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Australia's illicit drug problem: Challenges and opportunities for law enforcement

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BY AUTHORITY OF THE SENATE

JUDKINS, Dr Simon, Chair, Mental Health Working Group, Australasian College for Emergency Medicine

LUBMAN, Professor Dan, Executive Clinical Director, Turning Point; and Director, Monash Addiction Research Centre

NIELSEN, Professor Suzanne, Deputy Director, Monash Addiction Research Centre

[09:51]

CHAIR: I now welcome representatives of the Australasian College for Emergency Medicine, Turning Point and Monash Addiction Research Centre. Good morning to you all. I understand that information on parliamentary privilege and the protection of witnesses giving evidence to Senate committee has been provided to you. I now invite you to make an opening statement for each organisation, and then we will go to committee questions. Professor Lubman, do you want to open with your comments?

Prof. Lubman: Thank you to the committee for inviting us to speak today on this really important national issue. I'd like to start by acknowledging the traditional custodians of the land on which we are meeting, the Wurundjeri people of the Kulin nation, and pay respects to elders past, present and emerging, and I extend that respect to Aboriginal and Torres Strait Islander peoples with us today.

One in four Australians will struggle with alcohol or other drugs in their lifetime and roughly half a million aren't accessing the treatment, care and support they need. This is largely due to stigma and fear of judgement, which causes many Australians to delay seeking help for years and even decades. This large and unmet demand for treatment significantly contributes to police workloads because people struggle to limit or stop their drug use if they don't seek treatment and the appropriate treatment. Unfortunately, only about 20 per cent of the total drug budget is currently allocated to treatment services, even though we know that every dollar invested in treatment saves seven dollars and that treatment significantly and effectively reduces recidivism.

As a frontline service, at Turning Point we see first-hand that a punitive approach to people who use drugs negatively impacts treatment outcomes and destroys lives. We see how a criminal conviction for personal possession and use can derail a young person's life, making it extremely hard for them to gain employment, find accommodation or engage in study. Every day we work with people who use drugs to help cope with underlying trauma, poor mental health or significant life challenges, yet our system rarely shows compassion for these Australians who are in desperate need of our support and care. Instead, we know that the criminalisation of drug use maximises harm. Just as prohibition of alcohol did not work, criminalisation of drugs has resulted in an expanded drug market and a more dangerous drug supply. The drug supply is more dangerous, as illicit manufacturers move towards higher purity substances so that more doses can be obtained from smaller quantities that are easier to transport undetected. We've seen this overseas with the emergence of highly potent fentanyl and the resultant North American opiate crisis, which my colleague Professor Nielsen can speak to in more detail.

The fact is that addiction is a health problem we can't arrest our way out of. As Australian Criminal Intelligence Commission data shows, the number of consumer drug arrests has more than doubled in the last decade, from around 69,000 consumer arrests in 2009-10 to over 146,000 consumer arrests in 2019-20. Criminalisation of personal drug use is not working as a deterrent but instead comes with an enormous economic and human cost, as well as diverting scarce police resources away from more important law enforcement priorities such as terrorism, cybercrime and human trafficking.

So what can we do about it? We know what works, because decades of international experience has shown us the way. As noted in our submission, effective and comprehensive decriminalisation for personal possession and use of small quantities of all illicit drugs, coupled with a national network of drug checking services, will significantly reduce the harms created by criminalisation and improve law enforcement responses. Drugs will still be made by criminals and therefore be more dangerous than they otherwise would be, but the feedback loop created by drug checking services will put pressure on illicit manufacturers to produce safer products while also gathering useful insights into the nature of the illicit drug market.

I recently toured the drug checking service in the ACT, led by Directions Health, the first such facility in Australia. Queensland also announced in February that it will implement drug testing. This is a significant and welcome addition that will help keep the community safe and reduce the tragic number of drug related deaths in these jurisdictions. Professor Nielsen has been actively working in this space and is happy to answer any questions you have on the subject.

