind of problem we see in many schemes, including, say, the infringement system in Victoria, which is hugely complicated and very problematic and creates all kinds of unintended consequences.

So I just want to put that on the record, that whilst there could be cost implications for good or bad, for police and courts, from any reform, there's also a massive problem in the legal services sector that I have huge concerns about that we need to think through.

MS HEWETT: Alex.

DR WODAK: Thank you. Firstly, analysis. And I think I agree with all the comments that have been made before about the disappointing results of current policy. Current policy has been an expensive way of making our drug problems worse. And one of the ways it's done that is that it's given us more and more dangerous drugs over time. And I favour the kind of comments that Annie and Kate and other have made, not despite ice, but in part because of ice. Let's be clear. Ice is here in the Australian market because of Australia's drug policies. Without those drug policies, we may possibly have never have got ice.

DR WEATHERBURN: Really?

DR WODAK: I mean, why did crack develop in countries with extremist drug prohibition policies? Why - - -

DR WEATHERBURN: It's not really answering my question, Alex, by asking me one.

DR WODAK: Why does fentanyl get into the US market? There are good pharmacological explanations for why that happens in highly repressed drug markets.

DR WEATHERBURN: Isn't it fun to use ice?

DR WODAK: But let me go on without – if I may, and then we maybe can have this - - -

DR WEATHERBURN: Okay. Sorry.

DR WODAK: - - - discussion later on. I favour, as Annie and Kate and others outlined, I favour decriminalisation. I favour legalisation, if that was possible. And, ultimately, I think that's where we will end up. But I appreciate this is an incremental, slow process and best we can hope for is to improve, not perfect, the situation we're dealing with at the moment. So I think it's unfortunate that we have included ice and ecstasy together, MDMA, together, when they're really two very different drugs with two very different kinds of toxicities. And pharmaceutical MDMA is a low risk drug and can be in appropriate doses can be kept as a low risk drug. I appreciate that's not on the table now, but that's something we should be mindful of.

THE COMMISSIONER: It's certainly well within this Inquiry's remit to look at the difference between MDMA and crystal meth and different policies in relation to each

other, so I don't want you to be under a misunderstanding that whatever we do for one we have to do for the other.

DR WODAK: Okay. Well, thank you for that clarification. But Professor David Nutt, who is a very eminent international psychologist pharmacologist in this area has – and others have published attempts to try and rank legal and illegal drugs, and MDMA is not the bottom, but it's close to the bottom, in terms of toxicity, harmfulness. But it's to individuals in the community. So I want to make one other comment and that is that Annie spoke very movingly – and thank you for your comments, Annie, about – especially about stigma. They were very important and comments we would be well to be mindful of.

As far as I've concerned, they didn't go far enough, and they didn't go far enough because not only is stigma enormously damaging to people who use drugs, but it's also enormously damaging to health systems and social systems where people are trying to help people who are struggling with serious drug problems. And it damages the health and social systems – and it's important that we talk about health and social systems both – it damages those systems in many serious ways. One way is to reduce the amount of funding that they should have and don't have, but also, when they manage to get a bit more funding, they either can't get any staff to respond to advertisements or else they get – forgive me – the bottom of the crop, and they're left with poor quality staff to deal with.

So if we want to raise the quality and quantity of treatment available, we have to look at the damaging effects of stigma on the treatment services available. People who work in there pick up the stigma of the people who attend those services, and that point is rarely made and it's very important. I think the important points that Kate really made also shouldn't be forgotten about the importance of having a legal system that is funded to protect these people as much as possible. I'll stop there.

THE COMMISSIONER: Alex, just to let you know that I've heard quite a lot of evidence from some clinicians practising in the drug and alcohol field about exactly what you're saying, about feeling stigmatised in their clinical role because that is the field they're working in.

DR WODAK: Forgive me for making an anecdote there. I'll be brief. Some years ago I went down to Canberra to – for some purpose and I got involved with – actually it was to support someone of the methadone program, a science teacher on the methadone program, who was going before the court system. Because of the boundaries between what he was able to get in Sydney and then, when he got a promotion to Canberra, the benefits that he had in his treatment in Sydney weren't available in the ACT – and he warned the treatment service in the ACT that he would be thrown out of treatment and that that would mean he would go back on drugs and he would go back on crime and he would end up in prison. All those things, unfortunately, happened and I went down to Canberra to appear on his behalf.

Anyway, in the course of that exercise, I was told about the methadone treatment in the ACT tried to improve relations between staff and patients and they organised a gathering, and patients spoke very movingly about how they had to catch three buses and put their four children in care somewhere for an hour and a half while they went to get methadone and came back and, if they were five minutes late, everything would be dropped, and the staff were shocked to hear this. And then the staff were given an opportunity to tell the patients their side of the story, and they told the story which, in part, I'm just relating to you now, where they got some extra funding with great difficulty to open up some new positions and, when they advertised for those positions, there are no applicants. And this is the stigmatisation of the patients and the stigmatisation of the staff. It's a very serious problem.

MS HEWETT: All right. We can – so we've talked about stigma. I would like to talk about, if everyone says stigma is a bad idea, whether or not we then kind of go on to this broader question of stick and what's useful there. And the first – well, first of all, I would like to discuss the differences – I think, you know, Alex mentioned, you know, he was – didn't particularly want to associate - - -

THE COMMISSIONER: MDMA.

MS HEWETT: - - - MDMA with ice. So does anybody want to speak to this point of whether or not – you know, we talked – we've got them in the one category but whether or not the treatments should be completely different and also, you know, how that should be dealt with.

PROF RITTER: So I'm happy to make a couple of brief comments. First up, I just note that I presume we're now talking about de jure decriminalisation, given the numbers.

MS HEWETT: No, no, not necessarily. No. Well, no.

PROF RITTER: Okay.

MS HEWETT: No. I'm just saying - - -

PROF RITTER: Well, I'll speak to – I mean, I've just been - - -

MS HEWETT: Because, I mean, there's no – yes.

PROF RITTER: I've just been mapping the opinions. So there's a difference between the response and the law, and I think the law needs to be the same whether it's ATS or MDMA, but the response within that can be different. So from my position of de jure decriminalisation, it would be a criminal offence either for MDMA or ATS, but the response – and I think in the papers there's a lovely list of the different options that we have available. I think there's been a strong view expressed that fines are not a good idea. They're on page 7. So you might want to preference – having decriminalised both drugs, you might want to preference caution

and an educational response for MDMA, and preference health and social responses with 4, 5 – 4 and 5 on page 7 for ATS.

MS HEWETT: Right. Anyone else have a view on that?

DR WEATHERBURN: No. I agree, but just can't resist saying something about stigma. It's probably worth remembering that, even when a drug is completely legal like alcohol, if you're dealing with alcoholics, they're hugely stigmatised.

MS HEWETT: Yes.

DR WEATHERBURN: The same is happening at the moment with people who smoke cigarettes. Hugely stigmatised. So I don't doubt that criminal conviction contributions to the stigma, but I don't image it will all disappear magically if we decriminalise.

MS HEWETT: Yes.

MR SCIPIONE: And we use stigma to drive public understanding. Drink driving is not okay. It's a crime. We stigmatise people that drive when they're drunk because so many people die. We do it with domestic violence. If you're a domestic violence offender, you know, you're stigmatised - - -

DR WEATHERBURN: Sorry, I've departed from the - - -

MS HEWETT: No, no, no. That's fine.

MR SCIPIONE: The whole stigma issue is - - -

MS HEWETT: Yes.

MR SCIPIONE: Back to the other issue, though. MDMA and ice are two very different horizons when it comes to outcomes for a law enforcement agency, very different, and I would agree that it's difficult to capture them all under the one umbrella and do justice to the issues that are at hand here.

MS HEWETT: So you think the response should be different for them?

MR SCIPIONE: Well, I think it's difficult if you don't because you look at the outcomes. The end state for the, you know, use and – let's say it was overuse of MDMA compared to ice. It's dramatically different.

DR WEATHERBURN: Yes.

MS HEWETT: Yes.

PROF RITTER: But the law could be the same. It's just that the responses available under the law could be different. I suppose that's what I was trying to - - -

DR WEATHERBURN: Well, that's only true if it's decriminalised.

MR SCIPIONE: That's right.

DR WEATHERBURN: If it was penalised, the law couldn't be the same for both.

PROF RITTER: So a great argument for decrim. Thank you.

DR WEATHERBURN: That would be going, "okay" .....

MR SCIPIONE: Well, we're working on the penalise. But, no, I think we've screamingly agreed that there is a need for two horizons.

MS HEWETT: Yes.

MR SCIPIONE: Very different.

MS MADDEN: Can I ask a question? Is it a given that within the context of the work of this Commission that the discussion is only about methamphetamine – crystal methamphetamine and MDMA? Like, is there the potential to talk broader? I am really concerned about selecting things. We know drug use is a really movable feast. What's in one year is not popular, you know, two years later, things move. We've got rising levels of opioid use and overdose rates.

MR ODGERS: I think terms of reference is the appropriate response here and - - -

THE COMMISSIONER: Look, I think, although the terms of reference speak about amphetamine-type stimulants, a full range of those. One of the things we've clearly ascertained is that really many, many uses of these substances are polysubstance uses as well.

MS MADDEN: That's right.

MR ODGERS: Yes.

THE COMMISSIONER: And you can't really disengage those two things - - -

MS MADDEN: Exactly.

THE COMMISSIONER: - - - in many cases.

MS MADDEN: Completely.

THE COMMISSIONER: So I'm keeping an open mind about what further, perhaps ancillary, recommendations will tie in with specific recommendations relating to - - -

MS MADDEN: Yes.

