



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

**HOUSE OF  
REPRESENTATIVES**

STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

**Reference: Impact of illicit drug use on families**

WEDNESDAY, 9 MAY 2007

CANBERRA

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**HOUSE OF REPRESENTATIVES**  
**STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES**

**Wednesday, 9 May 2007**

**Members:** Mrs Bronwyn Bishop (*Chair*), Mrs Irwin (*Deputy Chair*), Mr Cadman, Ms Kate Ellis, Mrs Elson, Mr Fawcett, Ms George, Mrs Markus, Mr Quick and Mr Ticehurst

**Members in attendance:** Mrs Bronwyn Bishop, Mrs Elson, Mr Fawcett, Mrs Markus and Mr Ticehurst

**Terms of reference for the inquiry:**

To inquire into and report on:

How the Australian Government can better address the impact of the importation, production, sale, use and prevention of illicit drugs on families. The Committee is particularly interested in:

1. the financial, social and personal cost to families who have a member(s) using illicit drugs, including the impact of drug induced psychoses or other mental disorders;
2. the impact of harm minimisation programs on families; and
3. ways to strengthen families who are coping with a member(s) using illicit drugs.

**WITNESSES**

**BASSETT, Ms Meredith, Team Leader, Organisational Performance Team, Australian Federal Police ..... 1**

**PHELAN, Assistant Commissioner Michael, Assistant Commissioner, Australian Federal Police ..... 1**

**SLATER, Commander Julian James, Manager, Performance and Planning, Australian Federal Police ..... 1**



**Committee met at 10.37 am****BASSETT, Ms Meredith, Team Leader, Organisational Performance Team, Australian Federal Police****PHELAN, Assistant Commissioner Michael, Assistant Commissioner, Australian Federal Police****SLATER, Commander Julian James, Manager, Performance and Planning, Australian Federal Police**

*Witnesses were sworn or affirmed—*

**CHAIR (Mrs Bronwyn Bishop)**—I declare open this public hearing of the House of Representatives Standing Committee on Family and Human Services for its inquiry into the impact of illicit drugs on families. Today the committee welcomes representatives from the Australian Federal Police to give evidence again on this very important issue. Dr McFadden was to be with us but I understand he is unwell. We hope he recovers quickly. In his place we have with us Mr Slater, Mr Phelan and Ms Bassett. We are going to hear information particularly on the AFP's Drug Harm Index, which I think is really a very important index that has been developed. This index is a means by which the AFP quantifies the harm to the Australian community which is avoided by preventing illicit drugs reaching our streets.

The transcript of what is said today will be posted on the committee's website. If you would like further details about the inquiry or the transcript please ask any of the committee staff here at the hearing. Do you have any comments to make on the capacity in which you appear?

**Assistant Commissioner Phelan**—I am the AFP's National Manager, Border and International Network.

**CHAIR**—Would anyone like to make an opening statement?

**Assistant Commissioner Phelan**—I would. I understand that at a previous hearing of this committee Commissioner Keelty gave certain undertakings that we might be able to explain the Drug Harm Index a little bit further. It is my pleasure to be able to do that. Commander Slater is in charge of performance and planning and Meredith Bassett works in that area as well. I apologise for Dr McFadden's non-appearance today. He is very much the author and architect of the Drug Harm Index. Commander Slater and I can certainly give a lot of information on the technical data that underpins the harm index, but if we go into deep technical information then Michael would be best to give that. We are more than happy to take questions on notice and provide that information in a timely manner back to the committee, should you desire it. We hope to provide you with more information as a result of Commissioner Keelty's discussion with you earlier this year regarding the AFP's Drug Harm Index.

The Drug Harm Index weighs up the likely health, social and economic costs if the drugs reach the streets, which is the basis of our calculations. Since June 1999, AFP seizures have saved the Australian public nearly \$5 billion in drug related harm. The index was first established in 2001 using mainly overseas data. From the beginning, the index attempted to

estimate the average amount of harm that would be associated with a given amount of illicit substance—that is, a different amount of harm depending on the type of substance. Initial estimates were relatively crude. However, the Drug Harm Index has been revised on a number of occasions, most recently in 2003 and again in 2006, to maintain the currency of the index itself and to bring into account a lot of extra local knowledge that occurs around the drug scenarios in Australia and the additional costs that vary from time to time.

