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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Substance abuse in Australian communities

WEDNESDAY, 13 SEPTEMBER 2000

PERTH

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Wednesday, 13 September 2000

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

Members in attendance: Ms Julie Bishop, Mr Edwards, Ms Hall, Mrs Irwin, Mr Schultz, Mr Wakelin and Dr Washer

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.

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Committee met at 9.00 a.m.

CRANE, Mr Richard, Manager, School Drug Education Project, Education Department of Western Australia

LAMPARD, Superintendent Murray Wayne, Executive Superintendent, Crime Investigations Support, Western Australian Police Support Service

LARKINS, Mr Kevin, Director, Drug and Alcohol Policy Unit, Health Department of Western Australia

MARSHALL, Mr Andrew, Director, Policy, Ministry of Justice

MURPHY, Mr Terry, Executive Director, Western Australian Drug Abuse Strategy Office

CHAIR—Welcome everybody. Firstly, I thank the city council for their wonderful hospitality in accommodating us today. This is the second public hearing of the substance abuse inquiry, which was referred by the Minister for Health and Aged Care, Dr Michael Wooldridge MP, in March of this year. The terms of reference of the inquiry are to report and recommend 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.

The committee advertised in about Easter this year and has received around 200 letters and submissions from individuals, government and non-government agencies. Most of these submissions are authorised for publication. As I think most would know, we can receive submissions in confidence but that needs to be specifically spelt out to the secretariat and to the committee. If you would like to see some of these submissions—that is, any other than the confidential ones—please ask Jane Sweeney from the secretariat. The committee will work in a bipartisan way, and its members are keen to see the good models—and also those that have not worked—in the substance abuse area.

In the past two days the committee has spoken with a number of people working in the alcohol and drug field and visited a number of treatment facilities, a school and a prison. Today we are hearing from the WA Drug Abuse Strategy Office, the Western Australian Network of Alcohol and Other Drug Agencies, the National Drug Research Institute, Outcare Incorporated, Mofflyn and the Cancer Foundation of WA. It is my pleasant duty to welcome representatives from the WA Drug Abuse Strategy Office. I understand—and I stand to be corrected—that you are one of the agencies, if not the only one, in this country that brings all the disciplines together. Is that correct?

Mr Murphy—Pretty well—until recently when the New South Wales Cabinet Office set up a similar arrangement. But we are the only body that stands as a department in our own right with the responsible minister.

CHAIR—That is terrific. We are here partly because we are interested in what seem to be some pretty interesting models in WA generally in a whole lot of areas. I want to try to keep this session as informal as possible while understanding the issues as best we can. Of course the normal procedure is for each of you gentlemen to introduce yourselves. We are keen to get into the meat of it from the committee's point of view via questioning and interchange backwards and forwards. A brief introduction would be appreciated. Each of you may wish to give us a two- or three-minute oversight—you may have worked that out already. Thanks for joining us, and over to you.

Mr Murphy—Thanks very much, Chairman. You would be pleased to know that your secretary has been very clear in her instructions as to the brief introduction, so we have worked that out.

CHAIR—What time did she tell you?

Mr Murphy—Fifty-five minutes—was that right? I will make a brief statement, trying to keep it to the sorts of issues that are of interest to you. I will then open it up and seriously take no more than 10 minutes. I am executive director of the WA Drug Abuse Strategy Office. The other people here today represent main government agencies—or, in the case of Richard Crane, the School Drug Education Project, which is also cross agency.

Supt Lampard—Our portfolio has the responsibility for a major law enforcement response, which is multifaceted, to the whole issue of drug abuse in our community.

Mr Larkins—I have the responsibility for pulling together the Department of Health's response, which covers areas such as Aboriginal health, public health, mental health and general health purchasing. As you know, Health is a very large player in the delivery of services. I am also a member of the intergovernmental committee on drugs.

Mr Crane—Essentially the project that I operate deals with government schools and non-government schools, so it is a collaborative exercise between the Department of Education, the Catholic Education Office and independent schools. Essentially we plough out in schools four major initiatives: firstly, we make sure we have in place some really good curricula in schools; secondly, we make sure we have really well-trained and motivated teachers; thirdly, we support and develop drug policies in schools; and, fourthly and most importantly, we make sure we have parent and community involvement. They are essentially our four chief objectives in terms of our strategic plan.

Mr Marshall—I have an overall responsibility for policy in the ministry, and that includes the coordination of the ministry's basic drug policy and any of its new initiatives such as the drug corps.

Mr Murphy—You can see from the people who have come today that we are really trying to put bones on the rhetoric of a whole-of-government approach. The WA strategy emphasises whole of government and whole of community. In the information you have in the package before you, as well as the submission that was made, you will see our action plan. There you will see there are close to 10 government agencies involved in the drug strategy. Obviously police, health, education and justice are chief among those.

The structures in Western Australia are unique. We have had them in place now for more than three years. The WA Drug Abuse Strategy Office—to put some flesh on the presentation we have already made—spends about $14½ million out of $50 million in direct money. Additionally it has the role of coordination and management of the overall strategy. I emphasise that because it is very important that a structure has oomph behind it, and when we were thinking of doing this, some schools of thought were that you have a coordination office, with a couple of people who run committees. It just would not work. You need money and clout within the field to be a player as well as a coordinator. That is a chief part of our experience.

I would also say that setting up an office with a coordination responsibility—drawing a chart with boxes and lines connecting them between agencies and different strategies—does not provide the magic of coordinating in reality. Coordination is actually a very hard job, and when you think about drug strategy—I have mentioned the 10 government agencies and others come into play periodically—there are 70 local drug action groups, volunteer community groups. There are about 40 non-government services that one way or another provide service in this area and, as you know every bit as well as we do, this is an issue that every taxidriver and every parent and every grandparent has a keen interest in and an opinion on. So trying to coordinate that effort across government and across the community requires a lot of hard work. Structures take you half the way—and I think our structures are good—but I repeat: there is no magic in them. It really is about marshalling the efforts of a lot of people, and there I would return to what I indicated initially: political leadership is imperative.

In Western Australia we started with the Premier having responsibility for this area. It was transferred after about 18 months to a responsible minister, who you will see in the front of the Together Against Drugs strategy, Rhonda Parker. Now it is with the Minister for Police, but as a separate area of responsibility. Having that minister, a ministerial council, the office of government, its senior officers and then a range of other coordination structures is very important. But I would repeat: the money and the ethos of working in partnership are also essential.

The next point I would like to make is that the strategy in Western Australia is truly comprehensive. Once again, you know as well as us that there is not a single solution to this problem. However, if you pick up any newspaper talking about it, it is talking about the search for a single solution. Whether it is naltrexone or injecting rooms, that is what grabs the interest, because it seems like those things will solve the problem. We know it is not the case. The WA action plan—for this two years only—charts only 108 separate initiatives, half of which are further developments of old ones; half of which are new. If we try and do anything in this state it is to have a strategy for every issue that comes up. I would say that 95 per cent of those strategies are things on which both sides of politics—all sides of the debate—would agree.

Unfortunately, what tends to grab the public's attention are the issues on the margins, particularly those on the left—if I might characterise them in that way—which are the injecting rooms, heroin on prescription, and so on, and also the search for the miracle cure. Moving away from naltrexone, the one that received the largest amount of publicity that I noticed was a drug used for diabetes recently which grabbed headlines all over the place. We are forever searching for that magic bullet. If I can be presumptuous, I think public parliamentary inquiries can really try and get that balance out that we really cannot hear often enough: that there is not a magic

solution, that the approach has to be comprehensive and that we in fact agree on far more than we disagree on.

You have heard the portfolio roles of the different representatives here today. The headings under which the strategy is built are: education to prevent drug abuse—schools are key, but so are public education campaigns and so is reaching drug users themselves and trying to both reduce harm and introduce them to treatment. In relation to health and community support services, Western Australia by and large does not have waiting lists for treatment. There has been a massive increase in the investment in treatment services over the last five years or so, and that has given us a very good base on which to expand them further now with the diversion strategy, which will be clunking into place in the next couple of months. Diversion is one of the most important areas of law enforcement, as Murray indicated. Our diversion strategy, as part of the national approach, will attempt to target every drug offender—from the first timer through to the long-term user—and direct them towards treatment. That is thousands of people. One of the most difficult areas—and highlighted in the strategy itself—is community action. We often talk the rhetoric of getting the community involved, and the community taking ownership of this issue. Actually getting that to happen is also quite hard work. Local drug action groups are a key strategy—there are some 74 of those in place around the state now—but so are partnerships with TAFEs, universities, sports clubs, businesses, local governments and—most recently here in Western Australia—night venues. We are venturing into enemy territory to some degree.

Beyond those general issues and the coordination that I have talked about, a number of specific issues require their own attention. Heroin overdose is a very obvious one, and in the information pack you have there is a comprehensive outline of Western Australia's heroin overdose strategy. As was in the paper this morning, we have had some modest success on that front, in at least stabilising our rate of overdose deaths since 1997, when they started to go through the roof in every state. We are showing a small decrease this year, as we did in 1998. We hope that is sustained but, as you know, we are up against rising supply all the time.

CHAIR—I will lead off with a few general inquiries. In your presentation you made the point that collaboration, or coordination, is one of the hardest things on this earth to achieve, particularly when it is multifaceted and an individual solution is needed for just about every problem. I want to try to draw out jurisdictional issues. I understand, from the Commonwealth's perspective, that there has been a fairly significant investment made in trying to collaborate with the states. We live under a federation and, whatever the weaknesses of that are from time to time, that is our system in the Constitution. I guess I am interested to know the collaboration efforts that you make within your own areas, how they apply to working with the Commonwealth, and whether you have much interface with the Commonwealth.

Mr Murphy—At the state level we have structures to cover that. It then comes down to individual relationships and doing the best with the money. The Commonwealth is interesting, and I think Kevin will probably follow on. Both he and I are members of the intergovernmental committee on drugs, as is a representative of the police service. All other states except, recently, New South Wales have only health and police. For our end, that does make for some complications because the Commonwealth relates to the state as if it were the old structure that has just tacked a bit on. There is not much choice around that. It is better this way than it was, but it means that we have to work harder, talking to each other and coordinating.

I think it is very appropriate that you say we live in a federation and, warts and all, that is the reality. It is a frustration to governments and bureaucrats periodically about where the lines are drawn and who is responsible for what. The Tough on Drugs strategy has brought that home very strongly. Tough on Drugs attempts to be a comprehensive strategy. Its great potential is to add value to areas of primary state responsibility. In terms of funding, and I have it in front of me, the Commonwealth would fund roughly 10 per cent of what the states fund. The states have been moving along for years and years—in our case, perhaps more than some—with this approach, and now we have Tough on Drugs. It is a real challenge to make sure those fit. I think the process of working out the national approach to diversion was a very good exercise in the states and the Commonwealth working together and bringing the Australian National Council on Drugs into that equation. I think anybody who has looked at the wiring diagram of the national coordination strategy would understand visually how difficult coordination is.

CHAIR—You get lost in the maze.

Mr Murphy—Absolutely. You really have to know it to understand it. Fortunately those structures are under review at the moment. There may not be a terrible amount of room to move, but it is a real challenge that relies on a lot of elbow grease to make it work—actually getting together joint projects and so on.

CHAIR—Would anyone like to add to that, because some of you are connected with the federal structure.

Mr Larkins—I think generally what Terry says is true: it requires a lot of goodwill and a common understanding. Both are requirements of what we are attempting to do in the state. The thing that has made a big difference in the last few years is the alignment of state and Commonwealth objectives, particularly if you look at the state and national strategies. There is a very strong alignment, due to a lot of work that is done at officer level at the intergovernmental committee. We always go to those committees from WA having done a lot of work beforehand to ensure that we can align, and that we can deliver back home, as is required both at the national and the state levels. Things have come a long way from 1985, when the first drug summit was called. A lot of structures have been set up in the states that now are being mirrored in the federal arena.

CHAIR—I have been keen in the last few months to try and understand what the states have done, because—as you are well aware—there has been inquiry after inquiry in targeted and general areas. I did not want us to get into reinventing the wheel or into ‘We have come from Canberra to help you’ kind of stuff. We really needed to understand the states had a lot of experience in this and had done a lot of work in terms of inquiry, bringing the community together and that sort of thing. The states deliver predominantly all of the services, with some Commonwealth help from time to time. That principle of cooperative federalism is—it seems to me—critical, because the states have the knowledge but you have also done a lot of work in accumulating knowledge in inquiries over a long period. So our inquiry has to pick that up and then start afresh from the known data information that is with us now, as far as I am concerned.

Ms JULIE BISHOP—You were speaking about Commonwealth and state objectives. How do you deal with the different strategies within this group? Terry spoke of 108 initiatives. Who does the overview, the peer review or gives the expert advice as to what strategies a particular

section should undertake so as to avoid a conflict in approach? How does that work within the organisation?

Mr Murphy—WADASO takes the organisational responsibility for that coordination role. But with the development of the last action plan, for example, we began a year before it was released, with all agencies and all community groups providing input. It went through three drafts, with collaboration and review at each of those stages. With respect to expert and academic input—as well as staff in our own agencies who have substantial expertise—the national research centres also receive drafts of those strategies. Inevitably, as with the issue of Commonwealth and state, there are demarcation issues. One of the points I made about WADASO was that we have about a third of the money. That makes us a player as well as a coordinator. It means that Health particularly, and ourselves, have to do a lot of talking to make sure we are not both chasing the same piece of ground. At the end of the day, once again that relies on goodwill, structures and, in the final analysis, some political arbitration if necessary. Similarly, the thing that makes it work—far more often than not—is that plus, when it comes to diversion, a cooperative effort between police, Justice and us—but we are all involved as well. It really is a matter of working out those lines of who does what. There is not an easy pat answer; it really comes down to working it through.

Ms JULIE BISHOP—Particularly in the health area, there are some very divergent views as to what treatments should or should not be tried. How do you go through the process of working out who wins at the end of the day, in terms of these strategies?

