COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Substance abuse in Australian communities

MONDAY, 14 AUGUST 2000

CANBERRA

BY AUTHORITY OF THE PARLIAMENT

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Monday, 14 August 2000

Members: Mr Wakelin *(Chair)*, Mr Andrews, Ms Julie Bishop, Mr Edwards, Ms Ellis, Mrs Gash, Ms Hall, Mrs Irwin, Mrs De-Anne Kelly, Dr Nelson, Mr Quick and Mr Schultz

Members in attendance: Mr Andrews, Ms Julie Bishop, Mr Edwards, Ms Ellis, Mrs Gash, Ms Hall, Mrs Irwin, Dr Nelson, Mr Quick and Mr Schultz

Terms of reference for the inquiry:

To inquire into and report on:

The social and economic costs of substance abuse, with particular regard to:

- family relationships;
- crime, violence (including domestic violence), and law enforcement;
- road trauma;
- workplace safety and productivity; and
- health care costs.

WITNESSES

Committee met at 8.36 a.m.

CHAIR—Welcome. This is the first public hearing of the substance abuse inquiry and the committee welcomes the opportunity to hear from all of you. For the record, the inquiry was referred to the committee by the Minister for Health and Family Services, Dr Michael Wooldridge MP, in March of this year with a brief report and recommendation on the social and economic costs of substance abuse with regard to family relationships, crime, violence—including domestic violence—law enforcement, road trauma, workplace safety, productivity and health care costs.

The committee advertised the inquiry nationally at Easter and has so far received around 200 letters and submissions from individuals, government and non-government agencies. These tell of the many ways in which individuals, families and communities are affected by the misuse of legal and illegal drugs. It is clear that what we are dealing with here is a complex and sometimes very emotional issue—certainly one for which there is no quick fix. It is said that drug problems are people problems but it is very much something that the committee believes is of the community and that the issues of the community themselves are something that we need to get a far better understanding of than we currently have. We are looking to work very much with the community and all those peak bodies and organisations.

We are determined to address the broad terms of reference of the inquiry, both thoughtfully and thoroughly, and to write a report offering some grounds for improvement that we can effectively minimise the harm associated with drug misuse in Australia. I want to stress that the committee is seeking to conduct this inquiry in a spirit of collaboration and cooperation with all individuals, community organisations and governments. Obviously it is important to consult communities directly and combine the collective experience of everyone who has worked in this area to arrive at the best possible strategies. There are some good models and we are very keen to see those, as well as those that have not worked quite as well.

Today's hearing in Canberra provides the first opportunity to engage in discussions on the public record with the major organisations that have responsibilities and an interest in this area. This will form part of a series of public hearings the committee is conducting around Australia to be held in both urban and rural areas.

[8.38 a.m.]

FITZWARRYNE, Ms Caroline Margaret, Chief Executive Officer, Alcohol and Other Drugs Council of Australia

SMITH, Mr Wayne Christopher, Policy Manager, Alcohol and Other Drugs Council of Australia

WEBSTER, Professor Ian, President, Alcohol and Other Drugs Council of Australia

CHAIR—I welcome representatives of the Alcohol and Other Drugs Council of Australia, ADCA, who are our first witnesses this morning. Before we proceed, I wish to point out that while this committee does not swear in witnesses, the proceedings today are legal proceedings of the parliament and as such they warrant the same respect as the proceedings of the House of Representatives. Submissions received from today's witnesses have been authorised for publication and incorporated into published volumes, which are available to interested members of the public. We have with us Ian Webster and Caroline Fitzwarryne who would, I understand, like to make an opening statement, and I welcome Wayne Smith as well. We have all been getting to know each other over the last few weeks as we have visited the same forums and tried to develop our understanding. I invite Professor Webster to make an opening statement.

Prof. Webster—Thank you for the invitation, Mr Chairman. The Alcohol and Other Drugs Council of Australia is an elected peak non-government organisation which has reference groups distributed throughout the country which provide it with advice towards its policies and proposals that it takes up. We welcome very much the establishment of this committee and we are particularly interested in the social and economic reference that you have before you. However, having said that, one of the tests of the effectiveness or the outcomes of this committee's work will be the extent to which it is able to make recommendations about a wide range of effective interventions which will meet the needs of a wide set of populations in our community.

This organisation, the Alcohol and Other Drugs Council of Australia, is a body which has existed since 1967 under other names and it has been constantly engaged over that period of time with public dialogue about this issue. In 1985, we hosted the first summit in Australia which was called by the then Prime Minister Mr Bob Hawke when, you will recall, the premiers were called together and, from that time, the national campaign against drugs started. Now its more modern description is the National Drug Strategy. But the key principles which were established then at that working party and forum have become the underpinning principles of the national approach to drugs and alcohol since that time.

This council has promoted many discussions throughout the country on policy and strategies. I draw your attention to the fact that fairly recently we held a diversion forum which antedated the interests of the Commonwealth government in the Tough on Drugs strategy and that forum was on diversion when we brought magistrates, police officers and policy officers from around Australia and actually put on the map the issue of diversion from the criminal justice system into treatment.

I briefly want to highlight 10 key areas that we listed in our submission. I am only going to headline those because they are detailed in the submission, but I just want to give some emphasis to them in my presentation to you. The first area is related to prevention and early intervention. Much is said about that but it is important that we actually do effective programs and interventions in that area. There is actually very good research which shows that fundamental prevention, supporting families and children as they develop, has very positive outcomes in later substance use in adolescence and adulthood.

The second priority area which we addressed was reducing substance abuse amongst indigenous people, the Aboriginal and Torres Strait Islanders. In the organisation, ADCA, these people form part of our leadership and they report to us that the national approach lacks a specific focus on the needs of indigenous people. They point to that, particularly with the establishment of diversion programs. Both younger and older Aboriginal people who get in contact with the criminal justice system may not have access to appropriate treatment services and support.

The third area relates to giving support to families. We believe that families are important in the causation or the prevention of drug using problems in this community but, of course, families are affected by them and families are very important in prevention and in the treatment process itself.

The fourth area is alcohol related violence and disorder. We wish to emphasise comments made in our submission to you about more appropriate alcohol taxing policies, and I am sure that others will make submissions to you about that. Alcohol remains a major problem in relation to violence, disorder and work of the health care system. We also stress to you that drug and alcohol programs and issues cannot be separated clearly from that of the issues of wellbeing and mental health. They must be dealt with together because, of the many people who are in drug and alcohol treatment programs, of the order of 75 per cent have an underlying mental health disorder. Conversely, of those people who are in our mental health services now in Australia, between 30 per cent and 80 per cent have an underlying or an associated drug and alcohol problem.

So we must develop effective national responses to these combined substance use and mental health problems and follow those through. Some of the states are working on this as well. We are concerned also that there has been very little public discussion about the alcohol and drug issues in the workplace. We think that the Commonwealth has an important role in setting some guidelines and standards which might be implemented throughout the country.

Research in drug and alcohol issues is clearly important if we are to have effective treatment and prevention programs. Australia stands very high in international standing in the extent that we do this. We would like to see more effort placed on examining the outcomes that are achieved in the drug and alcohol sector and through the various programs that impinge upon it. In particular, we would like to see more effort, as I said in the first point I made to you, in research devoted to prevention, early intervention, the origins and the social determinants of these problems in our society.

One of the sad things is that smoking amongst young women is increasing. This must be an area of focus. It has been shown by research in Australia and in other countries that government mass media campaigns are effective and they do produce an agenda for change in people for giving up smoking. There is also evidence that if that effort is pulled back, smoking rates increase again. We stress the importance of smoking in young women.

The misuse of prescription drugs is a major problem in ageing people. Most older people are on many drugs, combine drugs and they interact. Many of those substances are pyschoactive substances, antidepressants, sedating substances, and, of course, alcohol is used in that group, too. This imposes direct health risks on those people, but also complicates the management of other problems in ageing people. For example, in that group, falls are common, and respiratory infections from delayed responses to treatment.

Finally, we stress the importance of fatal heroin related overdoses. In our view, this challenges our combined responses that we make to these overdoses. Not only are overdoses important from the point of view of deaths that they cause, not only are they important because in themselves they are a high risk, but there are many people who become damaged, who in effect are near death from overdose and who leave that situation with persisting disabilities. We believe that we should be trialling innovative approaches to this and that there should be very tight collaboration between police, ambulance services, health services and the like.

Underlying much of this is that, to achieve a national response, we need well-trained and educated people. This is deficient in Australia and needs great emphasis. The 10 points that I have made to you were highlighted in our submission and in the publication *Drug Policy 2000: A new agenda for harm reduction*, which we launched recently. That document has arisen out of extensive consultation and collaboration and out of the reference groups that ADCA has established across Australia and also other key groups of interest. I will now call on Caroline Fitzwarryne to briefly speak about this document.

Ms Fitzwarryne—This new agenda for change, we believe, gives you a blueprint of what needs to be done. Different sections of the book cover every drug, all the specific population groups and specific strategies. The book outlines research on effects, use, level of harm and action to date. It provides information on good practice strategies, policy recommendations and targets for harm reduction. It also outlines linkages between alcohol and other drug issues and other public health and safety issues such as suicide prevention, HIV and AIDS, hepatitis C and mental health.

We believe it is not enough to just present policy recommendations about what needs to be done. We have taken a significant leap forward in this document, *Drug Policy 2000*, and provided targets which we believe the alcohol and other drugs sector, in partnership with governments, businesses and communities, should collectively work to achieve.

The setting of targets is too often avoided by organisations, as they are afraid they will be held accountable if they are not achieved. We believe now is the time to take up the national challenge of setting targets for harm reduction. We have set targets in crucial areas where levels of harm are unacceptably high or where levels of services or resources are unacceptably low.

Targets can be achieved if good practice strategies are used and adequate resources are allocated to them. It is all a question of priorities.

ADCA hopes that your committee will use *Drug Policy 2000* as a basis for your deliberations. It is the voice of the alcohol and other drug field collectively saying what is needed—policy and program priorities and targets. The next stage is, of course, specific resource allocation for strategies, and ADCA will be pleased to work with you on this if desired.

We hope that you will also recommend the development of a real partnership in the planning, implementation and evaluation of all activities to reduce the social and economic costs of drug abuse. Currently, the National Drug Strategy is a government—that is, federal, state and territory—strategy using advisers from elsewhere. The independent voices of the community sector, the philanthropic business sector and the local government sector need to be part of a planning and coordination mechanism for the National Drug Strategy.

There is considerable expertise, resource allocation and program activity independent of these governments, and this should be recognised and utilised. In short, we believe that ADCA, the Australian Local Government Association and the Business Council of Australia should be real partners in the National Drug Strategy. In conclusion, we commend *Drug Policy 2000* to you, express our willingness to work with you further in developing your recommendation if desired and will now welcome questions. Thank you.

CHAIR—Thank you very much, Caroline and Professor Webster. Can I just open with a general question. Prevention and early intervention are generally ranked behind supply, control and treatment in government funding, and prevention and health promotion need to be repositioned as key priorities in the National Drug Strategy and adequately resourced. Why do you think such repositioning is desirable? I think you have answered some of that already, but, for the record, could we just work our way through that, please?

Prof. Webster—I think prevention has been shown in most public health areas to be cost effective and, of course, it is better as a matter of principle to prevent problems from occurring than treating them once they have occurred. It is a basic philosophy of public health that prevention is the key approach. When we speak about prevention, it is not necessarily prevention which can be clearly identified as an alcohol or a drug intervention. It is prevention which relates to the fundamental development of families and children and the support they get.

There are many studies—and these are well reported in the crime prevention strategy report produced by the federal government and in the working papers for that—which show that, if children grow up nurtured and valued, they become resilient and protected from adverse factors during their development and adolescence and that these interventions, or this support of young developing families, can have very positive outcomes in adolescence—in mental health, in drug and alcohol use, in health problems generally, in improved outcomes in education and in improved employment. So it is really reflecting that we need a broad based approach to prevention, and it is not simply straight education or public health campaigns, although they have their contributions to make. It is to do with the way in which we educate and support young people as they develop.

Mr QUICK—How do you link in, as Caroline said, the setting of targets? My office is in a low socioeconomic area. We have some sort of social partnership operating, but when you have so many players involved—so many departments, both in the state and the Commonwealth, each with a vested interest to maintain their bureaucracy and their silo mentality—it is fine to set targets, but how do you convince these people to work cooperatively out of the big cities and out of the big CBDs?

Prof. Webster—I think to some extent, Mr Quick, that cooperation can be best achieved in regional areas, and it is possible to get programs of community welfare, health and police to work together if they are given the authority to do so. The problem with many programs in regional areas is that they have to report back to their central offices in the cities. But I think there are many people now thinking that, certainly in some of the states of Australia, we should have much more comprehensive human service programs being developed in regional areas.

At a national level, the mental health program and the drug strategy program ought to be working together. The crime prevention program, which is being run by the Commonwealth, and the suicide prevention programs, which the Commonwealth and the country, as a whole, are investing in really overlap to a very great degree. In fact, if you read the first chapters of many of the major reports produced nationally of recent times to do with the issues that I have just been describing to you, the chapters read very similarly; they are saying the same sorts of things. There are good grounds for these directed strategies to work much more cooperatively. That is starting to happen through the department of health in the area of mental health and drug problems, but it has to extend, as you are implying, much more widely than that.

Ms Fitzwarryne—One of the problems, I think, in the whole prevention area, especially in the area of community education, is that often a little bit of money is thrown at community education without any proper planning about having an effective strategy. It is rather like herd vaccination: if you do not have vaccination up to a certain level, you do not get an impact. If you are going to have effective education programs, community education programs and prevention programs, you have to have a mix, maybe, of national mass-media programs and also a lot of grassroots community activities, social action and employment development dealing with the root causes, and you have to have legislation. You have to have all these different aspects of prevention integrated.

It is a big challenge for everyone to work together, but that is what we have to try to move towards. If everybody is trying to integrate what they are doing and have sufficient levels of resources so that they can achieve change through a program—and there is research showing what level of resourcing you need to achieve success in certain types of programs, and we need to use those best practice models—then we can achieve some of these targets that we have set. But we really have to work at it and make sure that we put the right resourcing in and use the good methods.

Mr QUICK—Surely ABS can provide the statistics? Each federal member and senator can roll off thousands of anecdotal experiences of families at risk. We have bureaucracies coming out of our ears. We have all these reports, but nothing seems to change. In your submission, there is $18 billion worth of social cost to society. Ten per cent of that is probably poured into communities. Do we identify the communities that are at risk? I could tell you dozens; I am sure

all the other federal members could, too, but we do not have the money. Each of the departments that service those areas do not have the money. We still have the silo mentality; we do not want to share. The big hospitals seem to be a never ending black hole that seems to suck up the money. When it comes to early intervention, it is not very fashionable, both in departments and in the media. The media would rather have photos of bags of heroin that the AFP have magically discovered coming out of a container somewhere or photos of a mother shooting up in a toilet in Cabramatta. That seems to be the media's response to it all. How do we change the whole image and say to society that, unless we turn it on its head and get some money on the ground and into the grassroots' organisations, we are just whistling in the wind?

Prof. Webster—I agree with you. It is possible to define communities at risk—and you would know them from your own local experience—but there are systematic ways that you can do that. I will just mention a program in New South Wales which is to do with home visiting. There are literally hundreds of international studies which show that when a new mother gets some support by being visited at home by a nurse, a volunteer or some other person, the act of visiting has a profound effect on how her child develops. That sort of evidence has been available for years and years and has not been implemented. It goes back to the old days, prior to the Second World War, where a midwife would follow the family home. And in England they have health visitors who follow up every child. I agree with you that we do know these things, but we have not had the will, the capacity or the intention to intervene in that way. In some ways, it does not belong to anybody. It does not belong to the health system; it does not belong to the community services sector, and it does not belong to the education department. But it is important that we do it.

Mrs IRWIN—Who do you feel that it belongs to?

Prof. Webster—I think we need to broadly have, at a regional level, a human service system approach and plan. Certainly in the review of health in New South Wales recently and in some of the reviews at a national level, the proposals are that we should be funding and managing local areas so that community services, education, health and so on should work together. That is particularly important in the drug area. In the United Kingdom they have drug action teams which are based on regional areas where the police, the social welfare departments, the local health services and the local education authority meet about (a) the generic problems and (b) individuals who run into trouble. That idea of drug action teams is now being introduced in New South Wales where there are eight regions which are defined for a so-called drug action team.

Mr QUICK—Should we provide the money through local government rather than through the states? Local governments, on the ground, are providing a whole lot of community services. Should the Commonwealth say, 'You've got 47,000 newborn babies in southern Tasmania; we will allocate the councils $5,000 per child to provide the services if the Commonwealth and state governments do not get around to doing it'? Do we bypass? My big concern is that we have been talking about it for years and years. There is evidence out there that it is a huge cost; let us take $5 billion of that $18 billion and redirect it.

Ms Fitzwarryne—I certainly believe that local government needs to have a more key role in the National Drug Strategy. As I was saying earlier, they have not been one of the partners of

the strategy. As you say, local planning through local government and local implementation, and doing a lot of community building and social capital development as well as service delivery, are absolutely essential at that level. The key thing is that, sure, local government needs more money, state government needs more money, Commonwealth government needs more money, but if they work together and integrate their activities that money can be used more efficiently and effectively. For instance, the Commonwealth government has its community partnerships program and that provides money to local activities, but often that is short-term funding for a couple of years, the money runs out and then state government or local government cannot take on those projects.

We need to look at a way of ensuring there are ongoing community building activities to do with the root causes of drug abuse, there are ongoing community services and there is ongoing commitment and integration between Commonwealth, state and local government services so that you do not have these short-term pilot projects. Okay, you need some pilot projects, but it should not be instead of having ongoing community activities that will be true prevention and early intervention.

CHAIR—We are focusing, which Harry has quite appropriately done, on the role of government: what the most effective level is and how we get community ownership and that sort of thing. About 80 per cent of ADCA's revenue comes from government. There is this whole business of government in this process. You have mentioned local government and you have mentioned the Business Council. Governments, for all their sins, have become involved because of community concern. What I would like to try and explore is the in-principle observations that you make about other agencies—for example, the Business Council, other private agencies, your own agencies. All of this is dependent at the moment on government—on national government and state government collaboration, and, by all means, local government as well.

What evidence do you have that there is community ownership from—and I do not want to single out the Business Council—other private agencies, non-government organisations, which are accepting the need to take up the fight as well? From your experience—going back to 1967, as Professor Webster has mentioned—what initiative has come from the community other than the cry for more government funding? What sort of structures have developed there?

Prof. Webster—Mr Wakelin, can I give a slightly different cast to that?

CHAIR—Yes.

Prof. Webster—When ADCA in its earliest form was established, basically the people that formed its board were leading citizens who, with a noblesse oblige, made themselves committed to this. People like Weary Dunlop were among those involved in the leading responses to alcohol and drugs in their particular states. It has been essentially the non-government sector, small organisations and some of the larger welfare groups that have carried the services for people affected by drugs and alcohol because it has been an unattractive area, for the most part, for governments and for professions to see themselves committed to. So most of the charitable organisations, in a huge part of their work, would have either directly or indirectly carried the

burden of caring for people affected by these problems. Then it has been through their advocacy that governments have invested in it.

It is a remarkable thing that in the last decade or so the national government of Australia has directed itself to policy and strategic development in the whole social health and social wellbeing areas—we discussed those earlier today. So there is something going on in the community which is looking for a different form of leadership in response to these almost social existential questions in our society.

It has not been an attractive area for businesses to make a commitment to because it has been identified with disadvantaged people and with people who have essentially been criminal or criminal like in their behaviour. So it has not been attractive from that point of view. I will ask Caroline to speak.

Ms Fitzwarryne—I would like to talk briefly about a document that ADCA has brought out over the last few years, called *Drugs, Money and Government*, which has been assessing the money that governments have put into dealing with drug problems. ADCA has been working with the intergovernmental committee on drugs to look at improving and extending that methodology. We did not bring out one of those books last year, because we thought we could improve the methodology and make it a lot tighter and better. One thing we have been working on, with the alcohol and other drug associations in the states, is to look at government spending and to classify it for treatment, prevention, research, et cetera so we can really look at what aspects of drugs the money is being spent on.

We have been talking with people in state governments about collecting it according to certain classifications. But we have also been talking with the non-government sector about looking at the money that they put in. As Ian was saying, a lot of money is put into non-government agencies from fundraising. A lot of community money is put into this and people think it is mainly government funded but there is a lot more money that goes in. Even though Australia does not have a very good record for business philanthropic giving—I am not sure of the exact figures but it is probably about seven per cent, compared with about 15 per cent in Europe and America, so we need to improve our act in the business community here—there is still a fair amount of business philanthropic money going into the drug field as well. So we really need to have a much clearer picture, and we are working on that with the intergovernmental committee on drugs. We need to have a clearer picture on what is government money, what is fundraising money from the community and what is business philanthropic money that is all going into help in the drug problems.

Mr Smith—Could I comment on one specific example of community action, through the trade union movement. The CFMEU—the Construction, Forestry, Mining and Energy Union—have set up, very recently this year, treatment facilities for its own members who are having problems with drug and alcohol issues. The union have put a lot of money into that and are working with other branches of the CFMEU around the country. When you are in Sydney it would be worth while visiting them; we will give you some contact details for that. That is a specific example of community action.

CHAIR—Thank you very much. I think we all agree that the collaboration that we talk about is really quite essential, and those are practical things and opportunities. I keep coming back to Professor Webster's point about 1967. As Harry has acknowledged, there is all sorts of regular and longstanding evidence which says that this is the way to go but we need to get to the next step of how we harness that.

Let me now move quickly to the education and training of all of the professionals in this area. Perhaps, Professor Webster, that word 'unattractive' comes to mind about how we attract those people who will make a real impact in this area. I would seek your advice on the professional education and training that is involved here, not just in each narrow, individual area of doctors, nurses and so on but also in how we develop that collaborative approach as well—the training that goes into dealing with this mental health and drug addiction. How do we bring those disciplines together as well?

Prof. Webster—You are right to identify this as a problem. Mr Smith has just come back from Western Australia where he met with agencies where people said to him that there was insufficient education and training in this field, and I think that is generally recognised. The drug summit in New South Wales had a major component of its report on education and training, but that yet has to materialise in any direct policies or programs arising out of it.

One of the problems about the drug and alcohol field is because of the fact that it gets mixed up with legalisation and criminality and laws which govern aspects of it. For example, doctors are very circumspect in prescribing narcotic drugs because there are restrictions placed upon them, and if you go to various facilities where narcotic drugs are administered—say, a methadone unit—they are quite bizarre places the way they are run at present. They are guarded closely, they have video cameras in them, they have bars across windows and they are nothing like the sorts of places where health professionals in general, nurses or other people, normally work. It is a very constrained and unusual experience.

At another level, if you look at the people who suffer most from drug and alcohol problems, they often end up grossly impoverished, as I mentioned in previous conversations with you, and homeless. That is a difficult area to get young people to think about positively or imaginatively. Young people who are aspiring to be professionals tend to see themselves dealing with fairly clean, straightforward problems—I mean clean in the sense of cleanskins; with things which have got fairly easy solutions to them and clearly have some standing and status. The problem for this area is that once you develop a problem you have usually got a handful of problems, you have got lots of other things going on in your life, and it is difficult to see any clear intervention which will fix you up, so to speak. It requires a different culture.

Also, professionalisation and training tend to be highly specific. You get taught how to take a history from a particular sort of person, you get taught how to run a smoking cessation program with a particular sort of person, but the comprehensive capacity to handle people with what are really life predicaments is difficult. It ought to be the most challenging, the most attractive and the most rewarding area because, in the end, you are dealing with young people and their futures. The fundamental thing we need is role models—people who will do it, who will demonstrate that they can do it and that it is exciting, and that other people will follow.

CHAIR—Extraordinarily difficult and complex. Thank you for bringing that to us.

Mr Smith—I would like to make a specific comment in relation to the education and training of alcohol and other drug workers. There is actually a lot of training around for workers. The problem is, though, that agencies, particularly non-government agencies, are inadequately resourced so they do not have the capacity to actually send their staff to training because there is no backup—there is no-one who will come into the agency and fill the position of the worker. That becomes a real problem for those agencies.

This is an area where there can be specific action taken by the Commonwealth government. There is a funding bucket at the moment for the training of front-line workers—those people who are not drug and alcohol workers but who work with people who are affected—but there is no specific funding bucket, as far as I am aware, for the training of drug and alcohol workers. There is a real need for that. That is certainly our very strong position.

Mr QUICK—Is part of the problem that governments of all persuasions, state and federal, are busily privatising and tendering out services, and therefore washing their hands in some way of the services, and so the whole issue of accountability and training and the kudos associated with it is part of the problem? Would that be right?

Ms Fitzwarryne—One of the problems in the funding of most community agencies through project funding is that there is not funding given for the infrastructure for staff development and those sorts of things. Funding is given to run programs, but you cannot run programs, as Wayne was saying, unless you have the adequate training and the backup—and there is not the funding for that. It is project funds to run a program, but not for the infrastructure support and the staff development.

Mr QUICK—So the governments are doing it on the cheap?

Prof. Webster—Yes.

Ms Fitzwarryne—Yes.

Mrs IRWIN—To follow up from that: a number of the complaints that have been made to me and my office are to do with police. It is felt that police have not had enough training or do not understand the problems of young people of all ages that are addicted to drugs. Are you finding that the police have got no training whatsoever?

Prof. Webster—My experience with police is that they have changed enormously over the years that I have been involved. They get training in mental health and they are getting increasing training in the drug and alcohol areas, but they desperately need a lot more support. A young police officer on the streets in the area that you represent—

Mrs IRWIN—Cabramatta.

Prof. Webster—is bewildered because residents expect him or her to perform in a particular way. They are often very conscious of the background that some of these people have come

from. They are aware of their other needs. And my wish, for that situation at least, is for police to be able to actually make contact with people to get advice and help. At present the front-line police officer is very isolated and virtually cannot get any assistance at all. Wouldn't it be great if he could ring up the local hospital and say, 'I have got a young person here who is using such and such. Could you send someone out to have a look at them, or could we arrange for them to go and visit somewhere?' That sort of cooperation, support and cross-linking at a local level just does not occur, but it must occur if we are to produce change. These drug action teams may help, but I think this idea of a wider human service response to these issues will help. In Cabramatta there is a drug action team in which police, health—in fact, I represent health on that—the schools and some local groups, the local council, meet. That has led to a much improved response in that place.

The first thing it has achieved is that it has stopped those agencies and groups from sabotaging each other's efforts. So the police know what we are trying to do in the health service, and the health service realise the predicament of front-line policemen and are prepared to go and meet and talk with them. Some of my staff go to the Cabramatta police station and sit there through the day, just so that officers can come up and talk to them about issues like HIV-AIDS. We have found that it is more effective than just going along and giving them a talk if we are available so that they can just, from time to time, take up issues. The police need a lot more support, a lot more help with their discretions, and they need it from outside the service as well as from within the service.

CHAIR—There is never enough time in the day, but several members of the committee still have questions to ask you.