But drug checking is only one piece of the puzzle. We need to harmonise and expand access to drug diversion programs across Australia so that they are accessible and consistent across all Australian jurisdictions. We can

ensure consistent and fair outcomes for Australians by harmonising threshold quantities that differentiate between possession and supply type offences as well as quantities of drugs that determine eligibility for diversion across all Australian jurisdictions. Importantly, threshold and diversion quantities must be evidence based and accurately reflect the use and purchasing patterns of people who use drugs, including people who live with addiction, who are more likely to possess greater amounts of drugs to which they are dependent. While improving access to diversion programs, we must also increase investment in treatment services to meet demand generated by diversion programs.

We must start treating addiction as the health condition it is. We need investment in prevention, early intervention, treatment and harm-reduction services to match the scale of the problem. Everyone wants to keep drugs out of the hands of children, and profits out of the hands of criminals. The only way to do this is with a public health response and better regulation. When it comes to illicit drugs, we keep doing the same thing and expecting a different result. It's time for a different approach. Thank you.

CHAIR: Dr Judkins, would you like to make a statement?

Dr Judkins: Yes. I will keep it brief because clearly we need to focus on the conversation and the questions from the panel. I'm here to represent the Australasian College for Emergency Medicine. I'm trying give the panel the views on what's happening at the coalface in our emergency departments across the country. We have made a submission, which hopefully you've had time to read, really commenting on issues around emerging trends and risks with new psychoactive substances. Our emergency physicians were involved in screening programs across various parts of the country. They were also involved in drug testing facilities as well. The college is very supportive of ongoing screening and drug testing facilities.

We're also very supportive, on Professor Lubman's point, of access to healthcare. One of the things that we find most challenging in emergency departments is the limitations we have when people present to emergency departments with drug and alcohol issues and the lack of access to appropriate facilities. So it really is a troubling space for emergency physicians, the staff in our EDs and, clearly, the patients and their families as well. We're very supportive about the need to increase the resources to tackle the drug problem that we face at the moment. As I said before, we really wanted to be able to paint a picture for you of the challenges we're facing on a day-to-day basis.

CHAIR: Senator Shoebridge, would you like to start with some questions?

Senator SHOEBRIDGE: I'm eager, Chair, but I can't at this second.

CHAIR: Mr Repacholi?

Mr REPACHOLI: Thank you for coming, everyone. I have a couple of questions around pill testing. I think what ACT has done there is amazing. Anything that keeps people alive is fantastic, and this is. They're testing what's in them. We all know there are illegal substances, and that's okay. We all know that in this room, right? But I think doing the testing and keeping people as safe as possible is great. How does that get taken to the next step to be done nationally through what we're doing here in this committee?

Prof. Nielsen: At the moment, when we have pill testing, we have very few places where that's accessible to people. We really only have one service in Canberra, which has limited opening hours, and a proposed service in Queensland, so clearly that's not to scale in a way that would have a meaningful impact on the harm that we're seeing in Australia. One of the points that I would raise is: at what point in that supply chain are we testing drugs? At the moment, we're testing individual drugs for individual people as opposed to considering a more regulated supply. We're catching people as they're falling off the cliff, essentially, and often we're identifying these potent substances in emergency departments through toxicology as opposed to before people are using them. So I do think we need to think carefully about how we scale drug checking and whether we can scale it so it's further up the supply and not actually with the small number of people who are able to access those services, so we're able to have a greater impact on the knowledge of what substances are in the market. I don't know if there's anything you want to add to that, Dan.

Prof. Lubman: Obviously, this is a hot topic internationally. We've seen really great models overseas. In the Netherlands, for example, they've been doing this for 30 years. They have drug testing services throughout the country. It has really great buy-in from the community. They have a really great relationship with the police where information is shared with the community rapidly. What they've seen there is that, when they've had really harmful, potent substances come into the market and then shared that with the community, that has put pressure on manufacturers, and those compounds have rapidly been taken off the market. Compare that to what happened in the UK with the same product. In the Netherlands, when it was detected, it was shared with the community, the

manufacturers took it off the market and lives were saved. In the UK, that information wasn't provided and, unfortunately, we had lots of people dying.

We know that these things are incredibly effective. We know we've got great international evidence of their effectiveness and their acceptance by the community. I think it's really important that this committee is meeting and we can take on that international evidence. We used to be world leaders in the area of effective drug policy. I think it's a really great opportunity to think about how we can lead the world again and deliver things that we know that are evidence based.