Mr Larkins—We went through almost a mirror image process with Health, that Terry described in the major strategy. I think you have a copy of the interaction document, which represents 12 months work in the health arena from Derby to Esperance in all of the health services, working through what would be a strategy, and taking four main themes of that strategy. Mainstreaming is a very important part of that: recognising that Health is a huge portfolio that has enormous potential to deliver and does see a huge number of people, and trying to focus that so that it supports the community efforts that are being encouraged through the broader strategy.

We actually did that and then attached funds to that as incentives for best practice to develop good detox services, to develop good specialist services and to develop good clinical advisory services. The major impediment to health services becoming engaged very often is the feeling that they are going to be left alone, that they will not have that specialist support if they are a general service—that is, will they have the specialist support if they take on this role? So we have put a lot of attention into that, doing it exactly the same in a microcosmic way at the health level as the state level.

CHAIR—Terry, in your presentation, you mentioned illicit drugs, the media and the unfortunate phrase of the ‘quick fix’ approach from a community point of view. How do we strike the balance between the illegal drugs and the legal drugs with the long-term, hard slog about alcohol and cigarettes? We have talked about the cultural change in terms of smokes and the illicit drugs. How do we strike that balance? How do you deal with that?

Mr Murphy—I would say you rise to meet demand. With respect to treatment services, illicit drugs, alcohol and even tobacco create their own demand, and our challenge as governments is

to meet that demand. It is somewhat self-regulating and I would say that we do that. Similarly, when it comes to prevention, you have to have your eye on all of those. I think what we have seen over recent years with the amount of publicity that illicit drugs have received, with the increase in world production and so on is a rebalancing from a preoccupation with tobacco and alcohol in the professional services. It is not that illicits were ever ignored; it is just that the major structures for a long time kept saying, ‘Tobacco kills 18,000. Illicits kill half a dozen.’ That is true, but it does not quite tell all the story and the numbers have shifted somewhat.

So while the public debate moves more markedly than the professional services, we have always been doing both, and I think underneath that there has been a much smaller shift to rebalance with illicit drugs. Currently, illicit drugs are getting all the attention and people say to us periodically, ‘What are you doing about alcohol?’ We are still doing it and we are still doing tobacco. So within the strategy, it is all still there, but the rhetoric and the public debate perhaps do not reflect that fully.

CHAIR—I want to follow up on the media and the media’s role. A number of committee members are quite interested in trying to understand the media’s role and their interaction with the community. We all know they help set the political agenda and the pressure that comes on ministers and politicians, which is the general, normal democratic process. But in terms of the media and their presentation of the issues—and you have a local issue running at the moment which was on about page 20 this morning; it seems to be reasonably responsibly handled in the context of the community debate—there is a concern that they from time to time create unnecessary division and make the stories unnecessarily spectacular. That is the nature of the media and we forgive them for that, I am sure, but they do create their own tensions and their own ability—from administrators, to politicians, parliamentarians and ministers—to affect how we deal with things. Our work has to deal with some of this, and I am interested in your views about the media and how you people work with the media.

Mr Murphy—Very, very tough and an eternal frustration. In the holiday I took just before we published our plan, I made two decisions: one was to put subheadings in the strategy—which has really made a big improvement—and the other was to hire a PR person. For years, I have resisted that and I have said that our job should be to do the work, help the people, get the prevention programs and so on and so forth. But hiring a PR person at the Drug Abuse Strategy Office has been helpful in rebalancing what is out there in the media. It has not changed it fundamentally but it has provided for a bit of rebalance. Her job is not to handle the crises which happen all the time—

CHAIR—I welcome the media who have just turned up.

Mr Murphy—We always recognise that the media are partners in these efforts. They have to be part of it to get the message out there. But it has been very helpful having a PR person in the office simply to promote positive stories. There are a lot of positive stories and they have to get out there. They are often not as exciting as the ones that make the headlines, and that is simply the reality that we deal with. Sometimes I think about taking advertisements out that say, ‘This is what’s happening in drug strategy. These are the 100 things that are there.’ But you cannot do that—certainly not six months prior to an election. We simply have to work hard with the media to get that story out.

CHAIR—There is a huge investment in health generally and all of the facilities of government, let alone the issue of substance abuse. If the media are able to pursue us and administrators to a point of not maximising that and sending the wrong message to the community, you end up with this situation that you feel the need to make sure that the positive message is getting out there and to create a more positive environment for people to say, ‘All is not lost. We are going to achieve them and we are really working at this problem.’ There is actually an economic need—it is also a social need—to balance the debate. That is my personal opinion and I share that with you.

Mr Murphy—May I just tie the last two questions together? It is an absolute given what is in the press today. We put a lot of effort into ensuring that treatment investments are based on best practice. But there is a danger, as I indicated at the very start, in research for the miracle solution that those investments can be made in the media and public arena and are not necessarily as well considered and as fruitful as they might otherwise be when they are made in a much calmer environment. It is just to reinforce the point that we really have to get a bigger picture out there continually.

CHAIR—We can never measure the social cost. We can attempt to, but it is really only ever an approximate measurement. In terms of an economic measurement and cost-benefit analysis, you will see models run. We understand that there is interest now in what the actual substance abuse cost is to the nation. No doubt you have seen more data than I have. What is your view about cost-benefit analysis of substance abuse? How do you see that approach to dealing with that issue? You hear figures of $18 billion in 1992 and $25 billion more now. I am a little wary of numbers like that. Those figures are being fleshed out again now. You see US figures, that if you spend $200 million you might get $1.5 million back. What is your view?

Mr Murphy—This is not an easy area and there is important work happening at a national level that you may be aware of through the monitoring evaluation strategy. You will see in our submission that we have approached this at three levels—all of which are important to recognise. First is the direct expenditure by government targeting drug abuse. That is probably the number that gets the least recognition in the wider debate, although there was a terrific piece on it in the *West Australian* the other day, picked up off our web site. That is where we chart our direct investment. In this state it is $50 million. If you move then to what it costs government, our figure is about $240 million. That is roughly half and half Police, Health and Corrections. That is the damage and consequences of being cleaned up. If we then take those billion dollar figures developed by Collins and Lapsley back in the early nineties and apply them to this state—just looking at the tangible costs as opposed to the far more difficult ones to calculate—our figure is about half a billion. So you can see the various levels at which we can measure.

At the end of the day we have to be very careful, because a lot of the rhetoric, on some sides of the debate at least, talks about large percentages of the money tackling drugs going into law enforcement. The reality with much of that money is that the figures are very rubbery and that the money is not an investment that can be liberated to be spent in a different way. If there is less necessity for drug law enforcement, nobody is going to want to reduce the number of police on the streets, so we have to be very realistic about that.

CHAIR—In recent years Western Australia has had a focus on addiction and understanding it. I am not sure if everybody is aware of the work in Western Australia, which seems to be

taking a lead in this area—understanding addiction and developing that into training and education, involving academics and all the rest of it. Would you comment on the general issue of addiction and on the Western Australian experience?

Mr Murphy—We are going back into history here, and once again I think Kevin will be able to help. In the mid-1980s Curtin University established addiction studies. That had a very significant effect on treatment services and on the training of people who have gone into the field subsequently. It has been of enormous benefit also in focusing our attention on what is best practice in treatment, which also relates back to the earlier question. Now all universities provide some level of addiction studies or units in drug treatment. We have worked very hard trying to get it into preservice training for teachers, with less success. We were talking to Justice recently about an understanding of alcohol and drugs being a prerequisite for employment. That is important. That has also fed into—and here I will hand over to Kevin—a very substantial program of in-service training across the state that is still largely managed by Health.

Mr Larkins—The only thing I could add is that, building on that, the federal government, through DETYA, established, as you know, the three major centres, one of which is placed in Perth. I do not think that was accidental. It was probably because of the investment that we had made in training at all levels—tertiary and secondary. That is on prevention. The one in Sydney is on treatment and the one in Adelaide is on education. As Terry said, there is a huge investment and a culture within Western Australia among government service delivery departments of in-service training. Health has a major focus on this through its major deliverers, particularly nurses and undergraduate medical students, and has made it a particular focus with specialist services in training and education—in other words, developing an expertise and being able to offer support. Also one of the initiatives that have given us a lot of benefit was that, when the Curtin studies were developed, there was a partnership between Curtin and the next step services to set up a volunteer training program. That is advertised annually, and it is university based. It is always oversubscribed.

CHAIR—We heard about that just the day before yesterday.

Mr Larkins—That has been an outstanding success at two levels. One is that it shows the huge amount of interest out there for people who want to add a little bit more—and in the main they are professional people who want to get some expertise in training and understanding, so that they can apply their skills.

Mrs IRWIN—You are talking about quick fix cures, but I have noticed that Western Australia seems to be getting more media coverage than other states regarding the naltrexone treatment. I note in your submission that Western Australia is the only state to provide naltrexone free of charge. Would you tell the committee why you have decided to provide naltrexone on this basis and what, if any, conditions might apply?

Mr Larkins—I guess the reason Western Australia has such a focus is the work that was being undertaken in Subiaco by Dr George O'Neil, who initiated a procedure and proceeded to develop that. That attracted a lot of interest and people came to seek that, which created a lot of pressure. The government service at that time was limited in its ability to use naltrexone because of the guidelines. It was not listed for use for that purpose, but it since has been registered for use in the maintenance of people once they have been detoxified. To acknowledge

the fact that a lot of people were seeking that treatment, the government said that the state service, which is the Next Step service, would be provided to those who could not afford the private system—because that is what our system is; it is a private system where you pay and we provide a public service. Currently, over 950 people have accessed that, and the government service manages about 450 people currently with free naltrexone and also detoxifies people. People are referred from George O'Neil's clinic, once they are detoxified, to be managed by the government clinic; that is for those who cannot afford it.

Mrs IRWIN—When you say 'managed by the government clinic', is that just to get their daily tablets or is it ongoing counselling?

Mr Larkins—It is done under the best clinical practice, so it is not just a matter of, 'Here's a script. Go and get the pills.' They are actually managed in their detoxification by that clinic, but then for their ongoing maintenance, they are given an assessment, a good clinical history is developed and then they are managed. Sometimes they are referred out to general practitioners in the community.

Mrs IRWIN—And they are qualified in this field?

Mr Larkins—To date, there have been 100 general practitioners trained by Next Step, and 67 of those operate now in the community to deliver and support people. Fifteen of those are in the regional and remote areas as well.

Mrs IRWIN—Have you any statistics on deaths of people who have been on the naltrexone treatment? I know we have had a few in New South Wales.

Mr Larkins—Yes, there have been. I do not know the exact figure. There have been no deaths whilst they are on the program. The deaths are related to those who stop taking their naltrexone, and that is the great risk period—that is, the overdose related to that. Terry would have the current figures through the coroner.

Mr Murphy—Of the 53 suspected heroin overdoses this year—and I emphasise it is a suspected number—five had undertaken naltrexone treatment or recently stopped naltrexone treatment.

Mrs IRWIN—So these five deaths were people who had actually stopped their treatment? They were not taking naltrexone plus their heroin plus any other drug? Were they taking any other drug?

Mr Murphy—By definition, they would have stopped naltrexone. Whether it is the day before or two days before, these are suspected and are still subject to coronial review. Whether they were taking any other drugs, that is quite likely. The published research from Dr George O'Neil, for example, indicates that a very substantial proportion of clients on naltrexone continue to take other drugs—for example, Benzodiazepine of the order of two-thirds, amphetamines of the order of between 17 and 20 per cent, and a smaller number who relapse on opiates periodically.

Mr EDWARDS—Just to flow on from that, we spent a bit of time yesterday at George O'Neil's clinic and we had a very full briefing. Two of the things that interested me most—and you mentioned them yourself a little while ago—were the decrease in overdosing in Western Australia and also the comparisons between Western Australia and Victoria in relation to the fall off in the number of robberies. Both of these things were directly linked to the naltrexone program in Western Australia. Can you comment on that?

Mr Murphy—I am sure some members have a research background, and it is very tempting sometimes to say, 'There's a glass. There's a microphone. That caused that.' It is simply wishful thinking. The successes we have had in this state are the function of a multifaceted strategy and the efforts of a lot of people, government agencies, non-government agencies, volunteers in the community and families out there. The reduction in heroin overdose deaths we think is largely due to the increasing treatment generally—particularly methadone, which is much more protective than naltrexone—also the outreach education, follow-up of emergency departments and an ambulance insurance scheme; there are a lot of different strategies each adding a bit. Similarly, if there has been a decrease in crime—and I think Murray would like to comment—the first point I would make very strongly is that the amount of crime that is due to drugs is often exaggerated. Certainly, the people who use drugs do a lot of crime, but they are not responsible for all the crime. The best estimates we have are of the order of 30 to 40 per cent, which is often much less than is cited. I do not know whether Murray wants to reinforce that.

Supt Lampard—I certainly support that.

Mr EDWARDS—Terry, I am very strongly supportive of a lot of the work you are doing, but I am critical in many other areas because so much of it is patchy. I preface my comments by saying that my electorate is in the northern suburbs, as you are aware. I see a lot of parents and a lot of young people who just do not know where to go for help for a lot of the drug problems that come home to visit them. I basically want to ask you how you go about fixing up those areas where there are holes, what evaluation you do and what evaluation you have done to ensure that your work is fairly broadly spread and not just patchy. You would be aware that some local drug action groups are very successful and others simply have failed. I would appreciate your comments in relation to those things.

Mr Murphy—There are certainly a few bits there. As I indicated at the start, we do attempt to be comprehensive and to cover every issue and every area. It is a matter of continuing investment to make sure that it becomes deeper and deeper. Political representatives in particular would experience seeing people who cannot find the right place or who do not know where to go. Unfortunately drugs are not like broken legs. There is not a network of general practitioners, whereby you can go to anyone, and they will by and large know what to do. I said earlier that there are not waiting lists in Western Australia—that is essentially the case—but the trouble with drug treatment is people go and they fail. They then think, 'Well, that agency is no good,' so they go to another agency. They fail again and think that agency is no good, 'The place is hopeless. There is nowhere to go.' That is often the message that my office and your offices may hear from some people, because the ones for whom it did work on that occasion do not come to us so readily. The reality of recovery from drug addiction is that it is a struggle, and it takes two or three or four attempts to be in the right place at the right time in a person's life. So we often get more of an impression of patchiness than I would say is the reality.

