MONASH University

Response of Associate Professor Kate Seear
Response to the WA Select committee into alternate approaches to reducing illicit drug use and its effects on the community
July 2019

Dear Committee,

Thank you for the opportunity to provide responses to further questions. The Committee's questions (**in bold**) and my answers appear below.

Throughout this inquiry, the Committee has heard about the potential benefits of removing criminal penalties for personal drug use and possession. The following questions relate to how to set up a formal regime of administrative responses for personal use and possession.

1. What else would need to be in place for such a model to operate effectively?

As advised in my earlier evidence to the Committee, much turns on the Committee's view about the purpose/objectives of any administrative system for addressing personal use and possession. The Committee may wish to consider a formal pilot/trial period followed by an evaluation based on the stated objectives of the scheme. Some of my other answers below are relevant to this question as well.

2. How can these unintended consequences be avoided or mitigated?

I am not sure which unintended consequences are of concern to the Committee but I agree that some unintended consequences with administrative systems are possible. Some of these were discussed when I gave evidence to the Committee. They include:

- The development of a system which treats all people detected for drug use and possession as having a 'problem' (e.g. a 'medical problem') such as an 'addiction' warranting treatment. In such circumstances there is a risk of pathologisation and/or stigmatisation of drug use and possession. This is important because substance use is one of the most stigmatised activities in the world. Recent research suggests that alcohol and other drug-related stigma arises from a wide range of sources, that it can be long lasting (including across a person's lifetime), and that it carries a range of adverse health, social and economic consequences.[1] Stigma is a key cause of health inequalities. It has been said that stigma:

  > thwarts, undermines, or exacerbates several processes (i.e. availability of resources, social relationships, psychological and behavioural responses, stress) that ultimately lead to adverse health outcomes. Each of these stigma-induced processes mediates the relationship between stigma and population health outcomes.[2]

[1] C. Lloyd *Sinning and sinned against: the stigmatisation of problem drug users.* (London: UK Drug Policy Commission (UKDPC), 2010); C. Lloyd, "The stigmatization of problem drug users: A narrative literature review". *Drugs: Education, Prevention, and Policy, 20*(2), (2013): 85-95.
[2] Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a Fundamental Cause of Population Health Inequalities. *American Journal of Public Health, 103*(5), 813-821.

Stigma can also delay or impede people's willingness to seek help or health care.[3] A number of international organisations, key stakeholders and bodies are becoming increasingly cognisant of the prevalence of alcohol and other drug-related stigma, the adverse dimensions of stigma, the need to understand its origins and to address them. The law has come into increasing focus as a result.[4] For example, in the 2008 *World Drug Report*, the United Nations Office on Drugs and Crime (UNODC) described stigma as one of the 'unintended consequences' of the international drug control system and its application.[5] Ideally, therefore, any systems reforms should take care to avoid exacerbating or generating stigma.

- Importantly, even when people who use drugs are characterised as 'addicts' experiencing an illness, value judgments about their conduct and character persist.[6] This might occur where the individual characterised as experiencing an 'addiction' is conceptualised as sick, 'hampered' by their addiction, unable to make sensible decisions and/or diminished in capacity. These ways of thinking about all people who use or possess drugs can be stigmatising, and may be used to justify more paternalistic policies or practices.
- Importantly and in a related sense, there is evidence that systems design and systemic practices can then function 'to produce "addicts" as an effect of policy'; in other words, where all forms of drug use and possession are treated as medical problems to be addressed via medical treatment, 'the scale of the problem appears to be growing rather than shrinking'.[7] This in turn can create an impression that drug-related problems (such as 'addiction') are widespread, and can have other systemic flow-on effects, including the diversion of resources from other areas into drug treatment, which may not be necessary, efficient, or effective.

For all of these reasons, it is important to ensure that any administrative system has a suite of diversion options available in recognition of the fact that people use and possess drugs for a range of reasons, and that not all drug use takes the form of a medical problem.

I would also encourage the Committee to carefully consider how the procedural minutiae of any scheme might work. For example: if people are to be issued with an expiation notice (as in South Australia), for instance, how will they be notified of the fine (e.g. on the spot or by post)? How long will people be given to pay? What happens in the event that people do not pay on time?

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[3] Hatzenbuehler, M. L., Phelan, J. C., & Link, B. G. (2013). Stigma as a Fundamental Cause of Population Health Inequalities. *American Journal of Public Health, 103*(5), 813-821; Link, B. G., & Phelan, J. C. (2001). Conceptualizing Stigma. *Annual Review of Sociology, 27*, 363-385; Schulze, B. (2007). Stigma and mental health professionals: A review of the evidence on an intricate relationship. [Conference Paper]. *International Review of Psychiatry, 19*(2), 137-155.

[4] For a more detailed discussion, see: Seear, K., Lancaster, K., & Ritter, A. (2017). A new framework for evaluating the potential for drug law to produce stigma: Insights from an Australian study. *Journal of Law, Medicine and Ethics*, *45*, 596-606.

[5] United Nations Office on Drugs and Crime, *World Drug Report 2008*, https://www.unodc.org/documents/wdr/WDR_2008/WDR_2008_eng_web.pdf at 216 (accessed 24th February 2017).

[6] Fraser, S., & Seear, K. (2011). *Making Disease, Making Citizens: The Politics of Hepatitis C.* Aldershot: Ashgate; Reinarman, C. (2011). Cannabis in culture and legal limbo: Criminalisation, legalization and the mixed blessing of medicalization in the USA. In S. Fraser, & D. Moore (Eds.), *The drug effect: Health, crime and society* (pp. 171–188). Melbourne: Cambridge University Press; Brook, H. & Stringer, R. (2005). Users, using, used: A beginner's guide to deconstructing drugs discourse. *International Journal of Drug Policy, 16*(5), 316–325; Keane, H. (2002). *What's wrong with addiction?* Melbourne: Melbourne University Press.

[7] Moore, D. & Fraser, S. (2013). Producing the 'problem' of addiction in drug treatment. *Qualitative Health Research, 23*(7), 916-923.