Mrs IRWIN—I would love to be able to talk to you and have you here for a number of hours, but we have got some other great groups to see today. In your submission you were talking about reducing fatal heroin related overdoses. You stated:

> 737 Australians died from opiate overdoses in 1998, a 23% increase on the previous year … Overdose deaths have more than doubled in the past decade … It is clear that the current approaches to treating heroin dependence are not able to meet the needs of all people seeking treatment.

Your recommendations on that were a wider range of treatment options—you mentioned methadone, naltrexone, pharmaceutical heroin—support for supervised injection place trials and Narcan availability. I would have liked to have discussed those three recommendations with you so we could get it on *Hansard*, but I do not think we would have the time to do that. The one that I would like to discuss with you today is the support for supervised injection place trials. You recommended:

> ... that the Committee support trials of medically supervised injecting places in every Australian State and Territory in order to ascertain the effectiveness of a national approach to supervised injecting places.

You would be talking about one each in each capital city as a trial. Is that correct?

Prof. Webster—At that level, yes. We do not see this as a major solution to a problem, but it will have two effects, I think. It will improve the local amenity of areas—people who are injecting hurriedly in the street will inject in different circumstances. Secondly, we can ascertain

the extent to which it is likely to have an effect on the overdose rate. There is a genuine debate about what the outcomes of these will be. Our view, from wide consultation within our organisation, is that they should at least be trialled. The reason we have taken up the idea that they ought to be trialled in different communities is that there are different communities. The south-west of Sydney is very different from the centre of Sydney, and the centre of Sydney is very different from a significant country town. The population needs, the drug markets, the resources available, the degree of homelessness, the ethnic mix differ in all those sorts of places. Our basic view about this is that these can be properly established, they can be properly monitored and they can be properly evaluated, so long as it is done independently. And that independent valuation should include people with experience in the criminal justice system, the health system with epidemiology and representatives of the local community. That is what has been planned in the ACT and it is certainly what is being planned in New South Wales at present.

Mrs IRWIN—They have got problems in the ACT and New South Wales. A number of councillors that I have spoken to—not just in my own area—and people from my community and other communities have virtually stated, 'Let someone else have it. Not in our backyard.' Among suggestions that have been made to me by various community groups throughout western and south-western Sydney is, 'Why have only one trial? Why only have one in Kings Cross?' I am talking about New South Wales here. 'Why shouldn't we have, say, one in Blacktown, one in Cabramatta, one in Parramatta, one in Strathfield and one in Sydney?' They feel that then you would get away from the problem of, 'Why our area?' What are your feelings on that?

Prof. Webster—That is what Victoria was proposing. In New South Wales, with the drug summit, the meeting fundamentally agreed with a trial of one. I think quite a number of people have been critical of that, particularly the people who want to evaluate it. They say that one is not going to be able to demonstrate much impact on a community wide basis, but there are elements that you can evaluate in a particular area. I do not know that I can express a strong view about that.

Ms ELLIS—I would like to ask two questions. They are quite different from each other, but bear with me. One of the issues becoming apparent to me is the problem of the meshing together of people having drug abuse problems and people who have mental health problems, and the dual diagnosis side of it. Your submission talks a bit about this and I would like to ask you to elaborate a bit. It is not at all unusual to hear that someone presents at an emergency ward of a hospital and is turned away because they may appear to be under the influence of alcohol or a substance that tends to veer the staff toward believing that rather than a mental illness, and there can be a crossover. Would you give the committee your views on that.

Prof. Webster—There are two broad areas where this is important. One is in the treatment response which you have been describing. There has historically been this split between drug and alcohol and mental health, although in some countries they are together. The Burdekin report, in the inquiry into the discrimination against people with mental illness, pointed out the very tragic situation where the philosophy and drivers of a drug and alcohol program appear to be quite different from the philosophy and drivers of a mental health program. I think it is possible to put those together better, but again it is not only the mental health services and the drug and alcohol services that have to cooperate; it is right at the front line of general practice

and the emergency departments, as you describe. It goes back to some of these ideas of unattractive learning and capacity. Really, in the health system these things can be coped with well by people who are comprehensively and well trained. They do not have to be specialists in either area, in my opinion.

The other area in which this overlap is important, as I made a comment to you before, is prevention. The risk factors for suicide prevention are not very much different from the risk factors for the prevention of substance use. The same sorts of ideas of resilience, vulnerability, protection, families and communities at risk and so on overlap. If we as a community have a much stronger emphasis on community wellbeing and the promotion of mental health, and we have a national mental health prevention and promotion campaign, all of those will contribute to a better outcome in the drug and alcohol area.

Just take one group in Sydney, the homeless people, of whom 75 per cent have a major diagnosis which is a mental diagnosis. A sizeable proportion would be drug dependence and alcohol, but half of it, at least, is major mental health problems. And commonly they have got both. So mental health services have to be prepared to accept people with substance use as part of their core business, and vice versa. Many of the young people who develop acute psychosis are using drugs at the time, and it is not satisfactory to say, 'We're not going to treat it because you are using drugs.' What has to be treated is the onset of the acute psychosis, the mental illness. It has to be treated as a medical emergency and dealt with effectively, and then the drug addiction can be looked at subsequently.

Ms ELLIS—I will ask, very quickly, this question: you talk about workplace safety and productivity and you mention the appropriateness of training and support for employees who may have a problem of substance abuse. I would turn it the other way, asking about the need for employers or business to have some eye to the danger that employees also face, not through their own addiction but through the addiction of others—for instance, syringes left in fitting rooms of department stores. That has been given to me off the record as one example. Do you have a view about how we could start to approach that as well? It actually is a two-edged sword for employees: they have either their own addiction to worry about or somebody else's.

Ms Fitzwarryne—What we are advocating strongly is really good guidelines about proper occupational health and safety programs and drug policies and programs within every workplace. If you are going to have a proper program, that includes having a policy for how to deal with syringes left lying around. For instance, the builders union in New South Wales have a program in which people go around building sites picking up syringes before they start work each morning. That is part of that policy. You need to have a policy that is not just little bits but is a very comprehensive policy looking at anything that can cause harm to any workers. That would include syringes lying around and anything other people can do through their behaviour that can impact on workers who are not involved in drug and alcohol situations.

Mr Smith—Our view, very strongly, is that the insurance policies which businesses have to have should have a drug and alcohol component built into them.

Ms JULIE BISHOP—To follow on that question: does ADCA or do you have a position on drug testing in the workplace?

Ms Fitzwarryne—We believe very strongly that drug testing is essential in some situations where it affects occupational health and safety—the safety impact on other people in certain industries—but the sort of testing that you do needs to be part of a very broad occupational health and safety program. For instance, there has been a lot in the press recently about urine testing. That is one way of doing drug testing, to test for certain drugs, but at the same time it has limitations. What we are really interested in is the impairment. What impairment can people's use of drugs have on their ability to do the job, whether it is driving or operating mining machinery? You need to look at the specific situation and work out what type of drug testing is needed and when it is needed in the particular situation.

CHAIR—So it is workplace policy based.

Mr SCHULTZ—Just on that point, extrapolating it out: what is your view on the drug testing of law enforcement agencies such as the police service?

Prof. Webster—I am only expressing a personal view; I do not think we have got a policy on this. I think that introducing a policy like that in any work force requires both sides of the case to be put, and people who are workers in that field to be in the decision making process and have their views expressed. I can just give you an example from the health sector where the risk of HIV, hepatitis C and other problems is very high indeed. There is no enforced HIV or hepatitis C or hepatitis B testing of surgeons, of nurses. It is based on a voluntary code, but it is stressed very much in occupational health and safety and in the precautions which are taken in the industry, or in the medical environment. I think it has to be something which is agreed between the work force and employers and the public authorities.

Mr SCHULTZ—With due respect, I think that the issue of drug testing law enforcement agencies is slightly different from that of testing people who are basically involved in employment in private enterprise or the government sector as employees, because of their close relationship with the drug trade as a whole.

CHAIR—We are going to have to wind it up there, but would you like to make a quick response to that?

Prof. Webster—No.

CHAIR—I thank the representatives of ADCA very much. We believe that we will need to ask many organisations to come back again—and possibly yet again—because, obviously, we are not doing justice to all these very broad ranging issues in the short time available. I hope we will not, shall I say, get sick of seeing each other, but we would welcome your return. We thank you very much for the comprehensive nature of your submission. You have a long experience which we can benefit from. We will no doubt be asking you to come back and help us again. Thank you very much.

Prof. Webster—Thank you for the opportunity to present.

[9.40 a.m.]

BOURNE, Ms Jenny, Assistant Secretary, Youth and Students Branch, Department of Family and Community Services

BOYSON, Mr Ian, Director, Indigenous Policy Unit, Department of Family and Community Services

DELAHUNT, Ms Rosemary, Executive Officer, Family Capabilities, Department of Family and Community Services

HERSCOVITCH, Mr Andrew, Assistant Secretary, Office of Disability Policy, Department of Family and Community Services

McKAY, Ms Robyn, Executive Director, Family Capabilities, Department of Family and Community Services

SHARPLES, Mr Ian, Director, Employment Strategies Section, Department of Family and Community Services

HUMPHRIES, Mr Peter, Business Manager, Centrelink National Social Work Team, Centrelink

CHAIR—I welcome representatives of the Department of Family and Community Services to this inquiry into substance abuse. Do you have any comment on the capacity in which you appear?

Mr Humphries—I am from social work services in Centrelink.

CHAIR—As you would know, and as we indicated earlier, we do not swear in witnesses; we just ask you to recognise that these are legal proceedings of the parliament and they warrant the same regard as the proceedings of the House of Representatives. I feel sure that one or two of you have an opening statement to make.

Ms McKay—I will make a short opening statement. Chair, I will be led by you a little in how long you would like me to take in doing that. I am conscious that we have been allocated 45 minutes and that you would probably like to ask a number of questions in relation to our submission, so I was proposing to talk for about 10 minutes. If that is too long, tell me now.

CHAIR—That is fine. We are obviously running a little behind schedule. So anything that can help us there, would be appreciated. I do not know that I need to introduce each member as we go around. I think probably that is unnecessary. We will introduce ourselves as the questions come. So over to you and we will move through this as expeditiously as we can.

Ms McKay—Thank you. The main points that I want to make in the opening statement are really to draw out the highlights from the submission that we made to the inquiry. In particular, we see the Department of Family and Community Services as an important gateway to services. Because we have a very broad range of families and individuals who come to us for income support and services at different points in their life course, we see a very large number of people. The scope and I suppose the generic nature of many of our programs bring the department into contact with people who are affected by substance abuse but who present with other primary needs—for income support, financial counselling, relationship counselling, child support and so on.

We do not have a large number of programs explicitly related to substance abuse. We have a couple of new small initiatives, including the family crisis child care pilots, and new measures strengthening and supporting families coping with illicit drug use which have been developed in partnership with state and territory governments and the community sector. It is the prevention and early intervention policy context within which we are now operating that gives us a body of knowledge about substance abuse which comes from other programs, particularly the case work of Centrelink social workers, the Supported Accommodation Assistance Program and the emergency relief program, as well as employment support for people with disabilities, the Reconnect program for young people at risk of homelessness and relationship counselling programs.

That prevention and early intervention context provides a framework for developing service responses structured around life transitions. Because such transitions as relationship formation, the birth of children, young people's transitions from school to work and adult roles are so commonly experienced as to be almost universal, programs structured around those life events we see as broadly relevant as a means into dealing with specific needs of individuals and families affected by substance abuse. Those prevention and early intervention principles also suggest how we ought to intervene and, in particular, we are tending to focus on capacity building and partnerships—partnerships between government, communities and the broader social coalition of service deliverers. Those principles have reached a significant coming together in the Stronger Families and Communities Strategy, which was announced by the Prime Minister in April this year.

We undertook a fair bit of research for the development of the policy around the Stronger Families and Communities Strategy, and much of that research has been reflected in our submission. In particular, we are conscious of parental behaviours, particularly parental substance abuse and parental parenting behaviours as perhaps being significant in predicting later substance abuse by young people.

That research and practice evidence suggests that there is a lot of interaction between risk factors. However, we would like to emphasise that we see no simple causal relationship between substance abuse and other social problems and nor do we see one between the interaction of risk factors and the development of addictive behaviours. We do think that the use of mainstream services, such as child care and playgroups, to deliver support for good child development are important and we think they will act as gateways for parenting support and possible interventions with substance abuse problems. We are using those universal life transition points.

There are patterns of association with financial hardship, relationship breakdown, domestic violence, mental health problems and homelessness. Those are evident from the service delivery experience within the portfolio and from community agencies. We believe there is probably a great deal of underreporting nevertheless, so the experience we have from our service delivery angle is probably the tip of an iceberg, although we could not be sure of that. For that reason, we have been agnostic in our submission on what the quantitative costs of substance abuse are likely to be, although we have provided some lower range estimates. We do have some data from the SAAP collection and the Reconnect program. We also have some data on the number of Youth Allowance and Newstart recipients who are exempted from activity testing for those payments because of alcohol or substance abuse. We are only now beginning to collect information on applicants for the disability support pension.

A useful starting point for the service response is to consider the extent to which substance abuse has detrimental effects on an individual's capacity to manage various roles within the family and society, including parenting and family relationships, employment, community participation and self-management. Good service linkages are critical for a systemic response, including the linkages to specialist health services, community education and the criminal justice system, together with funding and policy partnerships across portfolios in the community. The principles underlying the Stronger Families and Communities Strategy are important to the way we believe that services should be delivered. However, that needs to be tested empirically and we propose action, learning and research associated with the implementation of that strategy to establish whether the community capacity building approach that we will adopt there leads to particularly satisfactory outcomes or whether there are combinations of ways of delivering services that lead to better outcomes.

We are looking at various models of coordination under that strategy and across the portfolio to give us an idea of what will give us consistent outcomes. Some of the models that we are looking at are active brokering in case management approaches, forming part of service agreements in programs and perhaps a systematised protocol for DFACS and its portfolio and partner agencies. This will enable us to ensure consistent management and referral of individuals and families affected by substance abuse. That approach really comes forward—to use the language of pathways—in making links between systems in the way that has been developed through the Youth Pathways Action Plan Task Force and through the Family Law Pathways Advisory Group, both of which still have to report to government. Thank you.

CHAIR—Can you tell us more about the effects on marriage of such variables as mental health and the abuse of alcohol, but especially alcohol abuse? What do you believe the implications are for the research of your policy and the program development of your department? What is the overall impression in terms of alcohol and research and what it is showing us?

Ms McKay—I will turn to Rosemary Delahunt to answer questions on the research.

Ms Delahunt—The research has indicated that there are a number of risk factors, of which alcohol and substance abuse can be one. Others may include poor socioeconomic status and poor attachment within your community so that families are isolated, and these are, in a sense, almost universal. They are very common factors for a variety of situations that lead to poor

development of children, relationship breakdown and other interacting social problems. Our difficulty is that it is problematic in being able to say that alcohol abuse causes relationship breakdown. Certainly, both from research and from the experience of the family relationship support programs that run counselling and some of the men's services that provided input to our submission, there was a very common thread that in cases where people had come to services for help with relationship breakdown alcohol abuse was a factor. But whether it was a factor in causing the relationship breakdown or whether it was a response to the stresses that may also have culminated in that relationship breakdown, it is very difficult to be categorical.

CHAIR—It is suggested that international experience would require careful adaptation for Australian conditions. What is the international experience from your observation and what is careful adaptation? It is difficult I know, but what are some of the things we might learn from international experience and then adapt into Australia's situation?

Ms Delahunt—Certainly, with any research into family problems and family dynamics, to some extent they are culturally influenced by the environment and the communities in which those families operate. I think it is that which would lead us to seek a cautious approach to adopting some of these holistically into the Australian community. I am actually not familiar in enough detail with some of the very specific alcohol abuse research from overseas to be able to respond to the first part of your question.

CHAIR—Perhaps we can take it on notice and we will see what we can find in that.

Ms ELLIS—I would like to jump in with a related question. I think it is fair to say that all of us in this room would understand that it is absolutely essential to understand and grapple with the problems that begin the process of abuse of substance, self or whatever so as to deal with the longer-term view of the subject. I notice in your submission you say in part:

> It would seem likely that the policy principles of early intervention and prevention, and of diagnosing key life transition points where such action would be most effective and beneficial, would be as important in relation to substance abuse as to other damaging intergenerational family health issues.

You then say:

> However, further research and data collection, and particularly longitudinal studies, will be necessary before policy can be well based in these areas, and intervention effectively targeted.

That really concerns me because what you are actually saying is that, despite all of the history and knowledge that we have nationally and internationally, we are still at a position where you believe that we cannot bring anything to bear in a proper, full and effective way to understand the need for intervention programs and support in the earlier part of this process until we go through further studies. Where do you see the responsibility for those studies coming from? Who do you think the research should be done by? What do governments do in the meantime?

Ms McKay—I think that is a misinterpretation of what we meant to say in our submission.

Ms ELLIS—Paragraph 1.1 of chapter 1 of your submission.

Ms McKay—We rely very heavily on the research that has been undertaken in other countries and in other jurisdictions on prevention and early intervention approaches. Australia does not have a long history of program responses of a systematic kind in the area of prevention and early intervention. That does not prevent us from giving it a go. Indeed, the Reconnect program, a number of our family relationships programs and the Stronger Families and Communities Strategy are an earnest of intent to follow the prevention and early intervention path. We are relying though on styles of interventions that have been tested overseas but have not been systematically tested in Australia. We propose to systematically test them at the same time as we are providing services to families on the ground so that there is a research component and an action learning component to all the interventions that we have undertaken since the introduction of the Reconnect program and which we will be undertaking through the implementation of the Stronger Families and Communities Strategy.

Ms ELLIS—Subsequent to that, what advice do you believe your department is or should now be giving to government in the priority of this? Where do you put this in terms of priority in lobbying the government or advising the government about where this sits in the grand scheme of things? What do you think you could be doing there?

Ms McKay—Where do prevention and early intervention approaches sit?

Ms ELLIS—Yes, absolutely. And the need for the research and the understanding and the cracker under the seat of this particular area of policy.

Ms McKay—We have already advised government of that and that has been reflected in their commitment to the ongoing roll-out of the Reconnect program and the Stronger Families and Communities Strategy. It will only begin to spend money from the beginning of 2001, but it is an ongoing program. There is a very strong commitment by government to the roll-out of that program and to its evaluation. Evaluative research components are built in to the design of those projects.

Mr QUICK—What do you mean by testing the programs? How do you test a program operational at, say, Horsham in Victoria? We are talking about early intervention as a longitudinal thing. Are we going to test it for the number of mothers and young children that come into the program? Are you going to provide the ongoing money to ensure, as you say on page 31 of your report, ‘being able to provide long-term support on demand’ and ‘keeping the lines of communication open with parents’? How do you test these programs? Do you say we are going to be involved in the Horsham district for the next 10 years so that we can say that these young siblings, whose brothers and sisters are involved in heroin addiction, are not going to come through the pipeline? What do you mean by testing?

Ms McKay—Pretty much what you have just described. It certainly means being involved in a community for a sufficient length of time to establish whether there are good outcomes, and outcomes do take time. I am wondering, Chair, if it would be useful just to give some outlines of the kinds of interventions that are built into the Stronger Families and Communities Strategy so that the committee has a clear sense of the number of different strands that are involved within it.

Mr QUICK—I can give you an example. I have a sole parent living in my state with an 18-year old son experiencing heroin problems in New South Wales. She has two younger children. All this sounds fine, that you have all these things such as Reconnect and the like, but we raised the issue in Melbourne the other day about what are families. It is okay if you live in a particular area and the service is there, but we have young homeless kids with drug problems wandering all around Australia. We have got dysfunctional families. You have these programs that you are running, testing and evaluating, and you are talking about 36 here and the government giving $20 million there and $60 million over 40 years. What do these programs mean to this sole parent, this mother? What does it mean to say that you are going to provide long-term support on demand? She is interstate and she does not have the wherewithal to keep an eye on this 18-year old who has a heroin problem in New South Wales.

Mrs GASH—That question is a bit unfair.

Mr QUICK—No, it is not.

Mrs GASH—Yes, it is.

Mr QUICK—No, with respect. These are the experts, these are the people that are putting in these programs and advising the government to spend hundreds of millions of dollars. It is fine to say on demand and keeping lines of communication. What do I tell this parent? What do we tell the parents? How do we relate theory to practice?

Ms Bourne—It might be useful if I talk a little bit about how the Reconnect program which you referred to will be evaluated. We will, as part of managing the program, in the first instance gather data about the number of people who use it, the sorts of family situations that are in existence when the young person is at risk of being homeless or in the very early stages of home leaving. So we are gathering information about the family, about the siblings, about any problems that that family might have. They are seen by the service over a period of time, and that can vary because, as the previous witnesses were saying, very often young people do not present with a single problem, they have a multitude of problems. So a whole range of information is gathered at that point.

When the young person and the family decide they do not need to continue coming to the service, a range of information is then gathered from that family. But we do not just leave it there, because that really does not tell us how effective it has been in the long term. So we will then have effectively a longitudinal study of that young person and their family and go back to them over three years to find out whether, taking into account the fact that a whole range of other things will change in those family circumstances over that time, there is a sustainable, positive influence from that family.

Mr QUICK—How do you link that in with—

CHAIR—Hang on, Harry.

Mr QUICK—I would like to butt in.

CHAIR—It is all right, Harry. We have other questions coming and I need to let Ms Bourne answer.

Ms Bourne—That longitudinal study is done over a period of time. It is not just the department who does it. We tend to do our evaluations and have community reference groups and service providers involved. As well as that—and this is very important and ties in with what Ms McKay was saying—the program has action research built in. We are paying the services to monitor their progress as they go along, decide how they are going to deal with families and young people, and then go back and see whether that worked or whether there is a better way of doing it, so they are continually improving the effectiveness of what they do and, as well, the program shares the good practice. We have built into the program a way of services across the country being able to access the good practice from other services. Something that might work in an Aboriginal community, for example, might not work particularly well in the western suburbs of Sydney.

Mr QUICK—Who do you share it with?

Ms Bourne—Our evaluations are published.

CHAIR—We have to cut it off there. If we have got time we will come back, but Joanna has been waiting very patiently here and I did allow some licence.

Mrs GASH—My seat is Gilmore, which is on the New South Wales South Coast. We have a large population of young people and we have a very large population of unemployed young people. Unfortunately, those unemployed young people are almost unemployable because of drug abuse or alcohol abuse. I notice that you have exemptions for activity tests. How is that judged? A person in my electorate, in the community, says, 'Why aren't they working?' and I have to say, 'Because of so and so.' Can you give me a guideline as to how you judge the rationale for exemptions for activity tests?

Ms Bourne—For young people in receipt of youth allowance, if they are under 18, they are generally expected to be in education and training—and the vast majority of them are. The data from April of this year indicates that for 15- to 17-year-olds there were a total of 677 young people who were exempt from activity testing.

Mrs GASH—How do you judge that? I understand the figures but what are the criteria?

Ms Bourne—There are a wide range of criteria. It could be that there is a crisis in that young person's life. Most of the exemptions are very short term. The young person's house may have been broken into and their goods stolen and they have to go off and do things.

Mrs GASH—No, I am sorry—I have not made my point clear to you. I need to know how you exempt them when either taking drugs or alcohol. What are the criteria for saying, 'Okay, that person will go to work because he takes five cones a day or whatever; that person doesn't'? How do you judge that?

Ms Bourne—I think it is very important to put it into perspective. In April, there were 52 young people around the whole of the country who were exempt from activity testing on the basis of their drug or alcohol abuse. They are seen by the social workers and they are assessed as to their capacity to actually participate at that stage. But it does not mean that we say, 'Oh well, you are in such a bad state, you can do it,' and you are left. There are other programs where young people can participate. The Community Support Program, for example, that is run by the Department of Employment, Workplace Relations and Small Business, is designed to overcome severe barriers to employment. The young person can participate in that and have very personal, very specific assistance given to them to enable them to address their barriers—in this case, addiction or a severe misuse—and then they can move on to other more regular or routine programs. But there are specific programs available.

Mr SCHULTZ—My area covers about 41,000 square kilometres in the south-west slopes of New South Wales. The electorate that I represent has similar problems to the ones that Joanna Gash has just described. But what concerns me even more is the fact that on page 15 of your submission you talk about alcohol related violence with young people in rural areas and, more specifically, you put some very worrying figures in your submission on that. What concerns me is that I have young people coming into my office accompanied by their parents, who have not only alcohol problems but also many of them have drug related problems—and hard drug related problems.

The difficulty that I have with regard to trying to assist and guide the parents is that there is nothing available for those young people to get any counselling or assistance for their problem, except in the major cities such as Sydney or down in the Albury area. That is a difficulty for my constituency because it is a 400 kilometre trip one way and a 300-plus kilometre trip the other way. When you make the appropriate inquiries, you find that invariably there is a six- to nine-month waiting list before you can get those young people in. What is your department doing to bring some practical programs and services into rural and regional Australia to accommodate the difficulty that parents have getting their children at a very young age—and I am talking about 13- and 14-year-old heroin addicts—into a program to assist them to get off their habits?

Ms Bourne—It might be useful if I mention to you the Strengthening and Supporting Families Coping with Illicit Drug Use program. This program is part of the National Illicit Drug Strategy and it constitutes about $11 million of a broader program of $220 million that is provided in conjunction with ourselves, the Department of Health and Aged Care, and the Department of Education. This program is really targeted at assisting families where the young people are using drugs and the impact that that has on the family group. We are concerned about siblings, the impact that these things can have on them.

This program is being developed in partnership with state and territory governments, although we have not finally signed an agreement yet for the New South Wales project. However, the sorts of things that New South Wales will be spending this money on really address the issue that you have raised, about being able to give assistance to people who are not in those large centres. The sorts of things include telephone advice and referrals, because people need somewhere to contact early. They will be having information online so that people can access it, if not from home then perhaps through their local library. They are developing a family drug kit which talks about what the drugs are, the early warning signs, how you can

protect young people, and the important role that the family has in actually protecting a young person from going down that route, and treatment information. They are providing training material to non-government organisations so that they are in a better position to assist families, as well as some detoxification and overdose prevention. As well, they are going to run five pilot projects that will offer family support.

I do not know the spread of those, where they are going to be, but they are looking at using existing service providers. So it could be that they will link into a service that already exists in a community and give them assistance and guidance as to how they can help locally.

Mr SCHULTZ—That does not bring any joy to me because what we are talking about is the dissemination of literature. I do that in my tri-monthly bulletins that I put out to the community aimed at educating them on drugs. What I am talking about is the face-to-face counselling and assistance that need to be given to people. I understand that it is physically impossible, and a monitoring nightmare, to expect to have that in every town in every state in Australia. But for the life of me I cannot understand why the organisations that are supposedly concerned about drugs and drug education and drug assistance for young people in Australia have not pushed for the sorts of services that I am concerned about into major cities, for example, in Wagga Wagga, Dubbo and Goulburn, not too far from here. We have a massive problem. There have been nine overdoses with drugs by young people in Goulburn in the last two or three weeks. We have massive problems out there and we do not seem to be addressing the issue.

CHAIR—We are going to have to speed it up. These are all important issues and they all need attention, but can we keep the questions shorter and the answers as brief as we can because we have only got six or seven minutes left in this particular segment and I have four people who want to ask questions.