Mr REPACHOLI: With the 30 years of experience they have overseas and the Netherlands, what is the percentage of drugs being tested and not being tested? Do we know?

CHAIR: And has it reduced the use of drugs?

Mr REPACHOLI: That's right—has it reduced the use of drugs at all?

Prof. Nielsen: What we do know about drug checking is that, where people are able to find out information about what's in their drugs, that will often—in around one in five cases—lead to people deciding not to consume those drugs, so it does directly inform behaviour and can reduce the risks that individuals will take.

Prof. Lubman: When I went up to visit CanTEST in Canberra, what was really interesting is that they were reporting that people from Victoria and from New South Wales were travelling before a festival to get their drugs checked before they went to the festival in Victoria or New South Wales. These are concerned consumers. They don't want to be taking harmful products, so they were travelling hundreds of kilometres to get their drugs checked to make sure that they were safe. So we have very concerned consumers that use these services to ensure that they can be much more informed in terms of what they're taking.

Senator SHOEBRIDGE: But it's also sharing the information, isn't it?

Prof. Lubman: That's right.

Senator SHOEBRIDGE: I think that's what you were saying, Professor Nielsen. Yes, you get it tested, and individuals may know, but then, if it's known that a particular pill or something in the market is dangerous, you share that information so that people don't buy it and so they're on the lookout for it as well. Different systems do and don't do that, and that can really change the efficacy, can't it?

Prof. Nielsen: We do see very effective use of alert systems in some social networks and from trusted organisations such as the Loop, for example, that will test and put out information. That does have a really clear effect when people get that information and they know what they're looking for and what to avoid. They might be similarly motivated to go and test what they're using, having seen these alerts. So it does definitely have a positive feedback loop.

Mr REPACHOLI: We're talking about people doing it before going to festivals, right? Most people take drugs when they are not at festivals. A lot more people do drugs outside of festivals than do while at festivals?

Prof. Lubman: That's right.

Mr REPACHOLI: You heard my earlier story about my brother. How would it stop him? Why would it make him think differently and go get his drugs checked?

Prof. Lubman: First of all, I'm sorry for your family circumstances. I've been working in this area for 30 years and I've probably seen over 10,000 individuals and family members who have come to see us about issues around addiction. It's an area that I think we need to talk about a lot more. I'd really encourage the committee to think about that in terms of your response. I heard your story before, and what it really says to me is that we need to have a good think about what addiction services are available in this country and how we approach this issue.

If this were cancer, we wouldn't be offering just a single chemotherapy and saying: 'Good luck. Come back when you're motivated. That single chemotherapy isn't working and it's your fault. That's what we've done over the last 30 years. We've heavily invested in our cancer services because we don't give up on somebody when the treatment doesn't work for them or they die because of that. We should actually invest in finding better ways to support people, understanding what is driving the addiction and putting that in place. I'm sorry for your situation, but I think it really speaks to the fact that we have a very rudimentary addiction treatment platform in this country. We don't have the sophistication of treatment responses that we have for every other health condition. In fact, for most individuals across the country, it's potluck what services they get offered or where they get offered. I really encourage the committee to recommend or think about how we consider the adequacy and the availability of addiction services in this country.

Dr Judkins: It's an interesting point that Dan makes about cancer services. I was involved in another forum yesterday, on mental health care and looking at how to better handle mental health care, and they were drawing

similar parallels to cancer services. Nobody blames anybody for getting cancer, and there's not a shame of getting cancer. People wrap supports around people with cancer, but, with drug and alcohol services, it's not the same level of support, caring and coordination of care. Often there's a little bit of: 'Well, we tried it once or twice. We referred you to a drug and alcohol service. You didn't turn up. That's your fault. We're not going to do it again.' I think we really need to look at much more comprehensive and accessible support services.

Senator SHOEBRIDGE: I go to Dan's point about pill testing. It's important to have it not just at festivals but more distributed so people can get it in their locality. Is that part of the answer?

Prof. Lubman: Absolutely. I don't want to speak for Simon, but, being in EDs and having to respond—I think it was in your submission, Simon—to people coming without knowing what people have taken is a core component of our health response. If our frontline clinicians are not aware of what's on the market and what's happening, it's really very difficult to make good clinical decisions that support people.

Senator SHOEBRIDGE: It would be like dealing with the snake bite without a photo of the snake.

