SELECT COMMITTEE INTO ALTERNATE APPROACHES TO REDUCING ILLICIT DRUG USE AND ITS EFFECTS ON THE COMMUNITY

INQUIRY INTO ALTERNATE APPROACHES TO REDUCING ILLICIT DRUG USE AND ITS EFFECTS ON THE COMMUNITY

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 13 MAY 2019

SESSION TWO

Members

Hon Alison Xamon (Chair)
Hon Samantha Rowe (Deputy Chair)
Hon Aaron Stonehouse
Hon Michael Mischin
Hon Colin de Grussa

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Hearing commenced at 3.54 pm

Ms ANGELA CORRY
Chief Executive Officer, Peer Based Harm Reduction WA, sworn and examined:

Mr PAUL DESSAUER
Outreach Coordinator, Peer Based Harm Reduction WA, sworn and examined:

The CHAIR: Hello. On behalf of the committee, I would like to welcome you to the hearing. I, of course, do know both of you. My name is Alison Xamon, and I am the Chair of this inquiry. I would like to introduce you to the other people who are here. We have Hon Colin de Grussa, Hon Aaron Stonehouse and Hon Samantha Rowe. We also have Ms Lisa Penman, who is assisting our inquiry. Hon Michael Mischin is currently caught up in another committee meeting next door. He may end up joining us at some point during the course of the hearing, in which case he will be sitting over there, so do not be confused when that occurs. Today's hearing will be broadcast. Before we go live, I would just like to remind you that if you have any private documents with you, to keep them flat on the desk so that you avoid the cameras. Please begin the broadcast.

I now require you to take either the oath or the affirmation.

[Witnesses took the affirmation.]

The CHAIR: You will have signed a document titled "Information for Witnesses". Have you read and understood that document?

The WITNESSES: I have.

The CHAIR: These proceedings are being recorded by Hansard and broadcast on the internet. Please note that this broadcast will also be available for viewing online after the hearing. Please advise the committee if you object to the broadcast being made available in this way. A transcript of your evidence will be provided to you. To assist the committee and Hansard, could you please quote the full title of any document that you refer to during the course of this hearing for the record, and also be aware of the microphones and try to talk into them. Ensure that you do not cover them with any papers or make noise near them. Also, could you please try to speak in turn so that Hansard does not lose track of who is saying what. I remind you that your transcript will be made public. During today's proceedings, if you wish to provide the committee with details of personal experiences that can be identified, you should request that the evidence be taken in private session. If the committee grants your request, any public and media in attendance will be excluded from the hearing. Until such time as the transcript of your public evidence is finalised, it should not be made public. I advise you that publication or disclosure of the uncorrected transcript of evidence may constitute a contempt of Parliament and may mean that the material published or disclosed is not subject to parliamentary privilege.

Before we start with questions, would either of you like to make an opening statement to the committee? You are aware of our terms of reference.

Ms Corry: Just for the committee's benefit, I thought it might be useful to give you a bit of an overview of who we are.

The CHAIR: Yes; that was one of our questions, so you can start with that.

Ms Corry: Peer Based Harm Reduction WA has been an incorporated association for over 21 years now. We are the only peer-based harm-reduction service in WA. We are a not-for-profit

organisation. As our organisation title states, we provide harm-reduction services to people who use illicit drugs. We provide a range of services, including peer-based support; education and training; and broader workforce development for the broader health and human services sectors. We also operate a health clinic, which is operated by a nurse practitioner, where we provide health services for people who inject drugs, including testing and treatment for hepatitis C, and STI testing and treatment. We also run a number of peer education programs, where we train peers to educate their peer networks. One of those programs is an overdose prevention and management program. Another one is a hepatitis C peer education program. That second one aims to increase the uptake of testing and treatment for injecting drug users in the community. We also have short-term funding from the WA Primary Health Alliance to provide a peer support and service integration project for people of CALD backgrounds who have problems relating to their mental health and drug and alcohol use. That is just specific to the —

The CHAIR: That is the program specific to the Mirrabooka region?

Ms Corry: Yes, that is right—to the City of Stirling.

I guess, just so the committee is aware, our vision—our organisation's vision and our board's vision—is for an inclusive society where all voices are heard; and a more just society where people are treated with dignity and compassion, and have equitable access and opportunities regardless of their choice to use drugs.

The CHAIR: Can I just ask, in terms of the peer support networks that you are establishing, how accessible are they to regional and remote Western Australia at the moment?

Mr Dessauer: We are largely funded to operate within the Perth metropolitan area. We also have a site in Bunbury. We have a van that goes into towns in the south west region. A couple of our outreach workers are attached to that Bunbury site, so they can go to people's homes in the south west region. Apart from that, we are not really funded to work outside of those areas.