MR ODGERS: Can I just follow that up? Can I follow? It's inconceivable that you decriminalise ATS and ice and not cannabis.

MR SCIPIONE: And not cannabis.

MR ODGERS: Basically all those different other drugs. Inconceivable.

MS MADDEN: That's right.

THE COMMISSIONER: Well, I think that probably is the case. And I think the point has been made. And that's something we need to bear in mind.

MS HEWETT: Thank you.

PROF GALLOP: Can I ask Alison, under the four types of change recommended in the Irish review, one is decriminalisation with targeted diversion to health and social services. If that was – let's just say that was the framework, how would your – you would fit into that by distinguishing between the drugs in terms of who's targeted – which ones targeted and which isn't? How would you - - -

PROF RITTER: Yes. So you would have a differential response. After you've - - -

PROF GALLOP: Yes.

PROF RITTER: After they've been detected, you would have a differential – well, actually, under decriminalisation, it's de jure. It's not a criminal offence so - - -

PROF GALLOP: Do we know how many people use ice without apparent, you know, ill effects?

PROF RITTER: I would - - -

DR WEATHERBURN: It depends on when you ask them.

MR SCIPIONE: Yes.

DR WEATHERBURN: Meaning that it starts off benign – or, actually, it can be a big problem straight off, but - - -

PROF RITTER: So just in terms of the research evidence from the US, there's not a direct estimate for crystal methamphetamine – the proportion of all of the people who have consumed crystal methamphetamine, what proportion become dependent

or experience a drug use disorder. We don't have those data. We do have it for cocaine and it's 23 percent. And we do have it for opiates, and it's 25 percent. So if I was going to guess, I would say it's around that. So about a quarter of all people who have used crystal methamphetamine are likely to develop a problem and the remaining 75 percent would not. And that's work by Professor Jim Anthony.

PROF GALLOP: And is that why you say in the Irish review that it's targeted?

PROF RITTER: That was Caitlin.

MS HEWETT: Caitlin.

PROF GALLOP: Caitlin. Sorry, Caitlin.

PROF HUGHES: I'll speak to that because I was the lead author. So for those who've not read the full report, because it was quite extensive, the models that we – we were tasked – so Alex Stevens and I and some other colleagues were tasked with looking at experiences in nine countries that have adopted alternatives to use and possession, countries like Portugal, the Czech Republic, Germany, Australia, United States, UK and others in looking at what have been the experiences to date in terms of impacts in relation to use, health harms, criminal justice systems, stigma, social issues to do with peoples' access to employment services and the like.

We then devised models that extrapolated from across all of the different experiences. So the whole goal was to look at like models across countries in different contexts because, by doing that, then you start to see what are the similar patterns of outcomes and what are the differences, and what does that then tell you about what might be the consequences if you adopt model A versus model B. And so, as you've noted, we came up with – well, there's actually six different models but one is depenalisation. And then there's three models of decriminalisation, one of which is decriminalisation with no sanctions, one is decriminalisation with civil sanctions or fines, and then the third is decriminalisation with a targeted health/social response.

So Portugal was the best known example of that, but there are also two other United States examples that have done something fairly similar, albeit to kind of sometimes lesser outcomes. But the – so, I mean, if you take that model, you could be targeting based on, you know, who is deemed to be dependent. So it doesn't matter what the drug is. You know, if it happens to be methamphetamine or it happens to be – you know, if you do it for all illicit drugs, which is what we have suggested is still best practice, if someone happens to be dependent on another drug like cannabis, providing those referral systems through to treatment or social services would still be recommended under that particular approach.

But it's about a targeted approach so not everyone has to go to the treatment system or social support system. You have to, of course, provide additional resources for treatment, social services, committed with any reform as has been spoken about.

PROF GALLOP: And would the police have any role in that?

PROF HUGHES: Well, yes. I mean, the police are the initial referrals. I mean, of course models can differ in some parts of the world. It's the prosecutors who make the decisions. In Australia it's more – you know, it's at the policing end. So if you applied that model here, it would be the police who are making the initial referral.

MS HEWETT: So if we talk about some of the differences between the drugs – obviously, Alison has kind of got a view – it seemed to me in terms of the treatment we're talking – certainly it's not just community perception, I think; I mean, it's the reality that ice is a very, very different drug to cannabis, or to MDMA. So I've seen your view about the response. Does anybody else have a very strong view about the need to have, like, maybe mandatory assessment or treatment in one case or not in another, or the admission of conduct, for example? Should that vary, or should it all be kind of the same, dependent on what illicit drug it is?

COMMISSIONER: I think someone made the point earlier – I've just forgotten who it was – that it's – the key thing is the impact of the drug on the individual, and the harm that it's causing.

MS HEWETT: But also on the individual and – would it be the harm that it's causing that person, but also what about the people around that person?

COMMISSIONER: Well, I think that's another, certainly, dimension of harm that any model would have to take into account. It must do that. And this is why I'm just wondering this – an idea of a body like the Dissuasion Commission, perhaps differently designed, but say a tribunal, that could, with some nuance, triage people according to the harm, be it harm to themselves or risk of harm to others around them. Would that not be a way of distinguishing between the relative harms of the different – of the different substances?

PROF GALLOP: Can I just – so one of the initial thoughts I have on that is that if there's a lot of people that – well, a proportion of people using ice, MDA – would we add cannabis in as well? – without any impact on their lives - - -

COMMISSIONER: Yes.

PROF GALLOP: - - - well, why should they have to go to a Dissuasion Commission?

COMMISSIONER: Well - - -

PROF GALLOP: Only to be sent away?

COMMISSIONER: Well, this is what happens in Portugal, you know: they are sent away. The matter is stood over, and left in limbo until, perhaps, one day, they come back.

PROF RITTER: And it's expensive, and it's a waste, for 75 percent of the people who are detected.

PROF SEEAR: And also, too, I just want to say something, at the risk of putting in something very controversial to the discussion - - -

DR WEATHERBURN: No.

PROF SEEAR: - - - but I must say this. I'm not sure if this is what you mean, Commissioner, too. But if the harm of drugs were to be adjudged according to some kind of population-level criterion, whatever it might be, you know – there's not only the point that Geoff makes, which I think is a very important one, which is that many people will take those drugs without experiencing harm, but also, too, there is some complexity in the way that we think about and understand harm. And I have some reservations about family violence in particular, and gendered violence in particular, and the attribution of harm to substances.

Now, I know there's a lot of work done on these things. I know Don has done a lot of work on these issues. You know, I have recently completed a project where what I did was interview lawyers and judges from across Australia and Canada on these issues, and one of the things, perhaps unsurprisingly, that I heard repeatedly through that research is that lawyers very much deliberately attribute something like family violence to drug use because they believe that it's strategically advantageous for them to do so, in certain contexts, with certain magistrates or judges; and then this very much contributes to, and sort of concretises, an understanding of family violence or other gendered violence as caused by drugs.

And so, I guess, given that, you know, the vast majority of such violence is perpetrated by men, and there's been no discussion of gender here today, I just want to put that on the table; I think it's very important, and that if women – you know, generally – if women or others who didn't perpetrate such violence, had to go through such a system, and were in some way kind of sanctioned, or if the sanction or administrative response was based on population-level understandings of the relationship between drugs and violence that troubles me.

DR WEATHERBURN: Well, can I just say that the evidence on ice and violence takes full account of the other factors that might be going on. I don't think there's too much debate that regular ice users are more likely – not definitely, but more likely – to engage in violent behaviour. And I take your point about not wanting to dismiss domestic violence as purely a consequence of being drunk, or purely a consequence of being on ice. The public policy issue is not whether it – is not that; it's whether it increases the risk. And I think it is no – no doubt having a bad attitude towards women increases the risk, too.

PROF SEEAR: But – yes. But part of the point I'm making, Don, is that if there's a – if it increases the risk at that level, and then that logic is applied to the individual who goes through the system – for instance, if a person were to come in front of a

tribunal or other dissuasion committee, and the view was, "Oh, you've taken ice, and we think – we know that that increases the risk," you know, based on the research that you and others have undertaken. "Therefore you'll be sanctioned in a particular way, because of the theoretical risk." That - - -

DR WEATHERBURN: Well, I wouldn't - - -

PROF SEEAR: - - - troubles me, that - - -

DR WEATHERBURN: - - - agree with that, no.

PROF SEEAR: - - - kind of conflation of - - -

DR WEATHERBURN: No. Well, I mean, the criminal law is not supposed to sanction people for what they might do.

PROF SEEAR: That's my point.

MR ODGERS: Well, can I can just follow upon that, because I think one of the benefits of the Portuguese model is, it attempts to do an overall assessment of a person's problems. They come – they may be coming because they've – using drugs, but the first thing that the tribunal will do, or the – what's it called? Commission?

COMMISSIONER: Dissuasion Commission.

MR ODGERS: Is look at whether there are problems – in terms of dependence; obviously that's one, but also in terms of other considerations. And it may be that domestic violence will be mentioned, and they'll – I mean, they've got a social worker; they've got a psychiatrist; they've got, you know, a lawyer. So they'll be – they'll be trying to come up with not just a response to the drug problem; they'll be trying to assist that person to deal with what may be a whole range of problems.

PROF SEEAR: But you know - - -

DR WEATHERBURN: That's fine if you don't believe that the prohibition has any effect on willingness to use drugs. If it does have an effect on willingness to use drugs, that solution is not going to work on its own. Now, I'm not taking a position; I'm just simply saying, that's predicated on the assumption that the only harm is the harm felt by the user or inflicted by the user. I mean, the criminal law, for example – the prohibition against drinking and driving is taken not because there aren't plenty of people who could drive around drunk without having an accident; it's because it increases the risk of having an accident. So we prohibit it for everybody. And the logic behind – I'm not – you've already heard my views on this.