Mrs IRWIN—Regarding chapter 2 of your submission, 'Working with substance abuse in established FaCS programs,' the thing I am really concerned about is that your submission notes on page 19 that some of your emergency relief service delivery agencies have been asked to assist with the cost of methadone. You say that some people are finding it hard to meet the $40 per week cost of methadone, especially while managing on income support. Is this a recent problem you are noticing, and does it reflect some change in the way methadone is being delivered to heroin addicts?

Ms McKay—I am going to have to take that question on notice. I do not have anyone here familiar with the emergency relief program.

Mrs IRWIN—I would appreciate it. I know it is a very big concern when people are on methadone program. They might be on income support and they have to go to the department to get their $40. There should be some better system.

Ms JULIE BISHOP—You refer to Centrelink as a gateway to a broader cross-section of the community because of its income support role. Yet you note that it is an opportunity for the Centrelink workers to come into contact with people with a range of problems including drug abuse. What happens when social workers determine there is a drug abuse or substance abuse problem? Do you have any best practice guidelines, including referral practice?

Mr Humphries—That is a good question—as we were saying before, it really depends on where you are. If you are in an area where there is a range of services, obviously the first thing you can do is try to refer that person to a specialist service. But I want to add a quick word of caution to that. Referral is not as easy as it sounds. It is not simply a matter of saying to someone, 'There is this good service for you, please go,' because a lot of people are very reluctant to be referred to other services. I guess one of the opportunities that the Centrelink social workers try to take is to work with people wherever they come in. I think we say in there that one of the key things that you have take time to develop is trust; you cannot refer anyone anywhere unless they trust you, particularly in the area of substance abuse, which as we know is a stigmatised area.

They would look at the options that they have got, look at what other services are available, what other supports they have got in their community, and it is really very much an individual matter. I cannot generalise because every situation is so different, but certainly their job is to look at all of the factors of that person's situation and try to put together somewhere for them to go.

Ms JULIE BISHOP—But is this part of an actual best practice guideline that is available to the workers?

Mr Humphries—No. It is what we were saying in there about the proposal for an intervention pilot, and I guess that is exactly what we want to look at. We have certainly got the anecdotal feedback about what constitutes best practice; what we want to do is research it and find out what actually are the most effective things that we can do.

Mr QUICK—I have just a couple of quick questions. You mentioned on page 30 that there would be 100 Reconnect services by 1 July this year.

Ms Bourne—That is a typographical error. It should have been 2001.

Mr QUICK—How many families/people are you proposing to service by those 100 Reconnect services?

Ms Bourne—It will be about 7,000 young people, and about 5,000 families.

Mr QUICK—For a total cost of initially $60 million to set it up and $20 million on an ongoing basis. Would that be right?

Ms Bourne—No. The $60 million is over the first four years of the program because it is a staggered implementation. It will be approximately $20 million a year.

Mr QUICK—Can you provide us with a list of where those 100 Reconnect services are likely to be placed?

Ms Bourne—I can tell you where the first two rounds will be. I cannot tell you where the last 25 will be, because we have not yet gone out to tender for those and the state governments have not yet identified the areas of high need.

Mr QUICK—So you do not decide the areas of high need. The state governments do?

Ms Bourne—It is done in partnership with the state governments.

Mr QUICK—My second question is: how many pilots are currently being run by the department at the moment, and—you might need to take this on notice—how many over the past five years? Could you give us the state breakdown. If you have any evaluations of any of these pilots that have been completed I would like—I do not know about the rest of the committee—copies of the evaluations, if possible, of those pilots in this area.

Ms McKay—Could I just clarify: are you asking that question in relation to services for young people under Reconnect or more broadly?

Mr QUICK—I would like to know how many pilots this department is running in this particular substance abuse area in the way of early intervention, Reconnect and all the other subsections that are part of the thing. Please tell me how many have been set up over the past five years with a breakdown by states and an evaluation of those that have been completed.

My last question is to do with the Health and Aged Care submission, page 131, where they say:

> Regional plans, developed by key stakeholders, providing an opportunity to develop service plans which take into account all the resources available within a region and which reflect the local environment and priorities.

I ask that in continuation from Mr Schultz's question. How are you involved with Health and Aged Care and in developing those regional plans? Could someone answer that now please?

Ms McKay—I am not in a position to answer that now. I will have to take that on notice.

Ms ELLIS—I just want to take this morning's opportunity to ask Mr Boyson a couple of questions in relation to indigenous communities and substance abuse. As you are probably aware, this committee has just tabled a report into indigenous health which took us a couple of years. Whilst we were not concentrating on drug abuse or substance abuse, it did come across our table to some degree.

In the department's submission there is some attention paid to this issue and you mention the National Indigenous Substance Misuse Council. Could you explain for us where you see that fitting in the general overall approach that is required to try to—in my terms—up the ante in terms of dealing with substance abuse in indigenous communities and where do you see any inefficiencies or deficiencies in that? To what extent are we really failing to attend to the issue of substance abuse? I recall in my mind a picture of a young man in a wheelchair in a remote community, completely and absolutely in a vegetative state purely because of sniffing. The impact that left on my brain will probably never leave me. I will leave it now to you.

Mr Boyson—I probably would preface any comments by saying the problems in indigenous communities are very deeply entrenched problems. They are not the sorts of problems that are conducive to quick fix approaches. I think part of the emphasis that we have tried to place in the

department's submission is looking at the broad range of activities that FaCS is involved in that relate to substance abuse and looking at it in a holistic sort of view. It is coming from the angle that to deal with substance abuse in indigenous communities in isolation is not something that is achievable or is going to happen. Substance abuse is usually a manifestation of a wider range of problems that are associated with breakdown in communities within cultural structures, family structures and structures within the communities themselves. Therefore, to look in isolation at substance abuse without looking at the range of other factors that are necessary to strengthen those communities and strengthen families is probably not going to achieve the sorts of outcomes that this committee would be looking for.

In particular, opportunities for social and economic engagement, counselling and diversion programs, parenting skills, household budgeting, adequate housing and that plethora of opportunities need to be created in conjunction with each other to be able to see a way forward. One of the comments that we get from indigenous communities when we are talking to people is that people see government programs coming in to fund a youth worker here and to fund a drug and alcohol worker there but they are not joined up. I think the key is to join responses up.

The material that the department has provided, particularly on the Stronger Families and Communities Strategy, is an indication of the department's thinking and where the department is approaching these sorts of issues in terms of looking at joining up the range of responses the department has. I would also say that the department has not got programs that are specifically targeted at substance abuse but the range of responses that the department has are particularly important in terms of substance abuse.

Ms ELLIS—Very briefly, can you tell me how that council fits in to this, who it reports to and how it operates.

Mr Boyson—I would have to take that on notice.

Ms ELLIS—Could you do that and advise us.

Mr Boyson—Yes, I will do that.

Ms ELLIS—It says it was established only in very recent times, at a conference held in May this year.

Mr Boyson—Yes, that is right.

Ms ELLIS—If you could supply the committee with some background on the constitution—how the council was put together, who is on it, when it meets, how it is run, the frequency of its meetings, to whom it reports and how it fits into the big picture of things—that would be very helpful. Thank you.

CHAIR—I thank the representatives of the Department of Family and Community Services for being with us this morning and for the comprehensiveness of your submission. As I said earlier to the ADCA people, we are at the beginning of our inquiry so, no doubt, we will be drawing on your experiences and knowledge again.

[10.28 a.m.]

BUSH, Mr William, Vice-President, Families and Friends for Drug Law Reform

McCONNELL, Mr Brian Peter, President, Families and Friends for Drug Law Reform

McCONNELL, Mrs Marion Josephine, Member, Families and Friends for Drug Law Reform

CHAIR—I welcome you all to the hearing today. You understand that these are formal proceedings of the parliament; this is a public hearing which Hansard is recording. I invite you to make a brief opening statement.

Mr McConnell—We have a brief statement and a number of additional papers that we would like to present to the committee. Families and Friends for Drug Law Reform is vitally concerned in this matter, especially in respect of illicit drugs. Drug laws and their implementation are life and death issues for users and strike at the integrity of families and, indeed, the integrity of the whole community. Because many of our members have suffered so much from drugs, we have no love for them. Our greatest wish is that the community could be rid of them. However, we believe that there is no hope of rolling back the extent of drug use until we undermine the enormous profits that criminals make from their distribution.

Access Economics, for example, has estimated that the street price of heroin is more than 3,000 times the farm gate price of opium. Indeed, the enormous profit is one of the major drivers in the drug issue. We have made a recommendation, No. 19, in respect of investigating the economics of this issue. In the meantime, it is essential that the laws, which are designed to protect the community, reduce rather than increase the suffering and death.

The group does not promote one extreme model over the other—that is, absolute prohibition versus unconditional liberalisation. I would like to provide this diagram to the committee to illustrate our view on the issue. Along the bottom axis we show one extreme or the other—that is, unconditional liberalisation on one side and absolute prohibition on the other. We believe that there is an optimum position in this matter, but one that we have not yet attained. Indeed, while ever we allow lives to be sacrificed to ensure that we do not send the wrong message, we are a long way from the optimum. In finding that optimum point we cannot emphasise too strongly the importance of evidence to shape those drug policies—drug policies with clear and achievable objectives such as those that come from the National Drug Strategic Framework 1998-2003. But these objectives need to be evaluated to ensure that they are being achieved, and this is something, to our knowledge, that has never been done.

Your committee, Mr Chairman, has before you an array of conflicting assertions about the relative harm of illicit and legal drugs and the effectiveness of various measures. This conflict, unfortunately, has dogged drug policy for years. Just as you would not prescribe what should be done to prevent another Concorde crash without expert advice, you must look to expert advice when it comes to drugs as well. To be guided by half-truths, fears and prejudice is really a

recipe for disaster. The evidence is that present government policies—and I am talking of all governments—have not protected the community by stopping the drugs from getting to our young people in the cities or in the country areas. The present legal regime disempowers families and alienates young people; treatment options are denied; and, fundamentally, addiction and problematic drug use continues to be treated as a law and order issue and not a health one.

I present a review that we undertook of the current Tough on Drugs strategy in August 1999. Even though it is 12 months out of date, little has changed. Few drug barons have been caught, drug use is increasing and thus our children have not been protected. Deaths have continued to rise and critical lifesaving research is not allowed to proceed. In the three years since the veto of the heroin trial, for example, we estimate that at least 2,000 people have died from opiate overdose.

Laws, or their application, constrain what families can do for drug using members or, indeed, limit the knowledge that is necessary. This puts families in an impossible position. We are now told that families and local communities are to take greater responsibility for the problems of drugs with our youth. If the law stands in the way and legislators, through lack of courage or neglect, do not rectify the situation, then, really, who is responsible?

We have one additional recommendation to make to the committee. I would like Marion to briefly talk to that issue.

Mrs McConnell—I would like to present a couple of personal stories which I think illustrate the point that many of our present policies are making the problem of illicit drug use in families much worse. We need to treat problematic drug use as a health issue. The first story that I will tell you is my own story. The first I knew that my son was using heroin was that early one morning we had a knock on our door. It was a friend of our son who had awoken us. He took us down to a nearby oval, where we discovered our son was unconscious. My daughter phoned the ambulance. The ambulance arrived, revived him on Narcan, and told us then that he overdosed on heroin. That was the first that my family knew that our son was using heroin.

The ambulance took him to hospital. Unfortunately, the police had also arrived on the scene and they followed the ambulance to the hospital. We were not allowed into his room but the police were allowed to go in to interrogate him. There were at least four policemen that did this. He was afraid of the police and he discharged himself. He took an unplanned holiday. He overdosed again on that holiday and this time he was alone; he had no-one to call an ambulance. He died alone at the age of 24.

My family do not blame the police. The police were doing their job. They were doing what the laws told them to do: they were treating my son as a criminal. However, if his problem had been treated as a health problem, as we believe it was, and there had been no police interference, our son might have accepted treatment and we would have been given more time to work through his problems with him. At least I believe we should have been given that opportunity.

Another story: Gary, a father living on the Central Coast, after years of trying to help his daughter Sunny with her drug problem, finally got her into a rehabilitation centre in Sydney. She was insulin dependent as well as dependent on heroin. He phoned the centre almost every day to inquire of his daughter's progress and was told each time that she was doing well. About a month after his daughter's admission to the centre, Gary was visited by two police officers, who informed him of his daughter's death. Sunny had been evicted from the centre the day before for disobeying a rule. The father had not been notified of her discharge. Indeed, two years later, he has still not had satisfactory answers as to why she had been evicted. He would have gladly collected her, taken her home and kept her as safe as possible. Instead, Sunny was upset and very distressed at being discharged. She used heroin again, she overdosed and died. Sunny was 28.

I have to ask these questions: in whose best interest was it to discharge her? Why was the father not notified? Surely, members of the committee, you can see that it would not be too difficult to have a better outcome in this instance. And, might I add, these instances are not uncommon.

Our present policies are confusing health issues with law and order issues. Even rehabilitation centres use a punitive approach in treating what is a very serious health problem, disrupting families and causing great tragedy. We urgently need to separate the health issues from the criminal issues surrounding illegal drugs.

Mr McConnell—This goes to the point of our further recommendation which we have given you. It really goes to the point of the debate about drug treatment and interventions. There is a lot of controversy about that. We say that in other areas of health issues this sort of intervention would not be tolerated. Addiction is a chronic relapsing disorder and needs to be recognised as such.

What we are proposing here is a clear, arms-length separation of the health aspect of problematic drug use from the political and the policing arena. We have got a list of five suggested functions for the authority and the composition of the authority. The composition we feel is very important. It should be composed of those qualified in disciplines relevant to health, including public health, and they should enjoy the highest professional reputations within their fields. Thank you, Mr Chairman. We will take questions.

CHAIR—Thank you both very much for that. Can I come to the issue of the authority? It is quite explicit. Can I just be clear that recommendation 20 is an additional recommendation?

Mr McConnell—Yes. We had 19 in our original submission and this is an additional one.

CHAIR—You would see that authority with all the professional strengths that are needed to make that decision separate from any other issue than the health issue and that separates out the legal and the policing and all those other issues. Is that correct?

Mr McConnell—Yes. We would see this authority concentrating solely on treatment and public health issues.

CHAIR—There are practical jurisdictional things but would you see that as a state responsibility or national? Have you thought about how that might work?

Mr McConnell—In a sense it would have to be a national type authority. It would have to involve the states because the states implement many of the health issues that we are talking about. In a sense it would have to have agreement from the states, and preferably those sorts of agreements before it was set up so that there is commitment to it from all of the states. Again, we would see it as being arms-length from the political and the policing process. There are a number of examples where those processes have interfered with possible health measures. A photograph of a young boy in Redfern almost undid the needle exchange program. It was the political process involved in that that almost did that. Fortunately, it did not happen but it could well have.

Mr Bush—It is important that this committee and parliaments are conscious of setting the parameters within which such an expert group operates. You need to look very closely at the objectives that this country has to have set out in relation to drugs. There is no unanimity on this, even on the basic question of death. We had a member of the Legislative Assembly here in the ACT asked about the possible deaths that would occur as a result of the delay of injecting rooms being established here. He was asked if he was concerned about it. He said, 'No, I am not.' There are other instances, and you can read letters to many papers which give no value, or very little value, to the life of drug users. So even on that basic question of life there is not unanimity of view. People put becoming drug free in front of human life. This is one thing where you, the committee, have to come out and be very clear in your own minds.

Mr QUICK—As you read these submissions, you read more and more acronyms. I am discovering them day after day. In the next group's submission we hear of the National Advisory Committee on School Drug Education and the Ministerial Council on Drug Strategy. Are we going to set up another quango? In my mind—I am playing devil's advocate here—all these need funding. We know what the problem is: there are no resources, as Mr Schultz said. Parents come to us and we have got these acronyms all over the place. We have got some experts, and I pay them due credit for their expertise. But why should we set up another one? We know what the problem is: it is lack of money and it is lack of availability. I am sure you were here when the last group spoke about being able to provide long-term support on demand, keeping the lines of communication open with parents and adequately resourcing the people who are out there on the ground facing the problem. Why set up another one?

Mr McConnell—You have covered a number of points in your question. On the question about funding, our view is that the funding allocation is wrong. There is far too much funding channelled into the law and order issue, when the effectiveness of that is questionable. Some of that funding should be redirected. We know, for example, from research that is done overseas by the Rand Corporation, that providing funding for treatment options is far more effective—something like seven times more effective—than law enforcement in terms of reducing drug use, yet we are still putting money into the law enforcement issue. It is a knee-jerk reaction and we do not evaluate the law enforcement issue. We do not see whether they are actually stopping the drugs from coming into the country, or even reducing them.

Mr Bush—If I may add to that, you could well ask the Attorney-General's Department on this.

Mr QUICK—I have got a whole heap of questions for them too.

Mr Bush—Their submission virtually says that the amount of money that is put into drug law enforcement does not really matter. Their submission, at page 2187 of volume 9, says:

Although the earlier studies indicate that illicit drug law enforcement generally attracts more expenditure than illicit drug health programs, relative expenditure by governments on health and law enforcement is not the central issue …

As Brian McConnell said, the Rand Corporation study has not mentioned that. It has found that:

The extent to which supply-control measures are more expensive, however, does vary depending on the evaluation of measures chosen. Domestic enforcement costs four times as much as treatment for a given amount of user reduction, seven times as much for consumption reduction and 15 times as much for societal cost reduction.

Mr McConnell—One of the other points in your question was whether we are setting up another quango or not. The answer is probably yes, but I think we need to look at the ones that are there and see if they are effective. Again we get to the point of the evidence that is there and the evaluation. Organisations need to be effective or they should really go out of existence.

We see a gap in what is provided in treatment services. We see that all of the possible interventions are not necessarily available or not necessarily identified and the extent of them known. We see a need for standards for treatment centres. Recently we saw that a young girl died in one of the clinics in Sydney that were doing ultra-rapid detox; that clinic is now closed. There are no standards that we are aware of that establish these. Organisations or service providers such as this really need to be accredited, so that we know that we are providing the best possible service and not just some fly-by-night organisation.

Mr QUICK—The DETYA people mentioned the *National Framework for Protocols for Managing Possession, Use and/or Distribution of Illicit and other Unsanctioned Drugs in Schools*. Are you aware of those protocols, and what do you think of them?

Mr McConnell—We had some input into the draft of the framework that was put forward. We have some real concerns about the way that it is put in terms of zero tolerance for illicit drugs in schools. It says very little about the individual student and how the student might be dealt with; it says very little about the counselling or treatment or other sorts of options that are there. Marion might want to say something.

Mrs McConnell—We did have some input. It is a while since I have read that document but, as I remember, there was very little said about how we could help individual students who may be in trouble with illicit drugs. What they say is 'no illicit drugs in schools', which is a very comforting statement and one that all parents want to hear, but what our group feels is that if there are students who are in trouble with illicit drugs they need to be helped. The best place that children can be is in the school environment. If you put them out of the school environment—and I think there has been research done on this—they are likely to get into more trouble. What we really need to be trying to do is to keep them in that environment and give

them as much help and support in a health manner that we can. So while I see 'no illicit drugs in schools' being a statement that most people want to hear, it is not really addressing some of the realities on the personal side of problem drug use.

Mr McConnell—If you followed 'no illicit drugs in schools' to its logical conclusion, it would mean expulsion of students. If you look at the statistics, somewhere over 50 per cent of our school age students have used marijuana, which is an illicit drug. What are you going to do—expel some 50 per cent of school age students? I do not think it is practical.

Ms HALL—What you are arguing here is for a whole new approach to the problem of drug addiction; for us as a community to move away from the approach that we have at the moment to treating it purely as a health problem and for our responses to change to being responses to a major health problem in our community.

Mr McConnell—Yes, absolutely correct—shift from treating problematic drug use and drug addition as a law and order issue, a punitive type issue, to treating it as a health issue and a health problem.

Mr Bush—That does not mean that the law does not have a role in that new model, it clearly will, but at the moment it is still the dominant element. It needs to be subservient to a health model and it is not that at the moment.

Ms HALL—What role would you see for law enforcement in the model?

Mr Bush—One of the aspects that your committee is considering is the licit drugs and the doctor shopping that goes on with that. Our law has a role in that. That would well be the sort of model that you might consider extending. There are criminal elements behind that, but basically you have law subservient to the regulation of the supply of, in that case, medically prescribed substances.

Ms HALL—Thank you. Would you like to add to that, Brian or Marion?

Mrs McConnell—You are asking whether the law takes a place there?

Ms HALL—Yes, what is the role of law enforcement in your model?

Mrs McConnell—In our recommendation 20—

Ms HALL—Yes, I have read that.

Mrs McConnell—Some people in our community see what we do in relation to illicit drugs as also reducing crime and corruption. So maybe part of this would be to show how, through dealing with this as a health issue, we could actually reduce crime and corruption. I do not know if that is quite what you were expecting, but I see that that may be part of reducing the problems of law enforcement.

Mr McConnell—This has been the experience of the Swiss. When they had their heroin injecting trial, they found that there was a reduction in crime associated with that. And it was quite a significant reduction; better than a 50 per cent reduction in crime. In some cases it was up to a 90 per cent reduction in crime. There would need to be some cooperation between the two bodies.

Ms HALL—So you are saying, 'Get the treatment right, get the community approach right, and then the need for law enforcement won't be as great'?

Mr McConnell—If I can give you a quick and simple example: the drug distribution process is really a pyramid selling type process where a person who is addicted to drugs is more often than not a person who is dealing in drugs. They may well deal to 10 other people and they are looking for new markets so they can take some proportion of the drugs that they are selling and keep that for themselves. If you put that person into treatment, you have effectively taken a dealer off the street.

Mr SCHULTZ—Just getting back to the comments made in your submission about more funding being dedicated to treatment and less to law enforcement—and I think you have answered this to some extent—does your organisation feel that there is any legitimate role for law enforcement in minimising the social and economic costs of drug abuse? It is painfully obvious to me—and I have had an interest in drug problems in the community for over 14 years—that we have been very successful in terms of the government building up a very large industry; an insatiable industry that devours between two-thirds and three-quarters of the funding that comes from the taxpayer and that delivers very little, if any, outcome to the people that the dollars are supposedly put into the system to assist. What are your feelings about the responsibility of government to audit the dollar that they are delivering on behalf of the taxpayer so that it is in fact delivering more of the dollar to the people that need to receive it to assist them in their addiction?

Mr McConnell—One of the issues that we talk about in our submission is the need for evidence and evaluation. There are two areas in the particular field of illicit drugs that are really not evaluated properly. One is the law and order side of things and the other one is education. The law and order side of things really needs to be evaluated. The objectives need to be clear as to what they are trying to do and they need to be evaluated. We need to make sure that we have got value for money from that issue. Law and order has a role, as Bill said, in the regulation of drugs that may be available, whether they are licit or illicit. Also, police are on the streets or are called to various homes and see some of the social disruption that goes on there and so on. So the police have a role in that respect in that they are the front-line and there may be opportunities for the police at that point to identify the issues and then channel them to the health areas.

Mr SCHULTZ—Don't you also feel that both the police and Customs have an obligation to this community as a whole to ensure that the influx of drugs to this country is slowed down, stemmed or stopped as expediently and as quickly as possible? Don't you also agree that for them to be able to do that they indeed need more money than they have now to carry out that function?

Mr McConnell—It is a question of how much money and what sort of state or country you would like to live in. The evidence, not only from Australia but from overseas countries, is that it is virtually impossible to stop the drugs from coming into the country. We saw an example on the North Coast—I think it was last year or maybe the year before—of 400 kilograms being seized off Port Macquarie. A couple of weeks later, the Police Commissioner stated at a conference that this seizure of 400 kilograms of heroin had made absolutely no difference to the availability or to the street price of heroin.

Mr Bush—In 1970 the estimate of the amount of illicit drugs in America that were interdicted was 10 per cent. That same figure was estimated by the New South Wales police force about four or five years ago. It is estimated, as a result of that big north coast haul, the percentage might have gone up to 15 per cent. But, essentially, we are not looking at any increase—in spite of, in the United States case, billions and billions of dollars of expenditure on law enforcement.

Mr SCHULTZ—I am not interested in what is happening in the United States. I am interested, as a federal member of parliament, in what is happening in this country and what we need to do to assist all of the young people and other people who are, unfortunately, victims of what is occurring in the country. There appears to be, from your point of view, a focus on harm minimisation. I do not have any problems with that, to some extent. How can we, as politicians, possibly convince the community that harm minimisation is the right way to go? When I, as a New South Wales politician, see needles and syringes that were being exchanged in 1988 at the level of 1.2 million per annum now being distributed to the extent of 10.5 million per annum, how in the hell can we have our credibility endorsed in terms of harm minimisation? Those sorts of harm minimisation exercises not only have blown out of all proportion but have done so in an environment where the industry that it supports to distribute the needles has also exploded. That is the point that I was making earlier.

Mr McConnell—The needle exchange program is a public health measure to reduce the transmission of blood borne viruses. To that extent, it has been very successful. The evidence from comparisons to overseas countries where they have not had needle exchange programs is quite compelling for Australia.

Mr SCHULTZ—Does that include hep C as well?

Mr Bush—I think you should look at a recent study that was published by M. MacDonald and a number of other authors in the *Medical Journal of Australia* which surveyed hep C in needle exchanges. People went to needle exchanges over a period of about three years and there was, in that survey, a reduction from something like 65 per cent of those who attended to something like 50. Do not quote me exactly on those figures, but there was a reduction. That, at least, is optimistic. On the question of needle exchanges, I refer you to a very good account on pages 2023 and 2025 of the department of health submission which you will be considering later on.

Mr ANDREWS—Can I just clarify a couple of things. In your submission under recommendation 20 you state:

This authority ... should be independent and technically qualified and would prescribe and administer appropriate standards for provision of treatment and services for drug and alcohol matters.

By that, do you envisage that this proposed authority would determine what types of treatment would be appropriate to be provided?

Mr McConnell—Yes, in broad terms; not in individual cases. We would not see this authority as being involved in individual cases but it might, for example, have access to some research that might have just been completed. They might say, 'This is a good treatment,' or 'This is a treatment that could be applied in these special circumstances.'

Mr ANDREWS—Would this authority be totally independent and be able to determine what treatments could be provided?

Mr McConnell—Yes.

Mr ANDREWS—Would that include treatments which are not provided currently because they are illegal?

Mr Bush—If you are referring to things like heroin prescription and needle exchanges, yes—if the evidence was to that effect. This is the radical aspect of that; it puts these hard decisions outside the political agenda and within a framework, as I said, of objectives which have to be set by the legislatures of this country.

Mr ANDREWS—Isn't that passing the buck, Mr Bush? You have parliaments at the state, territory and Commonwealth level around the nation with elected members—in this case, senators—of those parliaments there to respond to communities' views about it. You say:

While health measures remain political footballs we can be certain of only one thing: that the problem will get worse and worse.

It seems to me that what you are really saying is that the outcome that democratically elected parliaments around the country have provided to date is not to your liking.

Mr Bush—Let us come back to the Concorde example. Would you refer to members of parliament around this country and to the constituents the recipe for fixing up the Concorde?

