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**HOUSE OF
REPRESENTATIVES**

STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Reference: Impact of illicit drug use on families

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HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Wednesday, 7 February 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, Mrs Irwin, Mrs Markus and Mr Fawcett

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.

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Committee met at 10.55 am**ALLBON, Dr Penny, Director, Australian Institute of Health and Welfare****COOPER-STANBURY, Mr Mark, Head, Population Health Unit, Australian Institute of Health and Welfare****PSYCHOGIOS, Ms Chrysanthe, Project Manager and Senior Analyst, Australian Institute of Health and Welfare****KILLION, Ms Susan, Senior Executive, Health and Functioning Group, Australian Institute of Health and Welfare****STEVENSON, Dr Christopher Eric, Head, Functioning and Disability Unit, Australian Institute of Health and Welfare**

CHAIR (Mrs Bronwyn Bishop)—Good morning and thank you very much for being with us. We always look forward to hearing the information you have. Dr Allbon, would you like to make an opening statement?

Dr Allbon—Thank you very much, Chair and members of the committee. We are delighted to be here and to have this opportunity. It is really what we are about. The Institute of Health and Welfare is a legislated body under the AIHW Act and it is our charter and our role to collect information that is objective, independent information available for the public and for policymakers so that policy can be based on good, sound information. That is really what we are all about.

I have been at the Australian Institute of Health and Welfare for a year now. Other members here include Susan Killion, who is head of our Health and Functioning Group; Chrysanthe, who works on the alcohol and drug treatment services data; Chris, who runs the unit that has the alcohol and drug collection in it; and Mark Cooper-Stanbury, who runs the National Drug Strategy Household Survey. Mark has come in from recreation leave today, so we are all very grateful to him. He has run that household survey for the last three surveys. They are three years apart, so he has a wealth of knowledge on that. He is in the midst of preparations for the 2007 survey at the moment.

The latest data that we have available and that we have pulled together into the report we have for you here is 2004 data from the household survey and 2004-05 data from the alcohol and drug treatment services. The difference in those two data collections is that the survey goes out to all households and it is ages from 12 up, so it gives you a very broad understanding of what is going on in households, and we think the way the questions are asked allows it to get some good, confidential information in there. Mark can explain that a bit more if you are interested.

On the alcohol and drug treatment services, that is basically a by-product of the administrative services of the counselling and treatment services that are undertaken in the states and territories. We bring together all the information with common definitions et cetera so that you can get a picture of what is happening across Australia in those treatment services—what the services are being devoted to in terms of the different kinds of drugs. That is the data that we have for you

here. We also use a lot of other information that is out there and pulled together and that is also referred to in here.

Just as an overview—I will leave you to ask the questions; I am sure you have specific things you would like to talk about—I have two points I would like to make. One is that it is good to have this opportunity to talk about the data because sometimes it is not what it seems on the face of it and I am sure you all know that well. Depending on whether the question is about short-term or long-term applications, the data may tell you different things, and depending on whether the person surveyed has used, for example, ice in the last 12 months, the last month or the last week you will get different kinds of results, and so it is good to have the opportunity to explain some of that in more detail.

The other point is that, overwhelmingly and always, alcohol comes out as the drug to which most treatment services are devoted and also the drug that causes the greatest amount of risky behaviour. Whilst there is a plethora of drugs, alcohol certainly is a prominent one. And of course there is tobacco smoking, but its consequences are of a different nature. I will leave it at that and pass over to you for questions.

6I would just draw your attention to the table on the introductory page of our report *Impact of illicit drug use on families*, which shows trends in drug use over the years which I think demonstrates that probably the trends are fairly stable across the board. Tobacco has dropped, thankfully, but alcohol is going up. Of the others, methamphetamines were highest in 1998 rather than in 2004. Remember, it is 2004 we are talking about, and that is getting on for three years ago. So, basically, it is a stable position apart from the use of tobacco and alcohol. Thank you very much.

Mrs IRWIN—And when you look at heroin, you can see that use of that has come down, perhaps because of the heroin drought.

CHAIR—Can I start by getting the terminology correct. Ice is crystal methamphetamine?

Dr Allbon—Yes. We just had a clarification on this ourselves!

CHAIR—So ice is crystal meth—

Dr Allbon—Yes.

CHAIR—Ecstasy is—

Dr Allbon—a different drug altogether. The powder methamphetamine is speed, which is the most common form of methamphetamine. I have just been educated on this, so I am just double checking I am right. Speed is the powder form of the drug and about 78 per cent of the usage of methamphetamine is of the powder form—again, as at 2004. Ice or crystal is the crystal form. And then the base form is less. But ecstasy is a different synthetic drug.

CHAIR—And what is that?