Will the fine be increased (as with some infringement systems for other matters), or will the matter default to court? As the Committee will be aware, based on lessons from other similar schemes, procedural minutiae may not matter for many, but are likely to disproportionately and adversely affect particular vulnerable and marginalised populations, including people experiencing homelessness, people with mental health concerns, people from culturally and linguistically diverse backgrounds, Indigenous people and victims of family violence. I would thus strongly recommend that advice be taken from other jurisdictions (particularly South Australia) as to how to roll out such systems and minimise potentially adverse effects for other groups.

The Committee should also consider ensuring that safeguards are built into any administrative scheme so as to ensure that there are mechanisms for contesting higher fines or avoiding prison (if prison must for some reason be contemplated through the scheme). For instance, the Victorian *Infringements Act* allows for people to seek a 'waiver' of infringements or a reduction in the amount of infringements accrued where there are 'special circumstances'. The same system allows for people to enter onto payment plans in the event that they are unable to afford a fine in the first instance, and if fines are to be contemplated, alternatives to full payment should be considered. This might include allowing fee waiver on the basis of financial hardship.

3. A potential risk might be having the threshold levels for personal use set too high or low. Do you have any views as to what threshold amounts might accurately reflect patterns of use?

My understanding is that the most up to date and potentially relevant research comes from a 2014 project undertaken by Hughes, Ritter, Cowdery and Phillips.[8] This research did not examine the relationship between thresholds for personal use in diversion policies and personal drug use/possession and purchasing practices. Rather, it explored the relationship between threshold quantities for drug trafficking and personal practices in relation to drug use/possession and purchasing. Despite the different emphasis, the findings of that research tell us something important about people's drug use/possession and purchasing practices.

The purpose of that research was to establish whether existing threshold quantities for trafficking were 'proportionate, equitable and just' in light of what we know about people's drug practices. The authors found that patterns of drug use/possession and purchasing often do not align with threshold quantities for drug trafficking. For instance, in Western Australia, 'when measured against the maximum in a heavy session users of three drugs are at risk of exceeding the trafficable threshold for personal use alone: methamphetamine, cocaine and MDMA'.[9] These findings are based on the maximum heavy sessions of use for various drugs, as follows:

Drug type	Threshold quantity (trafficking)	Maximum heavy session (use)

[8] Hughes, C., Ritter, A., Cowdery, N. and Phillips, B. (2014a) *Evaluating Australian drug trafficking thresholds: Proportionate, equitable and just?* Report to the Criminology Research Advisory Council, Canberra; Hughes, C., Ritter, A., Cowdery, N. and Phillips, B. (2014b). *Australian threshold quantities for 'drug trafficking': Are they placing drug users at risk of unjustified sanction?* Trends and Issues in Crime and Criminal Justice no. 467, Canberra: Australian Institute of Criminology.

[9] Hughes, C., Ritter, A., Cowdery, N. and Phillips, B. (2014a) *Evaluating Australian drug trafficking thresholds: Proportionate, equitable and just?* Report to the Criminology Research Advisory Council, Canberra, p.38.

Heroin	2 grams	2 grams
Speed	2 grams	4 grams
Ice	2 grams	2 grams
Cocaine	2 grams	4 grams
MDMA	2 grams	3.5 grams
Cannabis leaf	100 grams	27 grams

People who purchase MDMA are also at risk of prosecution for trafficking based on purchasing practices alone. This is because there was evidence of people purchasing up to 29.0 grams of MDMA for personal use (perhaps for stockpiling purposes) – a figure far in excess of the traffickable threshold quantity. A more comprehensive overview of these data can be found in the final project report.[10] The authors also note that it is 'difficult to definitively estimate what proportion and how often users are placed at risk of unjustified charge or sanction'.[11]

We can then draw lessons from these findings for the adequacy of existing diversion policies. Western Australia offers diversion for both cannabis and other drugs. The relevant policies utilise eligibility criteria including threshold limits that are much lower than the threshold quantities for trafficking. These thresholds are detailed on pages 25-26 of our diversion report and are as follows: Cannabis: ≤10g cannabis and/or possession of cannabis paraphernalia; Other drugs: 25% or less of deeming weight for possession offences (eg 0.5g heroin, cocaine, methamphetamine) or up to two tablets; Officer discretion in regard to steroids & psilocin Possession of other drug paraphernalia.

Accordingly, the current diversion threshold limits in Western Australia for personal use and possession are much lower than the maximum heavy sessions of use, as follows:

Drug type	**Threshold quantity (trafficking)**	**Threshold limits (diversion)**	**Maximum heavy session (use)**
Heroin	2 grams	0.5 grams	2 grams
Speed	2 grams	0.5 grams	4 grams
Ice	2 grams	0.5 grams	2 grams
Cocaine	2 grams	0.5 grams	4 grams
MDMA	2 grams	2 tablets	3.5 grams
Cannabis leaf	100 grams	≤10g cannabis	27 grams

This will explain why at least some people in Western Australia are deemed to be ineligible for diversion, although it is not clear exactly what proportion of those not offered diversion are refused on this ground alone.

The Committee might therefore wish to consider increasing the threshold limits for diversion policies to ensure that they are at least no lower than the 2014 maximums on personal use/possession and purchasing practices.

[10] Hughes, C., Ritter, A., Cowdery, N. and Phillips, B. (2014a) *Evaluating Australian drug trafficking thresholds: Proportionate, equitable and just?* Report to the Criminology Research Advisory Council, Canberra.
[11] Hughes, C., Ritter, A., Cowdery, N. and Phillips, B. (2014b). *Australian threshold quantities for 'drug trafficking': Are they placing drug users at risk of unjustified sanction?* Trends and Issues in Crime and Criminal Justice no. 467, Canberra: Australian Institute of Criminology, p. 5.

It is also important to note some caveats. First, the 2014 data are now several years old, and drug practices and patterns of consumption change. It is possible, for instance, that the maximum in a heavy session of use has increased since these data were last collected and analysed. As such, the Committee may wish to consider commissioning Hughes et al. to provide an up to date analysis of these data for the purposes of reconsidering the threshold limits for diversion purposes. Second, there were low response rates on some Western Australian data documented in the research undertaken by Hughes et al. meaning that some of the findings may be less reliable.