The CHAIR: So, of course, you are recognised as being pretty much the main organisation in Western Australia delivering those sorts of peer-based services. Is anyone delivering those services in the Kimberley, the Pilbara, the Gascoyne or the Kalgoorlie region?

Mr Dessauer: Not the sort of work that we do, no. We do occasionally do workforce development, training and education or consultancy for other agencies in the regions. We are not actually funded to do that, so we actually have to ask those agencies to pay the cost of us delivering that education or training, if we do it.

The CHAIR: And is there much request for that?

Mr Dessauer: Yes. I average between 60 and 70 occasions a year where I am either providing training or education to other agencies or I am providing guest lectures to universities, in schools of medicine, pharmacy or law.

The CHAIR: Are there any particular types of drugs that raise more concerns amongst agencies that they are wanting to get peer support around, or is it pretty much across the board?

Mr Dessauer: I think most of the agencies in the regions have their heads around alcohol. That is something those people are very familiar with. They become less confident when we start talking about illicit drugs. There has definitely been an increase in harm related to methamphetamine over the last eight to nine years. We do not think there are more people using methamphetamine. We think forms on the market have changed, so that the market is dominated by the strongest forms of methamphetamine.

The CHAIR: I just want to be clear: are you suggesting that the experience on the ground is not that there is increased use, but that it is stronger?

Mr Dessauer: And it is more obvious. There is more obvious harm taking place as a result, yes, and I would suggest that in some regional areas methamphetamine has become more available. On a per capita basis, statewide, we have actually seen a reduction in use over the last five years or so, but there are some regions that, 10 years ago, saw very little of this drug that have seen more of that drug available in recent years.

The CHAIR: In your experience, are people able to use methamphetamine on a recreational, occasional basis without experiencing adverse effects as a result?

Mr Dessauer: With any psychoactive substance, the risk of harm has a lot to do with the dose, and the frequency or pattern of use. When you have a very high-potency form of the drug, such as ice, you are more likely to see people having acute problems, because it is easier to take too much, and, generally speaking, with any drug the more potent it is the easier it is to develop a dependency.

The CHAIR: Do you think this is actually a deliberate business model, if you like, on behalf of the manufacturers?

Mr Dessauer: I think we are actually talking about global drug trends. We have made it much harder for people to manufacture methamphetamine in Australia, largely through Project Stop, which is where pharmacies have to report pseudoephedrine sales, but we have not reduced the per capita demand for methamphetamine, and so what we have seen is major international trafficking syndicates now manufacturing high-purity methamphetamine in South-East Asia and shipping it to Australia. So, if you have got the same number of people using the drug and you put a kink in the supply, the demand does not go away. The market adapts, and the bigger and better organised the criminals are, generally speaking, the stronger the drug is going to be. Al Capone did not bother brewing light beer; he made the strongest spirits he could, and that is just a black market dynamic. If you are smuggling something that is illicit, you want the most concentrated, easy-to-smuggle form, and there is perhaps a marketing advantage there as well. The more potent the drug is, the more people will become dependent on it, so you get reliable repeat custom.

Hon AARON STONEHOUSE: Just to summarise, our interdiction, or our policing of drug manufacture here in Australia, has contributed to higher potency methamphetamine on the streets here in WA.

Mr Dessauer: I think that is quite possible, and also that the increase we have seen in novel psychoactive substances over the last 10 years is probably driven by the same sorts of things.

The CHAIR: Sorry, did you say "novel" psychoactive substances?

Mr Dessauer: Yes, so some of the so-called legal highs, things like synthetic cannabinoids and substituted cathinone, which are psychostimulants very similar to methamphetamine with crazy street names like flacker or gravel or bath salts—you might have heard those names in the media. We never heard of these drugs on the market 10 or 15 years ago, and so I think the same market dynamic is contributing to that as well. It is easier for them to smuggle. There are jurisdictions where they are not illegal yet. The sniffer dogs and the ion trackers we use at the borders cannot detect a drug if we do not know it exists yet.

The CHAIR: I know that you have been working in this space for a very long time. Could you maybe just give your thoughts about the way that illicit drug usage has changed, particularly with the transition from heroin as the dominant drug of concern to methamphetamine? What are you noticing are the trends?

Mr Dessauer: There was an interruption in heroin supply to Australia in 2001. We did not see a reduction in injecting drug use when that took place. What we saw was an increase in methamphetamine use, so we saw a shift from one to the other. Heroin availability and purity have

been increasing steadily ever since. Western Australia has the highest overdose fatality rate in the country. Since about 2009, our heroin-related harms have been increasing in Western Australia.

The CHAIR: Of course, people are not talking about that. Everyone is talking about methamphetamine at the moment.