Mr Cooper-Stanbury—They are both part of the amphetamine class of drugs. So they are stimulants, and ecstasy also has some hallucinogenic properties. So methamphetamines are chemically related to straight amphetamine. One of the confusing things about the term ‘speed’ is that it used to relate to straight amphetamine powder and now it is commonly used on the street to refer to methamphetamine powder. So we have had to adjust that language over the years in the survey. Ecstasy is methylenedioxymethylamphetamine; it definitely has that amphetamine group on the end of it, so it is chemically related but different.

ACTING CHAIR (Mrs Irwin)—Can you just explain about the survey. If you look at ecstasy, in 2004 it was 3.4. You are not doing this survey again until the end of this year—is that correct?

Mr Cooper-Stanbury—We start it in the middle of this year.

ACTING CHAIR—Looking at the 2004 figures, its use is virtually on the rise. It will be interesting to see the 2007 figures. How do you do the survey? What sorts of questions are asked?

Mr Cooper-Stanbury—We have two modes of the survey, but the main mode is sending interviewers out to households. We go to about 29,000 households in total for the 2004 survey. So it is a very comprehensive, large-scale survey. The interviewer randomly selects households within randomly selected regions of Australia, but we cover all of Australia.

Then, within a household, we select a person whose birthday is next—again, just to try and randomise it so people do not volunteer to do the survey themselves. Then they are left a confidential questionnaire. That is left with them for two or three days and then the field worker comes back and attempts to collect that completed survey or, if it is not yet done, they will leave a reply paid envelope. It then comes into the field office. The survey starts off with some attitudinal questions. The very first question is, ‘When people talk about a drug problem, what are the first two drugs that you think of?’ Another question is, ‘What drug do you think is of the most concern for the community?’

Then we move through and ask them a little bit about their personal health, so we can look at some relationships between their health and drug use that they are able to tell us about. Then we look at opportunities to use the drugs that the survey is about. Then we go through quite detailed modules on each of the 16 substances. We talk about tobacco and alcohol and ease them into the idea of talking about their personal drug use.

Mrs IRWIN—Sorry for interrupting. How old are they? Would these be 14-year-olds?

Mr Cooper-Stanbury—Twelve years and up. There is no upper age limit.

Mrs IRWIN—And a parent would be present during that interview. The reason I say that is because you know what some kids are like: ‘Gracious me! Mum and dad are in the room. I did have that cigarette and I have been smoking two a day for the last five days, but I don’t want mum and dad to know it.’ I am wondering how you get honest answers.

Mr Cooper-Stanbury—At the time that a particular respondent is selected, if they are under 16 we ask that a responsible adult consents to them doing the survey or participating, but we encourage the respondent to go off and do the survey privately. There is a question right at the end that says, ‘Was anybody watching you do this survey?’ Then we ask another probably stupid question, ‘Did that affect any of your answers?’ We may be creating some conflict within the household there, but at least we know from an analysis point of view the potential validity or invalidity of those answers. It helps put the whole picture together.

Then we move through each drug in turn. We ask them whether their friends and acquaintances use this drug, whether they have ever used it and then the questions cascade down and we ask them whether they have used it in the last 12 months, the last month and the last week. We ask them where they use it, where they first got it, where they currently get it, how often they use it, how much they use, in what form they use it and so on.

CHAIR—Do you ask them causative questions, like, ‘Do you think describing the drug as a party drug or a recreational drug makes it more acceptable?’

Mr Cooper-Stanbury—We have similar questions, not one in that form—although that is an interesting way of putting it. We certainly have a question that again goes through all these drugs and asks whether they think it is acceptable for an adult to use the drug. That is a general attitudinal question.

CHAIR—But that does not really help very much.

Mr Cooper-Stanbury—Perhaps not.

CHAIR—I find it personally very offensive to hear someone on the ABC say that so-and-so was using a recreational drug.

Mrs ELSON—Or a designer drug.

CHAIR—Recreational and party drugs are abhorrent terms to use. That gives them a seal of approval.

Mr Cooper-Stanbury—Perhaps you are right. That language comes up from the party culture.

CHAIR—It has been quite deliberate from people who want them made legal.

Mr Cooper-Stanbury—Sure. It would be interesting to see whether the language around the acceptability of it influences whether people try or continue to use the drug. It is not something that we have explored in the survey, but we could consider doing so.

CHAIR—Do you also ask them whether it being an illegal substance and the fact that they are committing a crime influence their decision?

Mr Cooper-Stanbury—I do not think we did in the 2004 survey, but we have asked: if cannabis were made legal, would they use it more or less?

CHAIR—Does the fact that it is illegal affect their decision, or do they think the fact that people say that it is a party drug or for recreational use make it okay?