4. ***The Victorian Law Reform, Road and Community Safety recommended last year that personal use and possession should be treated as a health issue rather than a criminal justice issue. Has there been any progress in this regard?***

I understand there has been no further progress as yet. The Victorian government tabled a response to the Committee's report, as per statutory requirements, but there has been no progress on the recommendations as far as I am aware.

The Committee has heard that diversion is a de-facto alternative to an administrative response regime.

5. ***You have recently looked at diversion programs across the country. Based on that research, which jurisdiction would you say has the best practice model of diversion for offences relating to drug use and possession?***

South Australia. I say this because the *National Drug Strategy 2017-2026*[12] includes a commitment to expanding/upscaling diversion and South Australia has the highest proportion of offenders offered diversion. Our diversion report also found universal support in Australia for expanding diversion.[13]

6. ***I note that WA appeared to have the lowest rate of police drug diversion in the country. Could you expand on the factors behind this?***

WA has the lowest incidence of police diversion in any jurisdiction – with just 32.4% of offenders with a principal offence of use or possession being given a police drug diversion in contrast with SA – where that figure is 98% (see page 5 of our diversion report).[14] Also, WA diverted 26.9% of adults compared with 84.3% of youth, a phenomenon at least partly attributable to the fact that adults can have only 1 cannabis diversion whereas youth can have 2.

Low rates were attributed to three main factors which were: the switch from a cannabis infringement scheme to a therapeutic cannabis diversion scheme; strict eligibility criteria (including threshold limits which are discussed in more detail above) and implementation issues which made it easier for police to simply charge offenders rather than divert them. Regarding implementation issues: we heard that there was a requirement that West Australian police

[12] Commonwealth of Australia. (2017). *National Drug Strategy 2017-2026*. Canberra: Commonwealth Department of Health.

[13] Hughes, C., Seear, K., Ritter, A., & Mazerolle, L. (2018). *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion. A report for the Commonwealth Department of Health.* Sydney: NDARC, UNSW.

[14] Hughes, C., Seear, K., Ritter, A., & Mazerolle, L. (2018). *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion. A report for the Commonwealth Department of Health.* Sydney: NDARC, UNSW.

schedule diversion appointments but that there is no 24-hour diversion phone line. This system differs from that used in some other Australian jurisdictions.

7. Adding diversion into police performance monitoring can facilitate diversion. Are any jurisdictions currently doing this?

For our diversion research,[15] we heard that all jurisdictions have or have at some stage in the past included diversion in police performance monitoring systems. There was a consensus that this incentivises police to offer diversion and that this would therefore be an option worth pursuing. There was a belief that this would help to motivate police to offer diversion and that it would increase police understandings of the value/worth of diversion. It would also clearly signal to police that diversion is the accepted/desired policy position. (See page 59 of our diversion report for more information).

8. Which jurisdiction has the strongest legislative provisions around drug diversion?

South Australia is currently the model exemplar of the benefits of a legislated approach. First, their PDDI program makes it a requirement for police to offer diversion to all adults detected for possession of drugs other than cannabis. Second, their Cannabis Expiation Notice scheme requires police to offer an expiation notice for all simple cannabis possession offences. It is also worth noting that the Victorian Parliamentary Inquiry into Drug Law Reform has recently proposed following such approaches, by 'codifying and removing the discretionary elements currently in place'.[16]

As we explain in our diversion report, there are strengths and weaknesses to legislating diversion. Entrenching diversion in legislation will make it easier for police to justify diversion, removing discretion and minimising other attitudinal barriers. However, if diversion and other factors such as eligibility criteria are enshrined in legislation, it may become difficult to change without legislative reform. These issues are discussed at page 54-55 of our diversion report for more information.

9. Did you find that diversion options were harder to access in the regions?

We heard some evidence that it was. Our study did not focus explicitly on this question, however, and thus I am not in a position to comment on how widespread a problem this might be, or whether there are specific regions where diversion is less likely to be offered, or less accessible, than others.

10. We have heard that the requirement to physically attend a drug diversion intervention session is a barrier for people living regionally or remotely, even where tele-health is an option. Does this align with your findings?

[15] Hughes, C., Seear, K., Ritter, A., & Mazerolle, L. (2018). *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion. A report for the Commonwealth Department of Health.* Sydney: NDARC, UNSW.

[16] Law Reform, Road and Community Safety Committee. (2018). *Inquiry into drug law reform.* Melbourne: Parliament of Victoria, p. 191.

Yes. This is discussed at pages 47-48 of our diversion report[17] and in Part 6.2 of the report.

11. Some Australian jurisdictions, such as South Australia, do have administrative regimes for cannabis possession. Are these regimes noticeably more cost effective?

Research suggests a number of benefits associated with administrative regimes. These include financial savings from reduced law enforcement activities[18] and improved social outcomes.[19] There is evidence, for example, that charging an offender for cannabis use/possession is six to 15 times more expensive than offering them diversion.[20] More information on the various cost savings associated with alternatives to existing approaches can be found on pages 12-14 of our diversion report.[21]

12. Which type of diversion mechanism is most effective in terms of directing people into other forms of support?

As noted earlier, South Australia has the most effective mechanism for diversion, in the sense that it diverts the highest proportion of offenders detected for use and possession. The South Australia model is highly effective due to a combination of factors including the fact that it is embedded in legislation (as discussed elsewhere in this response) and because of the different eligibility criteria that are used. The ACT diverts the second most offenders (proportionately).