Mr Dessauer: There is a lot of media attention on that, yes.

The CHAIR: And a lot of the submissions that the committee has received have been about methamphetamine-related harms as well.

Mr Dessauer: We are talking about the changes to the market. Our border protection is reporting record seizures of methamphetamine, and every year we seize larger and larger amounts of this drug. But to look at the global situation, the United Nations Office of Drugs and Crime says that the black market for these drugs is saturated, and producers are producing far more than demand. They are just accommodating the fact that the profit margins are so huge that they can afford to ship more than they expect to get to market. The interdiction is just seen as tax, because these people do not pay tax normally, and what we have actually seen over the last few years in Australia is that the purity of methamphetamine has increased. The latest data I can get in Western Australia indicates that 70 per cent of the drugs that the police test are testing at 75 to 93 per cent purity. That is pharmaceutical grade methamphetamine, and the price has gone down. When I started working for this organisation, 19 years ago, a point of methamphetamine—100 milligrams—would cost you $100. Over the last three years or so I have had people regularly reporting to me that they are paying $40 for the same amount. The fact that we are seizing record amounts of this drug does not appear to be reducing the availability. The purity is increasing and the price is going down.

[4.10 pm]

The CHAIR: Are you finding that most people who are taking meth are injecting?

Mr Dessauer: No.

The CHAIR: How are most people taking it?

Mr Dessauer: Most of the consumers we interact with are injecting it, because we run the largest needle and syringe program in the state, so we have a bit of a biased sample. We tend to see the most dependent users. The vast majority of people using methamphetamine in this country are not injecting it. A large percentage of people smoke it or they vaporise it in a glass pipe or off another surface and inhale the vapour. A lot of people still take it orally or insufflate it—they snort it up their nose. The research we have in Australia indicates that 20 to 25 per cent of people using meth are using it once a week or more often, so they are the people we would think of as being dependent on the drug—they are the "ice addicts" in the media headlines—but 70 to 75 per cent of people are using it less often. Nearly half of Australians who used methamphetamine in the last year used it two or three times. We are not talking about ice addicts; we are talking about occasional and recreational drug users, who go to a festival or a party and have a bit of meth. You were asking if people can use it in a non-problematic fashion. The majority of people using methamphetamine in this country will never present for treatment—they are not dependent on the drug. That does not mean that they are not at risk of acute harm.

The CHAIR: Because of the potency of the drug?

Mr Dessauer: Yes, because of the potency. The same is true of party drugs like MDMA. MDMA is a relatively safe drug. I really want to stress that I just said "relatively", especially if this is being broadcast. When the potency is unknown, it can be very dangerous. When other substances are substituted for MDMA to make a profit, then all bets are off for the consumer. We definitely need

to focus on harm reduction for those sorts of occasional recreational users. There are things we could be doing to keep them safer that we are not doing at the moment.

The CHAIR: You have touched on the issue of MDMA, which raises the issue of pill testing, which of course is a bit of a national discussion at the moment. Are there good pill-testing regimes? Are there bad pill-testing regimes? Do you share any of the concerns that have been raised with this committee—that any attempts at pill testing is effectively semi-promotion of drug taking or is sending a message that it is okay to take drugs?

Mr Dessauer: There is definitely a concern that we do not want to increase the level of drug use. We do not know what will happen if we change drug laws, but we can look at examples in other jurisdictions and see what has happened there. There is not any really strong evidence internationally that providing pill testing at festivals encourages people to take drugs. We do not see an increase in the number of people using where these programs have been in place for a number of years, such as Europe. In fact, in some ways it might actually work to reduce drug use simply because the person is talking to a health professional about what they are doing. If there is something they do not expect in that pill, then they are having a conversation with a health professional that they would not have had otherwise, and they are aware of something that they would not have been aware of otherwise. This is not an area that we work in, but it is an area that I have read some of the literature around. The majority of people who are told that the pill is not what they expected it was do not take it. We are talking about a specific population here. We are talking about people who go to a festival occasionally and they want to have a good time. They paid a lot of money for the tickets and then they buy some drugs because they think that is going to make them have a better time. If a health professional or toxicologist says to them, "That's not MDMA you've got in there; it's this other thing. We have someone in ICU at the moment who took it", they will not take it then because it will spoil the event they are going to. It is a very different population to people who are highly dependent on a drug and who might be more likely to take it anyway, just to maintain their dependence and stop going into withdrawal.

The CHAIR: You have said that you are not working in the area of pill testing—there is nobody in Western Australia who is working in the area of pill testing. Could you just describe to the committee what, in your opinion, the best possible pill-testing regime might look like if that were to be delivered? For example, people can buy pill-testing kits on the internet and potentially test their own, but what would you suggest does a good regime look like?