The Drug Harm Index was developed mainly to meet two purposes. First of all, it related to the accountability of the AFP to government and the Australian community in terms of the resources that were delivered to the AFP to fight illicit drug trafficking, so we could at least show the government and the community what we were doing in terms of economic benefit back to the community. Our studies and our validated research so far suggest that there is a return of approximately \$6 on the harm index for every dollar that the AFP invests in its operations to fight illicit drugs. This return takes into account not only the costs of the AFP but also our partner agencies, the judicial system and the prison system.

The second purpose was to assist the AFP in developing more efficient and effective ways to combat illicit drugs. If we know what we are fighting and the value of what we are fighting, it can help us target our resources a lot better. Recent economic evaluations have shown that key strategies such as intelligence-led policing, an emphasis on serious and complex crimes and partnerships, both domestically and internationally, all result in higher returns. In other words, the more effort we place at the top end of town and on our international efforts—that is, working with our international law enforcement partners and stopping the drugs before they reach our shores—the greater the return on the investment that the AFP puts in across the board.

If you could indulge me to go into some of the technical data that underpins the Drug Harm Index, I will go forward. The Drug Harm Index is based on a pretty straightforward assumption—that is, if the amount of illicit drugs consumed within the community is known and the social and economic harms that result from their consumption are known, it is relatively simple to estimate the average amount of harm that is given by a unit of drug; we just divide one by the other. We can also do that for individual drugs and individual drug types, which I will go into later on. For example, the most recent version of the Drug Harm Index estimated that the relative harm associated with one kilogram of MDMA or ecstasy was approximately \$280,000 to the community. For every one kilo, if it were to reach the streets, it would cost us \$280,000 in harm to the community. I will go into what some of those harms are shortly.

The most widely accepted estimates of the total harm associated with illicit drugs in Australia is in the report prepared by Collins and Lapsley, which I understand the committee has, in 2002 which talked about the overall harm. They concluded that the cost of illicit drugs to the Australian community in a single year was \$6.1 billion. Of this, \$345 million related to production in the home, so they categorised harm as being in the home—that is, lost productivity, family et cetera having to take days off work to look after sick relatives or people that had been addicted to drugs. The study prepared by Collins and Lapsley was used as the principal source for the AFP in developing our Drug Harm Index. The study did not identify the individual costs for each drug. The AFP has taken our Drug Harm Index a little further so we can identify particular types of illicit drugs and quantify what our return on investments—

**CHAIR**—So you can tell us whether ice coming into usage is going to be more or less costly to the community than, say, heroin.

**Assistant Commissioner Phelan**—We can do that, and that sort of information ebbs and flows depending on the costs of treatment and of the harm. One of the earlier iterations of the Drug Harm Index had heroin as a cost to the community, I think, of \$1,080,000 per kilo; amphetamines only being down around \$80,000 a kilo, I believe. The study has been updated to such an extent that the cost of heroin is less than \$1 million—it is still relatively high; I believe it is about \$550,000 per kilo—but the one that has skyrocketed is amphetamines and that has gone up to approximately, as I said before, \$280,000 per kilo, which is our relative measure of harm for every kilo should it hit the streets.

**CHAIR**—And that is because of its greater usage.

**Assistant Commissioner Phelan**—The Drug Harm Index talks about the costs of health and all those things as well. Ice is a very destructive drug and when we talk about ice we talk about the pure form of methamphetamine hydrochloride. A lot of people call ice lots of different things.

**CHAIR**—Crystal meth.

**Assistant Commissioner Phelan**—What it has effectively done is put a greater burden on our health system: the associated harms, the social cost of treatment, ambulance officers and the disruption to the homes of people that are on these pure forms.

**CHAIR**—Do you include loss of life expectancy in that? For instance, I only recently heard that for someone who comes off heroin and goes onto permanent methadone, which makes them a daily addict, their life expectancy drops to 46.

**Assistant Commissioner Phelan**—I cannot specifically answer that question, but we are more than happy to get that information for you.

**CHAIR**—That means they lose 40 years of life.

**Assistant Commissioner Phelan**—We measure based on studies that were done in Australia on the cost of a life and its effect on the family and the community, lost productivity and so on. But I am not sure about overall life expectancy. I am more than happy to look into that, unless Julian or Meredith have an answer.