The Committee might also wish to give some consideration to the human rights dimensions of directing or requiring people to undergo drug treatment. Research on drug law and mandated treatment by Dr Rick Lines in the UK explores some of these issues.[22] Lines has identified several regime tensions (i.e. tensions between international drug control and its implementation through domestic legislation and international human rights conventions and treaty obligations). One area Lines singles out is compulsory detention in the name of drug treatment. Compulsory drug treatment is a form of arbitrary detention. It has been questioned by the UN Special Rapporteur on the highest attainable right to health and the UN Special Rapporteur on torture. It is important to note that mandated treatment of various forms is sometimes claimed to be justifiable on the basis that people who use drugs are 'addicts' lacking 'free will' and on the basis that the decision to use or continue is an irrational one that requires correcting.[23] The UN Special Rapporteur on health has specifically critiqued the assumption that people using drugs lack the

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[17] Hughes, C., Seear, K., Ritter, A., & Mazerolle, L. (2018). *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion. A report for the Commonwealth Department of Health.* Sydney: NDARC, UNSW.

[18] Single, E., et al. (1999*). The Impact of Cannabis Decriminalisation in Australia and the United States. South Australia, Drug and Alcohol Services Council.* See also Baker and Goh (2004) http://www.bocsar.nsw.gov.au/Documents/r54.pdf

[19] Lenton, S., et al. (1999). Infringement versus Conviction: the Social Impact of a Minor Cannabis Offence Under a Civil Penalties System and Strict Prohibition in Two Australian States. Canberra, Department of Health and Aged Care; Shanahan, M., Hughes, C., McSweeney, T. (forthcoming). Australian police diversion for cannabis offences: Assessing program outcomes and cost-effectiveness. Canberra, National Drug Law Enforcement Research Fund; Males, M. & Buchen, L. (2014). "Reforming Marijuana Laws: Which Approach Best Reduces the Harms of Criminalization? A Five-State Analysis," San Francisco: Center on Juvenile and Criminal Justice.

[20] Shanahan, M., Hughes, C., & McSweeney, T. (2017). *Police diversion for cannabis offences: Assessing outcomes and cost-effectiveness. Trends and Issues in Crime and Criminal Justice No. 532.* Canberra: Australian Institute of Criminology.

[21] Hughes, C., Seear, K., Ritter, A., & Mazerolle, L. (2018). *Criminal justice responses relating to personal use and possession of illicit drugs: The reach of Australian drug diversion programs and barriers and facilitators to expansion. A report for the Commonwealth Department of Health.* Sydney: NDARC, UNSW.

[22] Lines, R. (2017). *Drug Control and Human Rights in International Law.* Cambridge University Press: Cambridge.

[23] Seear, K. (Forthcoming). *Law, drugs and the making of addiction: Just Habits.* Routledge: London.

capacity to consent to treatment and notes that this assumption creates a potential for abuse. I would similarly caution the Committee when considering mandated treatment for the same reasons and because of the significant prospect of such a practice being counter to human rights principles and obligations. This might be so even in the absence of compulsory detention.

13. Based on this research, did you find that cannabis diversion schemes tended to be more effective or more frequently used than other drug diversion schemes?

Our research did not examine the effectiveness of such regimes. As noted above, I can only comment on rates of diversion.

14. Overall, what are the key elements of an effective police diversion scheme that you recommend WA consider?

Our report lists a series of key facilitators that would enable expansion of diversion including: streamlining referral systems for police, increasing feedback mechanisms to police about drug diversion (given that police are the main gatekeepers to diversion and some believe it is a 'soft' option so are reluctant to use it, and so on). Another possible facilitator would be to move from a discretionary basis for diversion to a legislative basis as in the South Australian system, or for it to have a hybrid legislative basis. As noted earlier, there are strengths and weaknesses to each available approach.

I should also note, as the Committee will be aware, that drug offences differ by state and territory (page 18 of our diversion report) and some reforms to these could be contemplated. For example, it is an offence in Western Australia to use drugs, or to possess cannabis, other illicit substances or drug paraphernalia. It is not an offence to possess paraphernalia in the ACT or Victoria, however. It is not a specific offence to self-administer drugs in QLD. There are also differences in definitions (e.g. of possession), and these are also documented in our report. Some changes to those definitions or the provisions would of course have flow on effects for the system and would constitute an alternative (*de jure*) response that the Committee might wish to contemplate.

15. You have also been involved in research about the potential for non-criminal laws to discriminate against people who use drugs. Could you give us some examples of how this occurs, and the potential impacts?

An extraordinarily wide range of provisions in Australian law deal with alcohol and other drugs or are in some way relevant to the lives of people who use alcohol and other drugs. These provisions appear in a number of areas of law, including the criminal law and the non-criminal law (such as: family law, civil law, disability discrimination law, public health statutes and more).[24] These provisions have the potential to be discriminatory or stigmatising as I explain in more detail below.

Just as importantly, ideas about drug use (given its illicit status) appear in and shape approaches in other areas of law, too, even where the relevant provisions make no mention of drugs. These ideas can manifest in ways that result in people who use drugs being dealt with differently, or

[24] Seear, K. and Fraser, S. (2014). Beyond criminal law: The multiple constitution of addiction in Australian legislation. *Addiction Research & Theory,* 22, (5), 438-450.

being denied entitlements and supports. I will also explain these issues below. In what follows, I explain these two phenomena in turn.

1. Provisions in law that deal with drugs

To the best of my knowledge, there has been no attempt as yet to comprehensively map all Australian laws that might impact in some way on the lives of people who use drugs. Nevertheless, colleagues and I have undertaken some of this work in other jurisdictions and our findings may shed some light on the challenges that the Committee is likely to face in Western Australia.

First, colleagues and I recently undertook a major piece of research exploring how 'intoxication' features in Australian criminal law.[25] We found that over 500 provisions across the Australian criminal law attach significance to the fact of 'intoxication', alone. This gives a sense of just how prevalent alcohol and other drug provisions are in Australia, especially as 'intoxication' is just one way in which alcohol and other drug issues might figure in law, and also as these findings were confined to one area of law (the criminal law).