Local drug action groups are moving from treatment to prevention. Local drug action groups are also a good example of what you are saying, and I think your observations and criticisms are true. They are not a fail-safe, sure-fire solution in every case. Of 74 groups, we figure at any one time there are probably about 10 who are struggling to keep up—the key people leave, the energy goes out, they have done a big project—but we have not lost any in the process. What we find is that we can revitalise those groups and keep them growing. They are a very strong mechanism but, like all voluntary community organisations, they require a lot of support to keep on going. The other point: I would perhaps accept the criticism. We are by no means complacent in this state. We think we have put in a very good infrastructure. We have got good structures to direct strategy, but we know that we have to continue to get broader and deeper in every area, whether it be treatment, prevention or law enforcement. They are continual challenges.

Mr Larkins—I think what Terry says is true, but Perth has evolved from a very centralised system where pressures were being placed on the expertise that was centrally based. Historically, most of the treatment agencies located themselves in Northbridge or the inner city. Most of the major institutions were based there. We had three major treatment hospitals within a punt kick of each other. In the last 10 years, there has been a lot of effort to decentralise and regionalise the health system. I know the police have also regionalised. In the mental health system, we have developed community mental health teams. We recognise that those teams can provide expertise now and that they need to be skilled also in the drug and alcohol area, which we are now doing, to link with the community efforts that are being developed to meet this movement of population. In the northern suburbs, for instance, there is a huge expansion of sporting activity, as you would know. I can think of the Kingsley Football Club, which has something like 800 junior footballers play. That is mirrored elsewhere. That is a very strong positive bit but, to fit in the specialist needs of youth in that area, things are being developed and evolved. I think it is a task we are aware of. I know in the health area we are very conscious of the need to decentralise our specialist expertise.

Ms HALL—Firstly, I would like to thank you for your presentation. It sounds like you are doing some really exciting things here in Western Australia and that you are all very committed to fighting drugs in the community. You have adopted a zero tolerance approach to drugs in Western Australia—is that correct?

Mr Murphy—I am very happy to explain the policy framework and how it relates to the national framework. You will see it outlined there in your documents. We have said that there are two principles. The first is opposition to drug abuse, unequivocal, clear and uncompromising. It sends a solid message to the community. It encompasses demand reduction and supply reduction strategies. That is the first and foremost principle. The second, though, is that we are realistic. People are using drugs. They are not going to stop just because we have adopted a position of opposition or because we have provided treatment services and so on, so we must also recognise the need for harm reduction among people who continue to use drugs. That is how our policy framework is spelt out. That is quite compatible with the national embrace of demand reduction, supply reduction and harm reduction. We express it in a way that gives primary emphasis to preventing and reducing drug abuse.

Ms HALL—As I came in, I heard you mention safe injecting rooms. Has there been any discussion on that issue here in Western Australia?

Mr Murphy—Yes, nobody escapes that discussion. We are not quite Victoria—and I do not mean to be flippant at all—but there has been serious consideration of that issue by people who are seriously concerned about the drug problem. The government's view is that it boils down to probably two things. The first is that Perth does not have an open, injecting drug use scene like those with which Melbourne and Sydney are struggling to cope. Every European city in which these facilities have been established has struggled to cope. We simply do not have it. In the absence of that, we risk creating the very problems that other cities are seeking to ameliorate. The second issue—and really it is a related issue—is that, given the policy framework that I have just spelt out, governments have to be very careful of the unintended consequences of any strategy. In the drugs area, there is no strategy without unintended consequences. Even school drug education, which is the most benign and popular of strategies, will with some kids raise the issue before they thought of it and have the unintended consequence of sending them seeking the very things we are trying to prevent them seeking. You have to be very careful when you weigh up strategies. When it comes to safe injecting rooms, certainly for Western Australia the risks clearly outweigh the benefits.

Ms HALL—You mentioned diversionary programs and how you are trying to put every person who is using drugs into a program. How will you achieve that?

Mr Murphy—I will give an introduction and then pass to Andrew and Murray. We have had in place here in the state a cannabis cautioning and mandatory education system for first-time cannabis users. That is currently netting about 40 people a week, I am advised. We have also had in place a court diversion service for some 12 years, providing services to the district, magistrates and children's courts. We are building on those to provide a more comprehensive system. Police diversion, as part of a national approach, will be extended to drugs other than cannabis so that people have to undertake compulsory assessment and participation in treatment or face the courts. At the other end, a drug court system in each of the jurisdictions is being established, and that will have the opportunity to target all of those drug offenders going through the courts. There is a two-year roll out to this, commencing we hope in the next month or so.

Mr Marshall—I hate to reinforce the use of the words 'integrated' and 'comprehensive', which Terry has used quite often in his discussion, but the reality is that the justice response to drug abuse is certainly based on those two principles. It is integrated closely with the police cautioning program and it is comprehensive in that we have taken on the state—the drug court being across all jurisdictions as opposed to some other states which have concentrated in one jurisdiction. We intend to pilot it in the magistrates court, the district court and the children's court. It is comprehensive in that it will deal with all offenders from the second cannabis offence. Murray may want to talk about how we intend to deal with first cannabis offences, but this will deal with second cannabis offenders right through to serious offenders and drug abusers.

Supt Lampard—I think that does encapsulate it. From a first contact perspective, the cannabis cautioning program is working very well in WA. Up to date we have issued over 500 cannabis cautions. We are very pleased with the attendance rate of the diversion. That is up around the 88 to 90 per cent. So we feel that is working. One of the biggest challenges for police over recent years in Western Australia is to have our people understand that people who do take illicit drugs are not necessarily criminals. It is very important for police to adopt a

multifaceted approach and most important to work with other government departments to provide an overall service. So police still have their role to play and police will never depart from their responsibility to the community to provide a significant law enforcement approach, especially to drug trafficking and drug importation. However, we need to be very mindful of the greater need, and certainly areas such as a response to the health needs of these people is an investment for police for the future. If we can stem or stop criminal offending, then it is a significant success for us. But we are very pleased with our programs. We have a lot of programs aimed at educating the youth in conjunction with our partners. We are very much involved in drug court diversion and we are working very closely with MOJ in relation to that and actually allocating and specifically training people—police personnel now—to play a major role in that very important initiative.

Mr Murphy—We are very grateful for the Commonwealth funding in this area. It is significant.

Mrs IRWIN—Is it going to the right areas though?

Mr Murphy—We think so. We are fortunate with our treatment system. Because we have no waiting lists, we can build right across the board and increase capacity, so we can have a comprehensive approach.

Ms HALL—Yesterday we heard from a number of groups about the problem they have, because of planning issues, in setting up rehab centres or safe houses and getting local councils to agree to their proposals. What plans have you got in place to see if, at a government level, you can facilitate some of these services getting off the ground?

Mr Murphy—This is a very tough issue in every state. I visited a secure welfare centre in Victoria at the start of this year that was right slap bang in the middle of a residential area, and strong reference was made to the government they had at the time which did the planning approval because, by heck, those residents did not want it. It is the case everywhere we go. We have got two at the moment. One in the south-west has actually received in-principle council support, notwithstanding a very strong campaign. You are very familiar with Dr George O'Neil's issue in Northam. We have an issue in the town of Victoria Park for a replacement youth rehabilitation facility. It is very tough and it is not new, but it is probably tougher than it was 20 years ago. This is a personal opinion only: I think governments do need to retain a right of final say, and that means appeals through to the minister for planning when these issues have to be resolved in some manner.

CHAIR—In the evidence, these are issues all over Australia—the theme varies a bit but the principle is the same. What is the level of proof that justifies that response? Again, I guess it would be your personal opinion, but what is the evidence? It is a natural response but, when it comes down to the nitty gritty, what do you think is the proof and the evidence?

Mr Murphy—That is a very good question. If this has to be tackled in an organised way, then it is a matter of perhaps identifying criteria that need to be satisfied for such a development—issues such as preserving community amenity; more serious security issues because of the nature of the people; and community consultation and the like, which are largely built into the planning process. We would agree that it would be appropriate to specify criteria

against which a minister should evaluate any appeal, not just in the drugs area but in other human welfare areas.

Mr Larkins—One thing I would add is that if you look at the history in this state of the development of, say, sobering up shelters, we had similar issues but it was easiest where the community saw and were experiencing the problem fairly dramatically. The Kimberley is a good example of that, where Halls Creek, Fitzroy Crossing, Derby, Wyndham, Kununurra and Broome all now have substantial sobering up shelters—in Broome it is in one of the main street areas—and there was fairly limited resistance. There was a lot of community consultation, but then, if you look at the evidence of the impact of alcohol on those communities, they were desperate in some cases for facilities. In some of the other examples that have been mentioned, sometimes the community has been the last to be involved.

Ms JULIE BISHOP—Can I just add something which might assist the committee, because Western Australia is a little unusual in this regard. I used to be chair of the Town Planning Tribunal and I am very well aware that in this state we have a dual appeal process. I used to be the greatest critic of it, but in this instance I can see the benefit of having this dual appeal system because in WA you can appeal to the minister from a decision of a council or to the Town Planning Tribunal; in most states you only have an appeal to the tribunal or a land and environment court. The tribunal is constrained in that it can only take into account proper town planning considerations; a matter like this would have to come under ‘amenity of the locality’. However, the minister is not so constrained, and he/she can take into account moral or social considerations. So there is an aspect of the Western Australian appeals system that lawyers do not like, but, in this context, it will play quite a beneficial role. I point that out for the committee; it might be of interest.

Ms HALL—My final question relates to special programs and drug users with special needs. You mentioned only very briefly in this very good folder people that suffer the dual diagnosis of mental health problems and drug use. What special programs have you got in place for them and also for indigenous Australians? I noticed that there was a very small mention of them, too, in your document.

Mr Murphy—I will start with indigenous health and then pass over to Kevin. There is a relatively small mention, but that is the tip of the iceberg of what comes into the state strategy. Aboriginal health in this state has just gone through a very comprehensive planning process on a regional basis. Alcohol and drugs are a major issue in each of those regional plans, which are very close to adoption. It is fair to say that the Office for Aboriginal and Torres Strait Islander Health tries to integrate alcohol and drugs into the general Aboriginal health system to a greater degree than is done for the non-indigenous population. There are strategies—and the tip of the iceberg in the state plan tries to indicate those—which, through school drug education, through local drug action groups in remote communities, through Aboriginal staff in alcohol and drug specific treatment services, through Aboriginal specific agencies providing treatment and, into the broader health system, through community controlled health organisations and the general health system, provide a range of services for Aboriginal people. That said, it is probably an area where I would pick up Graham’s adjective ‘patchy’; it is more patchy than any other area with which we deal—at least in some parts. It is an enormous challenge, but there are very strong rays of hope.

I was in the Warmun Aboriginal community only two weeks ago, where their local drug action group—which consists of five people: four elders, all of whom are illiterate, and the convenor, who is middle-aged and not illiterate—is delivering a grog program, as they called it, for a week in the community. It was every bit as sophisticated as the programs that we deliver as a general rule. They are being trained up and supported by the community drug service team, which has predominantly Aboriginal staff, in the Kimberley. They were dealing with solvent abusers, marijuana smokers and drinkers. This sort of initiative provides great hope and really gives flesh to the rhetoric of communities doing it for themselves. Unless that happens—the communities doing it for themselves rather than professionals sweeping in with solutions that are not integrated with the community—we are not going to make the necessary mileage.

With respect to dual diagnosis, I would make the point that we can fall into the trap of seeing a new group of clients. One of the harsh realities is that people who have psychiatric disorders use far more drugs than they did 10 or 15 years ago, so the mental health system has to gear up to deal with its own clients. There is always that group in the middle over whom systems are unclear.

Ms HALL—That is the group that really concerns me. Everywhere we have gone so far we have heard that this person suffering from a psychiatric disorder cannot be treated by a drug rehab or detox centre because that centre is funded for drugs. The drug centre is saying, ‘We can’t treat this person because they are suffering from a psychiatric disorder, and we are funded to do this and this.’ The organisations are either faced with a situation where they have to close their eyes—which a lot of them do because they are very caring people—or people are turned away from both organisations and miss out completely.

Mr Larkins—We have acknowledged that as a major issue. As Terry said, it is not a definitional issue; it is a systemic issue and it is a failure of both systems to manage what are probably the most marginalised of their clients. There is a major commitment within Health particularly to a program that we have named ADAPT, Alcohol, Drug And Psychiatric Treatment. It is about establishing within Perth and also throughout WA a capacity for both systems to manage and hold their most difficult cases, and I think that within the next 12 months we will realise something in respect of that. At a practical level it really means treating someone as they arrive, managing someone regardless of how you so define them, and holding them until they can be properly managed. In some cases, unfortunately, the least experienced of the workers are given the hardest cases to deal with, so we want to reverse that a little bit.

Mr SCHULTZ—In your submission to the inquiry, you say:

> The Police Services has successfully targeted street level dealing and this has prevented the creation of public drug dealing cultures as is the case in Melbourne and Sydney.

What are the differences in the ways in which your police service operates? What are the benefits and risks of targeting street level dealing? Finally, isn’t it possible that, if dealing is not visible on the streets, it has simply shifted somewhere else or it has gone underground?

Supt Lampard—Thank you for that question. Western Australia is certainly demographically different from Victoria and New South Wales as far as the drug scene is concerned. We do have instances of physical drug dealing especially in certain areas around the

metropolitan area, primarily in our Northbridge area. However, our organised crime division specifically targets mid- and street-level drug dealing. Part of our strategy is that we have a task force approach to this, so we continually monitor throughout our intelligence holdings actually what is happening on the street and respond accordingly. There are issues here—you are quite right about that. When we do provide a significant response or target a particular area, often we do move it, we displace the problem to other areas, but we accept the fact that we are always going to do that. It is a little bit like a dog chasing its tail: we chase the problem wherever it happens to pop up. I think we are lucky in Western Australia in that we do not have the enormity of these specific types of problems. Through our crime department we are able to target these particular areas and we have moderate success—I think that is a fair comment.