MR ODGERS: Yes.

DR WEATHERBURN: But the logic behind prohibition on ice use is that it will discourage people from using it, and we want that to happen because we think that if they do use it, there'll be more people experiencing assaults and the rest of it. So, I mean, all I'm saying here is that the consideration of prohibition is not solely about – this is the point you made earlier – not solely about whether it will benefit the user, but whether there'll be a macro benefit for the population as a whole.

MR ODGERS: Quite.

PROF SEEAR: Can I just - - -

MR ODGERS: I'm just not - - -

PROF SEEAR: Can I - - -

MR ODGERS: - - - following why what I was talking about would not address those issues as well. I mean, surely, taking out of the equation a criminal conviction, a risk of imprisonment: sure, that's not there. But in every other respect, that body is not – I mean, it is therapeutic, but it also – it does have the capacity to impose sanctions; it does have the capacity to push people into places they don't want to go. I'm just not persuaded that that won't be an adequate response to the issues you - - -

DR WEATHERBURN: Well, I take it back to the – am I taking up too much time?

MS HEWETT: No, go on.

DR WEATHERBURN: So my point is simply this. Let's imagine two scenarios. One scenario is, we get rid of the prohibition against use and possession of the drug, we supply treatment to everybody, and there's no increase in consumption or prevalence: net outcome positive. Second scenario is, you do exactly the same thing, and you get a reduction in harm caused to people who are using methamphetamine, but blow me down if it isn't offset by the fact that more people are now using it who wouldn't have used it previously, so what we won with one hand we lost with the other. Now, I'm not saying one is more likely than the other; I'm just saying that both are possible scenarios, and the one you're describing has a net benefit on the on the assumption that there's no net increase in consumption. That's the point I'm making.

MS HEWETT: Okay. Well, if we go - - -

MR ODGERS: Well, on – even if – can I just respond very quickly – even if there is some increase in consumption, it may be that the net benefit still is greater - - -

DR WEATHERBURN: Oh, it may be. It may be, absolutely.

MR ODGERS: Because I think we need to emphasise the benefits.

DR WEATHERBURN: I'm just taking - - -

PROF GALLOP: Don - - -

DR WEATHERBURN: - - - issue with this certainty that everybody has that there's going - - -

PROF GALLOP: - - - nobody's certain.

DR WEATHERBURN: - - - to be no problem.

PROF GALLOP: Nobody's saying that.

DR WEATHERBURN: But they're saying - - -

PROF GALLOP: But, Don, you'd have to stick in harm reduction measures, too, into your analysis, wouldn't you?

DR WEATHERBURN: Well, I'm not quite sure what you mean by saying I'd "have to stick in harm reduction".

PROF GALLOP: Well, because - - -

DR WEATHERBURN: I'm big fan of harm reduction measures.

PROF GALLOP: - - - the consumption of something, if it's surrounded by harm reduction, doesn't necessarily lead to those conclusions you're talking about.

DR WEATHERBURN: Well, I tell you, there's a great paper you should read, by Jonathan Caulkins, about this. And the point is that you can reduce the harm for the individual user substantially and still end up with a net increase in harm if more people to start taking the drugs. Now, I'm not saying that will happen; I'm simply saying that's a possibility. So you can, for example, supply needles and syringes, of which I support, to drug users, and that's a net positive, as long as there isn't any increase in consumption. And that's, in fact, how it seems to have played out - - -

MS MADDEN: Well, that depends on how - - -

DR WEATHERBURN: - - - with needle exchange.

MS MADDEN: - - - you define "harm", though.

DR WEATHERBURN: No increase in consumption; a net benefit all around. Totally agree with it. Whether it's going to be exactly the same if we decriminalise, I think, is less certain.

MS MADDEN: But it depends on how you're defining "harm" in the first place, right?

DR WEATHERBURN: Sorry?

MS MADDEN: If you're defining "harm" as any drug use - - -

DR WEATHERBURN: Yes, I'm assuming any – my working assumption is that increases in the prevalence of use - - -

MS MADDEN: Is necessarily harmful.

DR WEATHERBURN: - - - and increases in consumption will generate more harm, and that can be – that could be mitigated - - -

PROF GALLOP: That's right.

DR WEATHERBURN: - - - but only up to a point, with harm – so for disease, you can do a substantial mitigation, through needle exchange and the like; in terms of crime, less sure, you know; in terms of violence, with this particular drug, less sure.

MS HEWETT: And that comes back to - - -

PROF RITTER: This was the discussion - - -

MS HEWETT: - - - Alison's point.

PROF RITTER: - - - before lunch, about - - -

MS HEWETT: Yes, and also - - -

PROF RITTER: - - - prevalence versus harm.

MS HEWETT: But, I mean, you use those figures of 23 percent and 25 percent, but, I mean, I think, the – again, the common perception would be that ice is a very different drug, and that it – that is – that it – I know it's very hard to get statistics on this.

PROF RITTER: Sure. Sure.

MS HEWETT: But certainly the common perception would be that there is virtually – it's very hard to have safe use of ice. It may be quite feasible to have pretty safe use of - - -

PROF RITTER: I'm not sure I agree with that at all.

MS HEWETT: - - - cannabis, so, you know - - -

PROF RITTER: Wait a moment. Yes, that is the common perception. That is absolutely the common perception.

MS MADDEN: That's the perception, yes.

PROF RITTER: And our problem is that that common perception is wrong.

MS MADDEN: Yes.

MR SCIPIONE: Well – well, I mean - - -

PROF RITTER: That is exactly the problem.

MS MADDEN: Thank you.

MR SCIPIONE: Then that's where there'd be a differing view, and you'd expect me to talk about the other side of the coin. Police engagement with people that are suffering from an addiction to crystal meth is that there is a much greater risk of serious violence than somebody that they were dealing with that had a similar addiction even to heroin.

PROF RITTER: Yes, we – I think we all agree on that point. The issue is whether any use of crystal methamphetamine is always associated with harm.

MS HEWETT: No, no. But I think that's extremes, isn't it? I mean, it's the "more likely". It's not 100 percent - - -

PROF RITTER: Well, it's - - -

MS HEWETT: - - - or zero percent.

PROF RITTER: It's that 25 percent.

MS MADDEN: Yes, that's - - -

DR WEATHERBURN: But that's – hang on. That's dependent use.

PROF RITTER: I mean – that is dependent use. That's - - -

DR WEATHERBURN: Yes.

PROF RITTER: - - - dependent - - -

DR WEATHERBURN: Well, I just wanted to point out that – I'm no medico – I happened to read that book that NDARC just published on this issue, and it does seem that methamphetamine, unlike many other drugs, carries significant cardiovascular risks even on a single use. I'm not saying they're that high at that

stage, but the health effects seem to start from the beginning, not only at dependent use. Whereas I understand it, with heroin, the risks are really low, in terms of health effects, as long as it's clean supply.

DR WODAK: Well, always have to distinguish between pharmaceutical - - -

MS MADDEN: Exactly.

DR WODAK: - - - methamphetamine and black-market methamphetamine - - -

MS MADDEN: Exactly.

DR WODAK: - - - where you don't know the dose, and don't know the contaminants. And likewise with heroin, and likewise with any other drug.

DR WEATHERBURN: Yes, I know, but we weren't discussing legalising methamphetamine, so it's still going - - -

DR WODAK: No, no, but - - -

DR WEATHERBURN: - - - be black-market - - -

DR WODAK: - - - you were talking about - - -

DR WEATHERBURN: - - - methamphetamine.

DR WODAK: You were talking about pharmacological risk, and I'm saying to you that - - -

DR WEATHERBURN: Yes.

DR WODAK: - - - pharmacological risk has to be based on knowledge of what happens with the pharmaceutical preparation of the drug - - -

DR WEATHERBURN: Right.

DR WODAK: - - - not with the black market, because the black market adds a considerable amount of toxicity.

MS HEWETT: All right. But if we could - - -

DR WEATHERBURN: I'll defer to you.

MS HEWETT: If we can – if we can agree – well, maybe not agree, but at least consider the possibility – that ice is associated with quite a degree of self-harm – not always, but a strong degree – and a particularly strong degree of violent behaviour that is associated with it as well, then we kind of get to the point of, "All right, so

how do we deal with it?" How do we deal with this as an issue before the Commission, in terms of trying to minimise that harm, and whether you need, you know, mandatory assessment, mandatory treatment, or whether you have to admit conduct – for example, you've said, that's a real issue in terms of the cannabis thing.

MR ODGERS: If it's a crime.

MR SCIPIONE: Caution.

MS HEWETT: Cannabis caution.

MR ODGERS: If it's a crime.

MS HEWETT: Well, I don't know - - -

MR ODGERS: It doesn't feature if it's not a crime.

MS HEWETT: Well, it may be less of an issue if it's not a crime, but in terms of – in terms of treatment, and, I mean – I understand this view that some people think – have suggested that using ice is, you know – is a personal choice, and that there should be, you know, nothing against it, but there'd be an awful lot of people, I think, in the community, would say there's – it's still – it has the prospect of raising, you know, all sorts of other issues, all sorts of other criminal issues. So there is – there is some kind of benefit in a stick idea as well. So I'm just trying to get some sense of how that would be best done as part of a kind of a diversion program or a treatment program. Anybody got any views on that?

MS LLOYD: Well, can I just – there's just one thing I just have to say, and that's about the stick approach, and I think it's relevant to the – I think it's – people have, you know, said that it's almost supporting their argument for depenalisation, the stick approach. Well, someone that's suffering substance use disorder doesn't care about the legality of the drug, doesn't care whether the drug is prohibited or not; they're just going to use it notwithstanding. And that's evidenced by the very high risk of recidivism that we see of drug-related crime, the very long criminal records that I see of my clients that are using substances problematically, that I just don't think that's a good basis for going – for supporting the depenalisation model. And I just wanted to clarify the word stigma that's being used. I think Andrew used it in a way – I think he's trying to say the deterrent effect of laws - - -

MR SCIPIONE: It is.