In a second project, colleagues and I mapped how laws and policies might generate (or help sustain) alcohol and other drug-related stigma and/or discrimination in one jurisdiction (Queensland).[26] This project involved mapping relevant provisions in all areas of law (i.e. criminal and non-criminal law). We found more than 220 provisions across 11 areas of law. In this work, we noted that there was little guidance, either domestically or internationally, about how law relates to stigma and discrimination and what should be done about it.[27] Colleagues and I have argued that:

> Ambitious statements calling for the elimination of stigma and discrimination […] are rarely, if ever, accompanied by details on precisely how law produces stigma and discrimination. It is not clear, therefore, exactly how we might take steps to address it. Comprehensively understanding *how* law produces stigma (rather than merely assuming a relationship) would appear to be an essential step before determining how policy makers and legislators might address it.[28]

Drawing upon this work, therefore, we developed a framework designed to assist others to identify/map relevant laws in other jurisdictions and assess the extent to which such laws might stigmatise and/or discriminate against people who use alcohol or other drugs.[29] This framework is designed to illuminate which laws have the potential to generate stigma and/or enable

[25] J. Quilter, L. McNamara, K. Seear and R. Room, "Alcohol and drug use and criminal law: a national study of the significance of 'Intoxication' under Australian legislation". *UNSW Law Journal, 39*(3), (2016a): 913-949; J. Quilter, L. McNamara, K. Seear and R. Room, "The definition and significance of 'intoxication in Australian criminal law: a case study of Queensland's 'Safe night out' legislation". *QUT Law Review, 16*(2), (2016b): 42-58.
[26] Lancaster, K., Seear, K., & Ritter, A. (2018). *Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use.* Drug Policy Modelling Program Monograph Series, *26*, (pp. 119). Sydney: National Drug and Alcohol Research Centre.
[27] Seear, K., Lancaster, K., & Ritter, A. (2017). A new framework for evaluating the potential for drug law to produce stigma: Insights from an Australian study. *Journal of Law, Medicine and Ethics*, *45*, 596-606.
[28] Seear, K., Lancaster, K., & Ritter, A. (2017). A new framework for evaluating the potential for drug law to produce stigma: Insights from an Australian study. *Journal of Law, Medicine and Ethics*, *45*, 596-606.
[29] Seear, K., Lancaster, K., & Ritter, A. (2017). A new framework for evaluating the potential for drug law to produce stigma: Insights from an Australian study. *Journal of Law, Medicine and Ethics*, *45*, 596-606.

discrimination and to highlight the reasons why law is more (or less) stigmatising. These findings can then be used to inform future decision-making regarding reform.

There are many ways in which laws (especially outside of the criminal law) might stigmatise or discriminate against people who use drugs. For instance, laws may contain provisions allowing for people to be ejected from public housing if they are found to use or be in possession of drugs. In many cases laws attach punitive consequences to the fact of drug use or to criminal records or to use and possession. Examples of how this plays out in the Queensland context can be found at pages 33-57 of that report.[30] In summarising the position in Queensland, based on our comprehensive analysis of their laws, we concluded as follows:

> We suggested that the stigmatising potential of law is increased wherever the law isolates certain individuals, practices, activities and behaviours associated with [alcohol and other drugs], enabling key stakeholders to exercise power and authority over them (including in ways that are potentially arbitrary or insufficiently defined), without sufficient protections for the target. It is important to note that the stigmatising and/or discriminatory potential of each individual provision can only be established through a comprehensive/holistic reading of that provision using the aforementioned coding schedule. After undertaking such an analysis, we conclude that a proportion of provisions in Queensland law have the potential to stigmatise and/or discriminate against people experiencing problematic [alcohol and other drug] use. Our analysis revealed that: relevant provisions appeared across 11 different areas of law, with provisions most often being found in the domains of: substantive criminal law, employment law and professional regulation, public health and public order. We also found that Queensland law targets a very wide range of practices, activities and behaviours, and uses a wide array of terms to describe the practices, activities and behaviours that are targeted. Only 33% of provisions define the targeted practice, activity or behaviour, with the remainder of provisions targeting practices, activities or behaviours that are not defined. The lack of definitional precision and clarity is a problem, because it may allow for highly subjective and variable assessments to be made. In other words, problems such as disproportionate, arbitrary or discriminatory policing may stem from insufficiently precise legislation, and these problems might be able to be alleviated or minimised through specific reforms that more precisely define targeted practices, activities and behaviours. We also found that the provisions convey decision-making powers and/or authority to a wide range of decision-makers, bodies and authorities. In some instances these decision-makers are familiar, highly trained and regulated (e.g. the police) but in others, powers are conferred upon private citizens and organisations who may be less familiar, well trained or well versed in the exercise of power (e.g. mining operators, employers, sellers of goods). We noted that the stigmatising and/or discriminatory potential of law was reduced when targets were offered protections in law. While most provisions provide some protections for the target, 30.94% do not. The stigmatising and/or discriminatory potential of law might be alleviated or reduced where the protections in individual provisions are included and strengthened, or where the strengthening of overarching legal protections for people who use [alcohol and other drugs] is embedded in other laws (e.g. anti-discrimination protections).

[30] Lancaster, K., Seear, K., & Ritter, A. (2018). *Reducing stigma and discrimination for people experiencing problematic alcohol and other drug use*. Drug Policy Modelling Program Monograph Series, *26*, (pp. 119). Sydney: National Drug and Alcohol Research Centre.

In any discussion about drug law reform (including the possibility of a move to an administrative system), there is thus a need to first consider where in law drugs feature, and to make some attempt to grapple with the breadth and complexity of those provisions, as well as how they overlap and interact.[31]

As a first step, therefore, I recommend that a mapping exercise be undertaken in Western Australia of the kind previously undertaken by myself and colleagues in Queensland. The purpose of such an exercise would be to ascertain all areas of law in which drugs feature and then to assess the extent to which those laws might generate stigma and/or discrimination. If followed, this recommendation would result in:

a) A comprehensive 'map' of all provisions in WA law that pertain to drug use;
b) New knowledge on the stigmatising and/or discriminatory potential of each provision;
c) Insights into the specific reasons why certain provisions may be more (or less) likely to generate stigma as well as how those laws might generate, sustain or reduce the potential for alcohol and other drug-related stigma and/or discrimination; and
d) Insights for specific, targeted reforms to bring all areas of law into alignment with any proposed administrative scheme.

2. Ideas about drugs in other areas of law

Finally, it is worth noting that *ideas about drugs* also shape how other provisions are interpreted and administered in ways that might adversely impact the lives of people who use or possess drugs. This may be the case even where drugs do not explicitly feature in the legislation.