**Ms Bassett**—The Drug Harm Index takes into account reduced life expectancy and that was part of its development. With the recent changes to it and the increase in amphetamines, it takes it into account but not in detail. It is a very high-level measure, so unless the scientific studies are there, the Drug Harm Index will not take those things into account at that sort of level.

**CHAIR**—But it could if you have got the data.

**Ms Bassett**—Exactly. The problem is getting updated data. As you know, Collins and Lapsley was in 2002 so that is quite old and it is based on data from 1998. The Drug Harm Index in its

latest reincarnation was adapted from anecdotal information and a few other research studies that had been commissioned by the AFP to adjust the ratios of harm between heroin and amphetamines. It takes it into account but probably not to the level of detail that you would like in the question you just asked

**CHAIR**—I am sorry I interrupted you, Assistant Commissioner Phelan. We will come back to that question in a minute.

**Assistant Commissioner Phelan**—That is fine. I have almost finished my opening statement. I have talked about the amounts. The only amount I did not talk about was cannabis. The cost of the harm is approximately \$13,000 per kilo. But the one thing I will say, just to alert the committee, is that we find the Drug Harm Index extremely valuable, particularly from an operational point of view in the AFP. As I said earlier, it helps us to target our resources at where they should be targeted at the end of the day. It is about getting return on investment for the Australian community.

To that extent, we are very careful in making sure that we have valid documents. The documents themselves—or the drug harm indexes—have had a fair bit of external scrutiny as well. Three universities Australia have independently looked at the Drug Harm Index. Indeed, the authors of this had a look in the beginning to see whether or not it is valid. Their studies have said it is valid. If the committee is interested, those organisations are the University of New South Wales, the University of Queensland and the ANU, as well as some overseas organisations.

We will continue this scrutiny. We want to make sure that our indexes are valid. We do not only do this for illicit drugs; we also look at cost to the community for fraud. We also try to look at similar economic measures for counterterrorism and preventive actions like our protection services. We are continually trying to update those to make them valid. Basically, that is it unless there are any questions that you would like to ask.

**CHAIR**—Thank you. First and foremost, are you the first in the world to develop such an index? Have other countries developed an index?

**Assistant Commissioner Phelan**—Certainly from my experience none of the other organisations around the world that deal in illicit drug interdiction go anywhere near as far as the AFP in terms of measuring the return on investment for the Australian community. We must have been almost close to being the first. I would not be surprised if we were.

**CHAIR**—So we are world leaders? That is very good.

**Ms Bassett**—The UK have just completed their own drug harm index.

**CHAIR**—Copied!

**Ms Bassett**—They did reference our work.

**CHAIR**—They referenced your work—that is a nice phrase!

**Ms Bassett**—Their methodology is a little bit different. They based it on a Delphi analysis—essentially, a panel of experts are asked which drug they believe has greater harm. They did not do it based on cost; they did it more on what people thought—that is, whether heroin is of greater harm than cocaine. It is based on information from people who should know these things.

**CHAIR**—I do not think anyone knows that.

**Ms Bassett**—That is true. But their information is publicly available.

**Assistant Commissioner Phelan**—We have tried as much as we can—

**CHAIR**—Theirs is a bit more touchy-feely, whereas yours is a bit hard based.

**Ms Bassett**—We like to think so.

**Mrs MARKUS**—This one would also be more empirical.

**CHAIR**—Yes.

**Assistant Commissioner Phelan**—Yes, that is the point. We definitely try to move away from as much of the anecdotal stuff as we can even though we have to do some of that. But most of it is based on empirical, scientific data as much as we possibly can so that it has greater validity.

**CHAIR**—You could call yours an evidence based index.

**Assistant Commissioner Phelan**—That would be a good assessment. I would not mind that one.

**Ms Bassett**—I am happy to use it.

**CHAIR**—When you were doing the comparison you said that heroin used to be more costly to the community, but that has moved down and amphetamines have moved up. How do you make those adjustments? What is the basis of making that adjustment? Is it usage?