MS LLOYD: - - - like drink-driving and depenalisation, whereas a lot of us are using stigma in a very different way. So I just wanted to make it clear that, you know, general deterrence is a very important factor in sentencing and in drink-driving and those public policy - - -

MR SCIPIONE: That's true.

MS LLOYD: - - - laws, but in – for people suffering substance use disorder, I just don't think that that deterrent is a relevant consideration, because they're not – they're going to use drugs no matter what.

MR ODGERS: Are you saying you shouldn't use sticks? Is that what you're saying? I'm trying to clarify.

MS LLOYD: Yeah.

MR ODGERS: So sticks - - -

MS LLOYD: Yeah.

MR ODGERS: So the Portuguese model of having some kinds of sanctions - - -

MS LLOYD: For someone who's using – someone who's suffering substance use disorder, I don't believe that the stick is going to have any impact on their using; I think they're just going to continue using notwithstanding. But for people – and I don't really know the evidence behind it, people who are just using personally and not having any problems with their use, maybe that has an effect. I don't know what the evidence is, whether or not the stick approach has an impact or whether people are just going to continually to casually use MDMA at festivals or use cannabis with their friends and getting a penalty. I don't know if that's going to stop them. Is there any evidence anyone knows - - -

DR WEATHERBURN: Not on a single occasion. There's no specific deterrent effect from a tougher sanction on a person, whether it be for drug use or anything else. But that's not the issue; it's the longer term effects. So, for example, just to repeat, when we interviewed people seeking treatment at the peak of the heroin epidemic and asked them why were they seeking treatment, one of the most common responses, as I've said, was to avoid trouble with the police and the courts.

And, secondly, there are studies in Switzerland which show that when the police closed down the Letten drug scene, there was a rapid increase in the number of people seeking treatment. And that makes perfect sense. It's a real hassle when a drug is illegal trying to score, trying to get caught – trying not to get caught, trying not to get a red dot. So there's a whole lot of hassles associated with illegality that make treatment look pretty attractive after a few years. So it may not be everyone's preference for the way to get people into treatment, but as to the empirical question, "Does the risk of being apprehended encourage treatment entry?", yes, it does.

MS HEWETT: Well, that seems to be a kind of a fundamental difference of opinion here, because there's an awful lot of people saying it will encourage more people to get treatment – or it should encourage more people to get treatment. And you're saying the evidence is exactly the opposite.

DR WEATHERBURN: Well, yes, this is not a philosophic view. I am happy to cite the evidence if you like.

DR WODAK: There are two major international classifications of – diagnostic classifications of drug dependence disorders, an American diagnostic and statistical manual, WHO's International Classification of Disease. And they're very similar. And both of them have, as very important criteria – criterion – and all the criteria are supposed to be treated equally, but I think it's fair to say that most people treat – just one criterion gets – seems to get more emphasis than the others. And that is continuing use despite severe adverse consequences. And what that means is that people have lost their health, lost their family, lost their home, lost any savings they had, lost a career, lost everything that anyone reasonably would hold dear to them and they still use drugs.

We see that in life and we see that, no doubt, in the courts played out again and again and again. And here we are talking about adding more sticks to these people and assuming that that's going to change their behaviour. And I think it's inevitable we're going to have some sticks, but I very much agree with what Eddie's saying; I'd much rather see lots more carrots and less use, maybe no use, of sticks at all.

MS HEWETT: But it's a balance of risk, isn't it? Because, obviously, some people will continue to just do that no matter what they lose. And other people may be deterred.

DR WODAK: But I think the other reason I say this is the knowledge we have from behavioural economics, where people respond to stimuluses very asymmetrically and they respond much more to a positive stimulus than they do to a negative stimulus. Now, it depends on how you set up the experiment. So, for example, if we're talking about gambling, they'll respond much more to a loss than they will to a gain. But in a situation like this, I think setting it up so that people see that they get a benefit by getting help when they're really struggling. I think that's likely to be much more effective than pushing them down further and punishing them more.

DR WEATHERBURN: Well, hang on. I just want to be clear - - -

MS MADDEN: One of the things we haven't talked about here - - -

DR WEATHERBURN: I'm not suggesting tougher penalties.

MS MADDEN: Just hang on a sec. I think one of the things we haven't talked about here at all is some of the sort of neuroadaption effects of some of these drugs. You know, this idea that people will just do it regardless and keep doing it no matter what they lose, the fact is that people are unwell, they're suffering, they're sick, they're in withdrawal or whatever, depending on the substance they're using. And there are medical reasons for that. And I would, you know, like to see a lot of people sitting around this table just stop doing that, if they were really, really, unwell and you knew there was this thing that was going to stop you feeling unwell. It's not –

you know, it's not this – you know, and some people have mental health issues that they're managing, as well. Like, this is complex. It's - - -

MS HEWETT: But - - -

MS MADDEN: - - - it's not just some - - -

MS HEWETT: I don't know.

MS MADDEN: - - - aberrant human behaviour.

MS HEWETT: I don't think anybody is suggesting it's not complex, but I think we're trying to talk also - - -

MS MADDEN: Well, I think they are. I think you are.

MS HEWETT: - - - about volunteer – voluntary treatment, mandatory treatment, you know, that's the other kind of big fundamental issue, I think.

PROF HUGHES: I think if we're going to answer this, which I think we should and, you know, it's set out in the terms, it's really important to talk about whether we're talking about a model of decriminalisation or a model of depenalisation as kind of the first step. And, given the majority of people around the table have been in favour of decriminalisation model, that might be a good thing to kind of talk through. If we are putting up a model of decriminalisation as the preferred one, then what would the response be, if any? You know, threshold limits, all those sorts of things, requirements.

THE COMMISSIONER: I hate to put a dampener on that, but I think I'd like to hear about both, if possible.

PROF HUGHES: Well, maybe do it as both, but I think it's just too open, it's really – it's very – like, it's almost impossible - - -

THE COMMISSIONER: It's complicated.

PROF HUGHES: - - - to answer.

THE COMMISSIONER: Yes.

MS HEWETT: All right. So we'll look at those two options then, one, depenalisation; one, decriminalisation. What would be the differences in the preferred treatment there, in terms of voluntary and mandatory?

PROF HUGHES: Well, based on the evidence, I say definitely no compulsory treatment. You know, if there is going to be any sort of options, there needs to be voluntary only. But I think - - -

MS HEWETT: And that's in both systems or you're just talking to the decriminalisation?

PROF HUGHES: So – okay. So I'm talking about depenalisation, basically, like an expanded diversion scheme for use and possession of ATS. I think what we've learnt from the festival criminal infringement notice scheme was a great, you know, initial trial, but requirements for people to pay $400 in order to avoid a criminal conviction is pretty problematic for many people who use illicit drugs. As I wrote in the statement that's been passed out to all of you, the threshold limits that were set in regards to that particular scheme were very low. So particularly it had the requirement that people only possessed one ecstasy pill or MDMA pill, whereas we know that in – if you use the data on the – what typically people are carrying – or using, rather, most people will use two or up to three.

MS DOWLING: So what threshold of pills, or quantity - - -

PROF HUGHES: So I think if you're going to design the thresholds, then you need to do something like I did with Alison Ritter, but Nicholas Cowdery, as well, some years back, where you take into account the latest available evidence of what quantities people who use drugs – and that includes both regular users as well as occasional users – are using, but, also, what quantities are they purchasing, because we know, particularly with MDMA, a lot of people will bulk buy. So they may only, you know, have two – consume two pills on one occasion, but if they are going out and buying, you know, 10 or 20, then that's something that you need to be able to take into account in terms of the - - -

MS DOWLING: So it would be flexible definition of a personal – an amount for personal possession?

PROF HUGHES: Yes. And I think, ultimately – so Australia has been quite unique in terms of devising drug trafficking laws where there are deemed supply provisions in most states and territories, and where the quantity becomes the ultimate marker of who is deemed to be a trafficker versus a consumer. When you look in most parts of the world, if there are threshold quantities, quantity would be one indicator, but other indications will also be looked at, like what is the purpose of the drugs? Is there evidence of someone, you know, being a supplier? Like, do they have scales at home, lots of bags, those sorts of things.

DR WEATHERBURN: Can I just clarify something. At the moment that's exactly how the law works; it's a deemed supply that's rebuttable. And the issue - - -

MR ODGERS: Just going to the burden of proof. Just puts the burden on the defence, so - - -

DR WEATHERBURN: Yes. So the point is exactly what you described as happening in Portugal is what happens here. If the prosecution wants to argue that it's definitely supply and the defence wants to argue it isn't, the defence has to be

able to make the point that, "Look, there are no plastic bags. There's no pill press machine. There's nothing that would otherwise indicate supply."

PROF RITTER: But it reverses the burden of - - -

DR WEATHERBURN: Yes, it does reverse - - -

PROF HUGHES: It's the individual who has to make the case. But I think, bringing it back to the criminal infringement scheme, we can see that the scheme that has operated for the last six months, there's, you know, a number of people who have been able to access that scheme in regards to MDMA. But the threshold limit that was set was very, very low. So I think if you were going to do an expanded depenalisation scheme, you'd need much higher, more realistic, threshold quantities, taking into account, you know, current using practices.