Mr Dessauer: The kits that people can buy are not that great. They are a reagent test. They can tell you whether something is there or not. They can be fooled. A few years ago, WA police seized a bunch of alleged MDMA pills that were just compressed flour with a bit of sassafras oil in them, because sassafras contains one of the precursor chemicals you can manufacture MDMA from. If you tested that pill, you would think it was quite strong. Any effect you got would have been a placebo effect. Fortunately, that manufacturer had not put something else in there as well. The tests cannot detect things that they are not looking for, and they can be fooled. For a pill-testing regime that we would set up at festivals, for instance, we would want to have the right technology. That might be LC–MS testing. There is infrared laser technology that can be used to get a very accurate reading of what chemicals are in the pill. They do not just detect whether MDMA is in there; they detect every chemical that is in there and they can quantify the amount. If there is something in there that there is no record of before, it will still show a spike, so it will show that there is something there, but we just do not know what it is. That would be best practice in terms of the technology you are using. In terms of how you set it up, it would want to be front-of-house testing. That means that the consumer gets to bring the pill to the toxicologist. They take a tiny shaving off it and they get information straightaway about what it is. They can then make an informed decision about what

they do with that pill. Hopefully, if it is something dangerous, they do not take it. It is not going to stop drug-related harm. No harm-reduction measure stops drug-related harm; they are just things that can reduce the incidence or severity of drug-related harm. They are things that make it less likely. It is never going to be perfect, but it is an option that we are not doing yet that might save lives.

The CHAIR: What role do you think the police have in terms of trying to minimise drug taking at these festivals?

Ms Corry: I think with what Paul is talking about—the front-of-house testing—you would need a coordinated approach of all services that are available. While Paul talked about the best practice technical model for actually testing a pill, you also need to have responsible policing, you need to have medical staff who recognise the importance of the harm-reduction approach like pill testing, and you also probably need peers there to provide harm-reduction education and information to people who make the choice to use the drug or not use the drug. You would need a cross-sectional, collaborative approach for this to be effective.

The CHAIR: Getting back to the issue of heroin, what is your view on the heroin-assisted treatment that is occurring in overseas jurisdictions? Do you think there might be a role for that within WA, or are the current methadone programs sufficient?

Mr Dessauer: We have substitution pharmacotherapy in Western Australia. People can be prescribed methadone or they can be prescribed suboxone, which is a brand name for buprenorphine. The object of both of these is to give the person just enough of the drug to stop them going into withdrawal.

The CHAIR: Do you find that they are sufficient?

Mr Dessauer: If they are prescribed appropriately, they are a good fit for purpose for most people. The Cochrane review and the World Health Organization hold them up as gold standard. They are listed as essential medicines. They are not as accessible as they could be. We have quite restrictive policies around how these medications are provided to people. You have to present for daily supervised dosing. Even if you are stable in the program for several years, you can never get more than three takeaway doses per week, and no more than two on consecutive days. This means that if you are a fly in, fly out worker, you cannot access this treatment at all, for instance. For people in remote or regional areas, access is very, very difficult because of the necessity for presenting to dose every day. There are concerns around diversion, which is why that system is in place, but we have probably the most restrictive system in Australia.

[4.20 pm]

The CHAIR: In Western Australia?

Mr Dessauer: Western Australia has the most restrictive system in the country, yes.

The CHAIR: What sort of things would you be calling for if we were to look at a less restrictive treatment option?

Mr Dessauer: There are two things that stop people accessing treatment or that lead to people dropping out of treatment very regularly. One of those is the fact that they have to present to a pharmacy every day. That can be very difficult if there is no dosing pharmacy near them if they have transport difficulties. Some of the people we have on opioid substitution therapy have other chronic health problems which can make these things difficult for them as well. The other factor that impacts on people's ability to access this sort of treatment is the cost. The methadone or buprenorphine is provided to the pharmacist for free by the federal government, but the pharmacist then charges the patient a dispensing fee. If you were on any other medication chronically, the

Medicare safety net would kick in and your treatment would be subsidised. That does not apply to this, because it is a dispensing fee, so people are paying $5 to $10 a day, 365 days of the year, and a lot of the people who need this treatment are not in great financial circumstances to start with. That is a systemic barrier as well. In terms of heroin-assisted treatment, there are a number of countries that do that. In the UK, they have actually been doing it all along; they never stopped doing it. There is evidence that for people for whom other treatment options have failed, that is an option that can work. There is a number of places in the world that do it quite successfully. We were going to have a trial of heroin-assisted treatment in Australia back in 1999, which never went ahead.

The CHAIR: Whereabouts was that being proposed?

Mr Dessauer: All states and territories has agreed to it, actually, in 1999.