Mr SCHULTZ—Thank you for that. I understand that the geographic isolation of Perth, which is inconvenient to us from the east sometimes, is an advantage to you and I understand where you are coming from. On the question of heroin, your submission also refers to the increase in heroin related deaths in your state and the fact that you have designed a heroin overdose strategy. Would you outline to this inquiry the key elements of the strategy and tell us how effective it has been so far in reducing heroin related deaths?

Mr Murphy—It is multifaceted. That is the first thing to say. It is a matter of trying to get purchase on this problem anywhere that you can. First, it is about procedures so that people are encouraged to call ambulances to any overdose. This has required changes in police and ambulance procedures. Police have an explicit policy that they do not attend heroin overdoses. The ambulance services, for example, have changed their uniforms from blue to green so that their staff are not mistaken for police—subtle things like that. Recently we launched an ambulance insurance scheme so that the cost of call-outs to overdoses is nil, because our feedback from users themselves was that the cost was an impediment to calling an ambulance, particularly calling an ambulance for a friend. That is funded by a levy on needles and syringes.

Education through every possible means: FIT packs, which is the needle and syringe container, postcards, posters, magazines that reach users, on the needle and syringe disposal bins, getting the message out there. Peer and outreach education have specific programs. As well as needle and syringe services, the WA Substance Users Association provides peer and outreach education and the health department funds through the government agency a volunteer program of outreach education. That really tries to get out there amongst drug users themselves, which is not easy. It is very hard work, particularly because they do not congregate in one place. A major increase to that program is now focusing on resuscitation training amongst drug users. So the WA Substance Users Association will be getting out there with these dummies to train people to do resuscitation in the simplest manner and get them to teach others.

Following up emergency department admissions: one thing about this state and the way we use narcan, the heroin overdose antidote, in ambulances is that around 95 per cent of ambulance call-outs actually result in transportation of the overdose case to hospital. Those cases are followed up once again by volunteers, largely ex-users themselves, to provide support and education for that person and hopefully linkage to treatment.

I indicated earlier that the expansion of treatment services per se is very important. In 1997 we went from something like—these are very rough figures—1,000 people on methadone to 2,000 within a very short period of time. There are more than that now. Making sure that

methadone treatment particularly meets demand is very important. We monitor the numbers. We can give you the numbers as of last Monday, unlike any other state bar Victoria. We monitor that very carefully. We have commissioned a number of research studies of ambulance cases outreach to users saying, 'What works for you? What strategies can you suggest?' That is a continuing program. I think they are the main elements.

The only other one I would emphasise is that in 1997 we pulled every possible player together: ourselves, the health department, alcohol and drug agencies, police, the pharmacy society, the WA Substance Users Association, the AIDS Council and hospital emergency departments, and we have run an open heroin overdose strategy committee cum forum ever since. That has been very important. At initial meetings of the forum voices were at a high level as people got through the storming and blaming stage. Quickly, though, that became a very productive group pulling in all players to do whatever we can.

Mr SCHULTZ—Referring to your document 'The West Australian strategy against drug abuse action plan', on page 7 under community support services, under the heading 'Reaching drug users', it says:

Needle exchange services provide a key opportunity to directly reach drug users. The capacity to engage clients into treatment and to provide well targeted harm reduction education regarding blood-borne viruses and drug overdose will be further developed.

Can you extrapolate on that for the committee?

Mr Murphy—We take the view, as was indicated when I discussed the policy framework, that needle and syringe services are a necessary service of themselves, but they have to be managed carefully so that they are discreet services, so that they are not on the front counter of pharmacies. The needle exchanges are not up in lights and they essentially work by word of mouth. That is the first essential element, to keep them discreet. As services themselves, they attract people who are continuing to use drugs who are not fronting up to treatment agencies at this stage but who, like all drug users, will be having problems with their drug use but still wanting to continue drugs. So they are a very good opportunity to sow the seed to move them towards treatment. They are far more clearly an opportunity to talk about the spread of blood-borne viruses and the need for safer injecting practices and the heroin overdose risks.

Once again, with Commonwealth funding through the Tough on Drugs strategy, there are funds available to further develop needle and syringe programs throughout the state. We have a comprehensive availability of needles and syringes, largely through pharmacies and less so through exchanges. The additional Commonwealth funding, which is about $750,000 a year, will enable us to spread exchanges into areas like regional hospitals but, very importantly, that needs to be linked to education and passages into treatment. The two, as we see it, must go together.

Mr SCHULTZ—Just on the needle syringe exchange program—well, it is not an exchange program now from my observations of it; it is a distribution program—my figures that I have been able to obtain tell me that Western Australia distributed 1.86 million needle syringes in 1997. Can you tell me what the current distribution numbers are?

Mr Murphy—2.8 million.

Mr SCHULTZ—When we were talking to people who have got a drug problem, particularly some individuals who have come out of your prison system, they said that they would rather be on the naltrexone treatment than the methadone for a number of reasons. Some of the reasons are obvious—for example, as you know, all you are doing with methadone is maintaining them on their addiction. Is there any naltrexone operating within your prison system as far as the justice department is concerned? If not, are there any plans to introduce it into the system to treat addicts with a problem within the system?

Mr Marshall—Most certainly there are. I will just quickly summarise the methadone program. Our policy with regard to methadone is that persons who are on methadone and who are entering prison will be maintained whilst in prison on methadone. In relation to naltrexone, we established at the beginning of this year a pilot naltrexone program. Six persons have been through it. It is a 12-week program which is a combination of naltrexone and very intensive cognitive behavioural therapy. So it is a psychopharmacological intervention which is carried out by our substance abuse unit in our prisons. Six people have completed that program, and we have 12 people in a current program. The first six, by the way, were all females from our Bandyup prison. The 12 we have in at the moment are all males. We intend to do another eight women in the next program, which will commence in about three weeks time.

Dr WASHER—Andrew, I would like to follow on from that if you do not mind talking about prisons a little further. In certain states a major problem, with female prisons particularly, has been the high incidence of drug related crimes. When these people go into prison, the transference of hepatitis C and B and AIDS—which are drug related diseases—becomes quite incredibly high. In fact, it has been quoted that this is probably the highest population at risk. What are we doing in WA to address this problem?

Mr Marshall—I understand you visited one of the—

Dr WASHER—I did not. I am sorry, I missed that.

Mr Marshall—Some of you visited one possible solution, which is the Nyandi Annex of Bandyup prison which is designed to be and is running on a drug free regime such that there is an incentive program for all of the persons at that prison to be drug free. That, therefore, obviously reduces the possibility of infections. We are about to trial a drug free unit in one of our men’s prisons, again on an incentive based program as they work towards release.

Dr WASHER—Just to follow that up, and sorry to be persistent on this, would you say then currently that the incidence of new infections in prisons in WA at least would be very low?

Mr Marshall—New infections in the prison?

Dr WASHER—Yes.

Mr Marshall—I do not have the figures. I suspect they are relatively low, but infections of persons coming into prisons are quite high. As you would know, the rate of persons with all sorts of diseases coming into prison is very high. With the diseases you talked about, I think our rates are two or three times higher than in the general population—that is, for prison admissions.

Dr WASHER—If I could come back to you, Terry, it is good to see you again and I am sorry I was late. I apologised to everyone, but I was with the Premier at breakfast and we did talk about drugs, coincidentally.

Mr SCHULTZ—Name dropping again!

Dr WASHER—The reason I dropped names was not that it was the Premier especially—he was in Victoria and did not have a good time at the forum, as you have undoubtedly heard—but apparently he had a bad time with some drug affected people. From the speech he made this morning, I cannot see our getting, say, heroin trials in the West in the short term.

Terry, one of the problems I foresee is that, as you mentioned, we have a great education program in the schools, et cetera, but the adult public image of drug abuse in this community, from my perception at least, is perceived as a criminal activity. Sadly, it is sometimes marketed as such politically. It is not seen as a health or a social problem, to some degree. I know this is a big statement. How are we attacking that population that is no longer at school, that adult population who perceive it in that way? I think that is a major issue. I think Dr George O'Neil's organisation is an example of what I am talking about.

Mr Murphy—I hope I am on the right track, but I would make two points. First, our public education campaigns on illicit drugs really try to talk to young people, particularly, and parents in their language and as they understand drug problems. Illegality there is a minor issue, because at the end of the day it is a minority of people who are using or who are potential users who do get caught. So I think, over time, those public education campaigns help the community to understand that this is a health issue and a social issue as well as a legal issue. From our point of view, it is very important that all those elements are there. The illegality of currently illegal drugs keeps their use down to less than it would otherwise be. There is research to that effect. Our experience with alcohol tells us that. It is very clear.

The second thing is that I think our diversion strategy will reinforce each of those elements to the public. We are treating illicit drug abuse not just as an illegal criminal issue but really using the illegality and the potential for criminal sanctions as the lever towards a health and social solution. I think that is the thing we need to get across: that illegality provides a strong base for the community and that it provides the opportunity not to punish people but to get them into treatment.

Dr WASHER—Kevin, one of the comments made to me on the side yesterday—and I do not know if it is true—was that the incidence of illegal amphetamine use had started to increase again. Apparently, we had seen some decline. Just to follow that, the habit of prescribing amphetamines in this state is the highest of all states. It seems that WA has a disproportionately high incidence of attention deficit syndrome or related disorders, and the amount of amphetamine utilised is, according to the Health Insurance Commission, extremely high in WA from doctors prescribing that. Do you have any comments on that at all?

Mr Larkins—Firstly, that is true. This is outside the ken of our group here, because that issue is being managed within the mental health division of the department. A state policy on ADHD is being developed out of the mental health division. I think it is in its final stages only now. I understand there is a variety of reasons for that—historical and the fact that practices

have developed here that are different from elsewhere. Other than that, I think the policy being developed has tried to address all of those issues in relation to Western Australia and also in relation to the issue of ADHD. There has been a bit of discussion about the seepage of some of those prescriptions into the general community and what is called the ‘grey market’.

Dr WASHER—Research was mentioned a moment ago, and I think Terry mentioned that. What levels of money are we putting into medical, social, or whatever form of research, into this drug problem in WA? Are we putting in enough? Do you have some comments on it?

Mr Murphy—The state spends relatively little on research, but nationally the research effort is massive. Kevin mentioned the three national research centres, one of which is based here in Perth, and it focuses largely on prevention. The one in Sydney focuses on treatment, and the one in Adelaide on professional education and training. What we have sought to do in WA is try and fill some gaps. You will see in the action plan a very small WA research agenda which picks up issues such as cannabis and suicide. It tries to get more information to the public about cannabis, the role of families in prevention, supporting local communities to prevent drug abuse, making sure we have good information on the disposition of offenders, and there is one other which escapes me. There is a massive research effort out there and we have got to fill a couple of gaps.

The other point I would make relates to an earlier question in regard to treatment choices. We are about to publish a number of documents next week on best practice in treatment, and this is drawn from existing research as well as consultation with services. I mention that because one of the challenges with research is not to do a lot more but to utilise the research we already have and to implement that. You will see within our coordination strategies that one of the structures we have is a research and policy group where we try to get that translation of research into practice.

Mr Larkins—The department has made a significant commitment to research in the area of alternate pharmacotherapies—in the order of $2.5 million over the next three years—and that is to look at naltrexone as a detoxification agent, comparing the clinic at Subiaco with the government clinic in terms of the detoxification regimes, and then the long-term management of people on naltrexone. As well, there is a study that is comparing the use of buprenorphine, which is an agonist/antagonist, and the introduction of taking people off methadone onto buprenorphine. There are three trials that are exploring that capacity, mainly to look at what is efficient, what is effective and what works. They are all part of a national evaluation of programs on opiate dependence which are looking at alternate pharmacotherapies. There has been a significant investment in that here.

Mr Murphy—I missed the question on evaluation earlier on from Graham, so if I may, I will answer it now. The key elements of the strategy are subject to specific evaluations—community based methadone, school drug education programs, public education campaigns, and some treatment services such as Kevin has indicated. The big ticket items get specific evaluation. You will also see in the back of the strategy activity and outcome indicators where we try in a succinct but comprehensive way to monitor the levels of activity and the outcomes we are achieving in this state. They will provide the most insight over time, particularly as we look at prevalence rates over time.

CHAIR—Can we get a copy of those papers that you said will be released next week?

Mr Murphy—Yes.

CHAIR—Thank you.

Dr WASHER—Alby asked a little earlier on about the needle exchange program. I think Alby had some anxiety about the number of needles being used, and it is pretty horrific. There is unequivocal evidence that needle exchange does reduce the transmission of blood-borne diseases. Do you agree with that?

Mr Larkins—Yes.

Dr WASHER—I would like to have that on record.

Mr Larkins—I think that is an important point

Dr WASHER—Would you elucidate that point, please?

Mr Larkins—It is a major plank of a public health initiative. That is very important and it is recognised by the intergovernmental committee on AIDS and related diseases. It is actually part of the national strategy. What Terry was saying is quite true: it is a matter of managing that in an appropriate way, and we attempt to do that.

Mr SCHULTZ—Is there any documentation of a scientific nature to prove that? Is there scientific proof of the fact that it has absolutely nothing to do with the rapid increase of epidemic proportions in hepatitis C infection?

Mr Larkins—Yes.

Mr Murphy—There is a good article with the relevant references that has just been released by the Australian national council on AIDS and related diseases.

Ms JULIE BISHOP—Kevin, I was interested in your response to Mal’s question on ADHD, because you said it is a mental health issue and so is outside consideration here. But in the context of dual diagnosis, if we accept an estimate that possibly in excess of 50 per cent of ADHD people will abuse substances, where does a substance abuser who has attention deficits go for treatment in the public sector of both disorders? How can a substance abuser find out if he/she has attention deficits? Is there education on this issue in the public arena?