Prof. Lubman: That's right. You would want to know what the issue is.

Dr Judkins: Some of the ED services that are provided are about screening and community. Patients who are presenting to emergency departments, as we've outlined there, we test for what they've taken, and the frontline clinician gets information from the service saying, 'We've just found out that in this part of the state there's a rise in this, and this is how you treat this substance.' Previously, we've had young people coming in with seizures following the use of a synthetic cannabinoid, and we've had no idea what they'd taken, no idea what was in it, and no real idea how to treat it. Sorry; we had an idea how to treat it, but you're flying blind.

Mr REPACHOLI: Does anyone know what the rough cost of having a pill-testing facility is?

Prof. Lubman: It's actually on page 12 of our submission that the Parliamentary Budget Office recently estimated that operating 18 drug testing sites as well as testing at an Australian drug testing agency and a National drug warning system will cost about \$16 million per annum.

Mr REPACHOLI: That's for 18 sites?

Prof. Lubman: That's for 18 sites plus a drug testing agency and a national warning system. Obviously, there needs to be some thinking about whether or not that are adequate, but there are some estimates there that they've put in place. It's in the submission.

Senator SHOEBRIDGE: It's a fraction of the law enforcement costs.

Dr Judkins: And it's a fraction of the healthcare costs of the repercussions of somebody taking a drug that is going to result in them ending up on a ventilator in an intensive care unit.

Prof. Nielsen: I have a comment about drug checking. That is a fantastic solution for some harms and some drug problems in some populations, but, for example, for somebody who's using heroin multiple times per day, that might not necessarily be an accessible or practical solution. We also need to be considering things like injectable opioid agonist treatment and other kinds of treatments that aren't currently available in Australia and having more of an approach that considers a safe, regulated supply for people who are at the more severe end with frequent drug use that places them at great risk. We need to have a range of different solutions and think about how we're making drugs safer and reducing that harm. I think pill testing is one solution that's very important for a range of the population, but we need a much broader vision than that.

Senator SHOEBRIDGE: What your answer shows is that we probably need different solutions for different drugs. You'll have a very different solution for opiates than you perhaps would have for cannabis, and you would have a different solution again to, say, MDMA. We need to look at the evidence and actually tailor the response to different drugs, not just throw the police in at every occasion. Is that right?

Prof. Nielsen: It is different drugs and different populations. For a person who is maybe occasionally using opioids, they might be able to check those drugs beforehand, and that would be a reasonable way to reduce the harm, but that might differently apply to a more marginalised or vulnerable population that doesn't have that kind of access or that's using drugs so frequently that checking on each occasion is not practical. Treatment and safer supply options become more relevant there.

Prof. Lubman: What you're quite rightly highlighting is the lack of nuance in this space. Essentially, we have this massive bucket which is called 'illicit drugs', and we treat them all under the same rules and the same strategies. We know that there's a huge variety of different drugs on the market. There are very different populations that use that with very different impacts. I think we just need a much more sophisticated national strategy that really understands that and keeps the community safe.

Senator SHOEBRIDGE: On opioids: there was a big move about 20 years ago, including in Australia, towards having people who had an addiction to opioids getting prescription access from a regulated known supply, which provides a substantial public health benefit and personal health benefits. They'd know the strength of the heroine and are would be far less likely to overdose. It would also break the connection with the illegal market and drug dealers. It actually kills their market, so it has a double benefit. Where are we up to on that?

Prof. Nielsen: In Australia we haven't seen a lot of progress in that space. We have seen—in parts of Europe, for example, where these treatments are quite widely available—that those treatments were initially expanded and quite accessible. We've heard more recently that some of those services are in less demand now, because they've been able to resolve the problems of the population and move people away from injecting. When we see the trials of these treatments—for example, where it's appropriate, injectable opioid agonist treatments like injectable heroin—the treatment outcomes are very good, and that's in a population that has generally already not done well with a range of other treatments. In a population where it is very often quite difficult to get good outcomes in, we see very good outcomes. We haven't seen that progress in Australia. I believe there's one very small pilot study that's happening in Australia, in Sydney, with 22 people, but we do not have accessible treatments that are scaled that anyone in Victoria, for example, could access at this point in time. We really do need to make progress in that, because there are a range of evidence based options that are not available in Australia that are available in other parts of the world and that we should be offering to people where our existing treatments aren't working.