The CHAIR: What happened? A change of government?

Mr Dessauer: I believe John Howard was the Prime Minister at the time, and the Prime Minister stopped it happening.

The CHAIR: What are your views on medically supervised drug consumption rooms?

Mr Dessauer: Again, this is something that is done in lots of other places in the world. There are only two such sites in Australia. The international evidence is that they reduce harm and that they do not increase drug use. There have been numerous evaluations of the medically supervised injection centre in Sydney. Because it was so politically contentious and controversial, it has been reviewed over and over again. We do not see any evidence of increased use or increased risky behaviour. I spent a week working on the floor there some years ago, and just saw these nurses responding to overdose after overdose. It definitely has an impact. They are quite expensive facilities to run because you need to have medical staff on standby at all times during their opening hours. I guess in terms of cost effectiveness, if you have got a localised area with a high volume of injecting going on in the street, a medically supervised injection centre is probably going to be a very cost effective intervention. If you have a widely geographically dispersed population of people injecting drugs—maybe not so useful. I would want to see someone do an analysis before I would say yes or no for Western Australia. We want these sorts of decisions to be driven by evidence, but I suspect that it might not be as good an intervention in Perth, just because of the huge suburban sprawl we have. If I am a heroin user in Butler, I am unlikely to drive to the CBD every day to inject under medical supervision.

The CHAIR: Your evidence to this committee is that there may not be the demand to be able to justify the investment in that infrastructure?

Mr Dessauer: There would have to be some research done and a cost–benefit analysis done before we would know. That is just my suspicion. But, we would have to actually do some research to work that out.

The CHAIR: If you were to identify any regions that might benefit from that sort of approach, do any immediately come to mind?

Mr Dessauer: There is a couple of places, but again I would want to see some research.

The CHAIR: Could you give the committee some sort of indication about what those areas might be in the regions?

Mr Dessauer: In the regions, or in the metropolitan area, are you asking?

Hon MICHAEL MISCHIN: Both.

The CHAIR: Yes.

Mr Dessauer: Again, as I said, they seem to be most effective where there is a large street-based population, and there is a lot of street-based injecting going on. It is improving the amenity of the area by getting those people off the street, but it is also making those people a lot safer.

The CHAIR: That is why Kings Cross, of course, was such a logical starting point.

Mr Dessauer: Kings Cross and the area in Melbourne that has been chosen have been notorious for those sorts of issues for many years. Our main fixed site is based in Perth near McIver station. There are quite a few homeless and street-present people in that area and we know a lot of injecting goes on in that neighbourhood. There are a couple of other suburban hubs where you have a cluster, but, as I said, there is no point investing in something like this unless you are pretty sure people are going to use it.

The CHAIR: Can I ask where the clusters in the suburbs are?

Mr Dessauer: I do not know if I should be getting too specific based on my opinion.

The CHAIR: Okay, that is absolutely fine. One of the things that keeps coming up in the course of these hearings is the issue of stigma and the impact that that plays. In your experience, is the stigma more pronounced depending on what type of illicit drug is being used?

Mr Dessauer: Certainly. It is much easier for someone to admit that they have been smoking cannabis than it is for them to admit that they have been injecting heroin, just because a larger number of people in the population have engaged in the first activity than the second one, I suspect. The massive alarmist media attention to methamphetamine over the last eight or nine years has contributed significantly to the stigma around ice. I think a lot of the members of the general public have the idea that anyone who takes methamphetamine has no teeth and is a threat to everyone around them. That is not what we see in most of the people that we work with. Nicole Lee has done some research which indicates that the average time gap between someone identifying for themselves that they are having a problem with methamphetamine and them going out and actively seeking help to address that problem is about seven years. That is largely because people do not want to admit to a health professional or to their family members that they are having problems. My concern is that when we do stuff—I have heard people say that stigmatising drug use is good because it will discourage young people from engaging in the activity. I am not sure that I have ever seen any evidence that that is the case. The one thing we do know that it does is it scares the hell out of the people who do not use the drug that you are stigmatising. People who are having problems are far less likely to talk to their family members or friends. When you are recovering from a serious drug dependency, they are the sorts of social supports that are probably going to be most helpful to you. They are also not as inclined to seek help in a timely fashion from medical professionals, health workers or drug treatment workers. It does have a very real impact. I want to see that gap between when someone recognises they have got a problem and when they seek help get smaller not bigger.

The CHAIR: Through the course of your work, you would see a lot of people who undertake relapses.

Mr Dessauer: Yes.

The CHAIR: Can you give an indication of what tend to be the general risk factors for relapses? Is it just that the overall social determinants that have led to people drug taking in the first place, or is it a lack of services? What are the sorts of systemic barriers you are seeing to people being able to succeed in their recovery?