I have previously tabled one paper (based on research by Suzanne Fraser and I) that shows how this happens, through an analysis of victims of crime cases in Victoria.[32] I also explained how these issues play out I my (tabled) submission to the Victorian drug law inquiry but I repeat the key aspects of that here for the Committee's benefit. Like Western Australia, Victoria offers a comprehensive system designed to support victims of crime, established under the *Victims of Crime Assistance Act 1996 (VOCAA)* and administered by the Victims of Crime Assistance Tribunal (VOCAT). These schemes, including the VOCAT scheme, are generally known as 'therapeutic', 'beneficial' or 'remedial' schemes, in that they are intended to remedy wrongs, benefit victims and assist them in their recovery from crimes perpetrated against them. The stated purpose of *VOCAA* is to assist victims of crime (as per Section 1(1) of the Act), and there are three main objectives, as per Section 1(2) of the Act:

> (a) to assist victims of crime to recover from the crime by paying them financial assistance for expenses incurred, or reasonably likely to be incurred, by them as a direct result of the crime; and
>
> (b) to pay certain victims of crime financial assistance (including special financial assistance) as a symbolic expression by the State of the community's sympathy and condolence for, and recognition of, significant adverse effects experienced or suffered by

[31] K. Seear and S. Fraser, "Beyond criminal law: The multiple constitution of addiction in Australian legislation". *Addiction Research & Theory,* 22, (5), (2014a): 438-450.
[32] Seear, K. and Fraser, S. (2014). The addict as victim: Producing the 'problem' of addiction in Australian victims of crime compensation. *International Journal of Drug Policy,* 25, (5), 826–835.

them as victims of crime; and

(c) to allow victims of crime to have recourse to financial assistance under this Act where compensation for the injury cannot be obtained from the offender or other sources.

Importantly, and appropriately, *VOCAA* established a number of eligibility criteria and other hurdles that must be satisfied before a person might receive an award of compensation from VOCAT. Section 54 of *VOCAA* sets out a series of matters to which VOCAT must have regard when considering an application for an award of compensation. That section reads as follows:

> In determining whether or not to make an award of assistance or the amount of assistance to award, the Tribunal must have regard to the following:
>
> (a) the character, behaviour (including past criminal activity and the number and nature of any findings of guilt or convictions) or attitude of the applicant at any time, whether before, during or after the commission of the act of violence;
>
> (b) in the case of an application by a related victim—
>
> (i) the character or behaviour (including past criminal activity and the number and nature of any findings of guilt or convictions) of the deceased primary victim of the act of violence;
> (ii) any obligations owed to the applicant and any other related victim applicants by the deceased primary victim of the act of violence;
> (iii) the financial resources (including earning capacity) and financial needs of the applicant and any other related victim applicants;
> (iv) if the related victim is a close family member of, or had an intimate personal relationship with, the deceased primary victim of the act of violence, the nature of the relationship between them;
>
> (c) whether the applicant provoked the commission of the act of violence and, if so, the extent to which the act of violence was in proportion to that provocation;
>
> (d) any condition or disposition of the applicant which directly or indirectly contributed to his or her injury or death;
>
> (e) whether the person by whom the act of violence was committed or alleged to have been committed will benefit directly or indirectly from the award;
>
> (f) any other circumstances that it considers relevant.

In 2013-14, Suzanne Fraser and I conducted research into the nature and operation of section 54, including how the 'character' and 'behavioural' elements of the section had been interpreted and applied.[33] We found that a victim of crime's past history of drug use, (including their 'addiction') was found to be relevant in a number of cases to the question of whether a victim should be compensated. We also noted that:

> […] section 54 offers no guidance as to what might be a relevant consideration, what

[33] K. Seear and S. Fraser, "The addict as victim: Producing the 'problem' of addiction in Australian victims of crime compensation:. *International Journal of Drug Policy,* 25, (5), (2014b): 826–835.

> weight should be given to relevant considerations in deciding whether or not to make an award, and how those considerations impact on decisions about the kind or size of award to make. The upshot of this is that judges have considerable scope for determining what is both 'relevant' and 'problematic', notions that have the potential to be taken up in subsequent case law as self-evidently relevant and problematic […] It is telling, therefore, that drug use and 'addiction' were understood to be of note, and a potential obstacle to the provision of compensation […], although the apparent relevance of drug use and addiction varied.[34]

Judicial approaches to these questions were highly variable. While in general there are sound public policy grounds for permitting Tribunal members to retain a broad discretion in regards to eligibility, we argued that the character test in section 54 was overly broad. In its present form, it is possible, for instance, that a victim of a very serious crime (such as attempted murder, rape or family violence) might be denied victims of crime compensation, including vital financial, social and medical supports, by virtue of having a history of illicit drug use. This may be the case, as I have previously argued,[35] regardless of whether the crime was related in any way to past drug use (i.e. section 54 does not require a nexus between the act of violence and the victim's drug use).

I note, as an aside, that when the Commonwealth redress scheme for victims of institutional child sex abuse was originally announced, the Commonwealth proposed excluding some people (including those convicted of serious drug offences) from compensation.[36] This proposal was at odds with the proposal by the Royal Commission into institutional handling of child sexual abuse.

There is a range of problems with this approach, including that it:

1. Is at odds with the remedial nature of *VOCAA*, including its focus on supporting and rehabilitating victims;
2. Risks punishing people twice, as where, for example, a person has been previously sentenced in relation to a drugs offence and is then sanctioned again (through denial of compensation) for having a past drug use history;
3. Offends on public policy grounds, including because it establishes two 'classes' of victims ('deserving' and 'less deserving' victims). The provision in this sense has the potential to stigmatise and/or discriminate against people with a past history of illicit drug use; and
4. Is at odds with other approaches to drug use and/or 'addiction' in law, including under Victorian law. In other areas of Victorian law, drug use and/or 'addiction' is treated as a health problem (e.g. *Severe Substance Dependence Treatment Act 2010*), or a mitigating factor as regards offending (e.g. ss3 and 65 of the *Infringements Act 2006* (Vic), discussed in more detail below).