And I think the – one of the things we talked through a little bit in our diversion review was whether there may be a means to use more modern technology as a very quick sort of assessment potential referral mechanism, such as using apps or online mechanisms, so that people can very quickly receive some sort of – basically, a caution, they can do an online education system, a bit like about amphetamine-type substances, but there isn't a requirement, say, for people to go to a tribunal necessarily, because, particularly if you're thinking about New South Wales, it's very big. You know, rural regional issues, as Eddie has raised, are very complicated when you start talking about access to – you know, putting tribunals kind of all around the state.

THE COMMISSIONER: Can I just make a point there. I'm just thinking from past experience - - -

PROF HUGHES: Yes.

THE COMMISSIONER: - - - in another life, for example, the Mental Health Review Tribunal, it reaches out to the whole state, because of technology.

PROF HUGHES: Yes. Yes.

THE COMMISSIONER: And there are – you know - - -

PROF HUGHES: Yes.

THE COMMISSIONER: People present at the local community health centre and they have a link directly to Gladesville and that system is every bit as complicated as anything like this sort of scheme could be and it works very well, surprisingly well. It covers the whole state.

PROF HUGHES: Yes.

DR WEATHERBURN: I've got an idea. How about your scheme – because I was worried about bumping someone into a criminal conviction just because they didn't want treatment. That doesn't sit well with me. But how about you have an arrangement where you have a caution with a referral to treatment for those who want treatment? You might have two or three of those cautions. If someone decides then that they don't want treatment and they're not going to go anywhere near that, you have a fine with no criminal conviction attached. So there's some sort of - - -

PROF RITTER: Choice.

DR WEATHERBURN: - - - choice and it's not a choice that involves having a criminal conviction or not having a criminal conviction.

PROF RITTER: Yes. That's possible. But with the other - - -

PROF HUGHES: Do you want me to talk about the other model?

MS HEWETT: Sure. Yes. We're just running - - -

PROF HUGHES: Yes.

MS HEWETT: - - - close to time. That's all. But, yes, I think that's a - - -

PROF HUGHES: So in terms of - - -

MS HEWETT: - - - good idea.

PROF HUGHES: In terms of decriminalisation, which, as I said, was the preferred option, there I think – the two best models, based on our review are either decriminalisation with no sanctions and where you're expanding resources for treatment, social services and the like concomitant with any reform, but it becomes entirely voluntary for people to go and access services. And the other – the other model is the decriminalisation with targeted referrals. So it's like the Portuguese-type approach. And – but, you know, they would be the – all of them would require good threshold limits to be set.

MR ODGERS: Can I just query that. I thought Portugal wasn't just referral. They can take away peoples' entitlements, they can - - -

DR WEATHERBURN: They can. They can confiscate - - -

MR ODGERS: Yes. I just want to clarify that, because - - -

DR WEATHERBURN: Driving license.

MR ODGERS: Yes.

PROF HUGHES: They can – yes. They can ban you on going to a club, if - - -

MR ODGERS: Right. So just not referrals. It is - - -

PROF HUGHES: No.

MR ODGERS: They have sticks.

DR WODAK: Yes, they do.

PROF HUGHES: Yes. There are sticks attached. Yes.

MR ODGERS: Right.

PROF HUGHES: But the ultimate aim is about shifting from a criminal justice to a - - -

MR ODGERS: Of course. I understand that.

PROF HUGHES: - - - health/social response.

MR ODGERS: I understand that. I did ask earlier before lunch what the success rates are. And I'm not trying to get an answer to that.

PROF HUGHES: Yes. And I didn't answer it, but the evidence is that many people – the evidence shows that many of the people who are referred to treatment are – change their mode of consumption, so switch from injecting to smoking. So there's a lot of evidence of reductions in harms.

MR ODGERS: Harm reduction.

PROF HUGHES: And when you look at the overall social costs, the benefit to society, it's significantly improved post-reform.

MR ODGERS: Thank you.

PROF GALLOP: There's a difference, isn't there, when – the paradigm that comes to the table of policy is what we might call human rights plus health as opposed to just a narrow health, and Portugal is more, it seems to me, on the health side of that little spectrum. It's quite intensive. It's quite interventionist. But it's decriminalisation. But it is a very, very intensive and quite oppressive in some ways, I think.

MS HEWETT: On the issues of thresholds, which Caitlin – one of the things that struck me was this blurring of the lines between a lot of people who kind of supply – kind of also classed as suppliers because they're trying to supply themselves. Is that an issue that should affect the thresholds? How do you see that?

PROF RITTER: So I think it's – I think setting a single threshold is going to be problematic, however it goes. I think there does need to be a range used, and this is partly because drug consumption patterns differ, they change over time, and because of social supply or supplying friends or purchasing enough for one's own supply over a weekend or something like that. So I think it is complicated to come down to kind of a single number or a single figure for any one drug. I think the issue of social supply, which is purchasing enough for oneself and one's friends, where there's no exchange of money is not technically cast as dealing and that, therefore, you can have provisions for social supply in this notion of threshold quantities.

How social supply is dealt with under the law is probably a separate thing. I know New Zealand has struggled a lot with notions of social supply and there might be some good advice on that from - - -

THE COMMISSIONER: It's still a defence, of course, here.

MS LLOYD: Whether or not money is exchanged, it's still supply: offering, sharing.

PROF RITTER: Yes. There's been an endeavour to shift that to make it clearer and - - -

DR WEATHERBURN: The problem with the threshold level is that what's necessary for my consumption for one person - - -

PROF RITTER: Exactly.

DR WEATHERBURN: - - - is going to be enough to sell for somebody else.

PROF RITTER: Exactly. Yes.

DR WEATHERBURN: But, I mean, I know you don't like the presumption against, but at least under the current arrangement you can make the case if you're over three grams of methamphetamine - - -

MS LLOYD: But the practical reality of being in court is it's very, very hard – very, very hard, and if you've got, say, six grams of methamphetamine, which is double the indictable quantity, the magistrate doesn't need to see bags or paraphernalia.

DR WEATHERBURN: Right.

MS LLOYD: So double the amount, that's how - - -

DR WEATHERBURN: Okay. I take it as read, then.

MS DOWLING: It also means that they've got to give evidence.

DR WEATHERBURN: Yes. Okay.

MS LLOYD: But I think – does everyone agree that the thresholds now are too low?

MS HEWETT: Andrew, can I ask you on that?

MR SCIPIONE: Well, again, they have to be moving targets. The reality is things change, circumstances change, so it's never really too late to go back and review and see how they are. They may well be underdone. They may well be overdone, if you listen to some practitioners out there, in terms of quantities. But the thing is you would need to go back and need to test that. You need – and that was the point that was made, that you probably need to go back and have another look because it's - - -

PROF HUGHES: Yes.

DR WEATHERBURN: So maybe you don't - - -

MR SCIPIONE: - - - it's old research.

DR WEATHERBURN: Rather than have a situation where you change the threshold quantity, you chuck out the threshold quantity notion altogether and require the Crown to prove that it was dealing on the available evidence they have.

MS LLOYD: Throw the onus back on them.

PROF RITTER: Indeed.

MS LLOYD: Imagine that.

MR SCIPIONE: Yes. But that would be an unlikely outcome, I would think. Reverse onus is here for a reason and they'll stick to that, I would think, pretty heavily.

DR WEATHERBURN: Well, they can do that, but you can recommend whatever you like.

MR SCIPIONE: Yes. I mean, it doesn't stop you making a recommendation.

DR WEATHERBURN: How does it work under the old Poisons Act?

MR SCIPIONE: Deemed supply was still there.

DR WEATHERBURN: Was it?

MR SCIPIONE: Deemed supply was still there.

PROF SEEAR: Yes. But if someone – I mean, this was – this argument was run in the High Court in Momcilovic and that – it failed in that instance, but I think it's quite likely that another case could come to the High Court, and then it has to be looked at across the board, in my view.

DR WEATHERBURN: Tell us more. What failed? What happened?

PROF SEEAR: This argument. I mean, a Victorian case of Momcilovic went to the High Court where the argument was that the deemed supply approach was in breach of the Victorian Charter of Human Rights and it was unsuccessful for technical reasons which had to do with the limitations of the Victorian Charter. But I think it's just a matter of time until such an argument is run again. And the other thing I just wanted to say as a separate issue which does relate to this question of system design is that, as I think many of you will know and some of you might have been involved in, there was a case that was run in the United States last year of Eldred, in Massachusetts.

And the issue in question in that case was that it was a woman who had – I'm going to not quite remember the facts, but essentially what had happened was, she, I think, was paroled; she tested positive for drug use, and she was sent back to prison as a result; and what she then did was argue, in this important case, that she essentially was being punished for having a medical problem in the form of addiction – this was the argument she made – and that this was a form of cruel and unusual punishment, that was in breach of the American Constitution. Now, she failed in that case, again, for technical legal reasons, because the argument hadn't been run at first instance, but that is again a – that was a huge case, that many international experts – perhaps even Alison; I'm not sure if you did – but many international alcohol and other drug experts intervened in, and again is an argument that will be run again.

The reason why I think this is relevant to this discussion is because I think, if we – I think, one of the problems with the kind of hybrid system as we're discussing is that, you know, we might have – if we retained a threshold limit, which I agree we should move away from, for all of the reasons said, but if we retained a kind of threshold limit of, say, three detections, it doesn't make logical sense to me that we treat that as a non-criminal and non-medical issue up to an arbitrary line, and then we treat it as a criminal problem, if we also say that it's a medical problem. There's a series of different logics in circulation all at the one time which, under the Eldred case, that I mentioned, in the United States, sought to challenge that legally. And I think, actually, a legal challenge of that kind might be brought here at some stage, and we should take that into account in formulating any system design.

DR WEATHERBURN: There's one correction I'd make to your argument, and that - - -

PROF SEEAR: Yes.