Senator SHOEBRIDGE: When it comes to cannabis, a number of submissions have said the principle harm from cannabis at the moment is being caused by the criminalisation of tens and tens of thousands of people as opposed to the harms that come from the drug itself. Do any of you want to respond to that?

Prof. Lubman: I think that's absolutely on point. I think one of the challenges, as you've seen in our submission, is the varied nature of diversion programs that occur across this country. One of the things we're really highlighting is that the response to different Australians depends on where you live and who actually arrests you. We have a number of states that provide really clear drug diversion laws that are in legislation, which are mandated. For example, in the South Australian system it's mandated and 95 per cent of people are given a drug diversion charge, whereas in other jurisdictions that drops to around 50 per cent or less. That's often based on the individual viewpoint of the arresting officer and system.

Senator SHOEBRIDGE: Or the person they're arresting. First Nations communities often get much harsher treatment and less-positive use of discretion.

Prof. Lubman: That's right. I think it's fair to say that we would like to see a system that is equitable, fair and universally applied. I think there is lots of evidence—as you will see in our submission—around the human rights element and the cost effectiveness of a really well put together drug diversion program that makes sure we don't take away unnecessarily from law enforcement resources, so they can be applied more appropriately to other major issues in our community, and an appropriate drug diversion scheme that actually assists people to get the help they need in a timely fashion and is not punitive in nature.

Can I just come back to your previous point, which is a very valuable point around having a whole suite of different approaches for different addictions. I come back to my cancer analogy. If we only had a single drug approach for cancer, and that's all we had, that would be a tragic outcome for Australians. What we're able to have is very well invested tertiary cancer services, where, if you fail with your first round of chemotherapy, there are a range of additional options that are available that you can step up to that more-aggressively treat the underlying condition and that have been shown to be incredibly helpful for those people who don't respond initially. We don't have that in the addiction system. We have a single flat structure where you got offered one treatment, in general, and if that doesn't work for you, it's good luck and we'll see you later. We need to start considering this issue as we do for other health conditions. We need to say, 'It's not good enough if we have treatments that don't work.' We need to be investing in treatments that we know have international evidence and best practice, and we need to be offering Australians the health care that they deserve as we would for any other health condition.

Dr Judkins: I would like to add to that. If we diagnose somebody in the emergency department with cancer, and they've got metastatic cancer, they'll be seen by a specialist in a very short period of time. They'll get those investigations done. They'll start on their chemotherapy and radiotherapy. It's a multidisciplinary approach. If we see somebody in the emergency department who has a drug addiction problem and they've come to the emergency department for help, we'll try and refer them to a drug and alcohol service to get that specialist care. Most of the time there's a scrap bit of paper with a phone number on it: 'Give these people a call tomorrow, and they might be able to see you in the next couple of months. By the way, it's going to cost you a lot of money.' The difference between those two conditions is just extraordinary. We should have multiple access, multiple specialists, and it needs to be accessible because people turn up in crisis. We go: 'That's fine. You're in a crisis. You've come here

for help, but there's not much we can do about it. Somebody will call you in a couple of weeks time.' It's just not good enough.

CHAIR: I wanted to pick up on the comment you made in relation to cannabis. I don't want to misquote you, but you said, 'The harm that comes from using cannabis is about the impact that it has through law enforcement.' Are you saying that using cannabis is not in any way harmful to your health?

Prof. Lubman: I suppose we were responding to a question around where the greatest sort of impact—

CHAIR: But I'm asking: is there not a health issue related to the use of cannabis?

Prof. Lubman: There is a health issue associated with the use of all drugs, including legal drugs like, obviously, alcohol and tobacco. So all drugs that we use come with health—

CHAIR: I just wanted to make sure that I heard correctly. With this inquiry, we seem to have gone down a road about the decriminalising of drugs and pill testing. But, with pill testing, my understanding is that the pills get tested but that does not guarantee that no harm will come to the person who consumes that drug. So the testing is about quality and making sure that there are no harmful poisons like Ratsak—or whatever mixture—put in, but it doesn't stop people who will have an adverse effect from taking that drug.