Mr ANDREWS—In that case, if I can take your analogy, what you have is an expert committee, no doubt, or an expert group charged with the responsibility of determining what the cause is. Nonetheless, the overall regulations and the parameters within which the venture is carried forward will no doubt be decided by democratically elected parliaments.

Mr Bush—It is because drug problems are getting worse and worse while there is a large degree of consensus among experts—we are not experts—on things that work. Things that work are not being put into practice because of the high degree of emotion that surrounds them, the high degree of communal concern. We are suggesting this as a means of short-circuiting that. We are not suggesting that this is not going to require political courage, but can you think of any better way of getting an evidence based mechanism up? And evidence based—again, referring

to the objectives that you need to set—would be ones that the community would be wanting to achieve.

Mr ANDREWS—What I am suggesting to you is that those parameters, if you like, are established by the community. We have no lack, as Mr Quick has pointed out, of expert committees and advisers providing evidence, providing what they see as outcomes. I have to say—and we all know this—that, if there was uniformity about the evidence being provided, then this committee probably would not be sitting here. But there is not uniformity about that. This is a subject about which there are great differences of opinion, even amongst experts; even amongst the way in which outcomes are interpreted. So, to say that we should just establish some set of criteria without continuing community input into that through the democratic process, to me, seems like saying—and if I can be blunt about it—'We don't like some of the outcomes at the present time, so we'll find another forum by which we can achieve those outcomes.' I think I understand the answer, but can I clarify one thing. I think I understand the thrust of what you are saying, but—

Mr Bush—You have raised the really crucial question of the point of evidence. If you look at the drug debate, you will find the question of evidence itself becomes a political football. It is very hard to get absolute proof in relation to any intervention. If there is no proof, then those who are opposed to the intervention will say, 'Look, there is no proof; therefore, we shouldn't go into it,' even though there might be quite a bit of evidence in favour of it. I would submit that the reaction to the heroin trial—in looking at what happened in Switzerland—was a prime example of that. The Swiss heroin trial did not prove that heroin maintenance worked but, by jeez, it increased the evidence no end that it would work. So, that is one thing. The other thing is that people say, 'There is inadequate evidence; therefore, we can't do anything until we get proof.' So it becomes a recipe for inaction.

Mr ANDREWS—There is one further matter that, in a sense, relates to this and which I want to clarify. On page 5, in the first paragraph, you say:

> On balance compulsory treatments provide no greater results than non-compulsory treatments. In Sweden where compulsory diversion to treatment is standard practice there is no greater abstinence rates.

I would be interested in the source of that. I say that only because some weeks ago a Swedish politician, who I think was a member of the European parliament, was saying something to the contrary. In a sense, it illustrates your point, Mr Bush, as to what we are to believe. Here we have an assertion one way; I have heard an assertion the other way. We need more than a little bit of evidence one way or the other if we are to go down a certain track.

Mr Bush—The authority for that is a book by van Solinge of which we can provide the committee a reference. But I would also add that there are a lot of extra statistics that are included in the department of health submission in relation to relative drug use in countries. They, indeed, do show that Sweden has one of the lower rates, but there are other countries. One of the questions that I think you will have to consider is whether or not the social conditions that operate in Sweden are the sort of social conditions that make their policy reasonably successful. It is a matter of whether or not a policy that is subvented by a lot of money, a huge amount of money, is adaptable to Australian conditions—where it would seem to me that the conditions far more approach those in the United States than Sweden.

CHAIR—Thank you very much. I think it is a very good fleshing out of the issues and I appreciate that you have done that.

Ms JULIE BISHOP—I want to raise the issue of educational interventions. You raise drug education in two contexts: in relation to police drug education—which you suggest is a misdirection and an ineffective use of police resources—and again in the context of, I take it, more school drug education, where you say that education programs are rarely evaluated and are presently of limited effectiveness. Overall, you speak of drug education as being delivered as part of an integrated syllabus of education. Do you support the concept of targeted educational programs that could work to minimise drug related harms? Could you just comment on your position in relation to educational interventions generally?

Mr McConnell—The research shows that the education programs generally are not very successful—something like 0.14 per cent are successful. That is not to say that education programs should not be undertaken. We get to the point of using objective evidence to measure it. For example, if the education program is intended to reduce or delay the uptake of drug use, then these are measures that should be tried from the education programs. There have been some education programs—one here in Australia, back in the late 1980s, by Jeffrey Wragg was a specific trial on cannabis and that was successful, but it was not taken up because it was a longer term and probably more expensive program. Marion, you have got some other things to say about education.

Mrs McConnell—What we know is that it has been shown that education does not work at present, that it is not effective. However, education is very important and we do need to look for programs that are shown to make a difference. Geoff Munro from the ADF in Victoria says that we have to be very careful about what our objectives are, what we want to obtain from drug education. He sees schools as educators. They can be educating about drugs, but it is a systems approach where we need the whole community involved if we are going to reduce drug usage by young people—it cannot be just something that we expect the schools to be able to do. He sees it as an all-encompassing thing. Schools are very important, but the objective, what we expect to get out of drug education, is an important thing.

CHAIR—Thank you very much.

Mr McConnell—Concerning policing, the point there is that people providing education in schools should be qualified to provide that education. It is seems to me a knee-jerk reaction to say, 'Oh, the police know about illicit drugs and they should teach about illicit drugs,' rather than properly qualified people. It may well be that police can be educated to provide that, but I would think it is probably better in a broader context, a life skills type context.

CHAIR—Thank you very much, but we are running out of time.

Ms ELLIS—This is an excellent submission and I feel that the witnesses should be congratulated. Can we get the Families and Friends for Drug Law Reform people back at a later date?

CHAIR—I think that is the fairest way.

Mr McConnell—Can I just cover something for the record, just for *Hansard*. There is a submission by Geraldine Mullins containing a reference to me and Families and Friends in there. I would just like to correct the record. It is on page 1134 and it is talking about me and Tony Trimmingham. It says, 'Both these two fathers are main players in Families and Friends for Drug Law Reform and seem to think that if their sons had gone to a shooting gallery or had gone to a heroin clinic they would be still alive.' Just for the record, Tony Trimmingham is not a main player in Families and Friends for Drug Law Reform; he is a main player in family drug support. On a personal side, in any of the presentations we have made we have never made a claim that our son, if there had been a shooting gallery—and we never use the term 'shooting gallery' anyway—would be alive today.

CHAIR—Thank you very much for your evidence. Before you go, and in reference to those three documents, is it the wish of the committee that the documents entitled 'Tough on Drugs Report Card as at 19 August 1999', 'Relationship between Laws and Harms', and 'Recommendation 20', be incorporated in the transcript of evidence? There being no objection, it is so ordered.

The documents read as follows—

[11.21 a.m.]

JOHNSTON, Ms Mary, Assistant Secretary, Quality Schooling Branch, Schools Division, Department of Education, Training and Youth Affairs

CHAIR—Welcome to this hearing. I am sure you would like to make a brief opening statement.

Ms Johnston—Thank you, Mr Chair. I would like to make a very brief statement, given the time. My understanding is that the Department of Health and Aged Care is providing evidence on the overall Commonwealth initiatives on drugs. The focus of the submission from DETYA is on the Commonwealth initiatives for which DETYA is responsible, in school drug education and the management of drug issues in schools.

The government's initiatives in this area focus on the provision of school drug education and a safe environment for young people, and on addressing parents' concerns about the impact of drugs on their families. The focus of these initiatives is on both illicit and unsanctioned drugs.

The government acknowledges that drug use affects not only physical and emotional health of young people but also their chances of engaging in education and achieving their full potential. In working in the schools area, we recognise that schools must work in partnership with others in the wider community. They must work with doctors, health workers and law enforcement officers and, most importantly, with parents. Parents will often turn to teachers if there are problems with drugs. The Commonwealth recognises that the states and territories and schools themselves have the primary responsibility for curriculum and school management. For that reason, the Commonwealth works collaboratively with all school systems.

The government has provided a total of $27 million for initiatives under the National School Drug Education Strategy and under the COAG initiative, Tough on Drugs in Schools. The National School Drug Education Strategy was developed collaboratively across the government and non-government school sectors. It has the goal which was mentioned earlier: no illicit drugs in schools. It is based on a belief that illicit and other unsanctioned drug use in schools is unacceptable. The drug strategy focuses on educational outcomes for young people and provides funding for school systems to address their specific needs—including, importantly, things like professional development for teachers, to ensure teachers are qualified in this area. It also provides some funding for national strategic initiatives.

The COAG initiatives, also mentioned previously, the national framework for the management of drug issues in schools, is a more recent publication. I suspect that perhaps the previous witnesses were a little confused about the two documents. The first that I referred to, the *National School Drug Education Strategy*, has the goal of no illicit drugs in schools. The national framework, which I think the question was based on, is about managing possession, use and distribution of illicit and unsanctioned drugs, and it does address issues about individual young people and how the issues should be addressed for them.

There are other projects under the Tough on Drugs in Schools initiative. We have conducted a satellite broadcast targeted at teachers and doctors to promote a partnership approach to drug

education and drug issues management within schools and local communities. The Commonwealth will be providing funding for local school community summits to bring together school staff, parents and key community members to encourage stronger, broader and more integrated community engagement and support in addressing illicit and unsanctioned drug use by young people. We will also be providing support materials including professional development materials for teachers and a web site to share experience in this important area.

Finally, as has already been mentioned, we are advised by a National Advisory Committee on School Drug Education which has a wide variety of members with expertise from the education and the health area. We also work closely with the Department of Health and Aged Care and other Commonwealth departments and the state and territory governments and we work with other organisations such as the Australian National Council on Drugs and the Intergovernmental Committee on Drugs of which DETYA is a member, and I represent DETYA on that committee.

Mr ANDREWS—In the submission on page 7 you talk about the review and evaluation of the strategy. Can you just elucidate what that review and evaluation will involve and the criteria, if they are in place, for measuring the success or otherwise of the strategy?

Ms Johnston—In the strategy, of which I have copies for the committee, there are a number of objectives. In developing that strategy we identified at the very beginning some outcomes for each of those objectives and some performance indicators. We will be monitoring and conducting review on an ongoing basis throughout this strategy. We have built into our contracts and agreements with the states and territories an evaluation of their individual efforts on school drug education.

Mr ANDREWS—Can you just point out to me where these performance indicators are?

Ms Johnston—Page 9, section 3—objectives, outcomes and performance indicators.

Ms JULIE BISHOP—I was just quickly looking at the strategy and at page 5, discussion of the development of a national protocol for better ways of handling drug use in the school community. What is the status of the development of that national protocol? In particular could you just comment on a concern that I have as to procedural fairness in the management of drug related incidents at schools. I am particularly concerned about where schools, in fact, expel young people for their involvement in a drug related incident.

Ms Johnston—The status of this document, the national framework—which looks similar in colours but is actually a different document, which is available for you—is that it was released in June this year. It is currently being disseminated to all schools in Australia, and it will be a national framework for protocols to be developed at the school level. It does address the issue of support for students who are or have been involved in drug related incidents. When you get the document, it is under the heading ‘intervention’ on pages 8 and 9.

Ms JULIE BISHOP—Yes.

Ms Johnston—Page 8 mentions ‘action plans for early intervention for students at risk’. On page 9, at the bottom of the page, it talks about ‘support for students involved in drug related

incidents'. There is a specific reference there that it should include 'students who have been suspended, expelled or excluded'. It goes on to say that it should maintain their engagement in education, including facilitating reintegration into the school or integration into a new school or training program.

Ms JULIE BISHOP—So this assumes that schools will still be expelling students for their involvement in drug related incidents?

Ms Johnston—The matter of expulsion is a matter for the school management, state school systems and so on. The Commonwealth cannot support a view one way or the other.

Ms JULIE BISHOP—So there is nothing in your protocol that would go to that particular issue?

Ms Johnston—Every effort has been made to encourage the continued engagement of young people in school.

Mr SCHULTZ—The goal of the National School Drug Education Strategy is 'no illicit drugs in schools'. Is that goal realistic and achievable? If so, can you explain to me why?

Ms Johnston—I believe it is important to have a goal that is very meaningful to people. I believe that there are many schools which would have reached that goal or would be very close to it. I do not believe that it is an impossible goal. I think it is something that we should be aiming for.

Mr SCHULTZ—It is nice to hear some positive thoughts.

Mr QUICK—On page 8 of the national framework, under 'intervention', it states:

Despite the best prevention approaches of schools, parents and the community, some students will use illicit and other unsanctioned drugs.

My experience is that 'some' should be 'many'. A little further on it says:

Outlined below are the key elements that a school would have in place to effectively respond to the possession, use and/or distribution of illicit and other unsanctioned drugs by students ...

'Would', 'should', 'will'?' It all sounds really nice. Further on it says:

Protocols for liaison and referral are established with relevant professionals and agencies to provide:

- professional development for school staff;
- advice and resources for school staff, parents and students;
- medical assessment; and
- in particular, counselling and rehabilitation services for students involved with illicit and other unsanctioned drugs.

When are these things going to happen? Are we going to have pilot programs? Are we going to spend millions of dollars trialing these things? Is this going to be a standard thing for each high school in Australia?

Ms Johnston—There is a significant amount of work going on under the National School Drug Education Strategy to ensure that professional development is available for school staff. Many states and territories already have in place initiatives, such as the Turning the Tide initiative in Victoria, to provide that sort of support and resources for staff. We will be developing a range of other resources that will be available for school staff.

Mr QUICK—So when do you imagine that all states will have these intervention frameworks and protocols up and running—by 2001, 2002, 2003?

Ms Johnston—Many schools already have protocols in place, and over the next two or three years all schools would be expected to have a local summit at which they would talk with their own communities about what protocols they have in place.

Ms HALL—With the education of the teachers—the training and qualification of the teachers—that is going to be involved in the programs that you have identified, is there any specific course? Have you got accreditations? Are there guidelines for choosing those teachers or will it be across the board and just a generalist approach where there is in-service training for all teachers? Is it envisaged that there will be specialised teachers within all schools or specialised welfare officers that will be involved in the program?

Ms Johnston—There will be a variety of responses. There is certainly in the strategy an emphasis on this being a whole school approach and not one teacher or one counsellor and so on involved. It is quite clearly stated that in good practice drug education should be delivered by the teachers. It should be integrated into the curriculum, particularly into the health and physical education curriculum, and it should be developed sequentially over a period of time. That is perhaps a new task for some teachers. There are a lot of initiatives going on in the states and territories and in the non-government sector to train teachers and to provide them with the support for this. For example, in Queensland under our funding there will be a strong emphasis on the professional development of both teachers and principals and they will be developing resources to assist that—and I can give you examples from the other states and territories. Each state and territory is at a somewhat different stage and has somewhat different approaches to drug education and we are trying to work together with them.

Ms HALL—What are the key elements in the training for teachers? What do you believe are the essential elements that teachers should have in their training to be able to deliver on your responses?

Ms Johnston—I am not a qualified trainer of teachers. I could go through and give you some of the indications from the school drug education strategy of what is needed, but I think I have already outlined them—that it should be part of a health and physical education curriculum.

Ms HALL—The other question goes to the identification of students who have problems. Which one is that area in?

Ms Johnston—I was checking it while you were talking, but if you would like to finish your question.

Ms HALL—Yes, it concerns the identification and strategies that are going to be suggested to be put in place within schools. As well as the identification of students with problems, I will throw into that the identification of students who are at risk, who may come from families where the parents are involved in drug abuse.

Ms Johnston—The section on intervention does not specifically mention identification of students at risk.

Ms HALL—I know; I noticed that.

Ms Johnston—I think that is something that would be an issue in some schools, but I am sorry, I—

Ms HALL—Maybe you could supply some more information at a later time. It is not about putting you on on the spot; it is about getting the info.

Ms Johnston—Yes, thank you.

CHAIR—Let us take it on notice please.

Dr NELSON—Firstly, I congratulate the government and applaud the department on this initiative. I must say, though, that I do not think there is anybody on this committee who would not support education. Do you consider that $18 million over four years is sufficient funding to achieve what I consider to be laudable objectives?

Ms Johnston—It is a total of $27 million over four years, including the COAG initiatives. However, that cannot be seen in isolation. There is a lot of work going on within the states and territories, which are ultimately responsible for school education.

Dr NELSON—So you think that the $27 million—$18 million for the National School Drug Education Strategy—is adequate to equip young people for life in terms of drug education?

Ms Johnston—I am sure we could all do more with more funds. I point out that that is only part of the funding that is available for this.

Dr NELSON—In terms of the age at which drug education commences in school—and I understand and accept the fact that it has to be an integrated part of a broader health education strategy—is there an age at which drug education generally starts? Is that uniformly applied, both across the country and within state jurisdictions?

Ms Johnston—No. I believe that would be a policy which would be up to states and territories and schools to determine. However, there are certainly approaches that start dealing with some areas such as the use of tobacco at, say, years 3 and 4. One of the things one can do at an even earlier age than that is to talk to young people about healthy lifestyles in general

terms without necessarily drawing attention to the drug issue. In many cases now there are materials being prepared for students right throughout the school but it is in a sequential and targeted manner.

Dr NELSON—For example, my electorate is on the upper North Shore of Sydney. We have a drug problem, as we do everywhere in Australia. Does drug education begin at the same age in schools in my electorate as it might, for example, in the electorate of my colleague, who represents the outer western suburbs of Sydney?

Ms Johnston—I cannot answer when drug education starts in any particular schools, or even in any particular state or territory.

Dr NELSON—I am surprised that you are not able to answer that. To what extent does the education strategy involve parents?

Ms Johnston—The education strategy does very much involve parents. We have had parents on our advisory committee. A number of the projects we are undertaking both under the strategic initiatives and under the state and territory initiatives work not only with parents but with other members of the community.

Dr NELSON—I appreciate that—but on the ground floor level. In one of my high schools I have 1,200 parents. Fifty parents turn up for P&C. Interest in what is going on in the school is a minority position. So to what extent does the drug education strategy in the schools actively engage parents, apart from having parental representation on the development of the strategy?

Ms Johnston—I have mentioned before the local school drug summits which we will be funding. They are to encourage schools to get together with the whole school community, and particularly parents.

Dr NELSON—In New South Wales—I realise it is a state government initiative—parents are entitled to a $50 back-to-school payment, which is not means tested. Has any thought been given to some kind of incentive system to facilitate the participation of parents in drug and life skills education for their children which is appropriate to the age of those children? For example, we now talk in a contemporary sense about mutual commitment or mutual obligation, or whatever you like. Parents talk often—quite rightly—about their rights. Less often do we hear them talking about responsibilities. Is there a place for some sort of active program to involve parents in drug education and other things?

Ms Johnston—My colleague has just drawn attention to a pamphlet which I was going to provide you with, which is going out to schools starting today and which is to be distributed to all the parents of school children in Australia. It is information for parents on the National School Drug Education Strategy. There is a section on what we can do as parents.

CHAIR—Thank you very much.

Mrs IRWIN—In your submission you stated that the Council of Australian Governments agreed in April 1999 to strengthen its attack on drug pushers and its response to drug use within

schools through the development of enhanced protocols at a national level and associated supporting materials for management of drug issues and drug related incidents in schools. What were the reasons that you decided a stronger stance was required by the Council of Australian Governments?

Ms Johnston—I think that is a matter for the Council of Australian Governments to answer, not the Department of Education.

Mrs IRWIN—Well, you put that statement in your submission.

Ms Johnston—The council agreed to strengthen its attack. You are asking me why they decided to agree. I do not believe I can answer that question.

Mrs IRWIN—Fine. If we meet with them, I can ask them that question.

Mr QUICK—You mentioned the Commonwealth commitment of $27 million. What is the state commitment to this strategy?

Ms Johnston—The states each have their own programs. I do not have—

Mr QUICK—Off the top of your head—half, a quarter?

Ms Johnston—It varies considerably from state to state.

Mr QUICK—Roughly? Someone in the department must know how much the states are putting in, surely. Is it half, the same or double?

Ms Johnston—I understand in Victoria they put in $14 million for the Turning the Tide intiative.

Mr QUICK—Well, can we have that? How many students are there in Australian schools? What amount of money are we spending per capita?

CHAIR—Would you like to take that on notice?

Ms Johnston—Yes, we could take it on notice.

Mr QUICK—We are hearing later on that A-G's are saying that something in the vicinity of 84 per cent is being spent on law enforcement and some people think that is too much. I would also be interested in the drug summits you mention on page 6, where you say that phased implementation of local school-community drug summits is planned to commence in 2000 rolled out over four years. How many of those are planned and where are they planned? Who is deciding where and in what order?

Ms Johnston—The funding is available for all schools in Australia to participate in a local school drug summit. How those are organised will be a matter for schools and their local

community to determine, but there will be funding available for all schools to participate in that. The only state which has already undertaken similar summits is Western Australia and it will be undertaking some slightly different initiatives under this program.

Mr QUICK—How much will each school be allocated to hold a drug summit? Is it per capita, per school?

Ms Johnston—On average, it is $500 per school in Australia.

Mr QUICK—Is that realistic? You say on page 6 that:

The summits will bring the school staff, parents and key community members together to encourage stronger, broader and more integrated community engagement and support in addressing illicit and unsanctioned drug abuse by young people. These summits would also provide a vehicle to disseminate the National Framework for protocols for drugs in schools.

With respect, I think $500 is appalling.

CHAIR—That is a statement. You do not need to respond to that.

Ms Johnston—Thank you.

Mr ANDREWS—This is a question on notice. On page 2 of your submission you refer to the goal based on the belief that illicit and other unsanctioned drug use in schools is unacceptable. Then on page 9, paragraph 1.1.2, the *National School Drug Education Strategy* states the performance indicator to be:

The increased level of satisfaction in the school community, including parents, that quality policy and programmes are in place to ensure a school environment safe from potential drug harm.

What are the actual criteria by which that performance indicator is measured? Will the criteria be determined at a national level, a state level or in individual schools? Are there model criteria which the department is suggesting by which you measure that? Are there criteria also related to the overall goal that illicit and other unsanctioned drug use in schools is unacceptable? If it is not, what is the criterion for measuring that goal at the level of the individual school?

Ms Johnston—You suggested I take that on notice. I would just say that we have commissioned a national project to develop and refine the performance indicators and that will contribute to the overall evaluation of this program. The sort of issue that you raise about how some of those performance indicators will be measured will be taken up in that project.

Ms ELLIS—What did it cost to put together the pamphlets and the booklets you have just handed out?

Ms Johnston—I have to take that on notice.

Ms ELLIS—This one in particular: can you find out what the budget was for this pamphlet?

Ms Johnston—Yes, I can give you a rough figure.

Ms ELLIS—I would like a precise one regarding what they have cost.

Ms Johnston—Okay.

Ms ELLIS—How will the effectiveness of this be assessed?

Ms Johnston—I will take that on notice.

Ms ELLIS—My colleague wants to know whether they were printed in languages other than English.

Ms Johnston—We are looking at that issue.

Ms ELLIS—So it has not been done yet.

Ms Johnston—It has not been done yet but we are looking. It has been raised.

Ms ELLIS—Springvale in Melbourne is the Cabramatta of Victoria and a second, or equal, drug capital, with 155 languages spoken in the local primary school. I would suggest that English might be a bit inferior there. The pamphlet from the minister—and I am playing the devil's advocate to you here—says that it is telling parents where to go for information. I cannot see terribly much advice, at a very quick reading of the pamphlet, about where they do go for advice. I do not criticise this, but it gives a great run-down on what is being done and the federal government's perspective of the situation. It says on the bottom of one of the pages:

Ask your school if it plans to have a local summit. There is special money for it provided by the federal government.

That is one proactive thing that it suggests, but I cannot see terribly much else. I am terribly keen to get the information from you as to how the effectiveness of this is going to be judged, on what time line and what the aim is of this pamphlet. This is a really important document. It is a document that is going to go to every parent in every school—government and non-government, I take it—throughout the whole of the country. If that is the case, the value of this potentially cannot be overstated. Yet I am perturbed at this stage, until your answers satisfy me, that the value of this is going to be realised. I would like to know what the total budget for those summits is. You have said an average of $500 per school. I would like to know what the national budget is.

Ms Johnston—Six million dollars.

Ms ELLIS—Is there any compulsory or heavy suggestion that every school must participate? Can a school decide not to do this at all?

Ms Johnston—There is strong encouragement for all schools to participate.

Ms ELLIS—In what form?

Ms Johnston—Through the availability of funding. We will be providing a range of materials.

CHAIR—I think you said earlier, Ms Johnston, that this is a matter for the states. They have jurisdiction over these issues.

Ms Johnston—Yes.

CHAIR—In terms of jurisdictional issues, the Commonwealth does not have that power anyway.

Ms ELLIS—That is probably it, but can I just emphasise the importance of getting that information from you, because I think this is a very interesting piece of material.

Ms Johnston—This is one element of a broader campaign of the government. Other materials will be circulated.

Ms ELLIS—Are you indicating then that there are going to be further publications available for parents? What I am talking about here is the direct connection to parents of children in schools. Are you intimating that this is just a first of something to parents?

Ms Johnston—There are national campaigns on alcohol and tobacco. The illicit drugs one will be following later. I believe the Department of Health and Aged Care can talk about that.

Ms ELLIS—Can schools combine and do joint summits?

Ms Johnston—Yes.

CHAIR—Once again, I am sure the state governments have the final jurisdiction on those issues.

Dr NELSON—There are contradictory statements in this pamphlet. I do not know who put it together, but you need to pay a bit of attention to some of the content, I would suggest. It says:

Myth 1: Everybody's taking something.

Fact: Lots of students do drink or smoke. A lot experiment with cannabis, but only about 5 per cent ever try other illegal drugs—

Later on, in fact in the next panel, we are told that:

- Alcohol is by far the most commonly used drug. Eighty per cent of Year 10 students had used alcohol at least once—

Tobacco was second, at 40 per cent, and cannabis third, 35 per cent. In other words, in the second panel we are suggesting to parents, 'Look, it is not the problem you think it is.' If they do read to the third panel, then they are actually getting some factual information.

Mrs IRWIN—Earlier you said that these had gone to schools today.

Ms Johnston—They will be starting to be distributed, I believe.

Mrs IRWIN—That is state schools only?

Ms Johnston—No, all schools.

Dr NELSON—Who designed the pamphlet?

Ms Johnston—I believe it was done primarily in the department.

Mrs IRWIN—The principals will hand these to each student who will then take it home to the parents?

Ms Johnston—Principals have mechanisms for distributing, through their parents associations in some cases.

Mrs IRWIN—Can you take on notice when it will be in other languages? I have over 150 different nationalities in my electorate. While the children can read and speak English, the parents find it very difficult.

CHAIR—Thank you for that.

Mr EDWARDS—You would be aware that those promoting alcohol use and tobacco use tend to use some sort of vision or something which attracts young people to the type of lifestyle that goes hand in hand with these things. I wondered whether, instead of having the minister's message in there, you might have given some consideration to a role model, like one of our Olympians or someone like that, who might portray the same sort of message, or contrary, to kids?

Ms Johnston—I think there are some advantages in that sort of approach and there are also negatives in choosing any one particular person as a role model. What we have got in there is some advice to parents, from a leading expert, on the use of illicit drugs—they are the quite useful quotes for parents in the small box there.