Ms Corry: I think it is all the things that you have pointed out, Alison. It is a lack of available services when people need those services. It is also the discriminatory behaviour that people have experienced from health services previously that prevents them from accessing services when they

may be about to relapse. There are also not a lot of harm-reduction services to support people if they choose to re-use—how to do that as safely as they can. Paul could probably give you examples of when people leave the justice system, leave the prison system. There is not a lot of information provided to them about the fact that they have had a period of abstinence and then may choose to use again. There is a whole range of fairly simple initiatives that would support people to make choices about whether they relapse, and also to talk about relapses being one decision. It is not a lapse and a failure necessarily, it is part of the chronic relapsing condition that is drug dependency.

[4.30 pm]

Mr Dessauer: You mentioned social and economic determinants of health. Obviously, those same factors influence people's mental health and they affect people's drug and alcohol use. At the moment in Australia every year we have about 200 000 episodes of drug treatment and we know that there is somewhere between 200 000 and 300 000 other people looking for treatment who cannot find a place. I think in the briefing document Angela gave you, it mentions that something like 65 per cent of our funding is spent on policing and supply reduction, law enforcement and border control. About 21 per cent is spent on treatment agencies; less than 2.5 per cent is spent on harm reduction agencies. I think if we are serious about reducing drug-related harm in the community, then we should be funding drug treatment agencies to meet the demand that is already out there. We need to pretty much double our investment in drug treatment agencies to be able to treat everyone who is actively seeking treatment.

The CHAIR: What other harm reduction measures would you consider are a priority that need to start being considered?

Ms Corry: I think the investment at the moment in providing people who inject drugs and who choose to inject drugs with the health services that they need needs to be looked at, in particular, the investment around the testing and treatment of hepatitis C. While those treatments are available and they are readily offered through a number of different areas—through primary health, through tertiary health—generally the way that they are offered are not conducive to, in particular, the cohort that we work with, accessing those services for all the reasons that we have mentioned previously. If you look at the "Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015–2025", there is a breakdown in that plan of the number of hours invested in harm reduction and support services. In 2015, that was 5 000 hours. The projected increase required to meet demand to 2025 was up to 285 000 hours' increase. When a review was conducted last year of how that plan is tracking, that increase in investment in harm reduction and support services had increased by two per cent, so we are a long way off the projected goal, so there needs to be a greater commitment to the important role that harm reduction approaches, strategies and initiatives play in addressing drug-related harm in the community.

The CHAIR: What would be the sorts of initiatives that you would have as first cab off the rank?

Mr Dessauer: We supply naloxone, which is also known as Narcan—it is a drug that reverses opioid overdoses—to people who may witness an overdose. We have been doing this for several years. Again, it is not going to stop all drug-related harm, but the more we invest in that sort of program, the fewer deaths we will see. It is very simple. Angela just mentioned the new direct acting anti-viral treatments we have for hepatitis C. When they were approved in Australia and PBS listed, we saw a big increase in people seeking treatment, which lasted less than three months and then dropped back down to baseline again.

The CHAIR: That is interesting.

Mr Dessauer: The people who are health-literate and already had a relationship with their GP were waiting for these treatments to come out and accessed them as soon they arrived, but there are

probably 180 000 people in this country with chronic hepatitis C who have not accessed the treatments. We are actively going out and trying to find them, so our outreach needle and syringe program, we have piggybacked other programs off that, so we have a hepatitis C treatment case manager who kind of tag-teams with our outreach teams to get people into treatment. We have been sending our nurse practitioner out to conduct clinics in the community. Every couple of weeks she is down in the south west as well. There are some really simple things that we can do that could increase access to this treatment, and it would not just be good for the individuals who are suffering from hepatitis C; it would save the public health system a very large amount of money in the long run. If we can get people treated, we can theoretically eradicate this disease within this country. People are talking about eradicating it within the next 10 years, but it is a matter of getting the people into treatment, and that will have to involve the criminal justice system as well.

Ms Corry: The other point that I would like to make is that a lot of the development of our programs is driven by consumer demand, so a core principle of how we operate and how we deliver our programs is that they are co-designed and co-produced. When you talk about what would be first cab off the rank, I think if you look at your target population, they would have to be involved in developing and delivering those services that meet their needs, rather than that being a service being developed and provided that is not actually meeting their needs. Peer involvement is imperative.