**Ms Bassett**—We have seen a major decline in heroin overdoses in the last few years. Ambulance call-out data and any health data that we can access as well has all indicated that the harm of heroin to the community has actually decreased, although you could look at it as depending on the types of users. It appears that heroin is now restricted more to long-term users and less to recreational users which have transferred to—

**CHAIR**—We have to get rid of that term.

**Ms Bassett**—the recreational amphetamine type drugs.

**CHAIR**—‘Recreational’ was the term I meant.

**Ms Bassett**—I am sorry—to the more amphetamine type use. So the harm of heroin has decreased.

**CHAIR**—You would call that ad hoc use, would you?

**Ms Bassett**—Yes, that would be an appropriate term—the occasional user, who wants to have it at a party, as opposed to the heroin addict, who needs to have it on a regular basis. From that health data we can quite confidently say that heroin usage has gone down and amphetamine usage has gone up and, therefore, you can adjust the ratios.

**CHAIR**—We are going to hear some evidence from a family where a son began on cannabis and takes cannabis and ice. The net result is, when there is an incident, it takes eight police to hold him down. How do you count that? How do you measure that harm? The destruction of the family and everything else is huge. How do you measure that?

**Assistant Commissioner Phelan**—I suppose in essence the Drug Harm Index, like Meredith was saying, is very high level. We have not gone into individual cases. I suppose it gets amortised over the whole of the system. It might be small harm in one family and greater harm in another. The health system may be able to very quickly put one ice addict through the system and fix them up and do whatever they need to do but another one may take a lot more resources. So it is very much an amortisation across the whole board of doing that. Our level of detail does not go to individual cases. We have seen it first-hand. Some of these things, as you know, can be quite horrendous. Any costs—and these are the costs that are borne—include opportunity costs—

**CHAIR**—That is right.

**Assistant Commissioner Phelan**—Those eight police officers, for example, could be doing something else while they are sitting there holding him down. As a general measure, and this is what I said earlier on, the harm index takes into account all the law enforcement costs to judiciary. While the judiciary are putting through drug cases they are not working on something else. So there is an opportunity cost to everything. That is what we try to measure through the harm index in a very macro sense at the highest possible level. I do not think we would actually be able to measure right down to a case-by-case basis. It would be extremely difficult.

**Mrs MARKUS**—You can do it for single drugs, so do you do it if there is more than one drug? Obviously there are polyusers.

**Cmdr Slater**—We look at really three categories of drugs. When we are talking about amphetamines we are actually talking about the stimulants. We look at the Drug Harm Index in terms of heroin, cannabis and stimulants and then we categorise all stimulants together. The level of detail that you are looking at is not a level that is actually built into our Drug Harm Index. Amphetamine type stimulants and cocaine are part of the same category of stimulants. We would need to have further research to base a more detailed microanalysis of the different effects of the different drugs. Polyusers will cross between the different categories of drugs that we actually measure drug harm.

**Mrs ELSON**—In your harm index here I have not seen anything about how many people on drugs suicide. I guess ‘loss of life’ would be it. I know at my local hospital they would know it is a suicide by drugs—they are on drugs and they imagine that life is not worth living—but on record it does not show up that they actually suicided. Is that a difficult one to monitor? Is it difficult to get the facts right of how many die by suicide?

**Assistant Commissioner Phelan**—I think it is a difficult measure. The Australian Bureau of Statistics do put through—annually or every second year—studies that talk about drug related deaths as well as specifics, so there are deaths that are not necessarily directly attributable to but also collateral to that are included. That sort of data fills the suite of data that enables us to put these things together.

**Mrs ELSON**—Is that under ‘loss of life’ in your statistics?

**Assistant Commissioner Phelan**—Yes.

**CHAIR**—I would be interested to know whether you have done any work on this and whether you are thinking of doing this. We see ads on television that say 19,000 people this year died of smoking related disease. To get to that figure they are measuring people who might have started smoking at nine and might still be smoking at 99. The death of the 99-year-old who smoked is counted as smoking related.

When we look at things like cannabis, opiates and stimulants, we only count people who die of a directly identified overdose. Consequently, we are not getting the picture at all. There is a lot of work in this article by Dr McFadden measuring absenteeism, efficiency, distribution and so on. Do you also measure loss of life? Somebody could lose 40 or 60 years of life. They might have been trained and educated at a cost to the taxpayer and then, before we can get a return on that effort, they die or become inefficient. But they should still be counted. Have you done anything like that?

**Ms Bassett**—The data that we use is based on Collins and Lapsley, and they took into account loss of life and reduced life expectancy. The index also takes that into consideration.