Mr EDWARDS—In relation to your educational videos, CD-ROMS and resource booklets, et cetera, which you are putting out next year, was there any consideration given, instead of to these sorts of educational aids, to putting personnel on the ground who might be able to work with the school community and the surrounding broader community in pulling people together? You make the statement in the pamphlet that it is not just up to the school. Much of this stuff, which is costing a hell of a lot of money, is just going to be within the school community. What about the broader community? And was any consideration given to personnel, rather than equipment, who could work in a region or a local government area?

Ms Johnston—My role is in relation to schools and school drug education, so we have worked on that part of the overall strategy on drugs. We were considering the school as part of

the broader community, but not necessarily considering things that were simply targeted at the community. The Department of Health and Aged Care has a number of programs it funds—for example, the community partnerships initiative. In terms of putting people into schools, that is a matter for the states and territories who have jurisdiction over schools.

CHAIR—I am sorry, I have to cut it off there, Graham, we have run so far over time.

Mr EDWARDS—Just a quick question: what coordination is there with these other communities? Do you work with other agencies in putting these things forward?

Ms Johnston—We do work very closely with them.

CHAIR—I think we have been there before. I have just one request in relation to the little brochure there, which says at the back:

... there was a national satellite broadcast of a discussion between teachers, school principals, doctors and drug experts on the whole question of drugs in schools. Every school is receiving an edited video of this broadcast.

May we have a copy of that?

Ms Johnston—We would be very happy to provide you with copies of that.

CHAIR—Thank you very much, Ms Johnston, for your attendance here today and for the comprehensive nature of your submission.

Mr QUICK—Can we have her back?

CHAIR—Certainly. I think it is a given that we may request to have you back as we go through the various issues. I therefore propose that the following documents: the *National School Drug Education Strategy*, the *National Framework for Protocols for Managing the Possession, Use and/or Distribution of Illicit and Other Unsanctioned Drugs in Schools* document and the brochure entitled *Information for Parents on the National School Drug Education Strategy* be received as exhibits for the inquiry. There being no objection, it is so ordered. I just add that we will be putting in writing additional questions to the Department of Education, Training and Youth Affairs.

[12.02 p.m.]

CARNELL, Mr Ian, General Manager, Criminal Justice and Security Group, Commonwealth Attorney-General's Department

EVANS, Ms Sheridan, Senior Adviser, Law Enforcement Group, Commonwealth Attorney-General's Department

STEPHENSON, Mr Mathew, Project Officer, Law Enforcement Group, Commonwealth Attorney-General's Department

GORDON, Dr Alexander Donald, Intelligence Adviser, Australian Federal Police

HUGHES, Mr Andrew Charles, Acting General Manager, National Operations, Australian Federal Police

CHAIR—Welcome. I am sure you understand the protocols. The committee is an extension of the parliament and therefore needs to be respected in that regard. These are public proceedings being recorded by Hansard. Who would like to lead off?

Mr Carnell—I am conscious that the committee is on a tight time frame so I will make a brief opening statement and try to keep it fairly quick. Our written submission was a coordinated one on behalf of both the department and the relevant portfolio agencies, particularly the Federal Police, the Customs Service, the National Crime Authority and AUSTRAC, the Australian Transaction Reports and Analysis Centre. We also drew on research from the Australian Institute of Criminology, and I understand they have also made a separate submission.

CHAIR—Yes, indeed.

Mr Carnell—The focus of Commonwealth law enforcement agencies is on illicit drugs. While our submission focuses principally on the various dimensions of illicit drug law enforcement from a Commonwealth perspective, we hope we have also reflected the importance of strong partnerships and strategic linkages across all jurisdictions and between health and law enforcement agencies in tackling the problem of illicit drug abuse. I do not want to run over what is in the submission but I thought I might just touch on some of the key issues we think start to come out of the submission. First of all, there is the traditional role of law enforcement. In April 1999 the AFP Commissioner, Mr Palmer, noted in a speech on national drug reduction strategies that traditional policing deals with single incident or short duration crimes such as social disorder, assault, robbery or homicide. In the main, crimes and persons who committed them were local and jurisdictional limitations did not significantly impact on the effectiveness of law enforcement investigations. The commissioner suggested that, in relation to drug crime, seizures and the arrest of traffickers were seen as representing the completion of an investigation. Success was an apparently easily measured commodity counted by the number of arrests and the quantity of drugs seized. This emphasis is easy to understand when you consider

the traditional localised nature of policing and public pressure for reactive action. Against this background, one can understand why it has taken time to develop a greater understanding of the nature of organised crime, which tends to operate across state and territory jurisdictions and, in many cases, with international connections as well.

The committee would also appreciate that, traditionally, cooperation between law enforcement authorities was not extensive and was hindered by agency and jurisdictional priorities, patch protection and the desire to seize and arrest. Jurisdictional demarcations were mirrored in defined boundaries between law enforcement agencies, with health and law enforcement agencies working independent of each other. What is now recognised as a complex problem of global proportion was approached as a localised phenomenon affecting fringe elements of our society.

As other parliamentary committees have acknowledged, crime is now a global as well as a local problem. The changing nature of crime, particularly illegal drug supply, which is motivated by high profits, defies regional and national boundaries. Technology, communication, transport improvements and opportunities, together with quite fundamental changes in the world's strategic and economic focus, have combined to create an environment of mobility, instability and interjurisdictional interaction not previously experienced. In this regard, it is important to note there is a current inquiry by the Parliamentary Joint Committee of the National Crime Authority into the law enforcement implications of new technology, the extent to which electronic commerce facilitates the laundering of the proceeds of crime and whether international law enforcement cooperation is adequate to meet the challenges of new technology.

For law enforcement to be in a position to deal effectively with future challenges, new arrangements have been, and are being, developed to overcome those jurisdictional and agency demarcations of the past. There is greater sharing of intelligence and conduct of joint operations. In a fundamental shift, it is increasingly acknowledged that the seizure of illicit drugs is not the only important outcome for law enforcement. Also important is that we continue to develop strategies which enhance our capacity to confiscate the proceeds of crime and disrupt criminal networks. Trade in illicit drugs is just one element of transnational crime. Increasingly, Commonwealth law enforcement is targeting a range of criminal acts, including money laundering and people smuggling, rather than illicit drug supply on its own in order to protect the community from major crime.

Committee members would be familiar—and it sounds as if it was raised before I was able to be here—with the long-standing debate about whether funds that are allocated to supply reduction, including law enforcement, would be better allocated to treatment and rehabilitation programs aimed at reducing the demand for illicit drugs. However, it has clearly been part of the National Drug Strategy—and recognised from its evaluation—that the most appropriate way to target the problem of illicit drugs is through a balanced program of measures which address both supply and demand. Funding must be provided to all components of a balanced strategy. The simple fact is that demand reduction interventions are less likely to be effective in an environment of unfettered supply.

Relative expenditure by governments on health and law enforcement measures should not be the central issue. What is important is that health and law enforcement agencies work in partnership to combat illicit drugs. It also needs to be recognised that, given the changing nature of crime, it is getting more difficult to identify a specific budget for illicit law enforcement. Drug crime is increasingly intertwined with other major crime. If this trend persists, analysts will be less able to determine an exclusive budget for illicit drug law enforcement and it will become even less meaningful to make comparisons with the health budget.

What then is occurring in terms of action, given those challenges? As has been widely reported, the trade in illicit drugs and the abuse of these substances is an international problem, and Australia shares a responsibility with other countries to address both its causes and its impact. International cooperation in tackling the illicit drug problem is vital not only to protect the Australian community but also to enhance the wellbeing of the international community, advance international development and bolster regional and global stability.

Committee members would be aware that Australia is increasingly adopting a collaborative approach in the fight against illicit drugs at international level, with a particular focus on the Asia-Pacific region. Commonwealth law enforcement agencies are committed to fostering bilateral and regional cooperative efforts to reduce the production of, trafficking in and profit from trafficking in illicit drugs. This commitment is demonstrated through Australia's ongoing support of and cooperation with the activities of international organisations such as the United Nations International Drug Control Program, the Financial Action Task Force, the illicit drug enforcement areas of Interpol and the World Customs Organisation.

At the national level, law enforcement agencies are working cooperatively and in partnership with each other to ensure a seamless approach to drug law enforcement. It has been well reported that multi-agency task forces are the norm now in Australian drug law enforcement, whereas previously they have been the exception. With increased national and international cooperation, the quality and timeliness of intelligence sharing, so fundamental to effectively tailored law enforcement operations, has improved dramatically in recent times. With the continuation of this improvement and the increased use of technology, law enforcement agencies will be able to consistently target the key entrepreneurs and brokers involved in organised drug trafficking and related money laundering activities. The importance of that aspect of the illicit drug strategy should not be underestimated.

At the local level, as we increase efforts to divert drug users away from the criminal justice system and into treatment and rehabilitation and facilitate community action in dealing with the drug problem, the role of local policing is changing. Although drug law enforcement and treatment are often considered to be alternative approaches in dealing with the drug problem, both approaches have a role to play in minimising the harms associated with illicit drug abuse. A key Commonwealth initiative that recognises the importance of involving law enforcement officers, health professionals, governments and the wider community in efforts to address illicit drug abuse at the local level is greater use of diversion. Under diversion, first time or minor drug offenders are encouraged to make a commitment to attend treatment and/or education aimed at getting them off drugs rather than getting caught up in the criminal justice system.

In summary, the focus of Commonwealth law enforcement agencies, under the tough on drugs strategy, on reducing the supply of illicit drugs in Australia is only one part of what is a comprehensive matrix of anti-drug strategies. In tackling the illicit drug problem in Australia, governments and the community are seeking an effective and integrated policy outcome that balances the impact of health, education and law enforcement initiatives in striving to achieve a reduction in the harm caused by illicit drugs. Law enforcement continues to evolve in the way it conducts its business. Monitoring and evaluation is fundamental to the way law enforcement agencies operate in the current environment, particularly given those significant interactions between drug crime and broader criminal activity. One of the challenges for law enforcement is to make Australia an inhospitable place through which to traffic illicit drugs and do criminal business generally. That is the basic principle that underpins our anti-drug strategies and Commonwealth law enforcement agencies are making determined efforts to meet that challenge.

CHAIR—Thank you very much, Mr Carnell. Do you have any other presentations from any other people who would like to make a presentation?

Mr Carnell—I will ask Mr Hughes if he wants to say anything additional on the part of the AFP.

Mr Hughes—The AFP welcomes the opportunity to address the committee. Mr Carnell has referred to the changing nature of crime and the challenge this presents to law enforcement. He also referred to the need for greater sharing of intelligence and joint operations to counter the changing nature of crime and to the fact that international cooperation to tackle the problem is vital. The primary target of the AFP anti-drug effort is the upper echelon organisers, traffickers and suppliers of illicit drugs. The focus is on detecting syndicate groups or individuals involved in bringing illicit drugs into Australia—apprehending those responsible and disrupting or dismantling the underlying network.

As a central element of its international law enforcement activities, the AFP operates an overseas liaison officer network. We have 30 liaison officers in 19 overseas posts around the world. The major role of these liaison officers is to facilitate and promote the exchange and flow of information between overseas law enforcement agencies and those in Australia to counter drug trafficking. Rather than go on with what is in the portfolio's submission, I believe it would be useful to talk about some recent successes resulting from initiatives funded through the government's National Illicit Drugs Strategy—specifically, the AFP mobile strike teams, Operation Avian and the law enforcement cooperation program.

The AFP's 10 mobile strike teams are intelligence driven; thus ensuring major drug trafficking syndicates are identified for further investigations. They also provide a flexible response capacity in attack against all aspects of a drug syndicate's operation, including finance, transportation, distribution networks and money laundering. Their great advantage is that they will be able to act quickly to the changing operational circumstances that are common place in the effort to combat the drug trade. During 1999-2000, the Avian strike teams conducted 40 investigations. These resulted in the seizure of over 467 kilograms of heroin; 54 kilograms of cocaine; 185 kilograms of MDMA, or Ecstasy; 20 kilograms of amphetamine type stimulants; and over 580 kilograms of cannabis. Some of these seizures occurred overseas as well as in

Australia. Some 81 arrests were made as a result of these investigations, which in turn resulted in 114 Commonwealth charges, 102 state charges, two charges in the United States of America and two charges in Hong Kong.

The strike teams' operations have restrained over $9 million in assets and caused assets to be forfeited to the amount of $451,000. It should be noted that, due to the conviction based nature of the Proceeds of Crime Act 1987, there is often an extended time between the restraining of assets and their ultimate forfeiture. Aside from the serious disruption to these syndicates, the seizure of the drugs and the arrest of importers, there is also a deterrent effect in showing other potential importers that the AFP has the capacity to detect and seize large imports. I have some examples of recent large seizures which I can make available orally to the committee should it so desire.

As for the result that we have achieved in Operation Avian and from the overall efforts of the AFP, more generally, some might say that it represents only a small proportion of the illicit drugs entering Australia. The exact proportion is impossible to know. We believe it is important that these achievements are put into context. For example, it is typical for larger consignments of heroin to be broken into 350-gram blocks. A block that size could be broken down into a further 6,000 deals, or hits, which potentially exposes up to 6,000 people to the highly addictive and often lethal drug. Furthermore, there is no doubt that drug trafficking syndicates engage in a range of criminal activity associated with the organisation of importations and the laundering and dispersal of profits. Targeting and breaking up syndicates and seizing their assets has positive knock-on effects in terms of preventing further criminal activities from that source.

Finally, while demand reduction, education and treatment programs hold the keys to the long-term reduction of illicit drug use in the community, these programs cannot work in an environment of unrestrained supply, as Mr Carnell previously indicated. The direct effect of law enforcement action on the amount of drugs available in the community and the deterrent effect on supplies and potential suppliers are vital contributions to the effectiveness of a balanced anti-drugs strategy. Thank you.

CHAIR—Thank you very much. We are open for questions.

Mr ANDREWS—I refer to the table on page 9 of your submission on drug seizures by the Australian Federal Police. Can you explain something which seems curious to me? For 1996-97 there were 5,683,000 and some more grams of cannabis seized and 18,700,000 grams of cannabis resin but for 1999-2000 there were just 16,000 and 12,000 respectively. When seizures in all other categories have increased, is there some reason why there is this huge stop over three years from millions of grams in combined cannabis and resin, something like 24 million grams, down to about 38,000?

Mr Carnell—I will make one key comment about this table: just be aware that the 1999-2000 figures are only for part of the year. They are up till 1 May, so they are 10 months worth. So you need to bear that in mind.

Mr ANDREWS—Even if they are not quite comparisons, we are talking about 24 million to—let us be generous and call it—60,000.

Mr Carnell—There is obviously something exceptional about 1996 and 1997. I will ask Dr Gordon to address that.

Dr Gordon—We believe that what actually occurred there was that, through those successes in the mid-1990s and stretching on a little bit beyond that, we were able to break up some very important importing syndicates—particularly of cannabis resin—that were operating and importing those drugs into Australia. These were extremely longstanding syndicates which no-one had really been able to get to before that time. That was one reason. Let me just leave it at that. I think that is probably the main reason.

Mr ANDREWS—I have other questions of clarification on the figures. I presume that these figures relate only to drug seizures by the AFP, that there would be drug seizures by state and territory police as well?

Dr Gordon—Absolutely, also by the NCA.

Mr ANDREWS—The NCA figures are here for at least heroin and cocaine, in footnote 7. Is a combined table such as this available to us so that we have an overview of what the situation is when you take into account state and territory police operations as well?

Dr Gordon—I think one would be available through the *Australian illicit drug report*, which is put out annually by the ABCI—the Australian Bureau of Criminal Intelligence.

Mr ANDREWS—I have another question of clarification. It is revealed that in 1999-2000 there were 773,000 grams of cocaine seized, which was a huge jump on the previous year—more than double—and that cocaine was by far the largest type of drug seized. I know that seizures do not necessarily indicate prevalence of drugs, but there must be some connection. In your view, and on the evidence available to you, does this indicate there has been an increased influx of cocaine importation?.

Dr Gordon—I will answer that in two ways. Firstly, I will make a general point about seizure data. These data need to be taken with a great deal of care insofar as one very large seizure as an outrider figure can distort the figures remarkably and we need to note that. So, if a seizure is, to an extent, by chance and it is an outrider piece of data, then the whole of the data are distorted. Secondly, as regards cocaine, I think it has been our assessment and also the assessment, for example, of the Australian Customs Service that since about the mid-1990s Australia has been targeted in a much more resolute way by high level criminality for the importation of cocaine than we had seen previously. If you look at the data the average size of each seizure—these data are not available now—actually started to rise from about 1994-95 onward, which is indicative, to an extent, of greater criminal targeting. I do not know if my colleague Mr Hughes wants to add to that.

Mr Hughes—The only comment I would make is that we do have the updated table for the full financial year 1999-2000, which I am happy to provide to the committee. It shows an increase in the total cannabis seizures up to nearly 36½ thousand grams.

Ms JULIE BISHOP—This is obviously a very wide ranging submission, but I just wanted to focus on the issue of money laundering. You observe that money laundering is a vital component in drug trafficking and in the context of electronic transfers of credit, e-commerce and the like, you speak of Australia needing to ensure that its current effective strategies are reviewed as developments occur and that a watching brief is appropriate. Given the possibilities that technological innovation in a globalised, borderless economy can present, are you satisfied that this is a sufficiently proactive approach, or should more attention be given to this area of e-commerce and cyberspace transactions?

Mr Carnell—The last part of your question was very broad. As a personal view, electronic—

Ms JULIE BISHOP—I am referring to you saying that there is a watching brief. Is that a sufficient response?

Mr Carnell—It is a watching brief in respect of money laundering. There is much more consideration going on about electronic crime generally which has many other important facets like fraud. That is the subject of a study by a group commissioned by the police commissioners Australia wide. In terms of money laundering, yes, at this stage the best we can do is a watching brief to see how matters develop. Then it will be a case of needing to respond quickly. It is simply not possible to predict accurately which way things might go.

Ms JULIE BISHOP—Do you think we have the capacity to take necessary action quickly, as appropriate?

Mr Carnell—Part of the response is likely to be legislative. So there is a role for parliament in being able to consider what needs to be done swiftly. We have a very good basis to build on. AUSTRAC really is internationally viewed as a real model for how government can have good relationships with financial institutions and monitor the movement of money. So, in that sense, we have a past history of very effective administration to build on to meet new challenges.

Mr SCHULTZ—In chapter 2 you refer to the provision of additional funding under the Tough on Drugs Strategy which will provide an efficient exchange of intelligence and operational information between Commonwealth law enforcement agencies. What impediments have there been to that? Will the additional funds assist in overcoming those impediments?

Mr Hughes—The arrangements internally within Australia for the exchange of intelligence and information between Commonwealth law enforcement agencies are very robust. There are a number of mechanisms whereby the intelligence that is gained by one agency is shared with another. One example of that is that in the AFP our electronic case management system is now linked to the database of the Australian Bureau of Criminal Intelligence, which means that not only Commonwealth law enforcement agencies but also state law enforcement agencies can access the data contained therein. That is just one example of the wide front of mechanisms that we use to ensure that there is a free and frank exchange of intelligence.

Mr SCHULTZ—I want to refer you back to the issue of drug seizures. Whilst it is true that the public is constantly being advised about the seizures—and that in itself is good—isn't it also true that the increase in seizures is relevant to the increase in drugs coming into the country? Is

it also true that some of the scarce resources of the AFP, in terms of its intelligence and surveillance type expertise, are being utilised as an example in the investigation of low amounts of Commonwealth fraud, because the issue of drug intelligence surveillance is far more expensive? Wouldn't that in itself have some detrimental effect on the reasons for the increase in drugs coming into the country not being able to be detected?

Mr Carnell—I might comment specifically on the question of fraud and then ask my colleague to deal with the question more broadly. It has been the case since the early 1990s that with fraud, departments deal with the more minor matters themselves—and if necessary take them directly to the Director of Public Prosecutions—and that only significant cases of fraud are to be referred to the Australian Federal Police for follow up action. But I will ask Mr Hughes to answer that.

Mr Hughes—Just taking that one step further, the AFP employs a case categorisation and prioritisation model, which is effectively a benchmark beyond which we will accept investigations and below which we will not. As Mr Carnell rightly points out, those that are not accepted by the AFP are returned to the department or agency, who by and large have their own capacity to deal with it. We do not feel in any sense that we are wasting resources. The surveillance resources you referred to, which are deployed to these major upper echelon organisers, are actually funded under the National Illicit Drugs Strategy as part of our Avian strike teams and therefore are not used to do fraud related inquiries, so we do have a capacity with a dedicated team of surveillance officers in each of the major capital cities who are highly mobile and can operate Australia wide. In answer to your first question, I will defer to Dr Gordon.

Dr Gordon—Sorry—was the question beyond the fraud one whether or not we have adequate surveillance on the drugs coming into Australia?

Mr SCHULTZ—That is the question. The question is centred on the use of the resources being targeted into the cheaper role of investigating fraud rather than the more expensive role of surveillance and intelligence operations on drugs.

Dr Gordon—I do not think that is the case at all. Our priorities are set, as Mr Hughes just described them and, within our intelligence structure, we attempt to measure harms to Australian society from those crimes for which we have jurisdiction. Those assessments are constantly updated on a quarterly basis according to a set format. We attempt through those intelligence processes, firstly, to see what the harms are and put them in priority order and, secondly, to see how we are going against those harms in terms of dealing with them. We see this as an extremely dynamic situation. I mentioned earlier the situation with cocaine. Our colleagues in the National Drug and Alcohol Research Centre brought to our notice through their monitoring processes in, I think, it was 1998, that we had a new situation with injecting drug users injecting cocaine. This caused a whole lot of additional harms in terms of the use of cocaine than would normally have been the case. So, as I say, we are constantly monitoring these harms and attempting to adjust our operational resources in dealing with the harms.

Mr Hughes—I would just add one final point which may clarify the situation even further. The AFP currently deploys 31.44 per cent of its resources to investigating imported drugs and

some 2.5 per cent to trafficking internally in drugs. That compares to 14.39 per cent of our resources for fraud.

Mr SCHULTZ—I have a further question. Given the percentages that you have just quoted to me, are those resources sufficient to address the issue of the importation into this country, or the exporting into this country, of illicit drugs such as heroin and cocaine? Referring back to the comments made by PHARM—the reaction to that being stipulated by the degree of harm—are you aware, like I am, of the significant increase of heroin and cocaine in the community and are you alarmed about the increased use of heroin and cocaine in the community, particularly by our younger people? Do you think that the question that I asked is appropriate? Given that the amount of illicit drugs, such as heroin and cocaine, is increasing at a dramatic rate, is it impacting on the community in a dramatic rate? Do you feel that we are doing sufficient in terms of our intelligence surveillance operations to stop it coming in?

Mr Hughes—From the figures that I have quoted, you can see that it is a priority for the AFP, given the wide role that the AFP plays in Australian society. Obviously we are concerned about the use of heroin. Quite aside from my professional life, I have four sons. I have a personal interest in it, as we all do. It is a matter of grave concern, and the AFP, I believe, is responding accordingly within its portfolio charter.

Mr EDWARDS—I just want to follow on from what my colleague Alby Schulz said in relation to the amount of drugs that is coming into Australia. In Western Australia this year we had a record rock lobster catch, and that was because—

CHAIR—I must intervene here because I need to alert people that the time is fast running away. We have one more submission and it is going to be a very lengthy one. Can we keep the questions short?

Mr EDWARDS—The point I was making was that in Perth, WA, we had a record catch of rock lobster this year. That was because there was a record mass to catch from. Isn't that true? When you quote these figures about the amount of imported drug that we are picking up on, isn't it because we have a record amount coming into Australia?

Dr Gordon—If you look at the figures, and again I am simplifying here, the amount of to-take heroin that is interdicted has risen by roughly 500 per cent in the last decade. I think it would defy the imagination to suppose that the amount of use of heroin has risen that much in the last decade. If one looks at the surveys conducted by the Department of Health and Aged Care, they do show an increasing use of heroin. For example, between 1995 and 1998, those surveys appear to show that the number of people who have used over the last year has risen as a percentage of the community from 0.4 per cent to 0.7 per cent. That still does not accord with the amount that our seizure rate has gone up by.

Mr EDWARDS—Just to quickly follow on from that and then to take a slightly different tack, my next question is in relation to your effort overseas. You made the point that the Commonwealth has created new AFP overseas liaison posts in key transit countries. Can you tell us which countries you have established these new liaison posts in and if the new liaison

posts were formerly called something else? Are they totally new positions or people who were added on to the existing effort?

Mr Hughes—They are new posts.

Mr EDWARDS—Are they new personnel?

Mr Hughes—They are new personnel. The AFP previously had no presence in these places. They have been opened in Rangoon, Burma; in Bogota, Colombia; in the Hague, the Netherlands; and we have also increased our resources in Hong Kong by two officers. In the early rounds of the National Illicit Drugs Strategy, we opened a new post in Beijing and a new post in Hanoi, Vietnam.

Mr EDWARDS—Good stuff. You say that the use of cocaine in the United States has decreased. You suspect that there is a greater effort to push that cocaine into Australia. Why has there been a reduction in the use of cocaine in the US?

Dr Gordon—In fact, in the last year or so the use has stabilised again, as I understand it, and it is slightly increasing. But yes, between the decade of the eighties and nineties, there was a very marked reduction in cocaine use in the United States. It is extraordinarily difficult to know exactly why that has occurred but basically, as I see it—and I am not an expert in this area—there is a phenomenon of an epidemic in drug use, where you do see a cadre of users and that crests like any other epidemic. As well, there is the intervention by law enforcement and the resources that have been put in—the additional resources, both in the United States itself and in the producing countries. It would be very difficult to determine which of those two phenomena actually is most in play. But it would be something to do with each of those, I would say.

Dr NELSON—Did the 1996-97 seizure of the $18^{1}/_{2}$ million tonnes of cannabis resin have any appreciable impact on the availability or price of cannabis in the following year?

Dr Gordon—I think that figure was cannabis resin. We did not monitor that at that time so I cannot answer that question.

Dr NELSON—Can we be reassured that those sorts of things are monitored now?

Dr Gordon—Since the seizure of 390 kilos under Operation Linnet in 1998, we, along with the ABCI, have endeavoured to monitor the market at the time of very large seizures. However, that monitoring process is dependent on our colleagues in the state services and so we have no control over the data itself.

Dr NELSON—With the 1998 seizure of heroin, for example, that large seizure—what was it, 400 tonnes?

Dr Gordon—Nearly 400.

Dr NELSON—Did that have any impact on the purity, availability and price of heroin, for example, in Sydney.

Dr Gordon—Not according to the monitoring that was undertaken at the time. However, I would put a caveat on all of these figures, in that, in our view, the data are not yet adequate to make a case either way.

Dr NELSON—I understand. I seem to remember the ABCI report in 1998 identified 8,000 hard-core heroin addicts as being responsible for about 90 per cent of domestic household break-ins. Is that true; is that something with which you concur?

Dr Gordon—There are much better data. I am not sure if the Australian Institute of Criminology is going to come before this committee, but it has a monitoring project called Drug Use Monitoring Australia—DUMA.

Dr NELSON—Yes, that is right.