Based on this research and our recommendations the Victorian Law Reform Commission has recently recommended that these provisions be changed.

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[34] K. Seear and S. Fraser, "The addict as victim: Producing the 'problem' of addiction in Australian victims of crime compensation. *International Journal of Drug Policy,* 25, (5), (2014b): 826–835 at 830.
[35] K. Seear and S. Fraser, "The addict as victim: Producing the 'problem' of addiction in Australian victims of crime compensation. *International Journal of Drug Policy,* 25, (5), (2014b): 826–835.
[36] https://theconversation.com/when-it-comes-to-redress-for-child-sexual-abuse-all-victims-should-be-equal-86456

I note that section 41 of the West Australian *Criminal Injuries Compensation Act* has been adversely interpreted in the past and retains character and conduct criteria that can work to undermine victim recovery and punish people for drug use.

This is just one example of an area of law in which ideas about drug use circulate/feature, resulting in differential treatment for people who use and possess drugs. Changing entrenched views about drugs may be difficult, especially as practices such as the one identified in this section do not result from any explicit mention of drugs in the statute. Nevertheless, there is a need to consider how these ideas might be challenged and reformed if an administrative scheme is introduced. This might require reforms to judicial and legal education, among other things.[37]

16. The Committee has heard about the potential harm reduction benefits of medically supervised injection centres, but we have not heard that there is a particular area in Perth that needs one. Is concentration of users' key to the beneficial effects of an injection centre?

As the Committee may be aware, there are about 90 supervised injecting facilities around the world, with the majority of those based in Europe.[38] Australia has just two such facilities, being the Medically Supervised Injecting Centre (MSIC) based in Kings Cross, Sydney[39] and the relatively new Medically Supervised Injecting Room (MSIR) in North Richmond, Melbourne. The MSIR location was chosen partly due to disproportionately high rates of overdose in the area in the period prior to its opening.

There is a substantial body of evidence suggesting that supervised injecting facilities reduce fatal and non-fatal overdoses, facilitate connections with other services and have a range of associated benefits for the community.[40] The *National Drug Strategy* also acknowledges that supervised injecting facilities are an important intervention.[41] These benefits have been documented to occur in facilities around the world, regardless of the number of attendees at the service or its location.

17. What additional harm reduction measures would you recommend are available in prisons?

The UNODC, WHO and UNAIDS argue that a package of supports should be made available to people who inject drugs. As the Committee will no doubt be aware, Australia has a suite of harm reduction services available, including a national network of needle and syringe programs (NSPs). Efforts to distribute needles and syringes have been shown to effectively control rates of HIV transmission among people who inject drugs in Australia; however, coverage has been

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[37] Seear, K. (Forthcoming). *Law, drugs and the making of addiction: Just Habits.* Routledge: London.
[38] https://theconversation.com/why-australia-needs-drug-consumption-rooms-53215
[39] https://uniting.org/our-services/for-adults/sydney-medically-supervised-injecting-centre
[40] MSIC Evaluation Committee (2003*). Final report on the evaluation of the Sydney Medically Supervised Injecting Centre.* Sydney; Marshall, B.D., Milloy, M.J., Wood, E., Montaner, J.S. and Kerr, T. (2011). 'Reduction in overdose mortality after the opening of North America's first medically supervised safer injecting facility: a retrospective population-based study', *Lancet*, Apr 23;377(9775):1429-37; Tyndall, MW, Kerr, T, Zhang, R, King, E, Montaner, JG, and Wood, E. Attendance, drug use patterns, and referrals made from North America's first supervised injection facility. *Drug Alcohol Depend.* 2006; **83**: 193–198; De Vel-Palumbo, M., Matthew-Simmons, F., Shanahan, M. and Ritter, A. (2013) 'Supervised injecting facilities: what the literature tells us', *DPMP Bulletin*, 22.
[41] Commonwealth of Australia. (2017). *National Drug Strategy 2017-2026.* Canberra: Commonwealth Department of Health.

inadequate for controlling hepatitis C infections.[42] It has been suggested that distribution of sterile injecting equipment 'is limited by supply rather than demand and that increased coverage is possible'.[43] Consideration should be given, therefore, to how distribution can be increased and coverage extended. Although national NSP coverage is less than optimal, prisons are a particular problem area. They have been described as an 'incubator' for blood borne virus (BBV) transmission[44] and a 'powerhouse' for hepatitis C transmission.[45] Prison NSPs are a harm reduction measure designed, like other NSPs, to minimise the risk of BBV transmission. Prison NSPs have been around for 25 years, with the first opened in Switzerland in 1992, and there are now more than 60 prison NSPs worldwide.[46] Various prison NSP models exist, including: hand-to-hand provision of needles and syringes by prison personnel, and hand-to-hand provision by external personnel (which might include peers).[47] There are no prison NSPs in Australia.

Like NSPs in the general community, prison NSPs offer a range of potential benefits including the prevention of BBVs. There are also other reasons to consider establishing prison NSPs. Recently, for instance, it was argued that the absence of prison NSPs represents a significant human rights violation,[48] a proposition that appears to be supported that numerous international human rights principles and instruments. For instance, Principle 9 of the *United Nations Basic Principles for the Treatment of Prisoners* states that:

> Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.[49]

Some interpret this to mean that where countries offer NSPs outside prisons, there is a positive obligation to provide them within prisons. As well, principle 24 of the *World Health Organisation Guidelines on HIV Infection and AIDS in Prisons* states that in countries where NSPs operate within the community:

> Consideration should be given to providing clean injecting equipment during detention and on release to prisoners who request this.