**CHAIR**—Could we extrapolate a figure—for example, \$19,000 for cigarettes?

**Ms Bassett**—I do not think that the AFP could. We are not a drug research company, so we do not have the knowledge to be able to extrapolate that information. I would imagine that somebody like Collins and Lapsley would be able to do that, but the AFP would not be in a position to extrapolate it to that level.

**CHAIR**—Their study is now pretty dramatically out of date, isn’t it?

**Ms Bassett**—That is correct.

**CHAIR**—It uses 1998 data and was written in 2002. We desperately need some more recent stuff, don’t we?

**Ms Bassett**—Two weeks ago we presented the Drug Harm Index to the Australian National Council on Drugs and we highlighted that issue with them. They are also concerned about the adequacy of data and said that they would be championing the cause of getting more up-to-date data so that these things can be—

**CHAIR**—Did they offer you any money? They get \$1.6 million a year. I do not know what they do with it.

**Ms Bassett**—Again, it is not for the AFP to collect the data; it is to ensure that the health—

**CHAIR**—Yes, but to commission someone to do it.

**Ms Bassett**—They did not go into that detail, no—not at this point.

**Mr FAWCETT**—In his article, Dr McFadden says that one of the reasons for developing the index—in terms of reporting outputs back to government proceedings—was so there would be some way of looking at cost, which is fine. That is governance reporting type of stuff. How useful is that in terms of directing the priorities for the allocation of resources? Does it really have a practical outcome, or is it purely a cost that you are wearing in order to report to government in accordance with the guidelines that government has laid down?

**Assistant Commissioner Phelan**—It is two-way, and I can speak from experience because I run border operations. All the investigators in our regional and overseas offices have to prioritise their work. They do so in accordance with a case categorisation-prioritisation model that we use. That model looks at the impact of investigations—whether they are very high, high, medium or low. A lot of that takes into consideration the type of drug and the type of criminal enterprise. If it was a syndicate that was working on cannabis distribution, that would not be something that the AFP would deal with. We would work with our state colleagues on something like that.

So it does help to refine our work, and it helps us to work out where we want to push our intelligence. If the greater harm to the community now is through amphetamines and ice—even though we have known that for a period of time, and I think I am on record as saying that in this place—we would move our resources towards that. If we are going to do that, we like to know what the return on the investment is. When you see that the study has upped all stimulants almost fourfold, we know that we are heading in the right direction to do that sort of thing—it is not just anecdotal. There is empirical data backing our decisions to work on those priority investigations. That certainly comes into our thinking when we do it. We do not have knee-jerk reactions to something just because someone says that it is a problem; it physically needs to be a problem. That is why these studies are important to us operationally. We can then say, ‘Anecdotally you might think that ice was a problem a few years ago, but what is the actual cost of ice and is it really a problem?’ Of course, the studies say that it is, so we validate our own operational decisions through that.

**CHAIR**—When you say that ice is now the greater harm, what are the components that lead you to that conclusion?

**Assistant Commissioner Phelan**—The technical ones?

**CHAIR**—Yes.

**Assistant Commissioner Phelan**—Off the top of my head, it is obviously the increased harm associated with the health system and—

**CHAIR**—Violence.

**Assistant Commissioner Phelan**—Yes. Obviously, the hospitals need to do greater things. There is violence and crime associated with that. There are burglaries, break-ins and things like that. There is the domestic violence attitude.

**CHAIR**—As I understand it, amphetamines are pretty cheap. I have heard anecdotally that kids say, ‘It’s cheaper to take pills than it is to buy booze.’

**Assistant Commissioner Phelan**—When you talk about the trafficking costs—it varies from place to place of course—relative to the overseas markets, Australian illicit drugs are very expensive and still are because it is about the marketplace. For example, ecstasy pills here still may retail at a nightclub or wherever for between \$30 and \$40 a pill and sometimes up to \$50 but they are still being sold for \$AU8 in some places in western Europe.

**CHAIR**—So the cheaper the drug, the greater the usage; it just responds to ordinary market forces.

**Assistant Commissioner Phelan**—Yes, it is about supply and demand. Illicit drugs are no different to any other economic commodity. If we can restrict the supply and the demand is still high the natural consequence is that the price will go up.

**CHAIR**—And therefore fewer people use.

**Assistant Commissioner Phelan**—That is right.

**CHAIR**—If the price comes down, the market increases.

**Assistant Commissioner Phelan**—No, not necessarily. If the market is steady and the supply is there, then obviously the price will go up because not everybody can get their product. We have had some very interesting studies done over time.