Dr Gordon—I think the data given there would probably be the best data you could get.

Dr NELSON—Okay. There are two other things. I notice on page 2 of your submission you are forecasting a 20 per cent increase in heroin production from 1998 to now and Afghanistan, in particular, being one of the major sources. Would you argue, for example, to our committee—if not to the government—that you should therefore receive substantially more funding for what you are doing? I know they are all government departments—

MrCarnell—It is always too much of a temptation to ask bureaucrats if they want more money.

Dr NELSON—But, seriously, if we are going to run a supply deprivation model—which, I must say, I do support, along with other things—then we need to be doing it properly. If the problem is getting worse then one would think that you would require more resources.

Mr Hughes—In part answer to your question, after conducting the review of overseas liaison network, we were of the mind to reduce our Islamabad post from two down to one. We have kept that at two for two reasons: firstly, because of the large production of opium in South-West Asia, particularly in Afghanistan, as you rightly point out; and, secondly, because of an unrelated issue, which is people smuggling from South-West Asia. We have made the decision to keep that post at strength at two, and we are constantly monitoring our resources in that part of the world.

Dr Gordon—Can I just add something there. I think, almost like every other endeavour—just like the criminals too—we are benefiting from some of the synergisms now available through better communications, better networking, better coordination with overseas law enforcement agencies and so on. I think one has to cater for this development in the total picture of resources available to us. Mr Hughes mentioned that we did have a new data system that was brought in in 1997, I think, but that is only part of the synergisms we are getting.

Dr NELSON—That will not stop us, or at least me, from advising that we give you more money. The last thing I would point out to you is on page 5 of your submission where you say that, after tobacco and alcohol, pharmaceuticals are our major drug problem, and you say that

80,000 people are hospitalised each year as a result of problems from the abuse of pharmaceuticals. You then go on and talk about methadone, pethidine, morphine and codeine, for example, and the abuse of pharmaceutical. It should be pointed out that those figures relate to the use, the misuse, the failure to use, adverse reactions from not using properly as well as to a small number involved in abuse. That is just something you might like to think about and rectify.

Ms ELLIS—I will try to be brief. I want to refer to the other end of the law process, in fact, the grassroots community end. I refer to Mr Carnell's comment earlier about diversionary tactics in dealing with drug abuse offenders. It was said to me last week when I was on a trip in relation to this inquiry—'on a trip', if you will pardon the pun—that there are three definite ways that young people, if we can talk about young people for a moment, can fund their addiction. The one they appear to prefer is where they sell to others. They find that the least likely to lead them into trouble—rather than breaking into houses and all of the other choices they have. They have a rock and a hard place choice, and they make that one.

It has also been said to us that when a young person attempts to enter into treatment, if they fail that first treatment, they have not actually failed. Some people we have met have been back into treatment for the fifth time, and it is suggested that they are, in fact, succeeding because they willingly try to re-enter that process along the way and that while they are attempting to do that there is hope for them. Pardon my long introduction, but what I am getting at is: from the law point of view, how far do you see the diversionary proposal being able to enter into the law of the land when it affects that young person?

You mentioned diversion in terms of the first offender, low possession and so on, but with these other people in mind, of whom there appear to be a very large number, what sort of leeway do we give them, or do we say that on episode 2, 3 or 4 we slap them into the judicial system rather than allow them to persist. I am talking about the crime of selling, not crimes of property or personal abuse.

Mr Carnell—I guess I would make two points. One is that police constables have always had very significant discretion in how they act on the streets. If they didn't, an awful lot of people would be clogged in police stations, let alone at court, so they have always had significant discretion. The difficult thing in this area—and, let us face it, this is pretty new for us and there is not good information from overseas experience that guides us—is to work out how far you take people into the criminal justice system before you will have that nice balance between forcing them into a treatment and having a treatment that works.

We see that in all sorts of areas, like domestic violence. A strong pro-arrest policing response is more likely to keep perpetrators in programs. Similarly, in the drug area, we need to find that balance between how far we take them into the criminal justice system and where the point is that best works to push them into treatment that will be effective eventually.

Ms ELLIS—Do you think it is something that we should experiment with—I am not having a go at you; I respect what you said—rather than saying 'there is no evidence from overseas yet.' Somebody has got to create the evidence. How about if we have a go at it?

Mr Carnell—I think effectively we will see that, and we will not have exactly the same models out of each state and territory as they finalise and implement their plans from the 1999 COAG initiative. This is coming. In that sense, it is a fascinating period to be at the early stages of.

Ms ELLIS—Thank you.

CHAIR—I am going to have to cut it off there. There is never enough time. Thank you very much for your submission and contribution. I am sure, as we have said with all other submissions this morning, we will be seeking your advice again. Thank you.

Mr Carnell—I certainly will be happy to respond.

CHAIR—Is it the wish of the committee that the table provided by Mr Hughes be incorporated in the transcript of evidence. There being no objection, it is so ordered.

The table read as follows—

[12.50 p.m.]

BORTHWICK, Mr David, Deputy Secretary, Department of Health and Aged Care

CORCORAN, Mr Brian, First Assistant Secretary, Population Health Division, Department of Health and Aged Care

HALL, Prof. Wayne, Executive Director, National Drug and Alcohol Research Centre, Department of Health and Aged Care

KERR, Ms Sue, Assistant Secretary, Drug Strategy and Population Health Social Marketing Branch, Department of Health and Aged Care

WILSON, Ms Cheryl, Director, Illicit Drugs Section, Department of Health and Aged Care

CHAIR—Welcome. This is the second time you have appeared before the committee, so we look forward to your presentation. Would you like to make an opening statement?

Mr Borthwick—I am pleased to have the opportunity to address this committee on behalf of the Department of Health and Aged Care. In our submission we have aimed to shed light on the extent and pattern of drug use in Australia and on what the Commonwealth, state and territory governments are doing to tackle the drug problem. Our submission addresses issues related to substance abuse, covering both licit and illicit drug areas. There is no doubt that the social, personal and economic impact of the misuse of alcohol and tobacco is a significant burden to the Australian community, particularly in the context of health care costs. However, I would like to address my introductory comments primarily towards problems and approaches to illicit drug use.

The evidence presented in our submission suggests that, notwithstanding the considerable efforts of governments, illicit drug use in Australia has edged up. Population surveys indicate that lifetime cannabis use in the 14- to 19-year age group may be as high as 45 per cent. The use of ecstasy and amphetamine type stimulants appears to be becoming more widespread amongst teenagers and people in their 20s. Heroin-related deaths and overdoses have increased markedly. Polydrug use and injecting as a preferred method of administration are becoming more common practices. Finally, the age of initiation for those who experiment with drugs seems to be trending downwards.

In summary, there are worrying trends in the diversity of drugs available, their patterns of use and the harms they are causing. Why is this so? On the supply side, global production of heroin and cocaine has been growing steadily for many years. This is contributing to the increased availability of these drugs in Australia. Prices have been falling and drug purity has been increasing. Australia is confronting a ruthless, well-organised and resourced global industry. Our extensive coastline and its proximity to Asian production and distribution centres presents a particular challenge for our law enforcement agencies. Notwithstanding the considerable efforts and resources applied, which, as you have just heard, have resulted in record drug hauls, the

overall picture suggests to us that, when it comes to limiting the supply of drugs, we have not yet got the upper hand.

Australia is not alone in this regard. Many other countries are also experiencing an increasing prevalence of illicit drugs. Factors contributing to the demand side of drug consumption are complex and often interrelated. It is certainly hard to put a weighting on the different factors at work. However, factors that seem to play a part include particular influences such as family stress and conflict, physical and sexual abuse, isolation from family support, low income, unemployment and homelessness. Some commentators also suggest that changing patterns and social influences are also shaping the decisions of young people, with a particular focus on freedom, choice, keeping options open and living for the moment. Beyond the interplay of these specific influences, but also related to them, research suggests that in some sections of society there is an increasing sense of social isolation, insecurity, powerlessness and loss of control in individuals, families and communities. It is hard not to draw the conclusion that there is something in all of this which makes some in our community more vulnerable. That translates into a greater propensity towards self-destructive and risk-taking behaviour which, for some, is manifested in a culture of illicit drug taking and binge drinking.

Attempts to address this sense of vulnerability are being made through the government's Stronger Families and Communities Strategy which was announced by the Prime Minister earlier this year. The strategy recognises the interlinked nature of many of these contemporary influences and the need to strengthen the resilience of people and communities faced with such problems. Based on the principle of prevention and early intervention, the strategy represents an important change of direction for policy development in Australia in addressing these damaging community trends.

It is the complexity of the influences on both the supply and demand sides that explains why it has been so hard for governments here and abroad to make inroads into the drug problem. It was the clear need to do something extra, and decisively so, that lay behind the Prime Minister's Tough on Drugs Strategy and the reinvigoration of the National School Drug Education Strategy. The strategy recognises that the complex interplay of forces requires comprehensive and multiple approaches. It involves enhancing the capacity of enforcement agencies to intercept the supply of drugs on the one hand, and on the other hand it adopts a suite of measures to reduce demand, with additional services covering education, treatment and rehabilitation.

Beyond the specific measures, the strategy is based on four key elements. Firstly, there is the conviction that the strategy will be much more successful if governments work through cross-portfolio cooperation and collaboration at the national and state levels, and this is happening. The cooperation between police and health authorities in this regard is exemplary. Secondly, there is the conviction that the strategy will be immensely enhanced if communities, educators and families can be empowered to address drug problems at the local level. Again, this is a key feature.

Thirdly, there is a recognition that, despite all the efforts to limit the supply and demand for drugs, there will still be users. This means that there needs to be measures which reduce harms to drug takers. This is essential both for the health of the individual and for the health of the

wider population. Measures such as needle and syringe programs have been highly successful in containing the spread of HIV/AIDS and hepatitis C in those groups who are particularly at risk, and through that to the wider community. Australia's achievement of extraordinarily low transmission rates is recognised around the world. Fourthly, there is a realisation the strategy needs to be based on conclusive evidence about what works. For this reason an important part of the strategy is to draw on evidence based research and evaluation to inform policy and program development.

In conclusion, I have tried to briefly outline what we see as the current situation and our concerns about current trends and their causes. Each of the four elements just touched upon are vital if we are to get maximum value. Naturally, our submission concentrates on health issues but we know that while this dimension is important it is only part of the mosaic. My colleagues and I would be happy to answer any questions that the committee may have on these issues and the issues addressed more fully in our submission. Thank you.

CHAIR—I appreciated your effort in those opening statements about the changing lifestyles and community attitudes which contribute to substance abuse. You highlighted the four key issues which are the focus of the collaboration. You mentioned the needle exchange and the conclusive evidence of what works. You are looking very much at those sort of issues. What I wanted to bring out in my question in regard to this extraordinarily difficult issue is the something extra approach that you mention and try and link it back to lifestyle type situations which you have endeavoured to highlight. That seems to me the extraordinarily difficult part of the whole issue. So in terms of the conclusive evidence of what works and in changing attitudes, changing lifestyles, can we talk a little about what you endeavour to say in the beginning there. What do you think the changes are in the fundamentals of our community structure? You talked about isolation and things like that. Can we flesh that out a bit?

Mr Borthwick—These are very big issues. One of the reasons I singled them out was to illustrate how difficult it is for governments to come to grips with these issues. It requires a multi-faceted approach beyond those areas which health departments alone are involved in. At the very macro level it means running a damned good economy and getting unemployment down. It involves focus on particular groups and support systems for particular groups which, notwithstanding the running of a very good economic situation, are still feeling as though they need a lift. In that regard I focus very much on the need to have localised approaches—directed at families, education and specifically on drug programs—in the local community to try and buttress the wherewithal at that level. I guess it is not a very satisfactory answer but it requires a multiplicity of approaches from the general down to the specific.

CHAIR—Thank you for that. I did appreciate the answer you were able to give. I think it very reasonable. We are going to come across this regularly in terms of dealing with the multiplicity of approaches that we will need to ultimately recommend. I just wanted to talk a bit about the changes in the community, the escalating demand and escalating usage for a whole range of reasons to try and isolate out a couple of things so that we might try to understand a little better.

Ms Kerr—We undertake a range of social marketing campaigns and we have covered those in our submission. One of the things we do before we put social marketing campaigns in place

is extensive surveys and discussions, qualitative and quantitative work with stakeholders, to find out what their attitudes and approaches are to drugs and life in general. Without being able to comment on the reasons that attitudes and approaches are changing, we do know through the great depth of research that we have done over the last 15 years since the national drug strategy first began that attitudes have changed. Also, we track this through the national household surveys. So we have some idea of, at least, the impact of these changing social conditions on people's attitude to drugs. But that does not answer your question and get to the root of why it is changing.

CHAIR—But we are endeavouring to understand and we can see differences.

Ms Kerr—And it is useful input to our thinking.

Mr QUICK—I would first like to compliment the department on its 172-page submission. This is fantastic and as politicians we need to get a lot of this stuff out to our electors. I think it would frighten the pants off a lot of people, especially some of the trends. I was interested in your talk about particular groups and support systems and localised approaches. So much of Commonwealth funding is submission based, and a lot of the people who are 'suffering' do not have the wherewithal, the educational capacity, to enter into submission based funding. We have some excellent programs—for example, the national alcohol campaign, the Rock Eisteddfod, the national tobacco campaign, the national illicit drugs campaign and the National Mental Health Strategy—and we now have information for parents in the National School Drug Education Strategy. We have all these programs out there, but the trends are still going up.

How do we get it down to the localised approach by saying community X is being case managed by juvenile justice, Health and Aged Care, Family and Community Services, the education department, the Housing Commission, social welfare? There are heaps of programs, there are dozens of bags of money, there are more acronyms than you can shake a stick at, but how do we get it down to the localised approach? Do we say to the local government agencies and councils, 'What do you need? Come up with something innovative.' We have pilot programs flying all over the country. What is the solution? Our kids are entering into the system at a younger and younger age. Early intervention is glibly mentioned all over the place. What about international research? What is happening in Ontario? They are actually putting the money in. I just heard the previous witnesses saying they want more money in their bag.

Mr Borthwick—You are going to hear from everyone hinting that they want more money in their bag and, at the end of the day, there is a limit to what governments can do. The Commonwealth—

Mr QUICK—It is my opinion that we do not need more money, we just need a bit more cohesion.

Mr Borthwick—The Commonwealth has put in more money, but one of the points I tried to emphasise was rigorous research and evaluation into what works, so that, whatever the amount of money governments decide, it will be channelled towards something that is likely to yield a better return. Stepping back from that to your particular question about where it should go at the local level, a large thrust of the Commonwealth's effort is to fund directly the non-government

organisations on the ground where they can evaluate the situation in their area and adjust the program delivery towards what they perceive to be the particular circumstances. From our point of view, we try and get an overall national framework agreed at Commonwealth-state level but to liberate the people on the ground to try and deliver the best way they can at that stage.

Mr QUICK—But surely the cheapest way is to empower people on the ground. I know, for example, in my state of Tasmania that Centacare are doing a fantastic job.

Mr Borthwick—That is exactly what this is doing; that is what is happening. It has been a new emphasis in the last year or so.

Ms Kerr—I could give a couple of examples, Mr Quick. Under the Tough on Drugs National Illicit Drugs Strategy, a major thrust of activity managed by the department of health was the Community Partnerships Initiative, which got money out into local communities. This was a little new for the Commonwealth—traditionally this has been an area that has been handled by state governments—but it gave us a new opportunity to hear from the communities on a submission driven basis, so that the ideas came from the communities themselves, and to have an opportunity to fund those.

The Non-Government Organisation Treatment Grants Program was also submission driven. I know that means that can lead to delays in actually getting money out onto the ground but, again, there was a very deliberate decision taken to do that in consultation with the Australian National Council on Drugs so that communities who in the past may not have received funding from either state or federal governments had an opportunity to come forward with their ideas of what would work in their community. It is an extremely important question you have raised of how to empower these communities, but in those two programs at least we are able to hear what it was the community said they wanted.

Mr QUICK—On the other hand, if we do empower them, they need to have facilities. For example, they may say, 'We want to be part of this but we need respite for our young people and we need a 24-hour service. We don't need just a 1800 or a 1300 number; we need adequate housing.' We were in Melbourne the other day, and we found out that there are about 48 beds for the whole state of Victoria. How do we get the balance to say 'Raise the expectations, put the money out and involve the community, the grassroots'? There is nowhere for them to go, so they then think, 'Bureaucracy and the system have failed us.'

Ms Kerr—In relation to that, the funding that the Commonwealth provided for the treatment grants program paid for beds where that was an appropriate aspect of the grant. But, essentially, health issues are the responsibility of state governments, and we work very closely with state governments at the Commonwealth health and law enforcement levels. At the end of the day, the Commonwealth has had to say that it is adding new money into this field, but it has been made very clear through the COAG and other major Commonwealth-state forums that states should not stop the funding and, indeed, should increase the funding that goes into these areas. So the Commonwealth funding was always announced to augment that for which the state governments were responsible.

Mr Borthwick—As a general observation, there has been a marked step-up in activity in the last year or so—you heard that from the Federal Police. That is very important in terms of stopping the supply side. There has also been a marked buy-in by the Commonwealth in terms of health, education and law enforcement issues. I guess it is fair to say that the evidence of those interventions has not yet come in because they are relatively new programs and approaches, but the principle of evaluating what works is enshrined in all those new mechanisms. So, hopefully, if we start getting good results on both supply and demand sides, in the future, governments can have a look and say, 'This has worked,' or 'This hasn't, and this is the way to go.' But there has been a marked change in the approach at the Commonwealth level in recent times which the states and territories are endorsing. So, in a way, we are hoping that the deliberations of this committee can enrich the evidence which governments can react to, but we also appreciate the difficulty of inquiring into this right at the start of this changed approach.

Mr ANDREWS—Can I commend the approach to the inclusion of primary prevention as part of the strategy and ask a couple of questions. Mr Borthwick, in your presentation you mentioned a series of factors associated with substance abuse. Is the department promoting any research, or is it aware of any research, which is going on and which is trying to or has as an object the delineation of those factors in terms of what leads to the take-up of substance abuse by young people? Is there any research, for example, as to why some young people take up and abuse various substances while others do not, and is there any research as to why some of those who do take it up later desist from the practice? What do we know about this, and are we promoting research to find out more?

Prof. Hall—The short answer is that quite a bit of research is going on in Australia on that. I should underline the point made earlier that this has been funded only relatively recently and that a lot of it has been undertaken in areas where drugs have not been the central focus—in the mental health area, for example. There is some very important work being done in Melbourne for the Centre for Adolescent Health which has been following large groups of young people from early adolescence into adult life, looking at the characteristics of those young people who do become involved in the use and abuse of illicit drugs and what sorts of characteristics are predisposed to them. We do have a fair idea about that. A lot of research has also been done in New Zealand that has been very well funded and which probably has application here.

In terms of the factors that seem to make differences, they are school failure—for example, poor school performance in primary school is a very strong predictor of early initiation of alcohol, tobacco and, later, illicit drug use—family conflict and family breakdown. There are not a lot of surprises in these factors and these things tend to go together. Kids who have multiple disadvantages of these sorts—for example, poor school performance and family breakdown—are the ones at particular risk of getting into very serious strife and persisting. The other thing with respect to these factors is that it is not only about whether kids initiate drug use; it is about the factors that tend to get them locked into it and where that becomes a persistent problem that lasts well into adult life.

Mr ANDREWS—Is that being fed back into the Commonwealth strategy—for example, the Stronger Families and Community Strategy? If a consequence of those factors is a higher prevalence of drug use or the risk of drug use, is that being fed back in terms of the Commonwealth's holistic approach?

Prof. Hall—I think it is, but Sue Kerr might want to add to that. This realisation has come not only in the alcohol and drug area. In the crime prevention area there have been major reports funded by the government which have recognised the same factors: mental health, suicide, youth homelessness and so on. I think there is an increasing recognition of the common risk factors for a lot of these problems. Getting these various strategies to work interactively is what is desired.

Mr Corcoran—I was on the IDC which led to the stronger families program. The consultations were very broad and addressed all those issues of mental health breakdown and homelessness and there were extensive consultations with the school sector. DETYA, who appeared before you this morning, are working on a youth action pathways plan, which is also going through those same processes but is particularly focused upon the transition from adolescence to young adulthood. All those same issues arise in that context as well.

Mr ANDREWS—I have one other question, which is unrelated to this one. We are all aware of the contention, if I can put it that way, about the effectiveness of various approaches overseas to illicit drug use, and Switzerland is one of the nations which is mentioned often in this context. I was just wondering why the graphs in your submission include Switzerland as a comparison when dealing with alcohol and tobacco but, when dealing with the illicit drugs, there is no comparison with Switzerland amongst all the countries which are listed.

Prof. Hall—It depends on the availability of data. One of the problems in this area, until very recently, was that there had been very little standard forms of data collected across different countries. The European Monitoring Centre, which is set up in the European Union, has now started to produce those sorts of data and we have data for countries that are members of the European Union. Switzerland is not a member of the European Union, and sometimes you do not have data on prevalence of drug use.

Mr ANDREWS—Are you saying, Professor Hall, that we are not able to make a comparison?

Prof. Hall—It is difficult even when we do have the data. If you are talking about the case of Sweden, I think one can be reasonably confident that they do have very low rates of illicit drug use by comparison with a lot of other European countries. But the methods and the ways in which the surveys have been done—the age ranges, the questions that have been asked and so on—differ in various ways. So precise comparisons are often difficult for that reason.

Mr ANDREWS—I do not want to labour the point, but we can compare Belgium, Denmark, Greece, Spain, France, Italy, Luxembourg, Netherlands, Austria, Portugal, Finland and Sweden but not Switzerland.

Prof. Hall—A report by the Swiss government which includes that data was published subsequent to the preparation of material. We can supply that.

Ms JULIE BISHOP—There have been some fairly powerful statements in the report on tobacco use—for example, that tobacco contributes to four in every five drug related deaths and that tobacco use accounts for 67.3 per cent of the total social and economic cost of drug use.

The focus of the national tobacco campaign is adult cessation and targets the 18- to 40-year-old group—and there have obviously been some successes. But I also note that there is a fairly powerful statistic which says there has been a 30 per cent increase in recent tobacco use in the 14- to 19-year-old category between, I think, 1995 and 1998.

A couple of questions arise from that. Firstly, can you explain that increase? Secondly, is there data available to show that that cohort, that 14- to 19-year-old group, continues to smoke and are or are not likely to be long-term users? If so, is there an argument to suggest that we should be concentrating our national tobacco campaigns and strategies on the 14- to 19-year-olds in all our measures, efforts and mass media advertising, et cetera?

Prof. Hall—To make sure that I have all of the questions, you are asking whether that increase that has been reported is real, and if so, what is behind it, and where should we be putting our effort into the tobacco campaigns.

I think the increase is real, and that has come from a series of surveys. There seems to have been an increase in the uptake of tobacco use by young women and young men in recent years. This has not only been observed in Australia but also in the US and in other parts of Britain and Europe. There are suggestions about the activities of the tobacco industry, or changing social attitudes towards tobacco use amongst young people. It has almost achieved some of the status of an illicit drug. Therefore, there is a sense of rebellion about its use. It is certainly something that we ought to be concerned about and something a lot of people would argue that we should be putting more effort into, attempting to prevent smoking in that young age group, particularly as tobacco is a strong predictor of an initiation of cannabis use, for example, and the use of other drugs.

Ms JULIE BISHOP—Which is where I was coming from. Is research being done on what happens to the 14- to 19-year-olds who are taking up tobacco at that time? Are they the ones who are going onto other drugs? Are they becoming long-term tobacco users, or is it just an increase because of certain social phenomena between 1995 and 1998? Do we know?

Prof. Hall—I think we can make some fair guesses. The larger the proportion of young people who initiate tobacco, the larger the proportion will continue to use. The capture rate for daily tobacco use amongst people who are users is in the order of 1:3. If there are more young people experimenting with tobacco then the likelihood is that more of them will continue to smoke into adult life. This is something that we ought to be concerned about. Those who initiate early tobacco use are the ones most likely to be initiating the use of cannabis as well. For both those reasons, they are the group that we ought to be focussing effort on.

Ms JULIE BISHOP—You would agree with the suggestion that the focus of our strategies, campaigns, et cetera, whilst it has been on the 18- to 40-year-olds and has had some successes, ought now be redirected?

Prof. Hall—I do not know about redirected. The department might want to add to this, but I think we certainly need to put more effort into addressing younger smokers. We should still be attempting to persuade older adults as well to stop. I think there is real value in doing that. We need not do one or the other, we can do both.

Ms Kerr—Can I add to that? Two comments are relevant. The most recent phase of the national tobacco campaign, as you would be aware of from the media, is not only to enhance the activity that has been undertaken to date, but also to increase the relevance of the campaign with the 16- to 24-year-olds. That has been a very deliberate move. We do not want to move away from the 18- to 40-year-olds because we know we have had a lot of success with people quitting as a result of seeing the campaign. There has been an economic evaluation undertaken about the impact on people who have quit and who have stayed quit, and we know what the impact on health care savings has been as a result of that work. But the most recent phase of the campaign is to increase the relevance with the 16- to 24-year-olds.

I think we also need to note that the Ministerial Council on Drug Strategy signed off on an action plan on tobacco, and I think we have provided that to the committee separately. That includes a whole range of activities addressed at the issue of youth and smoking. Of course, social marketing campaigns are only one of those activities that both the state and federal governments are undertaking.

Mr EDWARDS—I have evidence from part of another submission to say that the misuse of prescription drugs by older people, especially older women, is of particular concern. In the submission they went on to say that the prescription and misuse of benzodiazopines and other pharmaceutical drugs is common among older women. I know that you have been doing a lot of work through the MPS and through the PHARM committee, but most of that seems to have been focused on providers. I am wondering whether you are doing any educational work with older people directly or through other agencies. If so, can you give us some examples of what you are doing?

Ms Kerr—Firstly, we need to be clear as to what has been the focus of the National Drug Strategy. The main focus in this area has been on the intentional misuse of pharmaceuticals. That is not to say that the use of pharmaceuticals is not a major issue and a major health concern. It is an issue that is dealt with in the Commonwealth department of health. But from the National Drug Strategy's point of view, ministers have been most interested in the intentional misuse. This picks up issues of doctor shopping and so on.

It has been an issue that has not received as much attention as it should have under the National Drug Strategy, but under the current phase of the strategic framework it was recognised that this was an area in which both state and Commonwealth governments needed to do more. The federal minister asked that his existing committee structures look at this intentional misuse of pharmaceuticals. The Australian Pharmaceutical Advisory Committee, which normally does look at the broader issues of older people taking pharmaceuticals, is now making sure that it is looking at the intentional misuse of pharmaceuticals.

Mr Corcoran—The current national prescriber service is particularly targeted at users to assist them in the quality use of their medicines. I think there was a forum in Sydney last Friday which was examining the uptake of that, and there were some very positive findings. There are other initiatives for safety and quality in the use of medicines. I would need to take on notice whether they have that strong educational focus for consumers, as you requested.

Mr EDWARDS—I will accept you coming back to us.