Human rights considerations might also support the development and establishment of prison NSPs. The UNHRC and the ECtHR have made clear that the right to life entails more than a negative duty to refrain from arbitrarily taking life, but also includes an obligation to take positive

[42] Kwon, J. A., Iversen, J., Maher, L., Law, M. G., & Wilson, D. P. (2009). The impact of needle and syringe programs on HIV and HCV transmissions in injecting drug users in Australia: A model-based analysis. Journal of Acquired Immune Deficiency Syndromes, 51(4), 462–469.
[43] Kwon, J. A., Iversen, J., Maher, L., Law, M. G., & Wilson, D. P. (2009). The impact of needle and syringe programs on HIV and HCV transmissions in injecting drug users in Australia: A model-based analysis. Journal of Acquired Immune Deficiency Syndromes, 51(4), 462–469 at 467.
[44] Fraser, S. (2013) 'Introduction', in *Stories from the other side: An exploration of injecting drug use in NSW prisons*, NSW: NSW Users and AIDS Association, Inc, 12-18 at 14.
[45] Hepatitis Australia (2011) *Consensus Statement addressing hepatitis C in Australian custodial settings.*
[46] Stőver, H. (2013). 'Prison NSPs from around the world', in *Stories from the other side: An exploration of injecting drug use in NSW prisons*, NSW: NSW Users and AIDS Association, Inc, 20-24.
[47] Stőver, H. (2013). 'Prison NSPs from around the world', in *Stories from the other side: An exploration of injecting drug use in NSW prisons*, NSW: NSW Users and AIDS Association, Inc, 20-24.
[48] Rubenstein, L.S., et al. (2016). 'HIV, Prisoners and Human Rights', *The Lancet,* **Volume 388, No. 10050**, p1202–1214, 17 September 2016.
[49] United Nations (1990) *Basic Principles for the Treatment of Prisoners.*

steps to safeguard life.[50] In practice, the courts will generally allow a wide margin of appreciation to states as to how they regulate such matters, as well as a reasonably wide discretion to law enforcement authorities as to how they deploy resources. However, the Courts have emphasised that a particularly high duty applies to persons in state custody, due to their particular vulnerabilities.[51] I have elsewhere argued[52] that prison NSPs should thus be considered as part of a suite of harm reduction services on offer across the state.

This is an especially important time for harm reduction in prisons. Approximately 182,000 Australians live with hepatitis C and there are around 10,000 new known infections each year.[53] For many years the most widely available form of treatment for hepatitis C was known as 'combination therapy', and involved the use of two drugs called pegylated interferon and ribavirin. A new generation of hepatitis C treatment known as direct-acting antivirals have emerged in recent years. These drugs have been lauded by some as revolutionary.[54] In the *Fifth National Hepatitis C Strategy: 2018-2022*, the Australian government described them as offering an 'unprecedented opportunity to change the course of the epidemic'.[55] The benefits of DAAs include: a treatment period reduced from 24–28 weeks to 8–12 weeks, and dramatic improvement in rates of cure (when compared to the previous regime of combination therapy).[56]

Crucially, the World Health Organization has announced an ambitious goal to eliminate hepatitis C by 2030. Australia is one of the few countries in the world to adopt this ambitious goal.[57] In a bid to reach the 2030 elimination goal, the Australian government has also added direct acting antivirals to the Pharmaceutical Benefits Scheme, at an estimated cost of $3 billion over 5 years.[58] The substantial investment to eliminate hepatitis C by 2030, being made by countries such as Australia may be undermined if other available harm reduction measures are not considered or implemented. Given the role that prisons can play in BBV transmission (and prevention), I would recommend that NSPs be established in West Australian prisons. Should the Committee wish to establish prison NSPs, they may choose from the range of available models, as noted above.

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[50] For example, the UNHRC has stated that: 'the right to life has been too often narrowly interpreted. The expression 'inherent right to life' cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures': General Comment 6, *Article 6: The Right to Life* (1982), U.N. Doc. HRI/GEN/1/Rev.1 at 6 (1994), [5]. See further Joseph, Schultz and Castan, *The International Covenant on Civil and Political Rights: Cases, Commentary and Materials* (2nd ed, 2004), Chapter 8, especially [8.01], [8.39]-[8.64]. The same interpretation has been applied to the equivalent right to life under the European Convention on Human Rights, see eg *LCB v UK* (1998) 4 BHRC 477, 456 [36]; *Osman v UK* (1998) 5 BHRC 293, 321 [11]; *Keenan v UK* (2001) 10 BHRC 319, 348-9 [88]-[90].

[51] See, eg, *Lanstova v Russian Federation,* Communication No 763/1999, UN Doc CCPR/C/74/D/763/1997 (2002), [9.2]. See also *Salman v Turkey* (2002) 34 EHRR 425, 482 [99]; *Fabrikant v Canada,* UNHRC Communication No 970/2001, UN Doc CCPR/C/79/D/970/2001 (2003); *Dermit Barbato v Uruguay,* UNHRC Communication No 84/1981, UN Doc CCPR/C/17/D/84/1981 (1982); *R (Amin) v Secretary of State* [2003] 4 All ER 1264, esp at 1283 [41] (Ld Slynn), and 1281 [31] (Ld Bingham).

[52] Keynote address to the Australasian Viral hepatitis conference, Gold Coast, September, 2016 https://addictionconcepts.files.wordpress.com/2016/10/viral-hepatitis-2016-keynote1.pdf

[53] Kirby Institute. (2018). *HIV, viral hepatitis and sexually transmissible infections in Australia: annual surveillance report 2018*. Sydney: Kirby Institute, UNSW.

[54] Gane, E. (2014) Hepatitis C beware - the end is nigh, *The Lancet, 384*(9954), 1557-1560.

[55] Australian Department of Health. (2018). *Fifth national hepatitis C strategy 2018-2022.* Canberra: Department of Health, p.5.

[56] Scott, N., et al. (2017). Reaching hepatitis C virus elimination targets requires health system interventions to enhance the care cascade. *Int J Drug Policy*, 47, 107–116.

[57] Australian Department of Health. (2018). *Fifth national hepatitis C strategy 2018-2022.* Canberra: Department of Health; World Health Organization (2016). *Combating hepatitis B and C to reach elimination by 2030.* Geneva: WHO.

[58] Rollins A. (2015). *Hep C cure comes with $3 billion price tag.* Australian Medical Association Online.

I thank the Committee for the opportunity to make this submission and for their time and consideration.

Yours sincerely,

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