DR WEATHERBURN: - - - is that it's not the case that you're treating it as a medical problem up to three grams and as a criminal one afterwards. What you're arguing is that the benefits of prosecution below three grams are not worth the cost. That's why we have section five – what is it now called? Section 10(1)(a), or (b) or (c), or whatever. I mean, it's in that case you decide that you're not going to impose a conviction on somebody, because what they did was so trivial, and the harm is outweighed – I mean, the benefit is outweighed by the harm. And that would – to me – would be the argument you'd make if you're stuck with a – I don't like the threshold, but if you're stuck with the three-gram rule.

MR ODGERS: And can I interrupt and just say, I'm a little confused about this discussion, because there is no issue here – we're not debating whether or not there should be a criminal offence of supply, and we're not debating whether there should be a criminal - - -

MR SCIPIONE: No, that's right.

MR ODGERS: - - - offence of possession for the purpose of supply.

DR WEATHERBURN: No.

MR ODGERS: The real issue is not what happens in the court. The real issue here is what happens to the – when the police officer comes across somebody who's got X number of grams in their possession, and what they then do. And, obviously, if the police officer believes that they're actually a supplier, then they'll arrest them, and they'll have to – they'll go to court, and they'll be dealt with. If the police officer, however, applying some discretionary guidelines, takes the view – considers that, on the material, the amount taken puts them in straight possession situation, then it'll – they won't be - - -

MR SCIPIONE: Stephen, you're 100 percent right. If a police officer sees one person transacting with another with one MDMA tablet - - -

MR ODGERS: That's right, it's still - - -

MR SCIPIONE: - - - they'll deal with them as a supplier.

MR ODGERS: Right.

MS HEWETT: They will deal with them as a supplier.

MR SCIPIONE: Of course.

MS HEWETT: Because they have to, you mean.

MR SCIPIONE: Well, they see an exchange of money, and they see - - -

MS HEWETT: Right.

MR SCIPIONE: You know, like - - -

MR ODGERS: It's a supply.

MR SCIPIONE: They'll say, it's a straight supply.

MR ODGERS: So the problem is really just where somebody's in possession of, say – they've gone to their dealer, because they want to get two weeks' supply, right, and then the police officer comes across them and finds them with X number of grams. Could be for personal use; could be for supply. What do you do? That's the problem you have to address.

MS HEWETT: And could I – and on that point, I'd also just like to ask – just to go over this thing of the different treatment of MDMA versus ice, in terms of your views of how they should - - -

MR SCIPIONE: Well - - -

MS HEWETT: - - - be treated differently.

MR SCIPIONE: Well, I think that the - - -

MS HEWETT: Or not.

MR SCIPIONE: The drug criminal infringement notice scheme that run – what was it, January to August, here in New South Wales?

MS DOWLING: Yes, it's been continued - - -

MR SCIPIONE: Sorry?

MS DOWLING: It's been continued - - -

MR SCIPIONE: Being continued, there you go.

MS DOWLING: - - - indefinitely now.

MR SCIPIONE: That covers not just MDMA and ice. I think the papers, in fact, reflected about seven or eight different drug types.

MS DOWLING: Yes, it's all illicits.

PROF RITTER: Page 17 of the - - -

PROF HUGHES: But mainly MDMA for which they were applied.

MR SCIPIONE: Yes, mainly MDMA, which is what it was – okay, so that was specifically - - -

PROF HUGHES: 83 percent were for - - -

MS DOWLING: That's because it's only been – it's only being applied at festivals.

MR SCIPIONE: At music festivals. That will change if you broaden that out into wider community settings.

PROF RITTER: That's right.

MR SCIPIONE: So – and that actually goes to Annie's question about – we're not just talking about MDMA and ice here, because that scheme applies to all drugs.

THE COMMISSIONER: Can I just intervene here. Jennifer, I note the time. I think I'm going to make it a – if people will indulge me to stay on till 4 o'clock – is that possible for people? That doesn't create real difficulties for - - -

DR WEATHERBURN: Well, I don't know. We could adjourn for drinks at 5.

THE COMMISSIONER: And I think we really need to try and capture as much of what remains of the questions on page 28 of the briefing paper as possible.

MS HEWETT: This is the administrative response to reply? Yes.

THE COMMISSIONER: Yes.

MS HEWETT: Yes, okay. Well, so – well, we've been talking about the administrative response that vaguely, kind of, should reply when a – apply when a person is detected with drugs, and voluntary and mandatory. And I think we certainly haven't come to any particular consensus on this. But can I get people's views, then, on whether or not there should be an educational response, whether there should be a mandatory health response, the combination, whether it should apply to different types of drugs. We do seem to have – maybe I'm wrong, but it seems that there's – would seem to be general agreement that fines had lots of problems. Have I – is there anybody wants to – that cautions are a better idea than fines.

PROF RITTER: Yes.

MS HEWETT: Okay. And then - - -

MR ODGERS: Can I just say, I wouldn't rule out having an ultimate – you know, one possible sanction for a tribunal, in certain circumstances – a wealthy user, you know, whatever – just, it shouldn't be ruled out as never available.

MS HEWETT: Okay.

DR WEATHERBURN: Yes, I'd go along with that. I mean, that was my suggestion for avoiding a criminal conviction - - -

MS HEWETT: I think, Don - - -

DR WEATHERBURN: - - - that you start off with your cautions, but when you reach the point where the person's not interested in treatment, still going to get picked up, you want to – you want to have some kind of sanction, but you don't want to have a sanction that results in a criminal conviction, that a fine might be appropriate then.

MS HEWETT: Yes.

DR WEATHERBURN: But not a criminal infringement notice at first notice, because – no offence to Andrew, but when they introduced court attendance notices, the number of people prosecuted in New South Wales went through the roof. So the easier you make it for police to arrest somebody, the more people get arrested.

MS MADDEN: What would be the purpose of a fine under those circumstances, though? What would you be trying to achieve with that?

DR WEATHERBURN: Well, it just gets back to my thing about being nervous – this is just the personal view – of being nervous about what would amount to decriminalisation.

PROF RITTER: You want a disincentive. Don wants a disincentive. Okay.

MS MADDEN: Okay.

PROF SEEAR: And can I ask you this, Don: what would be - - -

MS MADDEN: And is there evidence - - -

PROF SEEAR: - - - the consequence if someone didn't pay the fine?

MS MADDEN: Yes.

DR WEATHERBURN: Well, the usual problems.

MS LLOYD: Because that's going to impact Aboriginal people - - -

DR WEATHERBURN: But I'm comforted by the fact – you don't know this, but I do – that the number of people picked up twice for use and possession of amphetamine is quite small; the number picked up for three is almost – so that the

problem is going to diminish the more times you allow a caution. So you're going to have a far smaller problem when you got people at their third – I'm just guessing it's three; I don't know what my learned colleague here will choose - - -

DR WODAK: Well, is it possible that any system of fines could be adjusted for the income of that person?

DR WEATHERBURN: Oh, that's a great idea, yes.

MS HEWETT: But then would it make much difference? If they're very wealthy, would a $400 fine make - - -

PROF SEEAR: Well, in - - -

MR ODGERS: Well, that's the point.

DR WEATHERBURN: Well, that's what he's suggesting.

MR ODGERS: It could be adjusted.

MS HEWETT: Oh, I see.

MR ODGERS: It could be a $10,000 fine.

MS HEWETT: Oh, I see. All right. Sorry, sorry, sorry.

DR WEATHERBURN: It's the Bruce Chapman type of scheme, which I think was a good one. And the Swedish day fine system is another one.

DR WODAK: And Germany – Germany implements it.

MS MADDEN: And is there evidence that that actually results in some sort of deterrent in terms of behaviour? What does it do? Do we know what something like - - -

DR WODAK: Well, it's - - -

MS MADDEN: - - - that would do? Why would - - -

DR WODAK: It's introducing - - -

MS MADDEN: - - - we be doing that?

DR WODAK: - - - proportionality, after all.

DR WEATHERBURN: No, you mean the fine at all - - -

MS MADDEN: The fine.

DR WEATHERBURN: - - - does it have any benefit?

MS MADDEN: Why do – what are you trying to achieve?

MR ODGERS: If you completely drug – if you're completely dependent - - -

MS MADDEN: Are you just being moralistic about - - -

MR ODGERS: - - - you're probably right; it won't work.

MS MADDEN: - - - their drug use? Is that it?

MR ODGERS: But not everybody is completely drug-dependent. There'll be a range of problems.

MS MADDEN: Yes. So we're just being moralistic about people's - - -

MR ODGERS: No.

DR WEATHERBURN: No, I've got an answer to your question.

MR ODGERS: Just thinking individually.

DR WEATHERBURN: So if you come to the NDARC symposium, I'll give you evidence that fines work, but I have to admit right up front that, even though fines work, love, it's a very, very weak effect, and probably not worth having them.

MS MADDEN: Thank you. All right.

MS HEWETT: All right. Well, then, if we go to education – educational response, such as a pamphlet or – you know, you were talking about apps – or the requirement to attend an education session in general - - -

PROF RITTER: So I think – so I think C1, the provision of a pamphlet, is kind of a no-brainer. I think that's really simple to do, and could just be handed out as part – it could be an app as well. I think the requirement to attend an education session is probably not an important part of this. If we're talking about a Commission of Dissuasion type depenalisation, then they're going to be triaged through that system. If we're talking about de jure decriminalisation, then there's no need for them to attend an education session in any - - -

MR ODGERS: I'm confused - - -

PROF RITTER: In any mandatory sense.

MR ODGERS: Sorry to interrupt. I thought we were saying within the triage system having the option of mandatory – of requirement to attend counselling. We're not talking about a general – I mean, I – I'd understood. Maybe I – I'm just clarifying now whether the – it – it's available to a commission to require somebody to attend.