Ms HALL—My question goes to the percentage of the health budget that is spent on prevention, treatment and education in relation to licit and illicit drugs. Could you give me an idea of that? If you do not have the figures with you, I am happy for you to supply them. That is part A. Part B goes to percentage figures—and maybe you are not the people to ask. Could you also tell me what percentage of money from the Tough On Drugs strategy goes towards law enforcement, health and education?

Mr Borthwick—We will be able to provide you with that information. We might be able to provide you with the second material now, but vis-a-vis the first—what percentage of the health budget goes on this area—it would be a very, very small percentage. Our portfolio alone spends $26 billion a year on health. There are state spendings on top of that. That $26 billion accounts for about 15 per cent of the Commonwealth's budget. The state health spendings are 20 to 25 per cent of their budgets. It would be a very small number, but we will be able to get that information for you.

Ms HALL—I would prefer it on notice so that I get the correct figures.

Mr Corcoran—I can tell you that the studies on the percentage spent on population health—that is, primary prevention—as a proportion of all sorts of expenditure on health show that it is less than two per cent, and it has been that way for the last 30 years. It is very difficult to define. We have commissioned some studies over the last two years which suggest that, give or take small fractions, it is around the two per cent mark.

Ms HALL—Maybe you could give the committee a breakdown of those areas. It was a great submission. It shows that the department is doing a lot of research and policy development. Obviously, you have put a lot of time into your submission.

Mr Borthwick—On your second question, I think Ms Kerr could give you a breakdown.

Ms Kerr—The $516 million is the additional money that has gone into the Tough On Drugs National Illicit Drug Strategy, of which $303 million is for demand reduction measures and that includes health, education and family measures, and $213 million is for supply measures, which include Federal Police, Customs, and so on.

Ms HALL—Could you provide the committee with a breakdown of that $303 million? That would be very helpful.

Ms Kerr—Yes.

CHAIR—I have one significant question, which the secretariat has reminded me to ask. The drug use costs in Australia at $18.8 billion in 1992 have been described as conservative. According to you, this estimate does not include the costs of crime associated with illicit drug use nor a host of other costs such as workplace absenteeism. The intention of the question is to try to establish the type of economic costs. We all know that the social costs are not estimable in so many ways. Therefore, is the department intending to do further work or do you have available work which gives us a more comprehensive understanding?

Ms Kerr—Yes, we are intending to do further work. In fact we have engaged Collins and Lapsley, who did the earlier work to which you are referring, to update it and take on board what is now known about the new methods of looking at the costs in this area. We have encouraged them, through the contract, to look at developments overseas in this area. When they first undertook it for the Commonwealth, it was very much groundbreaking work. Since then, more work has been done along these lines in other countries. We thought it was timely that they now be contracted to update the earlier work in Australia. We are hoping that we will have some results from that next year.

CHAIR—Thank you very much for your contribution today. I support the comments on your excellent submission.

Proceedings suspended from 1.32 a.m. to 3.36 a.m.

[3.35 p.m.]

BARRY, Ms Frances, Manager, Alcohol and Drug Priorities, ACT Department of Health and Community Care

BEAUCHAMP, Ms Glenys Ann, Executive Director, Consumer and Community Priorities, ACT Department of Health and Community Care

MOORE, Mr Michael, MLA, Minister for Health and Community Care, ACT Government

CHAIR—Welcome. Would you like to make a brief opening statement?

Mr Moore—Yes. I would be delighted to make an opening statement. I appreciate the opportunity of being able to appear before the committee. Before I start my broad general opening statement, I draw your attention to an error in our submission on page 23. We have drafted a replacement page, and I table that page for inclusion in our submission.

CHAIR—Is it the wish of the committee that the replacement page be incorporated in the transcript of evidence? There being no objection, it is so ordered.

The replacement page read as follows—

Mr Moore—We referred to our position in Australia to draw some conclusions and suggested that, taking into account certain factors, the cost would be approximately $400 million, assuming that the ACT population is 3.5 per cent of the national population. The ACT population is 1.6 per cent, rather than 3.5 per cent, of the population. A little zero slipped onto that $400 million—it should have been $40 million. Having cut it in half, we are talking about $20 million. The corrections fit into the last two lines of the first paragraph. I appreciate the opportunity to correct that, and we apologise for that error. We are pleased that we have been able to identify it for you.

Substance abuse is a complex issue and one for which there are simply no easy answers. The ACT government welcomes the opportunity to provide information to the standing committee inquiring into substance abuse in Australian communities. I would like to offer something else, in somewhat of a personal way, as assistance to the committee. As part of my own masters thesis on this subject, I read about 25 Australian inquiries, either parliamentary inquiries or royal commissions, that went from 1971 through to 1996. I made a single-sentence comment on the thrust of each of those inquiries as I read them. I would be happy to provide copies of that to the committee if you would like them. Additionally—this is not my work—in a submission put to an Assembly committee that is currently looking into cannabis, there was a set of major studies of drugs and drug policy and their titles, with extracts from the conclusions of reports. If you do not have those already, I have provided one copy which might also be useful.

The point I am making—it became clear to me when I was chair of a committee looking into similar issues—is that there is already a huge amount of information available in the community. I think it is helpful to inform a committee like yours, and to put it into context, what has happened already in Australia. I do not think it undermines what the committee is doing—in fact, it helps to inform the committee.

The ACT government's main focus is our commitment to enhancing the health, wellbeing and safety of our community, which includes reducing the harmful consequences associated with the use of all drugs. As outlined in our submission, the policy context for the ACT government's approach to alcohol and other drug use is found in the *ACT Drug Strategy 1999,* which we called *From Harm to Hope*. *From Harm to Hope* acknowledges that health, economic, social and personal harms caused by alcohol, tobacco and other drugs are a major challenge for the ACT. Harms associated with the misuse of drugs are real; they are costly both to the individual and to the community. The *ACT Drug Strategy 1999* outlines broad directions and provides a basis for coordinated action through drawing together the various initiatives to be undertaken in the areas of health education, law enforcement, community safety and the environment.

Our strategy emphasises a partnership between government agencies, non-government agencies and the community in addressing the complex issues surrounding alcohol and other drug use. I should say, Mr Chairman, when the ACT government brought down our budget recently, we accompanied the budget with a paper on social capital. That paper on social capital emphasises the importance of having community groups working together with government and with business to achieve our goals to build social capital in the community. We believe that the building of social capital with regard to this particular problem is one of the myriad ways we need to employ to address the complex issues surrounding alcohol and other drug use.

Through links with appropriate agencies and stakeholders, *From Harm to Home* aims to reduce the supply of harmful drugs, to reduce harmful drug use behaviour, to reduce the use of harmful drugs, to reduce the demand for alcohol and other drugs, especially amongst young people, and to minimise the harms to the individuals in society associated with the use and misuse of alcohol and other drugs. The most controversial part of *From Harm to Hope* is the government maintaining its support for a supervised injecting room. It still does that although you may be aware of the political controversy that surrounded that issue through the last budget. We have now postponed it until after the next election, but we still maintain our support for a supervised injecting room. Similarly, we retain our support for something which I think is much more important—that is, running a trial of the provision of pharmaceutical heroin in the ACT. The government maintains that position and would continue to seek federal government support for us to proceed with that policy.

I emphasise that they are at one end of the extreme of our policy. It is a very broad ranging policy. It takes into account policing, reducing the supply and a range of other things that I spoke of. Nevertheless, it is important to make clear that we still do support those policies because we think they have an important part to play and, should you wish, I would be happy to elaborate on those as well as other issues. Thank you very much for the opportunity of making an opening statement.

Mr QUICK—Can I start first of all by thanking the minister for appearing. I have been to many of these hearings and usually it is the bureaucrats who appear. I am delighted that you have come along today and I acknowledge your widespread interest in this whole issue. One would assume, yours being a tight- knit little Territory, that you would probably have more success in trying to achieve goals because of that close interface with government departments and a clearly defined area. Would that be the case, or am I misjudging the situation?

Mr Moore—I think we certainly have the opportunities to be able to achieve more than in other places. The problems that face us are not so different from other capital cities, particularly in Sydney and Melbourne. On the other hand, because of the way our bureaucracy works, the closeness of the cabinet, the convenient size of the Legislative Assembly and the ability to be able to measure and evaluate what we are trying to do, I think that makes us an ideal place to trial new methods. I suppose we work from a fundamental position that what we have been doing so far has been having some success, but fundamentally it is not working. We are seeking other alternatives which we could pursue that might give us evidence of a better way to go about things.

Mr QUICK—How radical are the steps we need to take? We have pages and pages of evidence and 20 to 30 pages of research documents. How do we break out of the square? I am interested in hearing about your ParentLink program and your education programs. As a former teacher, my big concern is that a lot of the things manifest themselves in schools. If there is an incorrect exclusion policy and the school basically is ‘no drugs’, then that is the end of the story—no compassion, lack of support staff, lack of social welfare workers and the like. But that is an education department problem. You are dealing with health problems and we are all dealing with this overall drug problem. How were you thinking outside the square in the ACT to say, ‘We have this bag of money, and we are dealing with the same parents whether it is related to education, social welfare, road trauma and the like’?

Mr Moore—Each of our policies is examined departmentally and right across cabinet to ensure that we are taking into account what is happening in each of the areas. There is no doubt that the way we bring about the most fundamental change is through our education systems. The difficult part is that, according to the evaluations that I have read, systems of education in terms of drugs have often been counterproductive. Certainly, I am aware of an assessment of the DARE program in the United States that looked at young people two or three years after they had been through the program, where there was, in fact, a worse result for those people who had been through the program compared with those who had not.

You may recall that there was an evaluation done of Life Education in Victoria which suggested that, for all the effort put in, there was very little to show for it in outcomes. I hasten to add that Life Education has changed its approach since that time, and I think we do need to continue to pursue education as an important part of our drug strategies. However, we have to make sure that we are constantly evaluating programs to ensure that we are actually improving things, that we are not making them worse. The difficulty that educationalists are dealing with is neatly summarised in the joke: 'Why did the teenager cross the road?' Answer: 'Because he was told not to.' There is that fundamental problem of how you go about educating young people about these issues, how you provide them with alternatives, what is acceptable behaviour and what is not acceptable behaviour.

The ACT has recently launched its ParentLink program for parents who are struggling with these issues. I must say that—as a parent of two teenagers and of one about to become a teenager—these are, of course, difficult issues to wrestle with. The ParentLink program is available on our web site—and I am happy to give the web address—and also by phone for parents. Education is absolutely fundamental to what happens, but we have to evaluate programs just to make sure that we are doing it properly. Similarly, I have to say that I still believe the single most significant step forward, or radical step forward, we could make would be to proceed with the heroin trial that was approved by the Ministerial Council on Drug Strategy a few years ago. I think that is fundamental because it actually gives us the opportunity to deal with the black market.

I will just take a moment to explain the hypothesis behind that. When somebody is becoming involved in drug use, the first part of the process is that they are enjoying their drug use. Then it starts to become problematic when they begin to need more and more money. As they are needing more money, they really have a small number of choices as to how they will get that money to support what they are still enjoying, although it is beginning to cause some problems. They can rip off their families, they can go to prostitution, they can go to other forms of crime—burglaries, armed robberies and so forth—or they can go to a fourth choice. The most common choice is the fourth one: you find three or four other people to whom you can provide heroin and then you cream the top and thus starts a network marketing. The system will continue as a network marketing system, a system not dissimilar to Amway where somebody phones up and says: 'Do you want to buy some pots and pans and so on?' Instead of the notion of a dealer going out to try and find people, the system itself builds in a growth factor because, invariably, if you are finding three or four other people to use heroin they are likely to be just a bit younger than the current user.

It seems to me that if we provide pharmaceutical heroin to dependent users on a trial basis and if the evaluation says this has not increased the harm—if the evaluation says that it has increased the harm then that is the end of the matter—we then have available to us a policy option to undermine the black market. The step after that would be to say if it has not increased the harm, then what we should do is undermine this network marketing system, this black market, by ensuring that there is a fifth choice. The fifth choice being that pharmaceutical heroin is available for somebody who is semi-dependent within a government environment, which would also have with it the encouragement to take people away from the drug use, to deal with it and to work out what is going on in their lives.

But it seems to me that what is happening worldwide is that, as we see an increase in the production of heroin in particular, we see an increase in the number of people who are using it and we keep coming back to the same policies, trying the same things and trying to get them to work a bit better by finetuning them—but we are actually going backwards. Until we actually take a radical move then I think they will continue to go backwards. That it why the ACT still continues to support proceeding with a trial of the provision of pharmaceutical heroin, consistent with our international treaties of course.

Mr QUICK—That is illicit drugs. What sorts of steps can we take outside the square for tobacco and alcohol? I have been reading about the Canadian experience that if you up the price there is a response and a decrease in those willing to pay a fortune to buy a packet of 20s or 30s, and the same with alcohol. Do we have to think out of the square? If you look at the cost to the health budget in the Territory alone, what radical steps, if any, are being thought of in that regard?

Mr Moore—Some people find it quite ironic that I am a great advocate for more and more restrictions on tobacco. The ACT has been extraordinarily successful in passing new legislation to restrict tobacco sales and use in a range of ways. I will just run through those quickly. One of the things that has made it easy is that it has been something that has gone across the assembly. When Wayne Berry was the minister for health he really started the procedure on tobacco, and it has continued. There has always been across-assembly support for it.

Looking at the smoke-free areas legislation, the AMA in its last report suggested it was still the best smoke-free legislation in Australia. It means that under our legislation, there are about six or seven of the 200 or 300 restaurants that allow a quarter of their restaurant for smoking. We have managed to get the non-smoking message into pubs and clubs. Provided the pub or club meets airconditioning standards 60 and 68.2 they can have half of their pub or club available for smoking. What we are doing is sending a message that, even in the pubs and clubs, in the area where people would expect to be smoking—most of them expect to have the right to smoke—we are sending a message that says, 'No, you don't have a right to smoke.' Everybody already knows the reasons for that, although we will keep reiterating those reasons.

Mr QUICK—Do we say to the clubs: 'Look, I know you are the heart and soul of ACT and New South Wales society—and when they appear before us they will drag out a whole lot of statistical evidence to say that what they are doing is great for the general capital of society—but do we move to the next step and say that you are not allowed to smoke in restaurants, clubs, hotels, the lot?'

Mr Moore—In our submission we suggest that the percentage of people who smoke in the ACT is much lower than in the rest of Australia. It is 18 per cent here compared with 24 per cent with regard to smoking in their own homes. We have not stopped people smoking in pubs and clubs. What we have said is that within those pubs and clubs we are putting a restriction on. It is a radical move, but it is the like the restriction on smoking in restaurants: many restaurateurs warned us at the time that this would mean the end of restaurants in the ACT, but just the opposite has happened. Similarly, with the pubs and clubs we have had no adverse reports or findings over the use of pubs and clubs and yet we are getting a very clear message where we are not condoning the use of tobacco.

I do not think we have been successful yet in finding the right answer with alcohol. We are aware that alcohol in particular is a drug of violence. We are aware of the association of alcohol with domestic violence and a range of other issues. We are dealing with road trauma. Once again I think we need to begin the process that we have used with tobacco of putting on restrictions and making it more and more difficult to get, but not slipping across to prohibition. The balance is really important. We can see even with tobacco that we are pushing the line on the balance at the moment as we see the advent of chop-chop, the illicit market in tobacco. So I think it is an indicator for us that we are about right and perhaps it is time to look at the other areas. By the way, it also means that one of the important things for our police forces across Australia to do is to work vigorously now on chop-chop. Although it may not seem very important to them at the moment, it is like an epidemic: if you nip it in the bud, if you get it when it is starting, then you are much more likely to be successful than once there is a whole network established. I think that is an important factor.

Ms ELLIS—We had the Department of Education, Training and Youth Affairs here this morning and, amongst other things, they told us about their pamphlet called *Tough on Drugs*, which is beginning to be distributed to every school and parent in the country today. I was wondering whether, as you are the health minister, you had any input at all into the process. It is supposedly being done—and I believe that to be the case—through all of the state and territory governments. I am wondering whether you were aware of this pamphlet.

Mr Moore—I am certainly aware of it, and I have read the articles in the newspaper.

Ms ELLIS—Did you have any input into it?

Mr Moore—I had no input whatsoever. In fact, I raised the issue at the Ministerial Council on Drug Strategy and requested that we do have some input into it. Having not seen it, I must say I do not know whether or not I would agree with it. There is no doubt in my mind that there would be the vast majority in it that I would agree with because of the process that these things go through. But I have to say that it is extraordinarily frustrating to know that a pamphlet like that is going out to every parent in the ACT when we may have had the opportunity to finetune it or at least have an input.

Ms ELLIS—It might be food for your soul to know that we also asked some questions about the pamphlet, for which we are awaiting answers. Going to another subject, you say in your submission that, amongst other things, there is a pressing need to address what you would describe as a hep C epidemic, which is affecting injecting drug users in Canberra. Why do you

think that this has become such a problem when we have needle and syringe programs available which have worked so well in other areas? This has been a question that committee members, in particular Mr Schultz, have been asking many people. The needle and syringe exchange programs have been so successful, such world breaking examples of curtailing some disease. What is happening with hep C, in your opinion?

Mr Moore—I have asked for medical advice on this, and I would very strongly encourage the committee to find epidemiological advice and have it interpreted and explained by appropriately qualified medical people. The explanation that I have heard is that hepatitis C, whilst the outcomes are not as disastrous as for HIV, is a more vigorous virus and spreads more easily. Therefore, although the sharing of needles will bring about the spread of hepatitis C and HIV, it may well be with hepatitis C that even the lack of cleanliness in the process may be enough to share the virus. The other factor that needs to be taken into account with hep C was that we did not understand that it was there. Many of the people who are now identifying it as hepatitis C probably caught hepatitis C some years ago with the sharing of needles. So there are cases that are being reported now.

Ms ELLIS—So they have been dormant.

Mr Moore—They have been dormant or they just were not aware. The knew they were crook and when they have a blood test the disease reveals itself. Sometimes it occurs after only a single use of needles. I would like to use this opportunity to remind members of the committee that, according to the information provided to the Ministerial Council on Drug Strategy, we distribute 25 million needles a year across Australia. We have yet to have a single recorded case of hepatitis C or HIV from a discarded needle. We still do not have a single case in the literature of a discarded needle, not of a deliberate use. I think it does help us to understand that, although a program like that always has to have downsides and upsides, the evidence does not support the thing that people fear most. I think that is worth keeping in mind.

Mrs IRWIN—The committee has noted from your submission that the Department of Health and Community Care will provide funding to DFACT for the provision of residential support for drug affected families. What is the nature of this residential support? Could you explain how it works.

Mr Moore—I would ask Ms Barry to respond to the specifics on that.

Ms Barry—The organisation is actually ADFACT, the Alcohol and Drug Foundation of the ACT, so that might be a typo. They run a number of residential rehabilitation services in the ACT. The main one is the Karralika Therapeutic Community, which is a 50-bed residential rehab service. It is an abstinence based service. They have two campuses. At one of those, they actually house women and children. We perceived that there was a need for additional support for the families and the children to address both the issue of the parent's problematic drug use and the dangers for children growing up with problematic drug use in their families, without those issues being addressed when they were very small. So the funding will actually provide a part-time child psychologist to work with the children at Karralika and a part-time family therapist to work with the families and the children. It will also fund a child-care centre that is part of one of the Karralika campuses. The child-care centre actually already exists, but the

organisation has been attempting to fund it out of their recurrent base. This means that the children can be cared for in a fairly therapeutic safe environment while their mothers go off to treatment during the day.

Mrs IRWIN—When do you expect this to be fully up and running?

Ms Barry—The actual child-care centre exists now. The position of the child psychologist has been advertised, and I believe ADFACT is interviewing for the position at the moment. With the family therapist, I think ADFACT is intending actually to bring in sessional family therapists who will be starting in the next month or two.

Mrs IRWIN—Do you know whether there are waiting lists for the child-care facilities?

Ms Barry—No, not at the moment. The child-care facility is primarily for residents of the rehab. They also run some halfway houses, and the children at the halfway houses can access it too. They do after school care for the older children. It depends a little bit on which people they have in the rehab at any given time. Sometimes they have vacancies and sometimes they are quite full.

Mrs IRWIN—I understand that the ACT Government has a Simple Cannabis Offence Notice system. Would you outline for the committee how this works and what you see as its benefits?

Mr Moore—Certainly. The legislation was based on the South Australian legislation, with some modification. The Simple Cannabis Offence Notice is an option that police have when they find a young person who is using cannabis. The first option that they have is to do what a police officer often does, which is to say, 'This is a silly thing to be doing. If I catch you again, you are really in strife.' Police always retain that prerogative.

Mrs IRWIN—It is a warning.

Mr Moore—The warning bell. They normally have that discretion with anything they do. Secondly, they have the discretion to issue a $100 on-the-spot fine. That is what the cannabis offence notice is. That would be for somebody who has less than 25 grams of cannabis or up to five plants. The other option that the police officer has is to charge the person. If, for example, a person had just four plants, but each of those plants was bush size—a couple of metres high—then we would expect the police officer to charge the person so the magistrate can then determine the seriousness of the offence. Whereas if there were three or four very small plants, clearly for personal use, that would be the end of the matter.

With our agreement with the Commonwealth on the Tough on Drugs approach, we have also agreed, as part of the diversionary approach, to give the police officer another discretion, which is to provide information at that point. If there is a more serious offence, the police officer can apply a diversion approach similar to that taken across Australia for somebody who has a serious cannabis problem—the same as they do with a minor heroin or ecstasy problem. They can provide a diversion process. I think that is the nub of how it works.

We think that the difference between our approach and the South Australian approach, where the police officer maintains the discretion to charge, is one of the reasons why our system is more successful. I would have to say that it has not been through an evaluation as rigorous as that of the South Australian system, but we still believe that it is a successful system. We do have a problem with it, and that is that people have not been paying their fines. The government has determined that the appropriate way of dealing with this is to ensure fine collection is dealt with in the same way as other offences, such as parking offences. The method we use with regard to parking offences, which was introduced four or five years ago, is to take away people's driver's licences if they don't pay their fines. We have not ever taken away a driver's licence, but everybody pays their fines. We think we should apply exactly the same approach. When I pointed this out to my 14-year-old, he laughed until I pointed out that, 'We can make sure you don't get your learner's until such time as you pay $100, if you are silly enough to be involved in this,' to which he said, 'Oh, that's not fair.' I think the system, which we will apply but have not done yet, will resolve an anomaly in our system.

CHAIR—Thank you. We do not often have the advantage of having a practising politician with us. I would like to ask a more general question, about the balance between the licit and the illicit—between smokes and alcohol and between marijuana and heroin and all the illicits. In terms of striking a balance and the impact on society, you have heard the criticism that money is being spent on the illicits and that there is a whole lot of focus on that but we don't seem to find quite the same energy for those that have been there for a long time. How do you argue, in the ACT circumstance, that balance? Those things have been with us for a fair while, but they certainly capture public attention—in terms of the political attention and therefore of the political pressure. Can you give us an insight into how you see some of that?

Mr Moore—I have been in politics for the past 11 years and nothing has caught the imagination of the community like the heroin trial in terms of drug issues. The efforts of the ACT with regard to tobacco have been just as vigorous—probably much more vigorous, actually. I think the success has been remarkable. We have tried to illustrate that it is exactly the same approach—that what we are always doing is applying harm minimisation; if we can minimise the harm we will do it. I will put it in this way: Neil Blewett made a comment recently when he was given an award by the public health association—and remember, he was responsible, with the support of the then liberal health shadow minister, for the needle exchange program's acceptance in Australia. He said: 'Whatever you do, make sure it is pragmatic. Make sure you get in there and sell it.' To me it was a very good message. So too with tobacco; it is pragmatic. I think we have not done nearly as well on alcohol, probably because our focus was about where the greatest number of deaths are occurring and where the greatest health impacts are, and that it is tobacco by miles and miles in terms of measuring health in hospital and disease terms. But if you look at the health of the community in terms of the impact of alcohol, it is also quite extraordinary. We need a lot more effort in that area. I made a comment earlier about an epidemic of illicit drugs. The earlier you can tackle illicit drugs and contain the epidemic, the better off we are going to be.

CHAIR—Yes. You could make the case that if we applied the same attention we gave the illicit to the licit, and with the same enthusiasm and determination—

Mr Moore—I would encourage a committee like yours, when it reports—and in the things that I do—to always say that it is not just the illicit drugs; we must also be looking at tobacco and alcohol, because alcohol and tobacco are still our biggest problems. There are certainly more deaths associated with them than illicit drugs. Nevertheless, we have to take these other things seriously. We are taking them both seriously. Our greatest expenditure still should be on dealing with tobacco and alcohol.

CHAIR—Thank you very much. I have one quick question on the workplace, workplace safety and productivity, employee assistance programs and families dealing with drug problems. Are there other measures you would like to see adopted by government to help deal with workplace issues? Was there anything you have experienced, particularly?

Ms Barry—The inter-governmental committee on alcohol and drugs, which supports the Ministerial Council on Drug Strategy, is developing an options paper at the moment looking at the literature and the research around best practice for managing alcohol and drug problems in the workplace. I am hoping we will get some good ideas out of that.

CHAIR—You captured some of the comments earlier that this inquiry is occurring as a lot of other things are occurring, and we are chasing these things through as they are happening. A lot of it has not been appraised or tested. So a lot of things are happening. We are moving along with you, I suspect, and trying to understand at the same time, as you people are, if I can put it that way.

Mr Moore—There are a huge number of things happening. I am sure you have heard information on Naltrexone, on buprenorphine—on a whole series of pharmacotherapies that we are experimenting with at the moment. Methadone has been our major and most successful form of treatment for many years and has made an extraordinarily positive contribution to dealing with drug use. That was started well over 20 years ago. It is time for us to look at alternative pharmacotherapies. As you know, they are being trialed.

The really positive part about it is that jurisdictions are doing this together, rather than everybody trying to trial all the same sorts of things at the one time. It is that sort of approach that contrasted so much with the pamphlet that the deputy chair asked about before. The jurisdictions are all trying to work together to make sure that we have a coordinated and cooperative approach.

A pamphlet like that coming out actually undermines that cooperation and coordination. That was the disappointing thing about it—it came through the Australian National Council on Drugs, which ministers at the Ministerial Council on Drug Strategy accepted. It was a federal government initiative. However, the Ministerial Council on Drug Strategy accepted it and said, 'Yes, we will take advice directly from the Australian National Council on Drugs' and thereby, effectively, gave them a very important seat. Major Watters reports to the Ministerial Council on Drug Strategy at each of its meetings. What we need to do is make sure that we maintain a cooperative approach between jurisdictions.

Ms ELLIS—Did you have an input in that?

Mr Moore—I would love to see a copy.

Ms ELLIS—You have not seen that either?

Mr Moore—No.

Ms ELLIS—*The National School Drug Education Strategy* or the National Framework of Protocols—

Mr Moore—Maybe our education people have seen it.

Ms ELLIS—Health has it.

Mr Moore—I certainly have not seen those and, as of this morning, the trays on my desk were clear—I have to say that because it hardly ever happens.

Dr NELSON—Mr Moore, has generic packaging of tobacco been on the agenda of the Ministerial Council on Drug Strategy?