Mr Cooper-Stanbury—No, we have not asked that. But we have asked the flipside of that for cannabis, which is: ‘If it were to be made legal—

CHAIR—But that is giving it approval, too. That is putting the proposition that we are thinking about making it legal so it is probably okay. I never tried marijuana at university, and the reason I did not was because it was illegal and I wanted to be a lawyer, so ‘no’ was the answer.

Mr Cooper-Stanbury—Again, it is a useful concept that we could look at asking in the survey.

Mrs IRWIN—I would love to have a look at the 2004 survey. Is there a chance we could get a copy of it? I know you were saying that the 2007 one will not be done until late this year, but could we have a copy of the 2007 survey too, just to have a look at the questions?

Mr Cooper-Stanbury—We can certainly organise a copy of the 2004 survey. It is available on our institute website. Each of the survey reports that we have done since 1998 has what we call a first results report. In the back of that is the survey questionnaire.

Mrs IRWIN—I would love to be able to see a copy of the 2007 survey and the questions on it.

Dr Allbon—It is still to be finalised.

Mrs IRWIN—When it is finalised, if we could have a copy, that would be fantastic.

Dr Allbon—That is a very interesting point about the language. We will certainly have look at that.

Mrs ELSON—Is there a question on there that asks them if they want to be rehabilitated—to see the ones that really want it but do not know where to go, so they do not take that step?

Mr Cooper-Stanbury—We ask them whether they are in treatment for anything. I do not think we ask whether they want to be in treatment but are unable to be. You are thinking of unmet demand type of—

Mrs ELSON—They do not know where to go, so they just keep using it.

Mr Cooper-Stanbury—We do have a question about where, if they wanted to, they would get information about alcohol and other drug use. We have quite a long list of things that they can nominate for where they might go. That would give you an idea about what their health literacy is like, if you like, about being able to seek treatment.

CHAIR—Do you ask them whether they know what it is going to do to their brain?

Mr Cooper-Stanbury—No.

CHAIR—Why not?

Mrs IRWIN—That is not the purpose—I am sorry.

CHAIR—Could you ask them the question: are they worried about what it does to their brain and their health?

Mr Cooper-Stanbury—Again, we could—

Mrs ELSON—‘Are you aware of the side effects?’

Mr Cooper-Stanbury—One of the considerations for the survey is that it is already large—it is a 54-page booklet that we leave with these respondents—and we need to tune that to some policy objectives. The policy framework we are currently using is the National Drug Strategy, which is in about its fourth iteration. It gives us some parameters for tuning our household based surveys. The sorts of questions you are interested in, because we are getting at a very low prevalence of behaviours in the population, are perhaps better directed to people that are already in treatment or are coming through, say, the court diversion system, where you are actually accessing known users and perhaps even dependent users.

CHAIR—We really want to find out about how we prevent them becoming users.

Mr Cooper-Stanbury—Understood.

CHAIR—And that is government policy. That is what the Prime Minister says is policy. But then you have other people, lower down the food chain, who say it is not. I am a bit worried that your questions might be reinforcing what the people lower down the food chain say rather than what the Prime Minister says is the policy. I have a bit of a worry about that.

Dr Allbon—Because the National Drug Strategy is where we come from, I think that we are addressing those issues, but it is really about how much education is out there.

CHAIR—Is there anything that indicates what education is out there about prevention and how effective or ineffective prevention strategies are?

Mr Cooper-Stanbury—Certainly some of our colleague institutes, in particular the National Drug Research Institute, the National Drug and Alcohol Research Centre and the National Centre for Education and Training on Addiction, are involved in a range of evaluation studies on both prevention and treatment programs—

CHAIR—Not treatment, prevention.

Mr Cooper-Stanbury—I am just trying to give you the range of their work. They would certainly cover prevention programs. The National Drug and Research Centre folk, who are based in Sydney, are involved in a number of school based prevention programs. I think they

would be much better placed to tell you about the effectiveness of those programs and the evidence around that.

CHAIR—But you are measuring it and publishing it. This is the one that we go to first.

Mr Cooper-Stanbury—This is a blunt measure, if you like, of how effective those programs are, because this is telling you about how many people are taking up those drugs.

Ms Killion—It is the usage. It is measuring how much these substances are being used in the country. What you are looking at is program evaluation, or how effective the programs are in preventing.

CHAIR—If you are counting up people who are using, then it has failed those people.

Ms Killion—Yes.

CHAIR—I want to know—and you are talking to them—why it failed. Why did it fail them?

Ms Killion—Why did they access it in the first place?

Dr Allbon—It is a very valid question to ask, but it is probably not one you can deal with best in the household drug survey. Probably the treatment services information will give us a bit more bearing on that, but also specific studies that are looking at why people took it up or how effective—

Mrs IRWIN—Is there a question there asking why?

Mr Cooper-Stanbury—Yes, there is.

Mrs IRWIN—Have you got their answer to why? Is there something here that we can look at to see why they are taking it?