PROF RITTER: Well, that's what I'm arguing.

THE COMMISSIONER: I think it could be both.

PROF RITTER: That's what I'm arguing about.

MR ODGERS: You – so you're supportive of - - -

PROF RITTER: That there shouldn't be - - -

MR ODGERS: - - - that as distinct from - - -

PROF RITTER: Not required to attend. I would argue that irrespective of whether it's a depenalisation panel or it's decriminalisation, what we need to do is make available as many voluntary options as possible. Voluntarily attending an education session, giving everyone a pamphlet with - - -

MR ODGERS: Yes.

PROF RITTER: - - - good information. Voluntarily attending education. Voluntarily attending treatment and matching that treatment to the person's needs. I think all of it should be voluntary. We have mandatory mechanisms for drug courts, for people with drug offending and serious offending. We have a prison-based mandatory program in the CDP. We have a civil commitment program – the IDAT. Those mandatory mechanisms are available for people who are either at risk of harm to self or others or engaged in serious offending. They work well. We don't need that in the context of simple use/possess. What we need is voluntary options and good triage.

DR WEATHERBURN: Is this in a depenalisation or a decriminalisation model?

PROF RITTER: In a depenalisation model. In a decriminalisation model you wouldn't have anything because - - -

DR WEATHERBURN: No. So my next question - - -

PROF RITTER: - - - it's not a criminal offence.

UNIDENTIFIED FEMALE: Yes.

DR WEATHERBURN: Right. So my next question is: what do you do on the 14th used possession appearance? Do you - - -

PROF RITTER: I don't think you do – I don't think you do - - -

DR WEATHERBURN: You don't do - - -

PROF RITTER: If you've got the kind of treatment - - -

DR WEATHERBURN: So that's kind of de facto decriminalisation.

PROF RITTER: - - - system that Andrew's been – it – it's de jure decriminalisation. There's not a 14th because it's not a criminal offence.

DR WEATHERBURN: Sorry. I thought you were talking - - -

UNIDENTIFIED FEMALE: I heard - - -

DR WEATHERBURN: - - - about the depenalisation of it.

MS DOWLING: - - - talking about depenalisation.

PROF RITTER: I was trying to talk about both to address - - -

DR WEATHERBURN: Okay.

PROF RITTER: - - - the fact that both models are on the table.

DR WEATHERBURN: All right. So there's no problem with what you're supposing if it's decriminalisation. Got that.

PROF RITTER: Yes.

DR WEATHERBURN: But if it's depenalisation - - -

MR SCIPIONE: There's a problem.

DR WEATHERBURN: - - - what are you going to do when you get - - -

PROF RITTER: You – okay. Well, I mean, I would argue again that it doesn't matter if they come 14 times or - - -

MS LLOYD: Yes.

PROF RITTER: - - - 20 times or - - -

DR WEATHERBURN: Okay. Yes.

PROF RITTER: - - - 25 times. It's about somewhere there to listen to them, to offer them advice and support, to try and facilitate access if they need it. And as we know, with quitting any addictive behaviour, it takes many, many goes and you never know the moment that it's going to be the right time for that person.

PROF RITTER: You just keep doing it.

MS LLOYD: Can I just - - -

MS MADDEN: Alison, could I just ask you a question. With the mandated treatment stuff you just referred to - - -

PROF RITTER: Mmm.

MS MADDEN: - - - didn't you say earlier that that doesn't – it isn't effective?

PROF RITTER: But when it's not one of those, when it's the kind of – you know, the - - -

PROF RITTER: - - - compulsory detention - - -

MS MADDEN: All right. Thank you.

PROF RITTER: - - - programs like in Southeast Asian countries and so on.

MS LLOYD: Can I just share just an anecdote from a client I had many years ago. And I just think we do need to appreciate that this – if you are suffering substance abuse disorder, it is a chronic and baffling disease.

PROF RITTER: Mmm.

MS LLOYD: And it does take many people many times.

PROF RITTER: Yes.

MS LLOYD: And sometimes they fail.

PROF RITTER: Yes.

MS LLOYD: And I had one client, he had a 53 page criminal history and he was a user of heroin. And he just never wanted to give up. He'd been using since he was 13. He didn't have any other life experience besides using heroin. He was in and out of jail. He had low quality of life, from my observation, and was institutionalised. And he was lucky enough to go in the ballot for the compulsory drug treatment prison.

PROF RITTER: Mmm.

MS LLOYD: And I'm not saying that it works for everyone. And about a year after I got a phone call from him. And everyone had said, you know – my boss at the time had said, "Give up on him. He's always going to be before the courts" and his family had all walked away. He had no support. And he rang me a year later and said it worked.

PROF RITTER: Mmm.

MS LLOYD: "I'm clean for the first time in my life."

PROF RITTER: Mmm.

MS LLOYD: And he was - - -

MS HEWETT: And that was through the compulsory drug - - -

MS LLOYD: Yes.

MS HEWETT: - - - treatment program.

PROF RITTER: That's the prison-based program.

MS LLOYD: And I'm not saying that's the - - -

PROF RITTER: Yes.

MS LLOYD: - - - program for everybody. He was 43. He had a 53 page criminal history. I think it's just important to remember that it is a very difficult disease to overcome and that - - -

PROF RITTER: Absolutely.

MS LLOYD: - - - we need to continually provide opportunities - - -

PROF RITTER: Yes.

MS LLOYD: - - - for recovery from that, whether it be down a harm minimisation path or - - -

PROF RITTER: Absolutely.

DR WEATHERBURN: Mmm.

MS LLOYD: - - - an abstinent path. And that's why I agree with you that you just – if there are – it's the 14th time, you just keep offering, keep offering - - -

PROF RITTER: Yes.

MS LLOYD: - - - keep offering because it's a very ugly disease.

DR WEATHERBURN: Why – just not wanting to be provocative, but why wouldn't you combine that opportunity with an incentive?

MS LLOYD: What do you mean?

DR WEATHERBURN: Not a nasty one. Not a threat of prison. Not a threat of a criminal conviction. But, for example, a fine or, "Oh, God, not again. I've been sprung for use and possession."

PROF SEEAR: But isn't the fine only an - - -

MS LLOYD: They might not be ready.

PROF SEEAR: - - - an incentive if it carries consequences? And that comes back to that problem of - - -

DR WEATHERBURN: Well, hang on a secured. Not everybody - - -

PROF SEEAR: Isn't - - -

DR WEATHERBURN: - - - fined fails to pay their fine.

PROF SEEAR: No, but - - -

PROF RITTER: Not the majority anyway.

PROF SEEAR: - - - the clients of people that do are the kinds of people - - -

DR WEATHERBURN: No, not the majority.

PROF SEEAR: - - - that do are the kinds of people that come to Eddie and my services and often don't have money, and then – like, for example, under the Victorian infringement system, which is quite different - - -

DR WEATHERBURN: Yes.

PROF SEEAR: - - - the fine escalates multiple times. Ultimately you can have your possessions taken and you can be imprisoned. And then - - -

DR WEATHERBURN: Yes, I'm well aware of the adverse consequences of fines. And I'm trying to dodge or scale that problem down by avoiding fining people at first or second instance. So – I mean, I take your point. There are - - -

MS LLOYD: A fine doesn't determine the end of someone's health condition in any way.

DR WEATHERBURN: No, but the thing is that the evidence indicates that people – if it's unpleasant, constantly getting drugs, constantly having to score, whatever, sooner or later there's going to be an incentive to seek treatment. Now, I'm all in favour of giving treatment to everybody who wants it, regardless of pressure. What I'm wondering is, if you have a depenalisation model, are you going to do what Alison says: just keep on cautioning them – and I'm not going to comment on the political feasibility of such an arrangement, but are you going to keep on cautioning them forever, or are you going to have, at some point – "Well, look, you know, if you don't want to plead guilty and you don't want to go and seek treatment, then go pay the fine." And there's no criminal conviction. Otherwise go for the full decriminalisation model and live with the risk that consumption might increase and undo all the benefits you get from decriminalisation.

MS LLOYD: Well, I just think - - -

PROF HUGHES: Can I just note South Australia has had a depenalisation model where there have not been limits on the number of times people can be referred for use and possession of amphetamine-type substances or other drugs. They've had very, very few frequent flyers. Like, the – three plus - - -

DR WEATHERBURN: No, that's what I was saying earlier. But, you know - - -

PROF HUGHES: So it's - - -

DR WEATHERBURN: - - - you better tell them the other half of what happened in South Australia, which is the number of people on fine default went through the roof, and the number of people who were using – collecting cannabis for sale, you know, there was this 10-plant limit. So everyone was growing up to 10 plants, and someone was collecting the plants for sale. It's a complicated - - -

PROF HUGHES: No, I – I'm talking about the diversion for drugs other than cannabis.

DR WEATHERBURN: Right.

PROF HUGHES: And that particular scheme has – it's one of the reasons why South Australia has had very high diversion rights.

DR WEATHERBURN: Yes. Well, look, if I could think of a completely harmless solution to the problem, I would. But I happily concede that everything I can cook up has got a problem associated with it. And I venture to guess everything you've come up with has got a problem, too.

THE COMMISSIONER: Is there a point at which it would make sense to refer – and this is at point 4 A, page 28 – and this follows on from what Don's been saying – we were talking about fine which is B in paragraph 4 – but the point at which it would be appropriate to refer the person back to court.

MR SCIPIONE: Yes, absolutely.

PROF RITTER: Only if you attained it as a criminal offence.

THE COMMISSIONER: Yes, of course.

THE COMMISSIONER: …but would there be a point at which it would be appropriate to refer the person back to court.