Mr Moore—Not that I recall. We certainly are in the process of saying, 'What would be the next step where we can undermine what the tobacco companies are trying to achieve?' They are trying to achieve an increase in tobacco use. We are trying to achieve a decrease in tobacco use. Fundamentally, we are going in opposite directions. We think we have pushed the envelope a long way in the ACT but we are now looking for where our next steps might be. As I said earlier, that is right across the assembly; it is not party political.

Dr NELSON—Would the ACT government consider bringing generic packaging of tobacco to the ministerial council table for consideration?

Mr Moore—What an excellent idea. I would be very happy to do that. The most important thing is that we could not manage that on our own. Asking for the ACT to do generic packaging of tobacco would have minimal impact across Australia. However, to try to encourage others to do it is an excellent idea and I am quite comfortable about taking that as a suggestion and proceeding with it.

Dr NELSON—It would, of course, require the agreement of all the states, as we did with health warnings.

Mr Moore—It still takes somebody to bring it to that forum. I would be delighted to check and see if anybody else is doing it. If they are not I will do so.

Dr NELSON—Thank you.

Mr SCHULTZ—I have taken an interest in the issue of drugs for about 14 years now and I can vividly remember the issue of the HIV problem in the late 1980s in Australia. I can also vividly remember the then federal government bringing in an extensive safe sex campaign to try

to send the message out that there was a problem within the homosexual community with the spread of HIV-AIDS. At that time—and my memory is not as bad as some people would like to think it is—HIV-AIDS was mooted in the public arena time and time again as running at around two per cent. Here we are today talking about three per cent and justifying the needle syringe exchange program as an example of how we have kept it under control. I can only speak for New South Wales, but how have we kept it under control in an environment where in 1988 we were distributing—sorry, we were not distributing needles; it was called a needle syringe exchange program—and exchanging 1.2 million needles but today we are distributing somewhere in excess of nine million, and we are doing that in an environment where HIV has gone from two per cent in the late 1980s to three per cent in the year 2000? Those are your figures, and other people who have been giving evidence to this committee have quoted the same figures. We are continually hearing from people that the needle distribution program has, in fact, kept HIV under control, yet the figures quoted over that 10-year period would indicate otherwise.

The other point that I make is that the issue of hepatitis C, being at epidemic proportions in the ACT, is the same in the other states. We have got a hep C epidemic right across Australia in an environment where 90 per cent of the people infected by hep C are injecting drug users and who have access to the needle syringe exchange program. That would indicate to me that there is a pretty compelling argument that the needle syringe distribution program is not working and, in fact, is contributing to the increase of hep C and the increase of HIV-AIDS.

When I try to ask people, as an example, to justify the figures that they continually raise in a airy-fairy way about the return of needles and where they get these figures from, all you get are bland broad based statements. What I am asking is: how can you, in your position, justify the points that I make with regard to the HIV infection rate being 2 per cent 10 years ago and 3 per cent today, and then come to this committee and say that the needle syringe exchange program is keeping HIV under control? Certainly, on the evidence placed before us, that is also being used as justification for keeping Hep C under control.

Mr Moore—Let me start by saying the needle exchange program, however you call it, is making a major contribution to keeping HIV, hepatitis C, under control.

Mr SCHULTZ—Where is the scientific evidence?

Mr Moore—I will come to it. There is a huge amount in the scientific literature in epidemiological evidence as to why that is happening. Perhaps I will deal with that issue being called needle exchange programs. I always read it in the same way as you see a book exchanged. A book exchange does not necessarily mean one-for-one. That having been said, maybe we should call it a needle provision exercise rather than get caught up in the language. We are distributing, at the moment, about 25 million needles across Australia. I like to make the point I made earlier that we have yet to find a single case of a discarded needle that has caused somebody to contract an infection of either hepatitis C or HIV in spite of the fact that we have been doing 25 million needles a year.

The next point to make is that where you read the international evidence on needle exchange programs compared to where there are not needle exchange programs, it is very clear that where

there are not needle exchange programs the issue of HIV, hepatitis C, is much, much worse than where there are not needle exchange programs. We know, unfortunately, that although we do provide needles, some people still share those needles and, therefore, we do see an increase. However, it is nowhere near the rate of increase in places where there is no needle exchange.

I can give an example that I heard recently of the impact where you do not have needle exchange programs. The population of broader New York City is not so different from the population of New South Wales. In New York they now have 40,000 cases of paediatric HIV, 40,000 children with HIV. I do not know what the numbers are in New South Wales but I am sure it is in the hundreds.

Dr NELSON—It is 43.

Mr Moore—There are 43 three cases in New South Wales. That figure alone illustrates very clearly the impact of a needle exchange program. It is not working as well with Hepatitis C, as I said earlier. With hepatitis C we have to look beyond needle exchange, we have to look at cleanliness and use of the equipment as well. But there is no doubt that the epidemiological evidence shows very clearly the difference in the spread of HIV where there are needle exchanges compared to where there are not.

The best paper I have read on it is one that compared Liverpool, in the United Kingdom, with Edinburgh. Liverpool introduced a needle exchange program very early in the epidemic whereas Edinburgh was very reluctant to do so. Subsequently, it was found that there was a very small percentage of the spread of HIV in Liverpool. However, the figure—and it would be four or five years since I read this paper—for Edinburgh was something in the order of 60 per cent or 70 per cent of intravenous drug users who became HIV positive.

The most interesting thing from the study, though, was that there was no change in the increase in drug use between the two. So the argument that this condones drug use was not borne out by the study—and they did assess that. When we make international comparisons, we can probably draw the same sorts of conclusions, although it is always very difficult to extrapolate from one society to another because of the range of differences that there is. For example, if we want to learn something from the Netherlands or Switzerland—which, I would be quite interested in arguing, have very good policies in this area—it is very difficult to extrapolate from those societies, just as it is difficult to extrapolate from Sweden to see what it is doing. But we can learn some things from those societies.

Mr SCHULTZ—I will make just one point. Quoting overseas figures is all very well—I can quote overseas experience which tells the opposite side of the story to that which you are telling. It depends on how you look at it and what information you selectively use. The point that I made before—and you have not answered this—remains: how is it that since 1988 we have gone from an HIV infection rate of two per cent in this country to three per cent today?

Mr Moore—Without needle exchange, we would expect it to be well beyond three per cent; we would expect it to be in the order of 10 per cent, I suspect. I am informed by Ms Barry that the national committee on HIV related diseases as recently as last week produced a summary of the data supporting needle exchange, and I am certainly happy to provide a copy of that to the

committee. It seems to me that the evidence is totally overwhelming as to the success of needle exchange—even the figures that I have seen that looked at Vancouver, for example. There is a recent document around that suggests that the Vancouver experiment illustrates the opposite, but I have seen writings from the person who did the experiment that say that the arguments which suggest that needle exchange has caused more problems than it has solved are inconsistent with his findings. So we have to be very careful that we read the primary sources and that they are not taken out of their context.

CHAIR—Thank you very much. It has been very valuable. We appreciate your input, and we will probably meet again—we have a long way to go.

Mr Moore—Mr Chairman, thank you very much for the opportunity to appear before the committee. It is greatly appreciated.

[4.29 p.m.]

BROOKS, Mr Chris, Team Leader, Research Management and Strategy, Australian Transport Safety Bureau, Department of Transport and Regional Services

MAWHINNEY, Mr Vivan Hubert, Acting Assistant Secretary, Non Self-Governing Territories Branch, Department of Transport and Regional Services

CHAIR—Welcome.

Mr Mawhinney—I should mention at the outset that we are a joint effort. I am from the territories side of the Transport and Regional Services portfolio; my colleague Chris Brooks is from the Australian Transport Safety Bureau. With the committee's indulgence, I would like to say a couple of things about the territories, and then we will move on to Chris.

CHAIR—Thank you.

Mr Mawhinney—I would like to begin by thanking the committee for giving us the opportunity to appear. In relation to the self-governing territories—that is, the ACT, the Northern Territory and Norfolk Island—we are aware that the committee has invited submissions directly from those territories.

The Department of Transport and Regional Services has overall responsibility for the remaining territories, the administered territories of Christmas Island, Cocos (Keeling) Islands and Jervis Bay. In the main, the services in the territories are delivered by others. In the case of Cocos and Christmas Islands, we have contractual arrangements with the Western Australian government. In the case of the Jervis Bay territory, most services are delivered by the ACT government on the Commonwealth's behalf.

Some background has been obtained about these territories and was attached to the department's submission to the inquiry. The senior social worker for the Indian Ocean territories has provided information in respect of Cocos and Christmas Islands, and the community nurse has provided information in respect of Jervis Bay. That information tells us that the circumstances in these territories are not greatly different from, and certainly not worse than, those in comparable communities on the mainland. However, I will provide or obtain any further information about the territories that the committee might desire. I think that is enough from me in relation to the territories, and I will now hand over to my colleague Chris Brooks.

CHAIR—Thank you.

Mr Brooks—The committee's terms of reference include the contribution of alcohol and other drugs to road trauma, and that is the issue that we have addressed in our contribution to the department's submission and the area that I can speak to.

The states and territories have direct hands-on responsibility for laws relating to road user behaviour, including alcohol and other drugs, but the Commonwealth does seek to promote a nationally consistent approach based on identification and application of best practice. The coordinating structure for that includes the Australian Transport Council; ministers from the Commonwealth, states and territories; Austroads, which is the national association of federal state and territory roads and traffic authorities—New Zealand is in there too; and a national road safety panel which includes those players plus representatives of police, industry and community groups. The ATSB chairs that panel.

The material provided in our submission referred to a report by the Austroads working group on drugs and driving to which ATSB contributed. That report is a response to a directive from federal, state and territory ministers at Australian Transport Council. We had hoped to be able to include that as an attachment to our submission. The report has been completed, it is about to be distributed to ATC ministers but, as a courtesy to ministers, we would prefer to see that go out—which I would expect to be within the next few days—before tabling it in any other context. There are no secrets in that report. It is based on published information, and I can speak freely about the published research on which it is based.

In the road safety context, it is the psychoactive drugs that are basically of potential concern, those that act on the brain or central nervous system affecting perception, behaviour, judgment, reaction time and so on. There are many such drugs, and we can classify them broadly by purpose—the therapeutic, recreational or performance enhancing drugs; by legal status—the legal, the illegal and the prescription drugs in between; and by pharmacological class. The drugs that turn up from laboratory research as having a question mark against them in road safety terms include the depressants, including alcohol; antidepressants; antihypotensives; antihistamines; stimulants; hallucinogens; and some of the pain-killers—analgesics.

Of the lot, the one that really stands out, on the available research evidence in terms of contributing to deaths and injuries on the road, is the legal, recreational depressant, alcohol. On the available evidence, it is not only more important than any of the others; it is more important than the others put together. That is partly because alcohol is so widely used but it also appears to increase users' crash risk more than any other drug that commonly turns up in the fatality or injury statistics. That is not to say that the other drugs are no problem, merely that they are a smaller problem than alcohol. To put it into perspective, about 28 per cent of drivers and motorcycle riders killed on Australian roads have a blood alcohol concentration above 0.05. Roughly the same proportion—28 per cent—of all fatal crashes involve at least one driver or rider over that alcohol limit. Alcohol use by pedestrians is also a significant problem. Around 40 per cent of adult pedestrians killed on our roads have an elevated blood alcohol concentration and for young adults and older teenagers the figure is even higher.

Turning to the other drugs, traces of the sorts of drugs I mentioned turn up in quite a high proportion of driver fatalities—about 24 per cent, according to Australian data that have been compiled by Dr Olaf Drummer of the Victorian Institute for Forensic Medicine. He summarised essentially all of the available Australian data on road fatalities. There are several thousand cases. That sort of figure of 24 per cent is often quoted as proving that drugs are comparable to alcohol as a road safety problem, but there are a number of caveats on that. The first is that a lot of the crash-involved drivers in whom drugs are detected have also been using alcohol—roughly two in five of them, in fact. The second is that the drug positive cases can include

y two in five of them, in fact. The second is that the drug positive cases can include people with quite low concentrations of drugs in their system, including therapeutic drugs. The third, particularly in relation to cannabis, is that many studies have classified people as cannabis positive when what have been found in them are breakdown products of cannabis that can remain in the body for several days after use. So you are identifying they are cannabis users but not necessarily people who were behaviourally affected by cannabis at the time of the crash.

The most recent figures put the total cannabis user group at about 14 per cent but those with the active form of cannabis in their body at something nearer to three per cent. The other drugs that turn up in more than about one per cent include stimulants—perhaps around two per cent—benzodiazopenes, things like valium in about one per cent, opioids—about two per cent, and that is lumping in everything from strong pain killers to heroin—and other various combinations can turn up in anything between two and five per cent of drivers.

As I was suggesting a moment ago, just because we find traces of a psychoactive drug, that does not mean that the crash would not have occurred without the drug. If you tested deceased drivers for caffeine and nicotine, you would find that many of them had used those but they—at least caffeine—are probably not contributory to the crash. The method that has been used to tease this problem apart is called culpability analysis. You combine your data on what drugs are present in which drivers with data on responsibility for the crash. The basic logic there is that anything that has a causal link for crash involvement ought to be found more in the at fault drivers than in the not at fault drivers. That works for alcohol and it reproduces the sorts of risk estimates for alcohol that you get by other measures.

When you do that again, alcohol stands out, and alcohol in combination with other drugs stands out as being linked to culpable drivers. As a group, the drivers with cannabis in their system look about the same as the alcohol and drug free drivers, which is odd because they are more likely to be young, male and, by definition, are a less law abiding, risk averse group than the control group. But that is a finding that is consistent with overseas data. When we get down to the other drugs as a group, there seems to be some association with crash risk but it is only about as strong as the association with alcohol at around the legal limit of 0.05, much less strong than alcohol at higher concentrations. Multiple drug combinations come out as a high risk group. In the serious injury cases the benzodiazopenes, at about one or two per cent, also come out.

Drawing on that sort of data, we have provided in our submission some estimates of the sorts of crash reductions you might get if, hypothetically, you could get all the alcohol or all the drugs out of the road system. Basically, if no drivers used alcohol, the number of fatal crashes might go down by about 25 per cent and the number of serious injury crashes by about nine per cent. Alcohol is very skewed towards the high severity fatal crashes. If you could get all the other drugs out of the system, the number of fatal crashes might go down by somewhere between four and 11 per cent—different Australian data sets differ slightly—and the number of serious injury crashes by about one per cent.

We have also, in view of the committee's terms of reference, translated that into cost figures. The Bureau of Transport Economics recently estimated the total cost of road crashes in Australia at $15 billion per year. Of that, about $10 billion is associated with fatal and serious

injury crashes. Looking at the fatal and injury crashes and applying those reductions, if you could get rid of all the alcohol you would be looking at a $1,300 million per annum saving to society. If you could get rid of all the other drugs you would be looking at savings of the order of $200 million to $460 million. I would emphasise that those other drug figures include drug-alcohol combinations. I have spoken a bit longer than I intended to, so I will stop there.

CHAIR—Thank you very much, Mr Brooks. That was a very absorbing hypothesis of the what-ifs.

Mr SCHULTZ—I refer you to your submission, which on page 5 notes that a substantial number of drugs other than alcohol have been shown to impair driving performance. However, on page 6 your submission cautions that any proposed actions to address drugs and driving should not compromise existing anti-drink driving programs. Do you think drugs other than alcohol and driving is an important public health and safety issue worthy of some government action? If so, could you explain to me why federally funded needle syringe disposal facilities have been included in toilets and baby change rooms in rest areas strategically positioned along major arterial highways such as the Hume Highway?

Mr Brooks—Can I emphasise what I hope I said earlier, that I was making some comments about the relative contributions of alcohol and other drugs. I had certainly not intended to say that drugs other than alcohol were no problem; merely that, on the available evidence, alcohol is by far the bigger problem.

The second point is that there is a distinction between drugs where there is evidence of impairment of functions or tasks that we normally think of as driving related, compared to the effect out in the field on road crashes. I will add to that. Perhaps traditionally we have thought that the link between alcohol and road crashes was purely one of impairment—people's reaction times slowing and so on. Increasingly it is being recognised that there are other drugs which in the laboratory are as impairing but do not seem to show up particularly in the road fatality figures as much, and that is because alcohol produces a combination of impairment and overconfidence and, in some cases, aggression, which can be a particular worry.

Third, one thing that I did not say but I should have is that driving under the influence of drugs other than alcohol is illegal in every state and territory in Australia and the penalties are quite severe. The exact form of the legislation does vary and the extent to which the different jurisdictions have mechanisms in place to enforce varies, but I would not want to leave the impression that it was open slather on driving with drugs and impairment.

With regard to the issue of needle exchanges on the Hume Highway, I think that is part of the broader issue of drugs related policy that this committee is dealing with. It is really outside my area of expertise which is specifically the effects of alcohol and drugs on road safety.

Mr SCHULTZ—Given the issue that I have just raised, if Alby Schultz pulled into the truck or car rest area between Yass and Gunning, went into a toilet and injected himself with a dose of heroin and then got into his car and drove up the road, would my driving ability be impaired to the point that I could become a danger to other motorists on the road?

Mr Brooks—I can only go back to the available evidence which shows that the opiates—one of a general class of drugs which, on the available data, seem to be associated with some elevation in crash risk—at the moment are not statistically significant. Obviously, if you had to bet or if you had to make a choice of whether you would share the road with people who are free from any form of drug or alcohol and people who are using heroin, everybody would make the choice that they would rather be sharing the road with drug free people. In the overall contribution to road trauma, the numbers at the moment appear to be quite small.

Mr QUICK—Do all states have .05?

Mr Brooks—Yes, that is right, as a basic limit. There are special limits for professional drivers and in most states for young people in the first three years of driving.

Mr QUICK—Are the fines consistent across Australia?

Mr Brooks—No, there are variations. I do not have with me a current list of penalties in all the states, but there are variations. Essentially all of the jurisdictions have a graded system of penalties related to the severity of the offence.

Mr QUICK—I understand in New South Wales and the ACT on long weekends, if you are caught speeding, they double your points. I was talking today about another group thinking outside the box. Is there any thought of doubling the fine if you blow over .05? You mention future directions for the department—RBT, installation of alcohol ignition interlocks, marking of lower alcohol beer and intervention programs. Why not double the fines? Why not confiscate a licence, do something really radical? You are talking in excess of $1 billion.

Mr Brooks—As you say, the points demerit refers to demerit points and, in most jurisdictions, BAC offences do not attract point demerit points because they are too serious and drivers are losing their licence, in many cases immediately. That is not always the case. Some states do apply points demerit to low range alcohol offences. In the past the department, through the Federal Office of Road Safety and the Australian Transport Safety Bureau, has brought suggestions to ministers, particularly for toughening penalties for those low range alcohol offences, and for taking a tough stance on penalties generally for alcohol offences. I think the general perception in the community now is that the penalties by and large are tough. Certainly, penalties is one of a range of policy options that are there. The other important thing is the perceived probability of being caught. That is another thing that we often jump up and down about.

Mr QUICK—I know when I lived in Victoria the road toll was going through the roof and we had a national approach—seatbelts. There was a huge campaign on television and in the media. Bumper bars were standard on cars—airbags, the whole box and dice. We changed the whole societal look on road fatalities. Why are we not doing something really radical about alcohol and the road toll?

Mr Brooks—I think it is fair to say that some of the options that have been used with alcohol are really radical, we have just got rather used to them. Random breath testing when it came in was quite a radical step. The police were given powers to stop people who were committing no

offence, doing nothing to attract attention to themselves, but they could be stopped, checked, and suffer very severe penalties if they were over the limit. That is so radical that a lot of other countries still do not think they can do it. Our penalties for alcohol offences, by and large, are severe compared to a lot of other countries. If we look at what has happened over the last two decades, the figure is about 28 per cent for drivers and rider fatalities over 0.05. In 1981 that figure was 40 to 44 per cent.

There really has been a massive shift. Not only has the percentage gone down but also the absolute number of road fatalities has gone down very considerably over that period, partly because of the successful attack on alcohol. Not only do other countries not necessarily have random breath testing, but the intensity of alcohol enforcement is really quite unusual in Australia. In most jurisdictions now there is roughly one random breath test per two licensed drivers per year. That is far more than we were seeing a little over a decade ago. Alcohol really has been a focus of road safety activity, and it has been successful to the extent that while it has not been eliminated, drink driving has been massively suppressed.

Mr QUICK—This is not a facetious remark but is society happy with the level? At what stage do we say, 'That is about as good as we can get it, from 40-odd down to 25 per cent'? Is society going to be happy with 20 per cent? Is the health system going to happy with 20 per cent? Have you guys got a bottom line?

Mr Brooks—We do not have a bottom line that we advocate. We are in the process of putting up at the Australian Transport Council, in consultation with the states and territories, a road safety strategy through to the year 2010. Ministers at ATC have already agreed in principle to the target for that strategy, and that target is to reduce the current road toll in terms of the population rate by 40 per cent. Within the strategy we are putting a range of actions that would need to be undertaken to achieve that sort of target, and further measures against alcohol feature there. As well, we will be vigorously pursuing the current measures. So as a global thing we think a further 40 per cent reduction is quite achievable.

Mr QUICK—Thank you.

Mr EDWARDS—In the submission it is noted that RBT has been less effective in rural than in urban areas. Is this because country people still feel that they have got the right to kill themselves and each other, or is it simply because city drivers are visiting the bush and they are not used to the conditions, or is it because there is not as much effort in country areas in the application of RBT?

Mr Brooks—I will try to brief. There has been research into this area. First of all, it is essentially an issue with the country drivers rather than city visitors. The issues include the fact that country people can have fewer alternatives than city people, that is, there is not necessarily a tram or a bus or a taxi to get you to or from the pub if you want to take some option rather than using your car.

A second thing that comes out is that country people have very good networks, and news about exactly when and where the random breath testing is going to be can perhaps travel better than it does in the city. There was some concern expressed by research done in Victoria that was

suggesting that in some cases very visible enforcement could actually have a perverse effect because everybody knew when and where the booze bus would be and so they got home by taking the back roads. However, back roads are more dangerous roads than main highways. There was a concern that there were casualties being generated by putting the drunks onto the more dangerous roads. The Victoria Police addressed that by having the highly visible booze bus but also sending patrol cars out to the back roads to make damn sure everybody knew about it. Of course, the ultimate objective with RBT is not so much to catch people as to deter them. Does that answer the question?

Mr EDWARDS—Yes, but I have a quick follow-up question: is there any move nationally towards a zero blood alcohol level, enforced at .02?

Mr Brooks—There is already effectively a zero or .02 blood alcohol level for professional drivers, for novice drivers under the age of 25 in their first three years of driving, and in some jurisdictions for people who have had their licence taken away and are coming back. I am not aware that any government is looking at extending that to a universal .02.

Mrs IRWIN—I have three very short questions in one. Regarding heavy vehicle drivers and stimulant use, your submission on page 7 states:

... use of stimulants by truck drivers to combat fatigue is fairly common ...

We have been reading about that in all the national newspapers. How commonly are stimulants used by truck drivers? To what extent is stimulant use a factor in crashes among truck drivers? Can you elaborate on some of the measures that the department is taking, or proposing to take, to reduce driver fatigue?

Mr Brooks—On the first question, I would refer to the self-report survey data, and there is other evidence that that agrees fairly well with the facts. A survey that we funded in 1991 suggested that about 30 per cent of drivers use stimulants at least at some time. Encouragingly, by 1998 that was down to about 22 or 23 per cent. There were other things in the survey that made that seem reasonable in the sense that self-reported fatigue had also dropped. That sort of order appears to be the estimate you get from a variety of sources.

In terms of whether stimulant use as such is a factor in crashes, I think the weight of expert opinion is that there is no evidence that it is and that stimulant use should be seen as a symptom of the underlying problem of fatigue rather than as a problem in itself. That said, there are medical concerns that, in extreme cases, constant stimulant abuse can have detrimental health effects and that it can have short-term effects; people very suddenly can go to sleep at the wheel if they have been using stimulants to try to go well beyond normal endurance. One can imagine situations where a crash could be a direct result of stimulant abuse, but that does not seem to be a common pattern. The truck drivers, of course, will ask you this: it is a dark road at night; I am coming towards you and we are closing at a combined speed of over 200 kilometres per hour—would you like me to be drug free and drowsy or on stimulants and alert? To which the only answer is: isn't there a third option?

Mrs IRWIN—Please tell us about the third option.

Mr Brooks—Here I would not be talking simply about things the department is doing, because a lot of the fatigue management work is in the context of national approaches, including things drawn together by the National Road Transport Commission. The new driving hours regulations that came into effect a couple of years ago included 'chain of responsibility' provisions. They basically specify that if anybody does something to induce a driver to break the driving hours regulations or any other relevant regulations that person, as well as the driver, can be charged. That is seen by many people as a potentially important step towards reducing some of the pressures on truck drivers to work excessive schedules. We are still waiting for a test case on that, for a jurisdiction to bring that type of action, but it is something that people see as potentially important.

Within that framework there has been development of a fatigue management program which is giving operators the option of developing a comprehensive, company-wide approach to fatigue management rather than simply working within a set of regulated hours. We, together with the National Road Transport Commission, are also working with an expert group to come up with options for a better regulatory framework for driving hours, taking into account factors such as the circadian rhythms—the natural wake and sleep patterns—which are not recognised in any way in current driving hours legislation. That is a very quick overview and I am sure it is not exhaustive.

In Western Australia and the Northern Territory, where driving hours are not regulated, there has been a lot of emphasis on codes of practice based in occupational, health and safety regulation. There is a growing view that a combination of occupational, health and safety based and road transport regulation based approaches might see a more comprehensive approach to fatigue management than what we have had in the past.

Mrs IRWIN—I am just curious too about random breath testing. In all the years that I have been driving—I am not going to tell you how many years—I have never actually seen a heavy vehicle that has been pulled over and the driver being random breath tested. Does this happen?

Mr Brooks—I could not give you precise figures, but it would happen and I am sure it does. Alcohol use by heavy-vehicle drivers, particularly articulated truck drivers, just does not turn up in the crash statistics as much of an issue. There are many reasons for that: the professionalism of the drivers and the companies and also the fact that, if you are pushing yourself to the limits of endurance in terms of fatigue, the last thing you are going to do is have a beer on the way. They just know they cannot do it.

Ms HALL—There have been important cases of truck drivers and bus drivers being tested and having overprescribed levels.

Mr Brooks—It happens, but the incidence is far lower than for drivers generally.

Mrs IRWIN—Thank you, Mr Brooks.

CHAIR—I am losing my quorum very fast. I thank you very much for a very detailed and precise explanation of some of those issues around road safety and for your precision in the way you answered those questions. I thank both of you very much.

Before we close, when the ACT Minister for Health and Community Care, Michael Moore, appeared earlier this afternoon he provided three documents: one, an updated page 23 from the ACT government submission; two, a list of Australian drug inquiries; and, three, a list of major studies of drugs and drug policies. I propose that these documents be incorporated in the transcript of evidence. There being no objection, it is so ordered.

Resolved (on motion by **Ms Hall**):

That, pursuant to the power conferred by section 2(2) of the Parliamentary Papers Act 1908, this committee authorises publication of the evidence given before it at public hearing this day.

Committee adjourned at 5.03 p.m.