Mr Larkins—As to my comment about being outside, I was referring to the fact that a policy was being developed on that. The short answer is that it is about good clinical practice. When someone presents, we hope it would be in the co-morbidity area and that they are managed in the way in which they present. So the training needs to be that alcohol and drug workers and mental health workers understand both conditions and are able to manage them and that, where they are not able to manage, they are able to refer it to the appropriate specialist service.

Ms JULIE BISHOP—Is ADHD one of the areas that people are being trained in and counsellors are being alerted to in the context of substance abuse?

Mr Larkins—Within the context of mental health services they certainly would be. That then becomes a diagnostic issue about what needs to be done to this person in terms of management—which is the best form of management? One would expect that you would utilise the best specialist services and that the generalist service would do the same, that a generalist service would understand the broad parameters of people presenting and would not ignore those markers, and that it would then be linked to and attached to good specialist support. That would be the aim.

Ms JULIE BISHOP—Superintendent Lampard, you touched on the attitudinal changes that have been necessary in the police force so that there is an understanding that drug abusers who commit a crime are people who would not normally go near a criminal scene. How have you gone about selecting and training police to work in the drugs area and particularly to get involved in education, counselling and the local drug action groups? Could you comment on that?

Supt Lampard—Certainly. We are still working on it. It is a cultural change that we actually have to inculcate into the police service, but I think we are making significant milestones in relation to that. We in the crime portfolio have set up a specialist division, which is a proactive division rather than a straight law enforcement division, and our alcohol and drug coordination unit is staffed by about 12 people who work specifically in this area. They work very closely in line with the WA drug abuse strategy, but we provide a police response not only to the education of young people but also as a major commitment to the cautioning programs, the diversion programs.

They also are responsible for educating the broader police service in relation to, for example, cannabis cautioning. We actually have trained all operational police in WA now about cannabis cautioning. They provide a very important role there, and certainly part of their charter is not only to keep the broader police service up to date with things such as this but also to provide training, especially in cannabis cautioning. We have got to do a lot of work in drug diversion and the new drug courts so that we can play an important professional part in working towards the success of the strategy.

Mr EDWARDS—Terry, you might be the best person to answer this. Syringe disposal is a hell of a problem, as you are aware. Some local authorities will accept a bit of responsibility for it and put out disposal units. Others say, ‘It is not our issue’; it is not our problem.’ Could you comment on that, and also tell us where you see the responsibility and what you are doing to perhaps address this issue.

Mr Murphy—We recognised this as an issue fairly early on. It is one that has the potential to really undermine public debate on this area. We have set up a needle and syringe disposal strategy working group which has been in place for two or three years now with the substance users association, so the drug users themselves, local government, town of Vincent and city of Perth are the governments represented now, health, police and ourselves. The responsibility is shared. We have tried to educate drug users. We have developed a logo and posters and got those out and about, particularly through the exchanges and the users association. We have

developed a best practice model by local government, which the town of Vincent has done, and then we try and sell that to all other local governments. This involved doing things like developing a whole new disposal unit that they can access. We are very proactive whenever there is anything in the media or complaints to police. We actually have a project officer based at the substance users association and of course local government which can talk to local government and encourage them to put disposal units in discreet places. We target hot spots that come to light periodically—there are no single hot spots regularly—and we get them cleaned up. So it is an issue you really have to be on to, particularly working on the cultural amongst drug users themselves.

Mr SCHULTZ—All of those words are very fine in terms of justifying the needle and syringe exchange program, but what percentage of the 2.8 million needle syringes that your government is sending out there are coming back safely? In other words, what is the recovery rate of the 2.8 million?

Mr Murphy—In this state about two-thirds go out through community pharmacies. They go out in these things called FIT packs, which are a hard plastic pack. They can be disposed of through general rubbish, and most of them are. With needle exchange services, their return rates are very high, generally of the order of 95 per cent. On occasions when spot measuring has been done it nudges the 100 per cent mark and even over that when some exchanges draw in some of the needles obtained through pharmacies. So by and large there is not a significant disposal problem in this state, but periodically it erupts or there are examples of it and that has got to be attended to very strongly.

Mr SCHULTZ—You are well ahead of the rest of the community in this state.

CHAIR—We may need to put some questions on notice, but there are two or three things we have overlooked. With respect to the 12 community service drug service teams, the CDSTs—take it on notice if we cannot do it quickly enough—in 30 seconds can you tell us what they consist of and how they are geographically?

Mr Murphy—There is a nice little two-pager in the folder you have. The thing I would emphasise is that they are both treatment and prevention, and support to mainstream services providers.

Mr EDWARDS—Can you take on notice the question Mal asked about the new infections in prisons of hepatitis C? Can I also ask on notice whether we can get some information about your statement relating to roughly 30 per cent crime being related to drugs?

Mr Murphy—Yes.

Mr Larkins—If the committee likes I could get a little bit more information on ADHD from the division.

CHAIR—You provide naltrexone free of charge in Western Australia. This is a more deeply rooted subject, but can you tell us the philosophy and the conditions behind that?

Mr Larkins—The reality is that all drugs that are supplied at the drug clinic are free. The problem with naltrexone was that it is not on the PBS listing so it is at enormous cost. What happened in the early stages was that starter packs would be given and then there was an understanding that people would manage their own supply. They would get other drugs. But that became a problem because of the number of people who were seeking that. The hope was that it would get PBS listing. It currently does not have PBS listing, and I think the reason for that is that the evidence is not in. The hope would be that when the evidence comes it does get listing. There was a simple rationale on numbers, but it is at considerable cost. I think that at the last look it was close to $½ million expenditure on those drugs.

CHAIR—I am tempted to ask the leading question—how far are we away from having the evidence in?

Mr Larkins—I guess that the National Evaluation of Pharmocotherapies for Opioid Dependence—NEPOD, as it is called—funded by the Commonwealth, which is a compilation of all of the research initiatives being done on alternative pharmacotherapies, would form a body of evidence that could be used.

Mr EDWARDS—The evidence is there; it is just not being accepted.

Mrs IRWIN—I have moved a motion in the House on getting naltrexone on the PBS, and I would just like to clarify what Mr Edwards has said. The information is there but we do not seem to be getting anywhere. We have got support on both sides of the chamber on that.

CHAIR—The per capita cost rise—in your submission—is $39 in 1993-95 to $63 in 1997-98. Is there any focus there that would—

Mr Murphy—Can you just point to the page?

CHAIR—I cannot refer you to the submission but maybe you could just take the question on notice. It may well be in your submission anyway.

Mr Murphy—My recollection is that relates to health costs and reflects that research project. So it would be best if we got that information to you.

CHAIR—That draws this to a conclusion. I thank you very much again. It has been very valuable for us. All the best in your endeavours. We will no doubt meet again as the months go by. I propose that the WA strategy against drug abuse and information package be received as an exhibit to the inquiry. There being no objection it is so ordered.

[10.55 a.m.]

BATTLEY, Ms Jan, Member, Executive Committee, Western Australian Network of Alcohol and Other Drug Agencies

COLEMAN, Captain Michael Timothy, Member, Executive Committee, Western Australian Network of Alcohol and Other Drug Agencies

McDONALD, Mr Christopher William, Member and Former Director, Western Australian Network of Alcohol and Other Drug Agencies

RUNDLE, Ms Jill Maree, Director, Western Australian Network of Alcohol and Other Drug Agencies

CHAIR—Welcome. I point out that, while the committee does not swear in witnesses, the proceedings of the day are legal proceedings of the parliament and, as such, warrant the same respect as the proceedings of the House of Representatives. We all know each other from yesterday, so I do not need to proceed with too many formalities on that front. Who is leading off today?

Ms Rundle—I will.

CHAIR—Could you give us a brief overview and then we can get into a general discussion.

Ms Rundle—The Western Australian Network of Alcohol and Other Drug Agencies is the peak body for the alcohol and other drug education, prevention and treatment sector in Western Australia. It is an independent, membership driven, not-for-profit organisation. WANADA has been in operation since 1984 and its membership reflects a whole of community approach to AOD issues. The objectives of WANADA, which are listed on the cover letter of the submission, are to promote coordinated education, prevention and treatment services that are effective in terms of cost and outcomes; to develop and respond to policies regarding planning for effective service delivery, intersectoral cooperation and most efficient use of resources and information; and to increase public awareness of AOD issues and provide information on the ways in which education, prevention and treatment services and the community can work together to reduce the adverse effects of alcohol and other drug use.

WANADA currently has 52 members. These include a range of treatment agencies, agencies that are support and prevention focused, community drug service agencies, indigenous alcohol and other drug services, women specific services and other associated organisations. These member agencies are located throughout Western Australia. WANADA made a submission to the House of Representatives Standing Committee on Family and Community Affairs which was prepared by Chris McDonald, who is the former director of WANADA. The submission addressed the issues nominated by the committee and presented a number of recommendations. In summary, those recommendations promoted the importance of education, prevention and treatment. Aside from the issues focused on in the submission, there are additional points that

WANADA would like to raise in this forum. Firstly, we would like to stress that there is a range of clients with varied needs and therefore a wide range of services are needed.

With regard to treatment, the WANADA membership incorporates a wide range of services with diverse treatment approaches. It is recognised by members that this diversity is required in order to reach a maximum target group where people can be matched to the most appropriate services. While there are cheaper treatment options, such as pharmacotherapies or treatment for people with less complex problems, WANADA is concerned that due recognition for treatment services that cater for people with multidimensional needs may not receive the resources needed, especially in competitive tendering. There is a significant proportion of people at the harder end of the continuum of needs. They include people with drug problems as well as underlying issues and problems associated with the chaotic conditions of their current lifestyle. They may be homeless, have co-morbidity issues and no network of support, and their drug use is perceived by them as their only means of coping.

Another point that we would like to raise is that WANADA members generally agree that pharmacotherapies are one of the many options that should be available to substance users. However, there is an agency-wide concern with the current level of evaluation of the naltrexone program and the lack of public scrutiny of that evaluation. The local media has often been used to promote the naltrexone program, and consequently the general public may see it as being an authority on heroin treatment. Many WANADA members have raised concerns regarding the Subiaco naltrexone clinic. These concerns are primarily based on an abundance of feedback from clients, parents of clients and volunteer workers from the clinic. The feedback suggests a lack of consideration regarding best practice service at the clinic. Best practice requires that the safety and wellbeing of clients is integral to any responsible treatment intervention. WANADA members would like to stress that the lack of funds is not a responsible justification for any oversight in best practice. Many effective and established agencies are themselves fully extended and could benefit from additional funding and yet they provide responsible treatment.

Another point we wish to raise is that health providers, such as general practitioners, are accessed by many people with substance abuse problems, and their families. AOD service agencies, such as WANADA member agencies, receive feedback from clients on what these health providers have suggested, prescribed et cetera, and it is generally agreed that there needs to be some systematic education about AOD issues and referral options made available to health providers.

Alcohol is a major contributor to morbidity, mortality and indirect social and economic costs. WANADA members consider too much focus on illicit drugs as the drug problem by governments and media propagates the myth that alcohol is outside the drug field when, in fact, it is the most commonly used psychoactive drug with significant social impact. WANADA members would like to ensure that other legal drugs are considered in the inquiry into drug abuse other than the obvious alcohol and tobacco. There is significant abuse with prescription drugs and inhalants. Many WANADA members provide a service for people misusing prescription medication and inhalants.

It is recognised that, despite our best efforts, many people choose to use drugs. Providing such people with good information and educational interventions will prevent many from contracting blood-borne viruses and morbidity and mortality due to drug overdose and related

harms. WANADA members support an education/prevention focus but, however, not at the expense of support or treatment for those with existing problems.

A concern that has already been raised in many of these points— and it was raised earlier today—is that of media coverage of alcohol and other drug issues. There is considerable evidence of media inaccuracy, misrepresentation and sensationalism in relation to alcohol and other drug issues. The media also generate a perception of polarised positions in the alcohol and other drug field. While the media are the primary source of information to the wider public, it is generally seen that aspects of media reporting on AOD issues act as a barrier to prevention and harm reduction.

CHAIR—Thank you for that. I will now open for questions.

Mr EDWARDS—Firstly, in your submission you argue that prevention and education promotion activities are generally assigned a fairly low priority and/or are inadequately resourced. Have you got any specific examples that you could give us of this situation?

Mr McDonald—I must admit I have not gone back and read through the submission again. In terms of school based drug education, in Western Australia there is a fairly well-developed and developing school drug education curriculum, and it is being rolled out to all schools across the state. However, it is still fairly much in the pilot stage and that is actually going to require considerable resourcing to get it adequately into enough schools and to provide adequate training for the staff who would deliver those programs. In that sense, there is probably a deficit in available funds for doing that.

In terms of public education, one of the most successful methods is obviously media campaigns which tend to set the tone. And provided there is adequate grassroots support or enhancement of those media campaigns, then you would certainly get some more effective flow on. But I do not think there is enough attention given to that. There is probably a number of federally funded public education campaigns which do not take enough note of the role of community based organisations, and, indeed, state government and local government organisations, in pushing that kind of thing along. So there probably needs to be more thought and better planning and longer time frames in the planning and involvement of target groups and other participants in that process to enable the more effective use of it. That obviously is another issue that goes to resources.

Mr EDWARDS—The other issue that I am particularly interested in is evaluation of programs. Are you happy with the level of evaluation that is being carried out with these programs, or do you think that there should be a greater level of evaluation and perhaps that evaluation should be used in then sending parameters for funding in future diversion programs, or in future moneys that are available?

Capt. Coleman—In WA there are now the newly improved, if you like, best practice indicators. I think most agencies within the field would be attempting to operate to those indicators. There are some players in the field that maybe are not, however, and they do cause some concern in the field. For example, some practices perhaps overprescribe some benzos, and there are practices that refer clients to other agencies inappropriately. An example I have in mind is a client that was recently referred to a non-medical detox in a dehydrated state.