Mr Cooper-Stanbury—In the back of the detailed findings report in the youth chapter, we ask the questions, ‘Why did you first try any illicit drug?’ and ‘Why did you not ever try an illicit drug?’ To take Mrs Bishop’s example—

Mrs IRWIN—If we knew the reasons why, we could try to get these young people before they actually start on an illicit drug.

Mr Cooper-Stanbury—Yes.

Mrs IRWIN—I will never forget this. I got into parliament in 1998. In 1999 I met a young boy who was on heroin. I saw him injecting in Cabravale Park, just down from my office in Cabramatta. I went up to him, because it makes them happy, and I said, ‘Why?’ He said: ‘It makes me feel good. It takes the pain away.’ I ended up getting to know this young boy and we finally got him into treatment. Today, thank God, he has been clean for a few years. The reason why he took that up is because it took the pain away. That pain was that he had been sexually and physically abused and he did not know who to turn to at the time. His mother had an alcohol

problem. I said, 'Did you go and talk to a school counsellor?' He did not know what to do. This is where it all comes from. As we were saying with education, it is important to find out why from what they are saying to you.

Mr Cooper-Stanbury—Back to your earlier question, Mrs Bishop, we do, in fact, have a question where people can say that they did not try something 'because it was illegal'.

Mrs ELSON—Why is the survey not done through schools? You are going to get a more direct answer if there is a confidential envelope left that they can fill out in their own time and then hand back in to the school in a sealed envelope. I know as a parent that your kids are not going to tell you. My kids are close to 40 now and tell me all the things they got up to when they were younger that I was not aware of.

Mrs IRWIN—And you asked them, 'Why didn't you tell me before?' 'We didn't want to, Mum; we wouldn't have been allowed out.'

Mrs ELSON—If I had been given a survey to fill in for my household, I would have been ticking it all wrong, because I thought my kids were not doing certain things. I am just saying that the way to get the most honest answer would have to be through the school from the kids themselves who are 12 to 18. That is where you are going to get it.

Mr Cooper-Stanbury—There is a complementary survey that is run in school. It is called the Australian Secondary Schools Alcohol and Drug Survey. It is also run each three years and slightly offsets our survey. It is run in a sample of all Australian schools, including the Catholic, independent and government schools. It is also a fairly sizeable survey. I think there are around 20,000 respondents in all. Obviously only people aged 12 to 17 participate, which is year 7 to 12 or the equivalent—some states go down to year 6. As I said, it parallels our survey and gives corroborating information. They are showing the same sort of trends.

There is a bit of a debate in the survey world about whether school based surveys or household based surveys will give you the more correct information. I do not think there is a simple answer. What we like to encourage in this field is triangulation of these results. You have a result that comes from a household based survey. You have a result that comes from a school based survey. You have a result that comes with a batch of interviews with current injecting drug users, which again the centre in Sydney does. All of those three or four sources together are corroborating to give you a picture of the trends, patterns and issues.

One of the considerations with the school survey is that it is not done with the team or home teacher in the room. They do actually bring in other people. But they are all lined up in their classroom and it is like an exam situation. It is a very difficult thing to do because, regardless of how well you design the survey, you can think that the person who puts their pencil down first is essentially saying they have used the least things. So the person who is still going half an hour later is either slow or they have had to answer yes to all of these things. There is a whole lot of peer pressure and other influences that are going on even in that sort of mode. That is why the corroborating material is important.

Mrs ELSON—My thought was to give it to them for a week and then it gets handed in.

Mr Cooper-Stanbury—No, certainly you would never get any back.

Mrs ELSON—They would lose them?

Mr Cooper-Stanbury—Yes.

Mrs IRWIN—I have heard about some surveys that have been done in school. I do not think you get the honesty in a survey that was done in a school, because of peer pressure. They say, ‘I told them that I have a sneaky cigarette—I never do, but I had better put down that I have because I have told my mates that.’

Ms Psychogios—I actually participated in that school survey when I was in high school and I do remember to this day looking over and thinking, ‘Oh, they put that in—I had better do the same,’ because everyone was looking at each other’s. So there are these inherent issues.

Mrs ELSON—There is no perfect way of asking questions.

Mr Cooper-Stanbury—As I said, you need multiple sources of information that corroborate. That is why, in this material that we have put together here, we have tried to bring as much of that in to give a coherent picture.

Ms Killion—Mrs Bishop, in answer to your question, I have the 2004 National Drug Strategy Household Survey and there is a section on influences on first using an illicit drug. Would you like me to read you a bit of that?

CHAIR—Yes, please.

Ms Killion—It says:

All users (ex- and current) of any illicit drug were asked what factors influenced their decision to first use an illicit drug. Curiosity was the most common reason given: four in five (81.9%) users aged 12-15 years nominated curiosity as an influence in their decision ...