Prof. Nielsen: One thing that we do know in the model of drug checking that is operationalised in Australia is that often, in addition to providing information about what's contained in that drug, people have access to health information. So expanding those services and increasing access to those services mean that you increase the number of conversations that people who use drugs are able to have about potential harms that are involved in consuming those substances and that you raise awareness, by letting people know where they might be able to access help. So, while people may still choose to take those drugs, they're making a more informed choice and they're also put in touch with health services, health education officers and harm-reduction services—all of those things we know reduce the harm that's associated with drug use. So, while it might not mean that you eliminate drug use, you can reduce the harms. I think it's unrealistic for us to expect that we could eliminate all drug use. The foundation of our drug policy is about acknowledging that there will always be some drug use, and we have evidence based strategies that can reduce that harm which are currently not scaled or widely implemented.

CHAIR: With the evidence that you gave in relation to what's been happening in European countries—that they've been protesting for decades—you didn't answer my previous question as to whether or not having this pill testing in countries over the last three decades has reduced the use of illegal drugs.

Prof. Lubman: I think that's an important point in terms of understanding what the multifaceted strategy is that we need to put in place to reduce harm in the community. We've had 50 years of taking a very hardline approach to drugs, and I think it's fair to say that the international community is now in agreement that that approach has done nothing in terms of changing the availability and use of drugs across the world. So that approach isn't working. We're not going to be able to stop—

CHAIR: That wasn't my question. My question was a pretty simple one. Has there been a reduction in those countries that have been protesting for the last 30 years? Has there been any documented evidence that illegal use of drugs has decreased?

Senator SHOEBRIDGE: Well, Professor Nielsen's evidence was that—

CHAIR: Senator, I didn't interrupt you. Do you mind?

Senator SHOEBRIDGE: one in five people didn't take the drug and disposed of the drug. That seems to be evidence.

Prof. Nielsen: With the Netherlands as a case in point, there's no evidence in countries that have really rolled out these harm-reduction initiatives that drug use is any higher. In fact, we know that it's lower in the Netherlands compared to many other similar countries that have not implemented those things. So we have no evidence that it increases drug use. If that's the concern, I don't think that's supported by any international evidence that we've seen.

CHAIR: I'd like to now turn to the partnership with VicRoads. It would be nice to hear something positive about a program that actually is working to keep safe not only the users of illegal drugs but also—just as importantly, I think—the other users on the road. Can you inform the committee as to what that program is and how it operates?

Prof. Lubman: I'd like to talk about two programs. The first is the TAC program. We've been partnering with TAC and Victoria Police on a program supporting people who've been charged for drug or drink driving. I think people recognise that at the moment the approach has largely been a legislative approach—serving them with a notice and a fine. There's a recognition amongst all the providers that we need to do a better job at understanding

what is driving that behaviour, providing support to those people and explaining the situation and what supports are available in terms of advice and information they need on the nature of that charge and also what they can do to get their licence back.

I think this speaks to a broader point that relates to other work we do with Victoria Police. Our frontline workforce is very concerned about the community and wants to support them as much as possible. I think having this response with VicRoads and another program we run, which is called VPER—which is where the police, if they're concerned about somebody's drug use but there are no grounds to provide a charge, can refer them to our helpline service for follow-up—really speaks to the compassion of our emergency frontline services, the recognition when people are struggling and the opportunity for early intervention and support to help them get on the right path and to provide the necessary support to help them in that way. It just really speaks, I think, to this multidisciplinary, multifaceted approach that we need to take to this issue to make sure that, rather than just punishing people, we provide as many wraparound supports as possible, because we know that in the long term that reduces recidivism, helps people get back on their feet and allows them to contribute and stay healthy and well in our society.

CHAIR: I would also value any contribution about what more can be done to educate law enforcement and other frontline workers, including those who are in accident and emergency, as to the sort of training that they need to deal with the issues around people who have consumed drugs.

Prof. Lubman: I'm happy for others to chip in. My first comment would be that we have a public narrative around this whole issue that is very much a stigmatising narrative. We know that addiction is the most stigmatised health condition globally. Because of that—

CHAIR: Closely followed by mental health conditions, I have to say.