Obviously, the client needed hospitalisation. So there are some agencies that feel they can operate outside the normal parameters, or outside the system, however you want to describe that, and appear to do so with impunity. That is a concern to us in the field, and we believe that it is contributing harm to some clients.

Mr EDWARDS—Does that indicate that there is a lack of proper evaluation?

Capt. Coleman—I suppose in this particular example, yes, it would do.

Mr EDWARDS—Is it widespread?

Capt. Coleman—No. My experience is that it is isolated—it certainly is in this state—to a limited number of services.

Mr McDonald—Obviously, evaluation of interventions is a very time consuming and resource intensive process. One of the objectives of developing models of best practice is to get evidence of what works best and replicate that into other services. You then know pretty well that you are on the right track.

There is also the issue of trying to make the most of what we would call ‘practice wisdom’. There are a lot of interventions that we know are effective. They have not been scientifically evaluated as such but they are delivered in agencies which provide adequate training for their staff, they have well qualified staff, they appear to have very good outcomes. It is a little bit the case of having to say, ‘Yes, we would love to have well evaluated programs. However, we are mindful of the expense. Where possible we are aware of practice wisdom and in many cases we will use the example of other treatment programs.’

Due to pressure on resources, and I guess it is to that issue of competitive tendering and contracting, there is very little scope for organisations to build in a component for evaluation. If you are looking at the overall effect of the treatment intervention on your clients, it requires evidence to show what they are doing down the track and taking account of other factors that might come into it. There is a myriad of factors that come into it. Of itself it is a very difficult process to undertake some sort of evaluation. Therefore, I think the approach is more to using, where possible, best practice of evidence based practices. However, in answer to your question, no, there is not enough money provided for evaluation. I think a number of non-government organisations would welcome the opportunity to be compared with equivalent services in the government sector or elsewhere for no other reason than to ensure that they are on the right track and that they are providing the most effective and efficient service for the community.

Mr EDWARDS—And that the money that is being provided is being best used, obviously.

Mr McDonald—You would have to say that, for many years, the community sector has been asked to do more with less. At the meeting you were at yesterday you heard a number of views to that effect—that the agencies were really strapped. Yet that is no excuse for not delivering the best possible service. Groups like WANADA play a role of trying to bind the various groups together and provide a conduit from one group to another to enhance the referral processes that Captain Coleman talked about, and so forth.

Ms Battley—Could I add a point there. There is a higher level of compliance of agencies surveying clients at exit—once they have finished their involvement with the agency—to get some understanding of their satisfaction of the service and also any changes clients have made in their drug use or other factors in their life like their psychological wellbeing, their social wellbeing and their relationships. Some agencies, depending on the service they offer, ask those questions prior to the client going into the service as well as at exit. That is very short term and, as Chris has mentioned, you would need to follow that up at three, six and 12 months which, as far as I know, no agency does, and we do not have the staff to do. But there is high compliance with testing at exit.

Dr WASHER—Could I just ask a little about the industry side of things. You mentioned industry here, and I think it is an important component. We have spoken in the past about the impact of drugs on society and crime, but industry loses a tremendous amount of resources, money and people because of alcoholism, et cetera. How receptive is industry now to this issue? Screening is now traditional; most mining companies now screen for drugs. You commented that this is not necessarily the best policy, and I would frankly agree with that. Can you expand on what industry is doing in WA in particular, how you are working with that and what suggestions you would like to give back to industry?

Mr McDonald—Certainly drug testing in the workplace has a degree of popularity, although drug testing of itself, as you have noted, is not really adequate. It needs to be in the context of an overall alcohol and other drugs policy within the workplace. There is a safety issue if people are operating machinery or driving in the transport industry or in fishing or mining. They are traditional industries where people are putting themselves and the community at risk through using drugs and then performing their work. They are areas where drug testing is being carried out—and it is most appropriate that it is—and a number of other industries are starting to get on board. However, there is a tendency to think, ‘All we need to do is test workers for drug use, and that is our drugs policy.’ That is not adequate. The building trade’s group of unions have run a workplace alcohol and other drugs policy for quite a number of years now. That is working with the unions, the workers, employers and governments to develop comprehensive policies which involve early interventions with workers. It is about workers taking responsibility for fellow workers. In the past people used to cover up if someone was hung-over, a bit out of it, or something like that; they would tend to cover it up a little bit. There is a greater awareness now that it is a safety issue and involves a safe workplace, and that is what is paramount.

There is again a sense of getting ownership within the work force and that management adopt the comprehensive policies they are planning and that their implementation involve all the stakeholders within that group. It is not just management saying, ‘We’re going to drug test our workers; therefore, we can tick that one off. Yes, we’ve got a workplace drug program.’ It needs to be much more comprehensive than that, and there are moves under way in Western Australia to broaden that. However, it is a case of having to educate the community and employers about the need for it to be as comprehensive as that.

Dr WASHER—You see a tremendous amount of people lacking job opportunities and having low self-esteem who use or abuse substances. What facilities do we have in place, particularly here in WA, to help in the education, rehabilitation and job opportunities for these types of people?

Ms Battley—In terms of job opportunities, alcohol and drug agencies need to refer—this would be the majority—to other agencies that pick up those issues. Obviously, having a job is, in terms of how well a person is going to do, a very positive thing. But the alcohol and drug agencies concentrate on the continuum of people who are still using substances and keeping them safe through to working around their personal and interpersonal issues. In terms of helping them to get a job, the majority of agencies would not be doing that. They would be referring them to other agencies in the community that have that service.

Dr WASHER—I guess the question is: how effective are these agencies that you refer to? Do they look at these people as having a disability? Would they be treated in a special way? Would there be a greater focus on getting them a job—more input—to try and get them back into the work force?

Ms Battley—I could not really comment specifically because I do not have direct contact with those agencies. But there is no doubt that with someone who has had a drug or alcohol problem there are two sides to their difficulty. One is that lapsing is common. People do not do a program or have counselling for two weeks, two months or two years and then never have the problem again. It can be an ongoing problem. That is a difficulty for them. The other thing is that there is certainly still a lot of stigma and bias around and more work would need to be put into obtaining employment for those people and supporting them in employment. I think the support is the important thing—you just cannot dump somebody in a job. Although some people have got high skills—someone spoke yesterday who had very high work skills—that would not necessarily be the norm with the clients that we are working with. The norm would be people who did not.

Ms HALL—Do you think that the current system is integrated enough? Do you think that people are linked from, say, point A to point B well enough?

Ms Battley—No, not just in employment. That is one of the very difficult issues. When you say ‘case management’, there is not enough time that goes into getting people from A to B and supporting them there. Agencies—and also, I suppose, different sectors—are concentrating on what they are doing, but I think the actual link to the next part is not very good at all.

Ms HALL—You think that that needs to be addressed?

Ms Battley—Absolutely. Even finding the service that the person needs to go to is very difficult.

Mr McDonald—In a sense, it goes to what we call ‘after-care’ where people who successfully complete a program—or complete it to the mutual satisfaction of the therapist and the client, if you like—need to have ongoing support of some sort. That may tie in with that issue of, ‘Okay, I’m looking for work, where do I go?’ As long as they are able to remain in touch with the agency, that would offer that sense of after-care. Again, it is a resourcing issue. However, I think the agencies would make a great deal of effort if you had a client who was doing well and who wanted to come back and get continued support to branch out into other areas and to make their life more functional. I think they would endeavour to provide that. But it is not a structured thing, as such.

Ms JULIE BISHOP—Under the heading in your submission of 'Crime, violence, and law enforcement', you have made the link between alcohol and violence, of course, and then given some statistics, particularly in relation to young people between the ages of 14 and 19 and in relation to a proportion of people between the ages of 20 and 24. You conclude that paragraph by stating:

Although there has been a reduction in the number of victims of alcohol-related violence, this level remains unacceptable.

Do these figures include the issue of domestic violence, as related to alcohol abuse; and, if not, do you have statistics on domestic violence as a separate area? Secondly, what metropolitan and rural services are available in relation to this issue of domestic violence and alcohol abuse or, indeed, other drug abuse?

Mr McDonald—There are a number of sources of data, and I think it is probably more appropriate if we provided some follow-up information on the age groups and the types of violence. We could certainly provide some supplementary data and the sources of that data.

Ms JULIE BISHOP—And also the services that are available for that specific issue. Would that be possible?

Ms Battley—Yes, we can provide that. Could I just make the point with regard to domestic violence that there has been a split over several years between the perceived point of view of people who work in domestic violence who see the issue from the power point of view—that is, relationships—and the perceived point of view of people who work in the alcohol and drug field who see it is as alcohol caused or drug caused. I think in a way we have thrown the baby out with the bath water. Fifty per cent of domestic violence cases do involve alcohol or other drugs, but that is not the direct cause and if it is not addressed then domestic violence will not be addressed.

Ms JULIE BISHOP—That is interesting, because I did not notice a specific reference to domestic violence in your submission. It was not under that heading of 'Crime, violence, and law enforcement', and I wondered why. You have obviously answered the question by saying that it is now considered to be somebody else's issue, not so much a drug and alcohol issue.

Ms Battley—In the past, if alcohol—it was mainly alcohol—was involved then it was used as almost an excuse, and so people working in domestic violence have fought very hard to counter that. But I think we have got to a point now where, even though it is involved in 50 per cent of cases, we see it as a significant contributor but not as a cause. So I think those two parts need to come together.

Ms JULIE BISHOP—I have a second question—this issue was raised earlier, so those who were present might have thought about it—about dual diagnosis in respect of mental health issues and substance abuse. Jill raised the point earlier about the concerns that there are not services and treatments that specifically integrate these two areas. Could you comment on that? Another related concern which somebody mentioned is ADHD. What services does your organisation provide for attention deficit disordered adults with regard to alcohol abuse, substance abuse, education on the issue and the like—preventive practice?

Ms Battley—Could you repeat the dual diagnosis question, please?

Ms JULIE BISHOP—Concern has been expressed here this morning and elsewhere that some people may well fall between the planks; that, having been diagnosed with a mental health disorder and also being substance abusers, they seem to be slotted into one category or the other; that there is not an integrated approach. I just wondered if you could comment on your experience of what services are available for the dual diagnosis issue. My second question was in relation to those with attention deficit disorders who are also substance or alcohol abusers.

Ms Battley—I think it would be the experience in the non-government alcohol and drug sector that not only some people but many people with what you are calling dual diagnosis fall between. The health department has a program currently looking at piloting some work between mental health and alcohol and drug services. In talking to them the other day, it seems that some of that is working quite well but that other services fall out of that, that often there is this issue of the non-government sector not being able to access the procedures and protocols that have been put in place.

It is still very difficult for alcohol and drug agencies to work with people who have both issues. With regard to people who have alcohol and drug issues we talk a lot about complex situations and complex cases, but most of them are complex and they are getting more and more complex. It is a bit of a continuum. There are people who have a diagnosis in a certain area that in the alcohol and drug field we would find difficult to manage, particularly if they were not stable in that condition, so they do fall between. The mental health area finds them very difficult to manage because the alcohol and drug issues are causing them problems, and we find it likewise. It is about training, staffing and people broadening their understanding, but it is also about what you can actually cope with.

We are having clients who have been released from Graylands coming out into the community with drug problems. We need to have a mental health person who will look after those issues for them and work jointly with us. If that does not happen, we have people all over the place self-harming, who have tried to commit suicide four times in the last month. How can we look at the alcohol and drug issue when all that is happening if we do not have the added support? The combination makes things very difficult. We have to have good support. Workers in the alcohol and drug field have to have good supervision and back-up to cope. So there are some structural things and some internal agency issues that work against responding to those people with the high level of support that they need.

Ms JULIE BISHOP—Anything on ADHD?

Ms Battley—As a specific issue, that has not—certainly in my experience—been big except for younger people. In this state there has been quite a lot of awareness of it and a lot of prescribing of the drug they use. I have nothing to add from my experience; other people may.

Capt. Coleman—I could comment on that. A significant number of the clients that we experience would have ADHD type conditions. We try and absorb them into the general client population as best we can, but obviously there are significant difficulties. The attrition rate amongst them is high.

Ms HALL—I was interested to hear the comments you made about the naldrexone clinic. Would you like to expand on that a little for me?

Mr McDonald—I would be happy to respond to that. As background, George O'Neil is a wonderful man; he is very committed to what he is doing, he is very dynamic and has a great sense of social responsibility. We would also hope to speak to some of the media representation of the issues as well. You will recall that in, I think, *Woman's Day*, there was the headline 'I woke up cured of heroin'. It was a story about a young girl who went through a rapid detox. It looked really fantastic on the surface and it sparked a lot public interest. That, and also the need, particularly from parents, fed into the momentum for George O'Neil's clinic. Everybody is, unfortunately, looking for 'the' answer or 'an' answer to drug use problems. There rarely is 'an' answer. However, naltrexone certainly captured the public imagination. That led to the momentum that the Subiaco clinic developed and obviously it was then trying to keep up with the number of people that were applying and enrolling there.

I will echo Jill's points about feedback from a number of clients. It was almost a case of: 'We will take everybody; we will try to meet everybody's needs.' One of the things that treatment agencies really need to do is properly screen their prospective clients to see whether they are suitable for the program that they are offering, and whether the program does meet their needs. I do not wish to be critical of Dr O'Neil and his practices. However, there were probably some deficits there, more through enthusiasm and an honest belief that, 'Yes, this is an intervention which will work for these people and we would love to make it available to as many people as possible.' However—as was mentioned in an earlier presentation—the evaluation of the various pharmacotherapeutic trials and various pharmacotherapies are ongoing. There are something like 16 trials under way in Australia which are looking at naltrexone, buprenorphine, combinations of long-acting methadone and various other substances, and combinations of those.

We were talking before about evidence based practice. We need to be sure that the interventions that we are providing are based on sound and rigorous scientific evidence. That is not yet the case with naltrexone. There are some early indications from that NEPOD range of studies that are showing that there are other interventions, other pharmacotherapies, that are more effective than naltrexone. We would counsel caution in terms of people becoming too enthusiastic about naltrexone until the results are in. Any product has to be tested—and any procedure has to be tested—before it is widely available. It is a bit of a case of putting the cart before the horse.