**CHAIR**—No; the question I was asking was: if the cost of the pills was eight bucks instead of 40 bucks, you would have more people using them.

**Assistant Commissioner Phelan**—Not necessarily; not in an economic model. If the price goes down, it does not necessarily mean that more people are going to buy it. A lot of it depends on supply and demand. So if there is an oversupply then the price will go down because drug traffickers, like any other person who wants to sell their commodity, will drop the price.

**CHAIR**—Question: per head of population, Australia versus Europe—the drug is eight bucks in Europe—is there a greater percentage of the population using there than there is in Australia?

**Assistant Commissioner Phelan**—We have one of the highest percentages.

**CHAIR**—We have the highest percentage of users.

**Assistant Commissioner Phelan**—Absolutely. So price is not necessarily a determinant of whether someone is going to take a drug.

**Ms Bassett**—It is access and availability.

**Assistant Commissioner Phelan**—Exactly; it is supply and demand. We have—

**CHAIR**—So you are saying the distribution chains are better here.

**Mrs ELSON**—The better they do their job, the higher the price of the tablet. The more they bust and the fewer tablets they have in the market cause the price to go up.

**CHAIR**—The point is they are saying we are the highest users per capita—

**Mrs ELSON**—This country is a target for getting drugs into.

**Assistant Commissioner Phelan**—Yes.

**CHAIR**—But that means they must have very good distribution networks, doesn't it?

**Assistant Commissioner Phelan**—Arguably, yes. To put it in context, I think in 2004 in Melbourne we seized 1.2 or 1.3 tonnes of ecstasy in tablet form, and the price did not alter one bit. That was five million tablets, and the price did not alter on the streets of Melbourne or Sydney.

**CHAIR**—It stayed at \$30 or \$40, so that is the accepted price on the market.

**Assistant Commissioner Phelan**—That is what the market will bear so that is what the crooks will charge.

**CHAIR**—Why do you think Australia has the highest per capita usage—is this of all drugs or specific drugs?

**Assistant Commissioner Phelan**—It varies depending on the type of drug but, in terms of ecstasy, we are one of highest users in the world. There is a lot of anecdotal stuff but, intuitively, a lot of it has got to do with the affluence of Australian society vis-a-vis the rest of the world. We are a very affluent society, and that is the price. If someone was importing they would still make a good margin on their investment if they were to sell it at \$12 a tablet, but why would they if they can still charge \$30 or \$40? So that is the issue we have.

**CHAIR**—The more you can interdict, the more you can stop it coming here. We are reducing the burden on health, policing and everything else. Why does taking drugs lead to burglary if they can afford to buy the product?

**Assistant Commissioner Phelan**—It is arguable that sometimes they do not have the ready cash to be able to buy it so they can go to other methods to try and get the cash, which was very much what we saw before the heroin drought of 2000 and 2001 et cetera, where there was a decrease in burglaries followed that. This is occurring particularly with ice. I do not want to generalise about society because that is wrong and I cannot do that, but generally the people who would use ecstasy would come from a more affluent part of society with a lot more ready cash. Ice is a different story, as a general rule, even though there are other parts of society that use it. So ice users need access to cash and there are obviously other crimes that go with it.

**CHAIR**—You are saying that ice is used by a less affluent part of society?

**Assistant Commissioner Phelan**—Not all the time; that would be an overgeneralisation. But vis-a-vis ecstasy, for example, then, yes, that would be the case.

**CHAIR**—Is that because they want the bigger hit?

**Assistant Commissioner Phelan**—They are different hits. At the end of the day you get different highs from different things, I suppose, and that is something that goes well beyond my expertise. At the end of the day I suppose it is a drug of choice, as to what people want to use and whether or not they are looking for substitutes et cetera.

**CHAIR**—I think the statement has been made that the overall usage of drugs in Australia has dropped; is that true or not?

**Assistant Commissioner Phelan**—That would be difficult to say off the top of my head. People from other parts of the organisation or from other bodies would have a better understanding of that than me.