Mr Dessauer: This is something we do in most other areas; it is just that when we talk about illicit drug use, we are talking about a group of people who are not going to stand up and advocate necessarily on their own behalf in public, so if we want policy to influence the behaviour of a group of people, we need some mechanism of communicating with them, finding out what we are doing that works, what we should be doing more of, where there are gaps in what we are doing, and whether anything we are doing is actually counter-productive. A lot of things about drug policy are counterintuitive. It seems quite logical that if you put sniffer dogs outside a music festival, for instance, fewer people will take drugs into the festival, but what we are finding is that if people know there will be sniffer dogs there, they tend to take all their drugs before they arrive so they will not have anything on them when they get searched; or they tend to take novel drugs that they think the dogs will not detect. There are two things we should learn from that: one is that what seems like an intuitively effective approach might actually have no effect on the number of people taking drugs; the other is that it may even be counter-productive in that it might encourage riskier behaviour as people try to circumvent the control measure we put in place.

The CHAIR: In your experience, what impact do criminal penalties for drug possession have on people who are drug dependent or addicted? I want to be very clear about this, because we are not talking about people who end up with criminal records because they commit offences that might be associated with their drug use; we are talking about simply people who end up with criminal penalties for possessing the drug. What impact does it have, or does it have no impact?

Mr Dessauer: Well, it can have enormous impacts on your employment, it can have impacts socially, it can have all sorts of impacts. It does not seem to have much of an impact on per capita rates of drug use, though. That is one thing we see through all of the research internationally—there does not seem to be any relationship between how harsh drug laws are and rates of use. I think the rates of use have more to do with some of the social and economic determinants of health that you alluded to earlier.

The CHAIR: One of the things this committee has been looking at is other jurisdictions—the other states, and also international jurisdictions. In your opinion, who is doing it well? Who could we learn from? Or are there multiple different jurisdictions that are doing portions well?

Mr Dessauer: I think policy has to suit the environment that you are setting it in. It is not like we can take a policy from another jurisdiction and import it here and it is going to work the same way it did there. Australia has a very diverse population, and a lot of the countries we see that seem to be doing very well actually have quite culturally homogenous populations compared with Australia, but there are definitely lessons we could learn. There are a number of jurisdictions that have decriminalised personal use of illicit drugs. They have not decriminalised drugs—they will still prosecute people who are trafficking drugs or producing drugs or selling or supplying drugs—it just means people do not get a criminal record for being in possession of a drug.

[4.40 pm]

The CHAIR: Of course, it has been raised with us that if you decriminalise, you are basically going to increase usage of illicit drugs. You have just said, though, that you do not believe that to be the case.

Mr Dessauer: The international evidence does not seem to say that is the case. The international evidence does not show a strong relationship between criminalisation and personal drug use, and I would suggest that people who are deciding to use drugs do not think that they are going to get caught, that the decision is made long before there is any sort of criminal consequence, if there is one. In the jurisdictions we have seen that have decriminalised personal use of drugs, or personal use of specific drugs, there is no obvious trend in increasing use in those places. I guess the example that you have probably had thrown at you a few times is Portugal.

The CHAIR: It certainly has been thrown at us, yes.

Mr Dessauer: That might have been mentioned, yes.

The CHAIR: It is actually explicitly in our terms of reference as well, to look at Portugal.

Mr Dessauer: There has been a slight increase in the use of cocaine and cannabis products amongst people over the age of 24 in Portugal since they decriminalised personal use—not a very big increase but a slight increase—and there has been a decrease in the use of illicit drugs amongst people under the age of 24. Was that because they decriminalised or was that a trend that was already happening? That is the thing we do not know.

The CHAIR: If we were going to look at issues of law reform, what do you think should be the priority within Western Australia?

Mr Dessauer: I think there is an example in the document that Angela gave to you that applies directly to our work. Quite a few years ago, in Australian jurisdictions, we made it legal for people to buy or to source sterile injecting equipment, because we wanted to control the spread of HIV. But it is still against the law for someone to have a syringe that has traces of drugs in it. So when someone comes to our needle exchange, we can provide them with sterile equipment—there is no law against them going home with it, but when they bring it back to us to swap it again, it is actually evidence of a criminal act because it has traces of the drug in the syringe.

The CHAIR: Yet we have needle exchange programs.

Mr Dessauer: We certainly have.

The CHAIR: Are you saying that at the moment people are choosing to turn a blind eye, but that they could be criminalised for that?

Mr Dessauer: A similar thing is we have laws against secondary supply of injecting equipment, so our workers are authorised to supply sterile injecting equipment to someone. If that person gives a syringe to someone else, they are committing a criminal offence.

Hon COLIN de GRUSSA: Do you think that those laws discourage people from accessing the service?

Mr Dessauer: Only when they are enforced.

The CHAIR: Are they ever enforced?

Mr Dessauer: They are sometimes, yes. The majority of our consumers are probably unaware that they could get into trouble for having use equipment on them.

Hon COLIN de GRUSSA: For bringing back a used syringe.