MR SCIPIONE: Yes. Absolutely.

PROF RITTER: Only if you retained it as a criminal offence.

THE COMMISSIONER: Yes, of course.

MR SCIPIONE: Yes.

THE COMMISSIONER: Of course. Okay. When will you do that if it was retained as an offence in a penalisation example?

DR WEATHERBURN: I will tell you what the court will do.

PROF RITTER: You have to ask Don and Andrew as the only two people that are advocating for depenalisation.

DR WEATHERBURN: They'll give them a fine. Judged on the current way things work, it's either a fine or a bond and the majority get a bond and about half of the ones who get a bond get a supervised bond and the other half get an unsupervised bond and I'm here to tell you it makes no difference whether they're supervised or not.

MR SCIPIONE: Supervisor or not, doesn't matter.

PROF RITTER: Doesn't matter.

DR WEATHERBURN: Has no effect whatsoever.

PROF RITTER: Okay.

DR WEATHERBURN: But I worry about the court referral. I mean, it's kind of like, you know, I can't handle this. Maybe you take it. My worry about it is that they're going to end up with a criminal conviction and so we're back in the situation where someone picked up for use and possess simpliciter, nothing else but that - - -

PROF RITTER: Yes.

DR WEATHERBURN: - - - is ending up with a criminal conviction - - -

THE COMMISSIONER: Yes.

DR WEATHERBURN: - - - and that worries me that it's a – the benefit in terms of the social benefit is outweighed by the cost. I think that's the case.

THE COMMISSIONER: Right.

DR WEATHERBURN: I don't know that for sure.

MS LLOYD: If it's the 14th time that someone's getting a caution and they're not responding to any of the referrals, then I think you just – you know, there's a point where you've just got to stop intervening in someone's personal life and just - - -

DR WEATHERBURN: There is a happy scenario - - -

MS LLOYD: - - - refer them back to court.

DR WEATHERBURN: - - - which is no one at arrest 14 doesn't want treatment.

PROF RITTER: Yes.

MS LLOYD: Yes.

PROF RITTER: There is.

DR WEATHERBURN: Which is to say, you know, if you pick – stop talking about 14 because it's silly, but it would be a really interesting study to find out – I wrote this down – really interesting to interview people at their first, their second and their third arrest for use and possession and find out at each appearance what proportion of them believe they have a problem.

MR SCIPIONE: Yes. What's changed.

DR WEATHERBURN: Because at the third, I'm guessing that quite a big – pure guess quite a proportion would say, "I've got a problem".

MS HEWETT: Just to finish this off - - -

THE COMMISSIONER: I'm sorry, I have one last question - - -

MS HEWETT: Yes.

THE COMMISSIONER: - - - before 4 o'clock which is this: as far as an education or a health response and I've wondered, if at an early point of intervention when somebody is cautioned or whatever, there would be any sense in requiring the person to go and see a GP at Medicare rates to get a session of prescribed - - -

PROF RITTER: Prescribed healthcare.

THE COMMISSIONER: Where the doctor has to say, "Well, look, you have a family history of mental illness and you're using ice, you've got a heightened risk." Explain what it's all about and also give the person some useful advice.

DR WEATHERBURN: That's good.

PROF RITTER: Voluntarily, absolutely. A good thorough health assessment would be enormously beneficial.

MS HEWETT: That would be - - -

DR WEATHERBURN: And if they won't do that, then you send them back to court because you can combine this with your other suggestion. The consolation prize is that since you had to wait for n cautions to get to that point, the number of people who end up with a criminal conviction will be tiny compared with the number that currently end up with a criminal conviction.

MS HEWETT: So just on that – the other point that you wanted me to raise was that – what power should a body administering the scheme have? Would that go to your – would that go to your suggestion about being able to refer to Medicare?

COMMISSIONER: Possibly. Possibly, referring somebody to a GP from assessment. And I just – or an education session, or - - -

MS HEWETT: Yes.

DR WEATHERBURN: It just should - - -

COMMISSIONER: - - - a health check.

MS HEWETT: And that would be – and, I suppose, we still haven't gone to that system of that – well, we're divided on that compulsory versus – or mandatory – versus voluntary - - -

DR WEATHERBURN: Who's going to force them to see a GP?

PROF RITTER: Are we divided?

PROF SEEAR: Yes, I'm not sure - - -

PROF HUGHES: I think we could do a hands up.

PROF SEEAR: Yes, I'm not - - -

PROF HUGHES: Is anyone in - - -

PROF SEEAR: - - - sure we're divided.

PROF HUGHES: - - - favour of compulsory?

PROF SEEAR: I don't think anyone's in - - -

PROF HUGHES: Yes.

PROF SEEAR: - - - favour of compulsory.

PROF HUGHES: No.

COMMISSIONER: Then voluntary - - -

PROF HUGHES: Voluntary. Anyone - - -

COMMISSIONER: - - - is your recommendation.

PROF RITTER: Voluntary. Okay.

PROF SEEAR: Can I also just add that I think – just to tie that education conversation off – I think it's extremely important that if education or any other – you know, whether it's a pamphlet or a discussion with a GP, whatever it might be – were offered voluntarily – then it, I think, goes without saying that it has to be carefully designed educational material that's not in any way stigmatising or problematic. And in that sense I would recommend the involvement of various experts, peer experts in particular, who have expertise to design that material, including organisations that Annie has worked with, like NUAA and AVOL, Harm Reduction Australia, etcetera.

DR WEATHERBURN: Can I just add one last thing. Just so you all know, we're now talking about a really tiny number of people. So we've thrown out all the people that had a prior criminal record; we've thrown out all the people with a concurrent conviction for another offence; we're not talking about the people who will go on to commit another offence; we're not talking about the people who got one caution, or maybe even two. We're talking only about the residue. So I just wanted to tell you, there's a small number.

PROF SEEAR: Can I say – can I say, Don, I don't think we have discussed - - -

MS MADDEN: Priors.

PROF SEEAR: - - - people with a prior conviction. And actually that's - - -

MS MADDEN: No, we've not.

PROF SEEAR: I'm glad you mention - - -

DR WEATHERBURN: Okay.

PROF SEEAR: - - - it, because one of the notes I made is that for me, it would be hugely problematic - - -

MS MADDEN: I agree.

PROF SEEAR: - - - to have any system that excluded people particularly who have - - -

PROF RITTER: Yes.

DR WEATHERBURN: Yeah, right. Look, okay, I take the point.

PROF SEEAR: Because it creates a system of people's past - - -

DR WEATHERBURN: Sorry. Totally concede the point.

MS LLOYD: Signature with the cannabis - - -

PROF SEEAR: Punished under past systems and - - -

DR WEATHERBURN: But you'll still end up with a tiny number if you have a concurrent conviction for another offence, a non-drug offence - - -

PROF SEEAR: Yes.

DR WEATHERBURN: - - - and if you've gone through your first two cautions. I'm not criticising the arrangement, not at all. I just wouldn't want to see inflated expectations about the impact this is going to have on the justice system, or the police, or - - -

PROF RITTER: Sure. Sure.

PROF SEEAR: But we also didn't have a conversation about that eligibility criterion in relation to other offences, too. And I know we've run out of time, but in my view, you know, I think the Commission – it's something for the Commission to reflect upon carefully, what the logic would be in throwing out all people with any prior conviction. I don't know what the rationale for that would be, but personally I think that would be problematic, to throw out – to deem all of those people as ineligible.

DR WEATHERBURN: How does it work under cannabis cautioning in relation to prior record?

MS LLOYD: Two priors. Two prior cautions.

COMMISSIONER: Two prior.

PROF HUGHES: You're not allowed to have concurrent offences for violence, sexual offences. You're only allowed two options to go through the scheme.

MR SCIPIONE: So there's a range of things. It's in - - -

PROF HUGHES: Yes.

MR SCIPIONE: It's in those papers.

DR WEATHERBURN: You need - - -

COMMISSIONER: Thank you, Andrew.

PROF HUGHES: But again, in our diversion report, some states don't - - -

COMMISSIONER: Thank you very much.

MS HEWETT: Well, I guess, we - - -

COMMISSIONER: Most appreciated.

MS HEWETT: Do you want to say anything, Commissioner, before we draw this to a - - -

COMMISSIONER: Look, I think it is - - -

MS HEWETT: Before you draw it to a close?

COMMISSIONER: - - - time to draw this to a close, thank you. And I'd just like to make a few thank-yous. Firstly, to Jennifer, for facilitating this boisterous, and very productive, I think, very interesting and helpful roundtable. I'd like to thank Senior Counsel assisting, Sally Dowling, and the Commission's legal and policy research staff for the enormous amount of work that went into the preparation of the brief that was circulated to all of you. And finally, I'd just like to thank all of you for coming here, giving us your time, your expertise, which has just been splendid, and very useful to me in my deliberations. I've got a lot of hard thinking to do, and what you've assisted me with today is of great help. And with those remarks, I think, I'll call the meeting to a close.

MATTER ADJOURNED at 4.05 pm INDEFINITELY

Participants:

PROF GALLOP – Commissioner, The Global Commission on Drug Policy

PROF RITTER – Director, Drug Modelling Program, Social Policy Research Centre UNSW

DR WEATHERBURN – Adjunct Professor, University of Sydney Law School

MS LLOYD – Councillor, Lismore City Council

MS MADDEN – Scientia PhD Scholar, Centre for Social Research in Health, UNSW

PROF SEEAR – Associate Professor in Law, Monash University

DR WODAK – President, Australian Drug Law Reform Foundation

PROF HUGHES – Associate Professor, Centre for Crime Policy and Research, Flinders University

MR SCIPIONE – Former Commissioner of NSW Police

MR ODGERS SC – Barrister, Forbes Chambers