Prof. Lubman: That's a really great example, because in mental health what we have done is invested in a whole range of strategies. We have Beyond Blue, for example, and other great initiatives that have sought to destigmatise the issue in the community, to hear the voices of lived experience and to understand that mental health is not just about being weak-willed but that there are a whole range of underlying issues. That has led to huge investment from the government in educating and working with clinicians and the community to encourage people to seek help early, to give people the skills to be able to support people where they're at, and to recognise discriminatory, stigmatising policies and practices across our system.

So I'd be really encouraging the committee to think about what we need to do in terms of really thoroughly investigating our approach to addiction in this country and the need to explore how we deal with stigma and support our workforces more broadly at the frontline—police, emergency services and others—and for the education fields to be adequately supported and educated to provide evidence based approaches, because this is an issue that is not going away. This is an issue that affects one in four Australians and is costing the community over \$80 billion a year. It's something we need to get serious about, and it's something we can't continue to push under the carpet and pretend is going to go away.

Dr Judkins: It's an important point—the change in narrative. The resources and the accessibility of mental health care over the last decade have improved. There are more options available. People are more openly speaking about mental health issues. People with lived experience are involved in coordinating and helping to develop policy as well. On the front line, as I said, even though we still need to put a lot more effort and resources into mental health care, there are more accessible options when people turn up. Even from my perspective, working in a regional emergency department, I have options when people present for mental health care. I don't have any options when people present with drug and alcohol problems. I think the recognition that this is a healthcare issue does start to change that narrative. So I think the more we raise those issues—the more we talk about the need for, as I said, a wraparound multidisciplinary approach—hopefully the more options we will see.

Prof. Lubman: Can I just add to that? I think it's also important that the approach that we've taken has been over the last 50 years, and I think we've learned a lot over that time internationally. Within that 50-year period, we used to criminalise suicide. It's not that long ago that suicide was a criminal offence and, when people tried to take their own lives, they could receive a criminal charge and be put in prison for that. We now realise that is such a crazy idea, and we offer compassion and support to people who are suicidal. There's a whole range of other things that have changed in the last 50 years that we used to criminalise. It's time that we had a good rethink of this whole issue, looked at the international evidence and suggest what is actually working and what is best. I really welcome this parliamentary hearing, and I really look forward to your recommendations.

CHAIR: What more do you see that law enforcement can do, then, to promote a better relationship between healthcare providers and law enforcement on this issue?

Prof. Lubman: I trained in the UK, and I think what's really interesting is that, when I was working in the UK, the biggest advocates for a change in law enforcement activities were the British police. They recognised and were frustrated when things that they were asked to do weren't working, and they invested in drug diversion programs and treatment programs. They were the strongest advocates for a change in the approach to this issue. What we hear consistently from ex-commissioners of police is a similar narrative about how the current approach hasn't worked and is a drain on police resources.

So I think we need to look at what are the underlying structural issues that maintain an approach that we know doesn't work. We need to think about structures that create really honest conversations about how police and health are working together to address this response in a way that is fiscally responsible, cost effective and compassionate. I think there are lots of lessons from overseas where police and health are working hand in hand to deal with this problem in a much more sensible manner. So I think we need to understand why that is not working here and what are the structures or the different ways for how we bring police and health together to make sure we're doing this in the most effective manner. We used to have those structures in place. There was a very good structure between police and health in this country for a while. Those structures have, unfortunately, been dismantled for a while. I think it's really important that we get those back on track.

CHAIR: Why were they dismantled? Was it for budgetary reasons? Was it due to leadership from the government? What caused that dismantling of the relationship?

Prof. Lubman: As to the details of what underpinned the decision, I certainly couldn't give you a good answer. But, essentially over the last 10 years, we used to have a Ministerial Council on Drug Strategy and an Intergovernmental Committee on Drugs which brought police and health together across jurisdictions and nationally. That governance of our drug strategy and policy has been dismantled, and we don't have that in place at the moment. I think that is a major underpinning of why we're not having a coherent strategy across jurisdictions and between health and police. It'd be really important for us to revisit the sorts of decisions around why that took place, and I think it was around a shift in how different health ministers communicated, both state and federally. But it's really important to look at that because there were huge advantages of that model that allowed more conversations about care at the state and federal levels and across health and police. It's a really important structure and something to consider reinstating as soon as possible.