Ms HALL—At the clinic, and throughout this inquiry so far, there have been some people who have made very negative comments about methadone. Do you believe there is still a place for methadone?

Ms Battley—Certainly.

Mr McDonald—Yes, definitely. Again, there is no single response to it. In one sense, methadone is a highly addictive drug. However, it does enable people to stabilise their lifestyle. One of the difficulties in the past has been that methadone clinics tended to be like a honey pot, and people were finding it difficult to break out of the drug scene. However, with more of a dispersement into community prescribing, and people being able to pick up their dose from

community pharmacies, that obviated that problem to a degree. In that sense, people who are stable can earn the privilege of being able to go and pick it up in the community. It works very well for those people. However, it is not the answer either; it is one of the answers.

Ms HALL—There is a push for naltrexone to be on the PBS. Do you think that push should also cover methadone?

Mr McDonald—I am not in a position to answer that about methadone. I am not sure; I do not have enough information about it. I am not sure of the status of methadone and the PBS.

Ms HALL—Should they both be treated similarly?

Mr McDonald—Once the results of those trials are in, if naltrexone is shown to be an effective intervention for opiate treatment, as well as other dependencies, then it certainly should be. So you would not have the problem of George O'Neil having to get public contributions to keep his clinic going; it would be a properly funded trial.

Mrs IRWIN—Your submission refers to data about the benefits of treatment for people with alcohol or other drug use problems. You say in your submission:

Given the fact that substance misuse and dependency is a chronic relapsing condition ...

What would you say constitutes a successful treatment outcome?

Mr McDonald—What is a good outcome—is that what you are asking?

Mrs IRWIN—Yes.

Mr McDonald—There are various good outcomes, but certainly they include reduced hazardous use of a drug—even elimination of use of a drug; reduced criminality; improved social functioning; improved personal success in terms of job seeking and those sorts of things; and improved health. Those are the sorts of outcomes that most AOD agencies are looking for.

Ms Battley—For some people, success might be the fact that they stop sharing needles so they do not contract blood-borne viruses. There is a whole continuum of success—keeping people alive or keeping them well, through to people actually making major changes in their lives so that they can perhaps, in the final part, either not use at all or use in a minimal way that does not cause any harm; where their lives again become very workable for them and for the people around them. Success is many things, and people are presenting to our agencies wanting all sorts of different things. Success is a negotiated thing between what the person wants and what we can provide for them. That sometimes gets difficult if they are younger and parents are involved, because often what parents want and what young people want, as you know, are two different things. This has caused the agency quite a few problems—and will continue to—because that is the nature of what we work with.

Capt. Coleman—I think, in relation to this, it is important to give due recognition to the psychosocial aspects of drug misuse in the sense that very often media coverage focuses on pharmacotherapies, detox and those kinds of things when, of course, the psychological

withdrawal, if you like, is achieved in a relatively short time frame and at relatively small cost. By and large, the client is unlikely to stay drug free unless the psychosocial aspects are addressed. They could include things like ongoing counselling and referral to other services. For example, many AOD clients may have sexual abuse issues which may need to be addressed. Psychiatric support may be relevant. In almost all cases, life skills training is appropriate—learning how to live, managing anger, communication skills, assertion skills, work readiness training, relapse prevention techniques and drug refusal techniques. All of those feed into what goes to make a successful outcome.

Mrs IRWIN—I know that we talk about education campaigns, but sometimes I feel we should do an education campaign for the media.

Ms Rundle—WANADA, jointly with the East Perth public health unit, has conducted some research to initiate an education package for media and journalism students. Chris, would you like to expand on that?

Mr McDonald—Yes, very briefly; I am aware of the time. That has been one of the concerns—and I mentioned before about *Woman's Day.* Quite dramatic headlines can be achieved, and we know the needs of the media as well. I guess one of the issues is: how do busy working journalists get to the story and get accurate information? We cannot be critical of them if they do not get it exactly right and do not follow our jargon exactly. It was a case of WANADA and the East Perth public and community health unit thinking that they really needed to provide some sort of module, or education package, to media and journalism students at an undergraduate level so that they could begin to examine their own issues and preconceptions about drug use; to use a sort of case study approach to analyse various issues and, I guess, raise the students own awareness of it. We had been concerned about the portrayal of alcohol and drug use issues in the media, but rather than be critical of the media, we thought that we needed to work with them to educate them about the issues. So again, we come back to that issue about starting to educate the various stakeholders. There will be more about that project in due course.

CHAIR—I suppose it is fair to say that each uses the media to their own advantage: if you are looking for funds maybe there is a time to ramp it up a bit, and if you are a politician you want the worthy recognition of the community for the wonderful job you are doing. So everybody has their little piece of it, don't they? It is a fine art.

Mr McDonald—Absolutely. Sometimes the most successful funding application is through the pages of the *West Australian,* if you are in WA.

CHAIR—A very acute observation.

Mr SCHULTZ—In the family relationship section of your submission you recommend that family orientated projects funded under the National Illicit Drugs Strategy be evaluated to determine their effectiveness. Are you saying that you question the effectiveness of some programs that have already been funded and that not enough attention is being paid to the matter of evaluation?

Mr McDonald—It goes to the issue that we were talking about before, that proper evaluation needs to be built into various programs. The National Illicit Drugs Strategy has put in enormous

amounts of funds—albeit into the illicit drugs area, with relatively little into alcohol; however, that might be another point—so there is the need to evaluate programs. There are a number of family based programs that are under way, as well as many other programs funded under that National Illicit Drugs Strategy, so we put that in the submission because we wanted recognition of the need for an evaluation component to be built into it. We think there is very good scope for those community based programs working with families. However, they do need to be evaluated and then, in the light of that, maybe reformulated and other needs identified and other services designed and delivered.

Ms Battley—I would like to add a point about the family services. One of the issues is that just as every drug user is different and there needs to be a diversity of approaches to suit their needs, with families it is the same. Sometimes what we have seen is that people get stuck on saying that only parents can help parents. Some parents do want support from other parents who have been through the same problem, but other parents, or spouses or whoever they are, want professional help or different types of professional help. So it is really important that there is a diversity and a variety of help for families as well as for the drug users.

Mr SCHULTZ—You are obviously concerned about road trauma, and you are to be commended for that because it is a very serious issue. In your submission you point to the effectiveness of random breath testing in reducing alcohol related harm, but you also state that between 1995 and 1998 there was an increase in the proportion of the population aged 14-plus who were caught driving while under the influence of alcohol. Are you saying RBT is a less effective deterrent for the younger age group, or are the RBT resources too thinly spread?

Mr McDonald—Again, we will provide those data sources later, so I will not necessarily speak to those. Random breath testing, certainly in Western Australia and in other states, has been a very effective intervention—and, obviously, that is in relation to alcohol and drink driving—so long as it is properly enforced and motorists are aware that there is a good likelihood that they are going to be pulled up. So it has that deterrent effect which has been shown to be effective in relation to drink driving.

We made the point in the submission that there has been some talk about introducing roadside drug testing. Again, it is one of those issues that has captured the imagination. However, the vast majority of injuries and deaths of people in traffic accidents are as a result of alcohol. There may be people who have other drugs in their system at the time, but that is usually in concert with alcohol. We would say that alcohol is the main killer in respect of road trauma and that any resources for drug driving ought not to be drawn from random breath testing programs because we know that is an effective intervention. We would be very concerned if resources were drawn away from that to pursue something that is a minor concern in that sense.

Mr SCHULTZ—On the question of drug driving, could I ask WANADA for their views with regard to the philosophy of governments in putting needle syringe disposal units in toilets and baby change rooms on our major arterial highways. What do you think that sort of facility does in terms of creating a problem of people coming out of those rest areas under the influence of drugs and then driving on our highways?

Mr McDonald—The whole issue of the provision of needles and syringes is one where there are a whole lot of public health and safety issues that have to be weighed up. Again, there is no

single answer to that one. I guess that in one sense they are saying, ‘This is where a large proportion of people are likely to congregate and, if we are going to have an effective disposal system in place, then that is a logical place to do it.’ I personally do not think that they should be on major roads, because it implies, ‘Have a shot and off you go,’ whereas in busy public places where there are community facilities I think those disposal units should be made available there. But as far as having those on busy public roads—which obviously implies that the only way the person has gotten there is that they have driven there and that presumably they then go and drive away—then I think that that is a recipe for additional problems.

Ms HALL—What about their passengers?

Capt. Coleman—Can I suggest that an evidence based approach would suggest that we look at the impact or the messages that having those disposal containers in those toilets sends to the community at large and weigh that up against the harm that it reduces by having them there. Really, only by establishing that evidence based approach—which we may have to do here in Australia—would we arrive at what would be a sound decision on that type of issue.

Mr SCHULTZ—Basically that is coming back to the concern that you have about the evaluation of some programs?

Capt. Coleman—Yes.

Mr McDonald—Very briefly, about that one about the disposal of needles and syringes, I do not know of any cases where people have actually been infected by hepatitis C or HIV from a needle-stick injury. Yes, there is a lot of community concern about discarded needles. However, there is no evidence that I am aware of that there have been any—

Mr EDWARDS—I can give you some evidence.

Mr McDonald—I would like to talk to you about that.

Mr EDWARDS—We need to get back to evidence based.

Mr McDonald—Absolutely.

CHAIR—On the issue of services, you may have heard in the previous submission an evaluation of the O’Neil clinic and the Next Step clinic and the comparative services. I think Chris McDonald made the point that it is very difficult to be all things to all people. In Perth we have these two services doing great work. Can you describe for me what you think are the relative roles and the relative differences between those two services and the collaboration that may be possible over time in terms of how they complement each other and that type of thing.

Mr McDonald—I think that there is no doubt that there is scope for collaboration between them. As I understand it, the Subiaco clinic is a fee-for-service clinic and the government run clinic is for people who either have much more complex needs and are—

CHAIR—They are referred?

Mr McDonald—referred to them and/or do not have any capacity to pay and yet have been assessed as being suitable for naltrexone. Kevin Larkin mentioned earlier that they are evaluating it. They are in the position of being able to say, ‘Up front, we need to put our evaluation processes in place right from the word go—from the first client we have in we’re actually evaluating the effectiveness of the program.’ That is in contrast to the events that overtook the Subiaco clinic, if you like. In that sense, it is going to be a lot easier to evaluate the effectiveness of naltrexone under a controlled program, notwithstanding the fact that the clients may be a little bit more complex and you would need to take that into account in your assessment of its effectiveness. I think that there is great scope for collaboration between the two services, particularly if there is capacity to pay.

CHAIR—Providing a flexible service for the clientele is part of it. It is quite challenging to bring the discipline which is ultimately required to turn up and accept treatment, which is part of this overall issue. But the flexibility as well is part of it, because the nature of the problem means that there has to be some flexibility, I would presume. Would you care to comment on the rigidities and the flexibilities in an imperfect world?

Mr McDonald—In an imperfect world, the treatment agencies have barely enough funding to provide services for people who can turn up on time to their appointments and not be too messy, whereas it always falls to the workers to go that extra distance. You have someone who turns up, you think you have someone who is presenting with a marijuana problem and you might find that they have a heroin problem, or that there is some other very deep-seated problem or that there is some problem within the family that just cannot be ignored. You are funded to provide X amount of services with X amount of staff—and you are really shoehorned, to a degree, into providing discrete services—yet you get these messy clients who go outside that. But you have to be there to provide them. That is where you almost need to have some additional resources built into the system. Instead of everything being cut to the bone, we really need to have some additional resources to ensure that we can handle those emergencies.

CHAIR—We have to build in that shock absorber, or whatever you want to call it.

Mr McDonald—Yes.

CHAIR—Just quickly, on the next step: the 24-hour a day, seven day a week, counselling service is quite an extensive service. There are about 120 full-time equivalent positions—not just related to this part of that 24-hour service, of course. I understand it has about 120 full-time equivalent people and a budget of around $10 million. What do you think is the general knowledge in the community of the counselling service itself? What would be the awareness of that service?

Mr McDonald—I guess it is very difficult. I was at the forum yesterday and I was frustrated by one parent, or a member of the local drug action group, saying, ‘The services don’t work. They’re not there when you need them.’ Our frustration is always about how we promote the fact that the services are there. People do not seek out services until they need them, and then it becomes a bit of a crisis. On the issue of the alcohol and drug information service, it has been running for quite a number of years—at least a decade and probably longer— and I think there is a growing awareness of it, certainly amongst health professionals, GPs and people working in the community. People would simply look in the *White Pages* for alcohol and drug—

CHAIR—That is an 1800 number, isn't it?

Mr McDonald—Yes.

CHAIR—It would seem reasonably straightforward that people would be hugely aware of it.

Mr McDonald—I guess it is one of those things that you would think they would be aware of and that you would hope that the people who needed it would be aware of.

CHAIR—To the extent of a 13 number for interpreter services and that type of thing? I was just interested in terms of communication and awareness in the community and that sort of thing.

Ms Rundle—I think a lot of treatment agencies or other agencies also provide that referral. A lot of other agencies get calls 24 hours a day as well. If ADIS is not rung, then other agencies are rung.

CHAIR—Lifeline services would be of aware of it. I am sure there is a whole network.

Ms Rundle—Yes.

CHAIR—On the public education issue, you talk of your concern about shock tactics in public education campaigns. I think that is always a debated issue—about the effectiveness or otherwise. Could you just give us a quick overview of that?

Ms Rundle—Sorry; what is this in regard to?

CHAIR—I do not have the actual reference, but I understand it was in there—shock tactics in public education.

Mr McDonald—I guess it was a case of the imagery, and some of the television amphetamine campaigns come to mind. I think there is a greater sophistication now in the design and implementation of the campaigns. Again, as long as the target groups are clearly identified and are involved in the design and planning of it, there is no point spending money on a public education campaign if the message is not credible or it is not targeted to that particular group. In some sense, there is a risk with shock tactics that people will just turn off and say, 'That just doesn't ring true with me, as part of the target group.'