Mr Dessauer: Yes, but people are occasionally prosecuted under these laws.

The CHAIR: Presumably, I would have to hope that the police are not waiting outside a needle exchange, looking to prosecute?

Mr Dessauer: No; just as police do not routinely attend overdoses, they do not routinely hang around needle exchanges. I think the police probably have a pretty good understanding that major crime figures do not go to the local needle exchange. You are really picking at the bottom end of the food chain if you are trying to arrest people there.

The CHAIR: That seems like an obvious area for reform. Do you think that there any other areas of drug law reform that would be useful?

Ms Corry: I know, for our consumers, their registration on the drugs of dependence register is an issue for them. Potentially disclosing their drug use to a primary health care physician is an issue for them, for example. I know that that act has been reviewed recently, so it is probably unlikely that it will be, but it definitely poses a problem for our consumers and their accessing services that they need.

The CHAIR: What do you think about potential law reform around the criminalisation of personal possession of drugs?

Mr Dessauer: I have just said that I think there is pretty strong evidence that it does not increase harm. To any objective observer, there are drug-related harms that are to do with the properties of the drug and the person who is taking it, and the circumstances under which they are taking it—the physiological or behavioural problems that might result. But there is another class of drug-related problems that are to do with the legal or social status of that drug in the culture that you are talking about. As long as there is some level of drug use going on in the community, there is going to be some level of drug-related harm. There will always be people making mistakes, but the negative consequences that come from the criminalisation of personal drug use are something that could be shifted with legislative change, yes.

The CHAIR: Do you have any thoughts on the issue of the legalisation of marijuana?

Mr Dessauer: Well, for starters, I prefer to call it cannabis, not marijuana. We do not live in Mexico.

The CHAIR: If you read the submissions received by the committee, it is all about marijuana, but anyway—the legalisation of cannabis.

Mr Dessauer: I think a lot of drug policy is debated in very simplistic black and white terms, and, of course, it is about human behaviour, so it is very complicated. When the media or politicians talk about drug law reform, they generally talk about it as either it is illegal or it is not—so either cannabis is illegal or else it is available in corner stores. There are, obviously, a whole range of models that we could apply to reduce harm. We had a cautioning system in Western Australia that was meant to divert people from the criminal justice system if they were caught with small quantities of cannabis for personal use. That is not decriminalisation; that is just an option, rather than giving someone a criminal record. There are states in the US that have gone full–blown free enterprise, where cannabis is now a product like tobacco, to be marketed. I think there must be middle ground between those extremes. There are lots of substances that can be dangerous and can be beneficial in use every day in this country, and we have a whole bunch of systems and regulations to manage those things; so, prescribed medications, tobacco regulation, liquor licensing and alcohol laws are

all examples of other models of managing drug-related harm without explicitly prohibiting that drug. If we are going to have an intelligent conversation around drug law reform, there should be discussion of what are the particular models that we could have.

The CHAIR: We are about to run out of time. Before we finish this hearing, is there anything else that you would like to bring to this committee's attention or you think would be useful for us to be aware of?

Ms Corry: I commend the committee on what you are investigating. I also appreciate that it will take strong leadership to move away from the ideological position that this country has had over—I do not know—the last however many decades. I think when we look at the people on whom some of these ideological positions have had an impact on a daily basis, I would just like to implore you to have the courage to have strong leadership around what comes out of this committee.

Mr Dessauer: I would just suggest that drug law reform is not about which drugs are legal and which drugs are illegal; it is about how we use the resources we have to reduce the incidence and severity of drug-related harm. The Portuguese experiment has been pretty well evaluated. Most observers say that they have reduced drug-related harm by that change, but they did not do it by making drugs legal; they did it by decriminalising personal use, saving money that they were spending on policing personal use of drugs, and reinvesting that money in health services, drug treatment services, accommodation and social welfare services. They took some of the money that they were using in policing and they put it into reducing some of the economic and social factors that you alluded to earlier, Alison, that make problematic drug use more likely. That is the sort of broad thinking you need if you actually want to have an impact.

The CHAIR: Thank you both for attending the hearing today. Please end the broadcast.

A transcript of this hearing will be forwarded to you for correction. If you believe that any corrections should be made because of typographical or transcription errors, please indicate these corrections on the transcript. Errors of fact or substance must be corrected in a formal letter to the committee. If you want to provide additional information or elaborate on particular points, you may provide supplementary evidence for the committee's consideration when you return your corrected transcript of evidence.

Thanks, both of you.

The WITNESSES: Thank you very much.

The CHAIR: On that last point, when you go through the transcript, often that is when you will go I might actually want to just refer to this or make this point and we would be happy to receive further information.

Thank you.

Hearing concluded at 4.50 pm

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