More than half of users of illicit drugs were influenced to do so by peer pressure, although only 45.3% of those aged 12-15 years were so influenced.

CHAIR—That tells me something very important. It tells me that there is nothing to counter the curiosity—curiosity killed the cat and information brought it back. If, at the time their curiosity is raised, there is a whole body of evidence that says, ‘If you do this, this can happen to you—now weigh it up,’ you might get a totally different outcome.

Ms Killion—There is a similar section on influences in not using an illicit drug. So it is measured. It is maybe not asked in exactly the way you asked the question, but it is measured in the study as well.

CHAIR—We are dealing here with illicit drugs and that is what we are targeting. We are not only looking at the children being the users but we are also looking at the effect on the children of the parents being the users. We think that needs a lot of attention. With smoking

advertisements they now say that the campaign they have has been very effective in reducing smoking. If it can be effective for that then it can be effective for this. The consequences of what is happening to their brains are just horrible. There is no way back. It is the most precious thing we have.

Ms Psychogios—I can give a personal perspective on the curiosity killed the cat situation. A lot of the information out there I think elicits this curiosity. When you read some information about the drug, it often tells you about the positive effects that it can have for your body. You will feel euphoric or it can make you dance all night. I think people are focusing more on those aspects rather than—

CHAIR—Nobody tells you anything else, do they.

Ms Psychogios—That is right—rather than the flipside, which is the physiological effects and the harm that it can do to your body or the situations it can put you in. I think that is also influencing the curiosity of people.

CHAIR—Yes. They get the news: ‘Try it—it’s fun.’

Dr Allbon—It is the old short term versus the long term debt—that is the trouble. You can dance all night, but what happens in the long term?

CHAIR—But there is no campaign out there to tell you about the bad stuff. It does not exist.

Ms Psychogios—I think the tobacco campaign was another example of that—children took up smoking not knowing because, of course, the physical harms did not show up until 10 or 20 years later. So they were not getting the message as a child that, if you start smoking, you will not get the immediate physical harms to your body. It will happen in decades ahead.

Mrs MARKUS—Children are now telling their parents and grandparents to stop smoking. That is the effect of the ads.

Ms Psychogios—So those messages are now getting across.

CHAIR—All I am saying is that, if you can have a campaign that has that impact for that, you can have an impact on this stuff.

Mrs IRWIN—I do not think there is enough education in our schools. I just have to look at schools in my area to see that.

Dr Stevenson—One of the lessons from the smoking campaigns is that the critical thing is not so much to stop people taking up smoking as to stop them until they are an adult, because very few people take up smoking after the ages of 20 or 21. There is a critical window of opportunity to get people to not take up the habit because, once they have passed that point and are adults, the evidence is that very few adults take up smoking and probably very few will take up drugs. It is a campaign that is very focused on the younger ages.

CHAIR—We have the ridiculous situation where—and this a true case—a young boy who was smoking marijuana was asked, ‘If you’ve got to smoke something, why don’t you have a cigarette?’ He said, ‘Oh, no, that might kill me.’ That is how nutty it has become.

Dr Allbon—The issue of how to get information out to the people who really need it and at what time is something we have been having a look at within the institute and talking to NHMRC and other bodies about, trying to make some of the facts, information and statistics that we have—which are not necessarily the physiological facts; NHMRC has them—about the prevalence and what it does to people’s lives available in schools. It is partly in our best interest in the federal system to get something that is in a format that can be used routinely across the schools from NHMRC and us that is authoritative. It has to be visualised.

CHAIR—The stuff out there is booklets that say, ‘Just be careful how you use it.’ I had a mother in my office tell me that she had a child who first used marijuana at the year 10 formal. She was very upset about it and went to talk to the police and they said to tell him just to be careful how he used it. They went to a counsellor, who said: ‘You just have to be careful about what you do. Don’t upset your mum.’ That is what I mean—all the messages are wrong.

Dr Allbon—Some impartial information about the facts is missing.

CHAIR—But the emotional stuff has been proven to be right with regard to the smoking campaign. Without the emotion, there was no effect. I am saying that you have to learn that this is far more serious. There is no way back. There are a lot of parents who come into my office and say, ‘Mrs Bishop, do you support the need for more mental health beds?’ I say, ‘Son or daughter?’ Their answer usually is that their child took marijuana and has become psychotic. I know of a tragic case of someone who got a job sweeping the driveway of a particular establishment for two hours a week. This was somebody who had an education and was trained for something else.

Mrs ELSON—I think the real scenario out there at the moment is that young people who have been taking drugs get married and have a couple of little children. Those kids—we have some at our local school—are ostracised. The parents of other children will not let their children play with them at home or school because of the fact that they cannot trust their children going to their homes. Those kids are having this problem of nobody liking them and then they will be the ones to grow up and take drugs because it is their release. There is a cycle going on and we do not seem to have anywhere for those families can get help.