**Cmdr Slater**—Not from our area.

**Ms Bassett**—No; it is only heroin that we are aware of and that is because we have read other research that suggests it has gone down. I am not aware of it on a wholesale—

**CHAIR**—What is going to happen with Afghanistan coming on line again?

**Assistant Commissioner Phelan**—In terms of heroin?

**CHAIR**—Yes.

**Assistant Commissioner Phelan**—Our intelligence efforts have focused heavily on South-West Asian heroin. There are a lot of external factors there as well. The quality of South-West Asian heroin coming from Afghanistan is a lot better than it used to be. The traditional source of heroin in Australia came from the Golden Triangle area. China itself is soaking up a lot more of the Golden Triangle heroin. At this stage we are seeing an increased frequency in the number of seizures, but they are smaller seizures through Parcel Post et cetera not necessarily large bulk seizures. Our large bulk seizures of heroin are still predominantly Golden Triangle heroin.

**CHAIR**—Do you expect Afghanistan not to come our way?

**Assistant Commissioner Phelan**—At the end of the day I suppose it is about supply and demand. Our addicts at the moment across the board are a lot less than what they were before, so if the supply of good high-grade white heroin from South-East Asia is continuing there would be no need to move to substitute type commodities from South-West Asian heroin. South-West Asian heroin predominantly supplies Europe and, of course, they are soaking up a lot of that. So unless there is a bit of leakage that needs to come to us, then that is the case. It is all about economics and the quality of the product. Anecdotally, our addicts are rather discerning; they would want good quality white heroin. Until the heroin reaches that sort of grade in Afghanistan, and it is increasingly getting better, our addicts will still have a preference for heroin from South-East Asia.

**CHAIR**—I would be very interested to try and get a handle on the measure of life expectancy in the index, so we could start comparing like with like. In table 8 in Dr McFadden's paper, 'Distribution of costs relating to mortality and morbidity—cannabis, opioids, stimulants', which is on page 63 of our papers, there is the category 'Loss of life'. Is that telling me that 98 per cent of people who die of an overdose do so on an opioid?

**Assistant Commissioner Phelan**—Effectively, yes.

**CHAIR**—But the life expectancy of someone who is addicted to heroin is going to be shortened.

**Assistant Commissioner Phelan**—It is, and I think—

**CHAIR**—That is the sort of stuff I am really quite interested in.

**Assistant Commissioner Phelan**—We can get the information for you. We will look at the extrapolation out of the Collins and Lapsley report and see what further information we need to get. We can source that for you as best we can.

**CHAIR**—That would be very helpful. In your health measure, do you have a special category of psychosis?

**Ms Bassett**—Not that I am aware of.

**Assistant Commissioner Phelan**—We can look at the breakdowns for you. That would probably be best. We will get as much of a breakdown as we can for you and exactly what categories are counted, rather than the aggregate. We will not be able to give you the figures for them but we can give you what goes into the make-up so you can see what has been costed as part of the studies done by various organisations that we draw from and that form the index. That would probably be the best bet.

**CHAIR**—That would be great. In there also, do you have statistics on people who are addicted to amphetamines?

**Ms Bassett**—As opposed to the ad hoc users?

**CHAIR**—Yes.

**Ms Bassett**—No, we have not taken that into consideration. However, there has been a recent study by Turning Point that we commissioned. I am not sure if you are familiar with them. The study suggested that we could make the Drug Harm Index more sophisticated by separating those two user groups, but we have not gone into that yet. It is something that we are aware of and are considering.

**CHAIR**—It seems to me that what is missing in our drug kit is an anti-addiction policy. We do not have one. Methadone and the trade in methadone give me a lot of concerns. Do you have statistics on methadone?

**Assistant Commissioner Phelan**—No, I do not think so. At the end of the day prevention is always better than a cure. If we can stop the supply—

**CHAIR**—Yes, stop it.

**Assistant Commissioner Phelan**—But it is not only the supply; it is about education as well. If we look back, from my experience when we started the National Illicit Drug Strategy, way back in the late 1990s, we should never underestimate how much the advertising blitz and so on about the scourge of heroin and what it can do for you also contributed to the decline.

**CHAIR**—That is a good point.

**Assistant Commissioner Phelan**—It is not just interdiction. Whenever you tackle illicit drugs, it has to be three ways: education, law enforcement and health.

**CHAIR**—But there is a problem. When we say education, I just received a letter from one of my constituents today saying that the person who is now being put in charge of education is someone who has the attitude that you could translate as: ‘Drugs are here today; you had better learn to live with them and use them safely.’ If people in authority say that we are going to teach you to use drugs safely—there is just no such thing; it is just a nonsense.