CHAIR: I'd be interested in hearing your strategy in terms of societal change. We know it takes a long time to change people's way of thinking. Whether people like the question being asked or not, the reality is there are people in the community who will ask, 'Won't the change in the laws around drug use encourage more people to use drugs?' What's the strategy to bring the community with you? We all know that there's a huge problem. We know that the courts are changing. Seldom in my home state will someone using cannabis go to jail. In fact, we had a discussion just the other night with a group of people that work within law enforcement and the court system. They said, 'People don't even go to jail if they've been caught two or three times for drug use while they're driving.' The courts are very hesitant about sending people to jail for personal drug use. How do we then instigate a change in cultural views about the use of drugs, and what's the strategy for that? We took far too long to address mental health issues and to remove the stigma, and it's still there to some extent. There's stigma around people who live with dementia. So, to change society, what's the strategy?

Prof. Nielsen: I think that the criminalisation of drug use in itself means that people who use drugs continue to be considered as criminals in our society are stigmatised because of that. If we look at the media coverage of people who use drugs, it's very rare that people who use drugs are portrayed in a way that shows them to be deserving of care and deserving of compassion, and part of that is linked to the way that we perceive substance use. While we might not see that a single use of drugs leads to someone going to jail, we still have this system where people who use drugs are criminalised, and that affects how they're perceived, what treatment they're offered and how worthy they're considered by the community to receive our help. Addressing those issues is fundamental in bringing about a change.

CHAIR: Thank you very much for that. You have the opportunity, Senator Shoebridge, to have the last couple of minutes, if you like.

Senator SHOEBRIDGE: Thank you. A criminal conviction is a lot more than just going to jail, which is what the chair is saying.

Prof. Nielsen: I don't know if Professor Lubman wants to comment on the fact that one involvement with criminal justice doesn't necessarily mean going to jail, but it does put you on a different trajectory and it does have long-term damage.

Prof. Lubman: I think this picks up on your point, that personal possession of drugs is not putting people in prison. The reality is that the majority of people in prison these days have a history of drug use, so we have to understand the trajectory that puts people on that path. As I said in my opening statement, I see many young people who've been charged with personal possession of drugs, which has meant that they've lost their job—particularly people who are working as apprentices. They've had their apprenticeships stopped because they've got that conviction. That has put them on a completely different trajectory, where they are unemployable and they're unable to afford accommodation. It puts them in a very difficult position in terms of making life choices.

Senator SHOEBRIDGE: And that's happening now?

Prof. Lubman: That's happening now.

Senator SHOEBRIDGE: That's not 20 years ago. That's the current policy producing that now.

Prof. Lubman: That is what is happening now. I'm not sure where those young men end up, four or five years down the line, when they're not able to get a job, they're seen as criminals and they're not able to get housing. We're putting young people on trajectories of harm, and we need to consider what that approach is actually doing for the next generation of Australians.

Dr Judkins: Not everybody who uses drugs does so to become an addict; in fact, none of them do. This isn't a deliberate pathway. 'This is my ambition: to become an addict and lose my house.' People use drugs for all sorts of different reasons. The majority of people would be using them for recreational reasons. But, to take, as you said, an apprentice who gets caught for using drugs, having the whole system bash them up and make their life awful is completely the wrong approach.

Senator SHOEBRIDGE: Indeed, having that sort of collapse in those structures in your life may make you much more likely to use drugs.

Dr Judkins: Absolutely. It's a vicious spiral. That's right.

Senator SHOEBRIDGE: And it's the criminal response that, in thousands of cases, is aggravating the addiction and driving people down that pathway.

Prof. Lubman: I think it's the discriminatory nature of it also. I can tell you I see a lot of people who come from very privileged backgrounds, who work in a very eminent fields, who use drugs, and who have come into contact with police and aren't charged, and I see people from very socially deprived backgrounds who are using much fewer drugs who end up with a criminal conviction. I think it's about what we spoke about before—the equity of that response.

CHAIR: We have now reached the end of our time, so thank you. I think if we could use that principle of equality—not based on your credit card—across society in all areas, we'd all be better off. I thank you all not only for appearing today but also for your submissions, and the open and frank way in which we've engaged today. Thank you very much.

Proceedings suspended from 10:41 to 10:57