Dr Allbon—The links between marijuana and mental health is an area that Chrysanthe might like to talk about.

Ms Psychogios—Certainly. The drug treatment collection that Penny mentioned earlier collects information on all government funded drug and alcohol specialist services. It is a nationwide collection that reports on the number of episodes of a person’s treatment and their demographic information—such as their age, sex and country of birth—but also, more importantly, what principal drug of concern they are seeking treatment for, the method of their drug use, if they have ever injected and what type of treatment they have accessed, whether it be counselling or detoxification.

As Penny just noted, we are now doing enhancements on that collection so that we can include some co-morbidity identifiers in there. We will be able to pick up in the future on whether someone who is accessing drug treatment services also has a co-existing mental health disorder or if they are seeking treatment for a mental health issue.

CHAIR—What are the results?

Ms Psychogios—As to the results so far, as Penny mentioned in her opening statement, alcohol is by far the most common drug that people are seeking treatment for—

CHAIR—That is because it is legal.

Ms Psychogios—Yes. On the illicit side of it, cannabis is then the most common drug, with close to a quarter of all episodes relating to people seeking treatment for cannabis. That is followed by heroin at 17 per cent and amphetamines at 11 per cent. It sort of follows a drug use pattern in that there is alcohol, then cannabis, heroin and amphetamines as the most common drugs appearing across both collections.

CHAIR—We are dealing with illegal substances here.

Ms Psychogios—Okay, so I will take alcohol out of the equation.

CHAIR—Society says certain things are legal, and this lot is not.

Mrs IRWIN—But look at the 83.6 per cent with alcohol.

Ms Killion—It just puts it in perspective.

CHAIR—Just think if you legalised this how much they would be having.

Mrs ELSON—Identifying that they have a mental health problem to me is rather a useless process, because you have to get the states onto providing some services. The only way in Queensland that you can get any help for a marijuana user who has psychosis is to go to the court and to take out a mental health order against them and have them institutionalised for 10 days to be assessed. That is the only way.

Mrs MARKUS—That does not happen in other states.

Mrs ELSON—In Queensland the only way you can get into the public mental health system to get treatment is to go and have an order taken out on that person. And, for a parent or a relative to do that, where they are doing something that they feel is against their family member but is the only way they are going to get help, is extreme. You should be able to go somewhere. That is what I would like to know: with your mental health findings: is it taken one step further so that you can actually say they are getting mental health support?

Ms Psychogios—Yes, I think it is.

Mrs ELSON—That is where I think the big gap is.

Ms Psychogios—The two items that we are putting up for inclusion in this collection are: have you ever been diagnosed with a mental health disorder and are you accessing, or have you ever accessed, treatment for a mental health issue?

Mrs MARKUS—I notice in your submission you differentiate and identify methadone users—and you have since 1998, I think. In that study you are talking about, do you differentiate them by if they are multi-using or using other illicit drugs together with the methadone?

Ms Psychogios—The drug and alcohol collection itself includes methadone as a principal drug of concern. The proportion of people reporting that is only 1.8 per cent. However, this collection does exclude agencies whose sole purpose is to subscribe and dose for pharmacotherapies. If you turn to page 18 of our submission, we also manage another collection which is specific to opioid pharmacotherapies. That is where we are able to say how many clients are dosing for either methadone, buprenorphine or, as it will be from this year, buprenorphine/naloxone. However, at this stage, we are unable to see if they are the same people who are also using the mainstream drug and alcohol services. So we have these two sets of numbers that may or may not relate to each other.

Ms Killion—These are not studies. These are administrative data that come to us from the states and territories. What you are talking about is really trying to link these things up, and that would require something other than what we are doing at the moment.

Mrs MARKUS—Are you aware of anybody who is doing that?

Ms Killion—No. NDARC may know.

Mr Cooper-Stanbury—What is the link you are interested in?

Mrs MARKUS—Often methadone users continue to engage in the illicit use of drugs. Has that been explored and is data collected with regard to that?

Ms Killion—I would be surprised if NDARC did not know that to some extent.

Mrs MARKUS—So NDARC would be the best people to answer that.

Ms Killion—I think that would be a good place to start. If they did not know, they would know where to look.

Ms Psychogios—We do have a question in the drug treatment collection which asks for a person's principal drug of concern, so the main reason why they are seeking treatment. But we also ask them to nominate up to four other drugs of concern that they would also like to address. As I mentioned before, only a very small proportion of people attend treatment for methadone under the alcohol treatment services collection, but when you look at all their drugs of concern that doubles. It shows that there are people out there who are seeking treatment for another principal drug but who also use methadone as well. So we can identify those sorts of patterns.