**Assistant Commissioner Phelan**—I cannot comment on that specifically. I am not aware of that specific person or those comments, but certainly, from where I sit, no drugs are good for you. This comes back to education. If you look at the generation that we targeted back in the late 1990s, 10 years ago, they are in their mid-20s now, if not older. They are arguably not the ones who are on heroin. Maybe they were aware of the problems; it worked. In conjunction with a law enforcement blitz, we seized a lot of heroin at those times and created a shortage in Australia, but we created a shortage without moving to a substitute as well.

**CHAIR**—So you have evidence that we did not move to a substitute. That is very important.

**Assistant Commissioner Phelan**—It basically dried up. At the end of the day, we were the only western country to have a heroin drought. That was due to law enforcement. But what we did not see was a one-for-one rise in another type of drug at the same time.

**CHAIR**—That is really important.

**Assistant Commissioner Phelan**—That means, anecdotally, the education must have had something to do with it.

**CHAIR**—Yes. But that was education that said, ‘This is what it will do, so don’t take it.’ But if you are getting people who are bringing in stuff that says, ‘Well, learn to use it safely,’ we are going to get a different outcome, aren’t we?

**Assistant Commissioner Phelan**—Arguably, yes.

**CHAIR**—I think that has been terrific. Do you deal with methadone addicts at all?

**Assistant Commissioner Phelan**—No, not in our capacity as the AFP running national operations. Our colleagues in the ACT certainly would.

**CHAIR**—Yes, under contract.

**Assistant Commissioner Phelan**—Yes, because we have the community policing arm in the ACT; but certainly not on a national spectrum—and I would be talking well and truly outside my comfort zone.

**CHAIR**—Thank you very much for coming. If you could get that additional information to us I would be very grateful to have that.

**Assistant Commissioner Phelan**—Absolutely.

**CHAIR**—Congratulations on the work you do.

**Assistant Commissioner Phelan**—Thank you for your time.

**CHAIR**—Perhaps there is one last question I could ask. Do you measure yourself against other enforcement agencies? Do you give yourself a pretty high tick? Do you measure up pretty well against—

**Assistant Commissioner Phelan**—At the end of the day, the partnerships that law enforcement agencies do now are a lot closer than they were before. Everything is a joint effort when it comes to illicit drugs. The state police have their role to play. We have our role to play. The Customs service have their role to play. There are times when they intermingle. When they do, it is very much a joint effort. I would give the whole lot a tick at the end of the day because there are delineated areas of responsibility and that really works well.

**CHAIR**—I am talking about internationally.

**Assistant Commissioner Phelan**—Internationally, I think we do very well. That is in large part due to the coordinated effort that happens here in Australia and the whole-of-agencies approach to tackling the problem. You can see sometimes overseas that there is much more of a patch mentality than certainly occurs here. Sometimes that can result in some issues.

**CHAIR**—When I visited the United States three years ago—I was looking at an inquiry into crime and I visited with the Department of Justice and the FBI and like people—they told me that they had built an enormous database which Australia now has access to. It is an international database which we have been admitted to. Are you familiar with that?

**Cmdr Slater**—That may relate to their drug profiling databases. My previous role was in forensic and certainly we have very good collaboration with the DEA and FBI in terms of the drug profiling. That assists us in determining where our seizures are actually coming from and providing intelligence, some international, to detect what our trends are as far as sourcing of drugs goes.

**Assistant Commissioner Phelan**—We do have a full MOU with the Drug Enforcement Administration in relation to their intelligence-gathering abilities and the database holdings that they have at El Paso.

**CHAIR**—That is the one I am referring to.

**Assistant Commissioner Phelan**—Yes. We actually have an MOU between the AFP and DEA. The MOU talks about full cooperation and exchange of information in relation to access to their database and certain access to our information. We do that through our liaison officer network. We have a couple of people stationed in Washington.

**CHAIR**—Yes, indeed. They have been impressive people when I have met them too.

**Assistant Commissioner Phelan**—Thank you.

**CHAIR**—So we have our defence attache and our police attache. Thank you very much for coming this morning. We do appreciate it and we would be grateful to get that additional information.

**Assistant Commissioner Phelan**—Thank you very much.

Resolved (on motion by **Mrs Markus**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at public hearing this day.

**Committee adjourned at 11.23 am**