CHAIR—There are people who sell methadone. There are cases where they go into a chemist shop, get it in their mouth and transfer it by mouth to a person outside. A lot of those children

who died in New South Wales—those really young children—had small bottles of methadone that were obviously designed to sell.

Mr Cooper-Stanbury—I am not aware of that. I was just going to clarify that, in the drugs survey, we were only asking people about illicit use of methadone. I suspect that in your treatment data the methadone line is not people who are on prescribed methadone; it is people who are dependent on methadone and are seeking treatment for that dependence.

Mrs MARKUS—Sometimes they are in programs.

Mr Cooper-Stanbury—Yes, but that is not what that means in those tables. This is the diverted or illicit methadone, I would suggest, in both cases.

Mrs MARKUS—So they would not have obtained this methadone through a prescription through—

Ms Psychogios—through a pharmacist or through a prescription from their GP and then obtained the methadone or buprenorphine through the pharmacist or other dispensing agency.

CHAIR—And there is nothing about naltrexone.

Ms Psychogios—Naltrexone. The group that consisted of a representative from each state and territory and the institute, which managed this pharmacotherapy collection, agreed to the collection of data as well. That will be reported later this year for the first time so we will be able to identify the number of people being dosed for methadone, buprenorphine and buprenorphine/naloxone.

Mrs MARKUS—That will be good.

Ms Psychogios—Also, for the first time we will be able to get a demographic profile of those pharmacotherapy users—the proportion by age and sex and, where available, by Indigenous status. So we will have a bit more pharmacotherapy information in the future.

Mrs MARKUS—We definitely need some more information for use in planning. I would like to make one more comment. You highlighted that the reason people start to use, attempt to use or experiment with illicit drugs is for curiosity. I think it is important to highlight that while Julia Irwin mentioned that there are people who may choose to use it to remove pain there are many others, who come from quite healthy family backgrounds, who do not have those kinds of challenges but still choose—because of an initial decision and then because they are addicted—to do so.

Ms Killion—Or because their friends have used it and nothing bad happened to them, so they use it.

Mrs MARKUS—So it is okay.

Ms Killion—Yes. They use it infrequently and nothing happens.

Mrs ELSON—Another interesting survey was done in Queensland recently. They have found that a very high amount of users had problems at school—they were slow learners—but they were extroverts. They are getting their friends at school by being extroverts. They could not learn at school so they grew up having this problem about their inner self not being good enough, and the drugs were lifting them up. The survey showed, when they talked to adults and asked them why they took drugs, that it was an extraordinarily high proportion. I think 97 per cent showed up as being slow learners at school.

So we may have to identify kids as slow learners and look at that, so that they do not fall into drug use. They are extraverts and are popular around school; they compensate their slow learning by being a bit of card and a character. I have to say that since I heard about that survey, I have asked every parent who comes to me in my office, ‘Was your child a slow learner and an extravert?’ and I have not had a ‘no’ yet.

Mrs MARKUS—It is an interesting survey.

Mrs ELSON—Ask that yourself. I get up to about 20 people a day coming into my office looking for help. I now ask that question every time and I have not got a ‘no’ yet.

CHAIR—When I think back about people who come in with their stories, they say ‘He was a lovely child and had lots of friends.’

Mrs ELSON—That’s exactly right—Mr Popular. It is to do with the cognitive process, they say. That is what the survey found out.

CHAIR—It is interesting.

Mrs ELSON—As members, it might be interesting to ask that question when parents come up to us.

CHAIR—It would be interesting to do that properly.

Dr Allbon—It would be something we need to link educational outcomes with. We are currently in the middle of a project that links educational outcomes with children under guardianship orders to see what is going on there.

Mrs ELSON—This was only done with adults, so you cannot identify it. There is a child issue but it is to do with the adults who actually use it as adults—the way they take it.

CHAIR—Interesting.

Ms Psychogios—Going back to the treatment collection, I did not mention earlier that we are able to differentiate between people who are seeking treatment for their own drug use problems and those who are seeking treatment for someone else’s drug problems. Only about five per cent of all episodes are for people seeking treatment for someone else. The demographic of that category is usually females in the 40- to 60-year age group. The inference we have made from the data is that it is most likely to be mothers or wives seeking treatment—counselling, information or education—for either their child or husband.

CHAIR—I want to ask you about what is happening with heroin. We said there is a heroin drought. Australia, at the end of the world, is at the end of the chain—there are bigger markets than us—but there is some evidence that the big drug dealers in Colombia and wherever are moving away from agriculturally based drug products to chemically based drug products because the latter are not affected by the weather. I heard evidence at another inquiry that because heroin has a dirty reputation—it is grubby and people shoot up in backstreets; heating up spoons and all that sort of stuff is unattractive—whereas popping pills is seen to be clean and does not have all the negatives that heroin has. Again, I go back to all that language of ‘It’s okay, I only drink water.’ The trend is that there will be fewer people coming onto heroin but, unless something is done, more people switching to amphetamines.

Dr Allbon—I think that is probably a reasonable assumption from the data. Mark, heroin usage is not going up?

Mr Cooper-Stanbury—No, it is not. We are not seeing any resurgence of heroin since the shortage in 2001. You have to consider that most heroin users are already polydrug users—multiple drug users—so when heroin was unavailable they simply switched to something else. The reason why we have not seen a big increase in the use of, say, methamphetamine or ecstasy in the last two surveys is because we are not introducing any new users; it is just that heroin users are switching to these other drugs. So we are not necessarily generating a new group of users; we are just taking the polydrug users who have always told us about their ecstasy and amphetamine use and have not carried on with heroin. That is why we have not seen a big upswing in these other drugs.

Mrs ELSON—The use of the term ‘poly’ is typical of what we are talking about today. Young kids are not getting the message correctly because we are using these terms. Why can’t we just say multi drug use?

Mr Cooper-Stanbury—Yes, multiple drug use is a very good term.

Mrs ELSON—I hear the term poly used all the time, not just from you. I had to ask myself what poly means and why we use that term. It means many. We are not getting the story out that it is a serious problem because that term will just go over the top of people’s heads; they are not going to ask what it means.

Dr Allbon—And not associated with Pollyanna at all!

Mrs ELSON—As Bronwyn was saying before, we are not using the right terms to tell the story; we are using terms that go around it.

Mr Cooper-Stanbury—Again, the origins of that term may well be from a clinical setting where polydrug use with respect to pharmaceuticals is a typical, standard sort of term.

Mrs ELSON—Probably it is, but our using it in government or in government bodies is not telling the story. It is like saying, ‘We are using designer drugs’—they are death drugs.

Mrs MARKUS—I think also the average person’s understanding of the word ‘poly’ and other terminology—

CHAIR—It means a politician, does it not?

Mrs ELSON—I saw ‘heroin’ used as a term that made it look like it was not serious anymore.

CHAIR—Opioid?

Mrs ELSON—No. I was on a plane the other day and I was sitting next to a lady from a non-government institution, the Mental Health Council of Australia. She pointed it out to me. I cannot remember what it was, but it was a very soft term for heroin, as if it was not serious.

Something else I should mention, which we might have to look into, is that she said the use of ‘ice’ has gone up, especially amongst young males. I asked her why that was and she said, ‘Well, we have done a report on it and they are selling ice to young males at a quarter of the price they are selling it to young females.’ I asked her why and she said, ‘Because it makes young men impotent, but they do not know it when they take it. Then within 12 months’—it may have been 12 weeks; I will contact her to get that information—‘because they are impotent but they will not go to the doctor, they are sold Viagra at 10 times the price.’ That is a serious problem in itself.

Ms Killion—There is a good marketing tool for you if you want to have an anti-abuse campaign.

Mrs ELSON—If you want to frighten them, yes. She has a medical report into that which says that is definitely what is happening. I will get this contact’s name, because I think she would be an interesting person—

Mrs MARKUS—Susan, could you repeat what you said before? I missed it.

Ms Killion—If you are trying to deter young people from using something like that—if impotence is a side effect—then that is a good marketing tool.

CHAIR—That would frighten them to death.

Mrs ELSON—They are selling this to the young men at next to nothing. I think there was a young—was he a footballer?—on TV last night who was found with about 600 of these tablets in his pocket. I felt like saying, ‘Do you know what is going to happen to you, mate, or to anyone you sell it to?’ It is a problem if they find out that that is correct.

Ms Killion—I did not know that was a side effect.

Mrs ELSON—The lady I sat next to on the plane is in Canberra at the moment. She is the CEO of the non-government Mental Health Council of Australia, so she will be a good person to contact.

CHAIR—That is a very interesting point for us to look at, but the other side effect, as I understand it, is that it makes people very strong. If they are involved in a hold-up, for instance, they are much more likely to kill the person as distinct from injuring them.

Mrs ELSON—It does not make them stronger but it gives them the thought that they are stronger—that they are 10 feet tall and nothing is going to happen to them.

CHAIR—Okay.

Mrs ELSON—If you talk to the Gold Coast people, ice is the biggest problem on the Gold Coast.

Dr Allbon—It goes with the party and recreational image, does it not?

Mrs ELSON—It does: the party mode and the beach and going to the nightclubs all night.

CHAIR—If there are no other questions, I might say that I would like to regard this as our opening conversation. I think there are going to be lots of things we might like to come back to you on.

Dr Allbon—If you want at any time to email us or write us some questions, we would be happy to respond or find information.

CHAIR—Thank you very much.

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

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 11.48 am