CHAIR—I will give you an example. We had a minister of the Crown—who shall remain nameless—who used almost the reverse effect when talking to young people. He had a very good saying: why do I cross the road—to see if I can survive it. The reaction is almost inverse sometimes. I suppose that is the sort of thing we are dealing with as well.

Just a quick question on the licensing accords or voluntary agreements between licensed premises, police and local government agencies to establish responsible serving practices. It seems a sensible idea. How is it going? Is it having some impact and working all right?

Mr McDonald—I do not mean to take too much of the floor but it is an alcohol related issue and I would very much like to address it. The alcohol accords are, in principle, a very good idea. We talked before about evaluation and evaluation of effectiveness. There have only been a couple of accords in Australia that have been scientifically evaluated to show that, yes, they have changed serving practices or reduced crime, violence and other antisocial behaviour. The National Drug Research Institute did an evaluation of the Fremantle accord and compared it to the Northbridge area. They picked licensed establishments which were very similar and were then able to make a fair comparison. The results were not all that startling, in the sense that the Fremantle accord did not really show itself to be a terribly good intervention. They are very popular with police, publicans and the public, because they are about trying to do the right thing and wanting to do the right thing.

Western Australia has a very good liquor licensing act, with public health as one of its key elements. We would really stress the need to enforce that legislation. Police do have the power to enforce it, but they have to make it act as a deterrent, to make sure that they penalise any transgressions of the act, to encourage more training for bar staff in responsible service—those types of areas—in concert with an alcohol accord. A number of local government authorities are endeavouring to develop alcohol policies as well, and accords are a component of that. The local government is an area that has been neglected; and the Commonwealth government needs to work more closely with local government as well. They are the people on the ground, whether it is to do with needles and syringes, drunken patrons leaving licensed premises or whatever. There is a lot of scope there.

CHAIR—Close contact with the community, et cetera. Thanks very much for that.

Ms JULIE BISHOP—We got an interesting submission from the City of Perth speaking about that sort of thing and we might be able to take that issue of local government involvement a little further. You have been talking about evaluating different things for effectiveness. Your submission refers to the expansion of diversion opportunities and that they be monitored and evaluated for effectiveness. Are you questioning the compulsory treatment aspect of it and whether or not that is worth while? What are your concerns, if you have any, about the compulsory nature of treatments associated with diversion programs?

Capt. Coleman—There is quite a body of evidence to suggest that coerced treatment delivers the same or similar outcomes to voluntary treatment. In that sense, it has the capacity to deliver good outcomes.

Ms Battley—Part of it was to make sure that the service provision or service system that is being put in place is actually effective. For instance, cannabis cautioning is a one off, two-hour education session, and it goes up from there. Those decisions are not being made at a service delivery point, they are being made at a policy point. So, when that filters down, we need to evaluate that those interventions have been effective: whether it is enough, whether it is too much, whether the clients are actually making changes.

Ms JULIE BISHOP—Your submission said that you considered that 'the expansion of diversion opportunities must be monitored and evaluated against the risk that damage will be done to the effectiveness of treatment for voluntary clients'. Can you expand on what you meant by that?

Mr McDonald—From my experience of working in a residential treatment program, coerced clients, who are probably less cooperative or less willing to be involved in the treatment program, may cause disruption for the other clients. It is an issue that has to be very carefully managed. It is a management issue within a treatment agency—'Yes, we want to intervene early with people,' or, 'As an alternative to incarceration, those people should be given the opportunity to attend treatment programs. However, we have got to balance that against it.' With the introduction of the drug courts in New South Wales there was a flood of interest, and some inappropriate referrals probably went on as a result. Again, it is about matching people to the appropriate treatment. If that does not occur, it is a matter of, 'We've got a drug court, and we have got to refer X number of people into treatment programs. Let's just get them in there.' It is not good enough. People have to be assessed properly so that it does not impact negatively on that treatment program or on the public perception of the effectiveness of treatment. If you have got a whole lot of people going into treatment and they are coming out the other end with little change, that may have a negative impact on public perception.

Ms JULIE BISHOP—If they are severely drug dependent, would you treat them differently from infrequent users?

Mr McDonald—Yes. You would match the treatment to the needs.

CHAIR—It is a very interesting question, but we need to conclude. But if you have got the choice of Bandyup Prison versus Nyandi, which is a much more preferable place to be, it is a very interesting question. I am quite fascinated by 'coercion' compared to 'voluntary' that makes something that much more attractive. On that note, thank you.

Ms Battley—I have one small point, Mr Chairman. The big gap there in diversion is that alcohol is not being considered in the criminal justice system but only illicit drugs are. That is a major gap.

CHAIR—Thank you all very much. That was great.

Mr EDWARDS—A lot of coppers will tell you that, since the liquor and gaming mob were done away with, their enforcement in hotels has gone downhill. I might give you a yell one day and have a yarn to you about it.

[12.03 p.m.]

GRAY, Associate Professor Dennis, Team Leader, Indigenous Research Program, National Drug Research Institute, Curtin University of Technology

LOXLEY, Associate Professor Wendy, Deputy Director, National Drug Research Institute, Curtin University of Technology

MIDFORD, Mr Richard Gordon, Senior Research Fellow, National Drug Research Institute, Curtin University of Technology

STOCKWELL, Professor Timothy Richard, Director, National Drug Research Institute, Curtin University of Technology

SLEVIN, Mr Terry Joseph, Member, Management Committee, Alcohol Advisory Council of Western Australia

CHAIR—Welcome. Mr Stockwell will lead off and, after a brief opening statement, we will go into general discussion. Do any of you have any comments to make on the capacity in which you appear?

Prof. Stockwell—My main interest is in alcohol policy research, and I have been a drug researcher for a number of years.

Prof. Loxley—I have also been at the institute for a number of years, and my major area of responsibility is illicit drug research.

Mr Midford—I lead the team at the National Drug Research Institute that is responsible for community based research.

Prof. Gray—I am the leader of the indigenous research program.

Mr Slevin—I am representing Ilse O'Ferrall, Chairperson of the Alcohol Advisory Council. I am a former campaign director for the Alcohol Advisory Council and have remained a member of the management committee of the council.

Prof. Stockwell—Mr Chairman, I would like briefly to give a bit of background to our institute and to our submission and then introduce our two submissions. I would be grateful for permission to address the alcohol tax submission with Mr Terry Slevin, from the council, and then to move into the more general submission.

First of all, I would like to start by saying how much we welcome this opportunity. The National Drug Research Institute has been in existence since about 1985. We are one of three national research centres. We uniquely have the role of looking at prevention as well as at harm minimisation and public policy in our research. In my time there, about 11 years, it has been one of my priorities to make our research policy relevant. We believe it is our task to identify what is the evidence basis. We recognise that life is not so simple that the evidence basis inevitably leads to the policy, and of course often it does not.

We welcome the chance to discuss the nature of the evidence in our area. It is a large field. Drug problems are many faceted. There are many kinds of drugs; many types of harm experienced, even with one drug; and many different patterns of use. There is an enormous amount of literature evaluating the many kinds of interventions that have taken place. We cannot pretend to be totally expert on every single angle of that vast literature, but we have certain major areas of strength. As I said, we see it as our task to make this information and knowledge available to you, and we welcome the opportunity.

Over the 15 or so years we have been in existence, we have produced over 1,000 books, reports and published articles of different kinds. In doing this, we have worked closely with practitioners and policy makers and local communities. I would hate you to get the impression that we are distant academics with only our books to offer you. Our work has brought us into contact in very real ways with people experiencing problems and using drugs. My colleague Dennis Gray has worked and kept in touch with over 300 Aboriginal communities undertaking drug and alcohol programs—both at a distance and on hand in fieldwork. Wendy Loxley has overseen and taken part in literally thousands of in-depth interviews with injecting drug users, including some of the largest studies done of injecting drug use across Australia.

I should say that our work is not just in Perth. We are funded by the National Drug Strategy, in part—about 60 per cent of our funds—so we make it our business to collaborate with other research institutions and service delivery agencies in other states. Some of the largest studies of injecting drug use have been undertaken by Wendy. Just one example of Richard’s work is a study of 4,000 schoolchildren who are being followed up over four years to look at the impact of different types of alcohol intervention.

From my part, my alcohol research group has been subjected to hundreds of hours of experience of observing high-risk, licensed drinking premises and of interviewing thousands of patrons as they tumble out at closing time. We also have the job of looking at all the data in Australia on alcohol related harm and consumption, and we are swimming and immersed in that. One of our major jobs, the national alcohol indicators project, is reporting on that and improving the way we monitor levels of harm.

If I may just quickly introduce the tax submission. We elected to do this, partly because so many bodies are interested in making an input on the alcohol taxation issue. We are one of those bodies who has been interested and who has conducted relevant research. We also believe the evidence is so strong, that alcohol taxation can make a huge difference. If we get the tax system right, alcohol problems are not going to fade and disappear, but they will get a heck of a lot better than they are at the moment if some quite simple things are done.

I would also urge you to take this issue very seriously. I sit on the National Expert Advisory Committee on Alcohol, which is an example of a partnership approach with the alcohol industry to national policy. It is in sharp contrast to the National Expert Advisory Committee on Tobacco, which does not have the tobacco companies represented. Clearly, alcohol is benign in moderate levels of consumption—one should not get away from that—but one is hamstrung if national policy is limited by having to have agreement with every industry group that is present. The tax issue is one that we have not been able to address properly, and I see you as having a unique opportunity to do something about it.

Quickly, there are two pieces of research of ours that speak to this. We did a comprehensive study in Western Australia looking at 130 areas of the state looking at all data on alcohol sales, violence incidents or road crashes, all admissions to hospitals and all deaths that could be traced to alcohol. We looked at the kinds of alcohol beverages, and where the consumption levels of cask wine and regular beer are high the incidents of violence reported to the police and admissions to hospital for alcohol related causes are significantly high, and that is taking into account all of the socio-demographic variation across the state, including race, education, income, age structure and gender.

Another piece of work, which is really applying our national alcohol indicators project to the Northern Territory, was monitoring the impact of their living with alcohol program since its introduction in 1992 with a levy on all alcohol with a strength above three per cent. It has since generated revenue of between $4 million and $8 million to fund extra treatment and prevention services. The levy was removed after the 1997 High Court decision. We have only studied the first four years of the impact with the levy and with the program in place, and we have identified that during that period compared with the period beforehand there were 129 fewer alcohol caused deaths compared with controlled non-alcohol caused conditions. There were some 2,000 hospital admissions for alcohol related reasons prevented, and I think the figures were approximately 1,300 road crashes related to alcohol prevented—all for the Northern Territory, which has enormous levels of alcohol related harm.

So it appeared that some of these benefits were immediate. The research evidence is so clear that if you make a small increase in the price of alcohol you have almost a disproportionate beneficial impact on reducing high risk drinking. It has to be borne in mind that many problems from alcohol are a consequence of people drinking to intoxication. This policy is not about punishing the many for the sins of a few. People have the idea that one or two per cent of drinkers have a serious problem. Our recent research shows that over 50 per cent of all alcohol consumed in one year in Australia is in excess; it is done so on occasions in excess of NHMRC drinking guidelines—much of it is on episodes of intoxication, with people doing that once a month, once a week. Most people who drink engage in that pattern of drinking at some point. I would like to hand over to Terry, who would like to talk to the policy implications.

Mr Slevin—Thank you for the opportunity to appear here on behalf of the Alcohol Advisory Council which, I might explain further, is a very small non-government agency which takes as its objective the promotion of healthy public policy in relation to alcohol and seeks to draw very heavily from the research that is available—again, on the basis of seeking to operate on an evidence base. With that in mind, I think it is worth quoting research in the first instance—and forgive me for quoting an international agency. The submission quotes on page 6:

> Any country which intends to take the prevention of alcohol problems seriously must ensure that in determining the level of taxation, health interests are taken into account.

So I think it is fair to point out that, as Tim has already illustrated, the tax policy as it applies to alcohol is a key lever for government in relation to addressing the issue of alcohol related harm. I will not take your time by making the points about the volume of the drug and alcohol problem accounted for by alcohol abuse. I am aware that other people have made those points in very many circumstances, so I will not belabour those points.

I invite you to turn to page 11 of the submission that has been jointly put together by the Alcohol Advisory Council, the National Drug Research Institute, St Vincent's Hospital Alcohol and Drug Services in Sydney and Odyssey House, representing four of the more active bodies in the country in relation to alcohol related harm. The table on that page tells the story that the Alcohol Advisory Council would like to ensure is told today. Bear in mind we are working in terms of measures of standard drink, which is 10 grams of alcohol, and the cost per standard drink. Also bear in mind this submission was written prior to the introduction of GST. I invite you to look at the second column of the table and to add some information to that table which is drawn from other parts of the submission.

If you look at the post-GST price per standard drink and at the various categories of alcohol, you can see that for cask wine—assuming a purchase price of $10, which still stands today; it is possible to get that volume of wine for that price—people will be paying approximately 30c for a standard drink of alcohol. If you add a column to that about the tax paid per standard drink, that will illustrate the point best of all. The tax paid on that 30c is 6c currently. If you look at bottled wine, the purchase price is $1.30 per standard drink, on a $10 bottle of wine, and 26c of that is accounted for by the tax. For full strength beer—and obviously these prices will vary slightly, according to individual products, but these are taken from real examples—it is 76c for VB and the tax on that is 24c. For light beer—in this case, Light Ice—the cost per standard drink is $1.15 and the tax paid is 28c.

If we accept the fundamental principle that tax is an important lever in terms of influencing alcohol related harm, I think you will agree with me that the system is back to front. The system places the highest tax levy and the second highest cost per standard drink on the low alcohol product, which is least associated with alcohol related harm. Then the product that is second least associated with alcohol related harm—the bottled wine product—has the second highest tax applied to the standard drink and the highest cost per standard drink. I readily accept that there are arguments about social equity and the progressive or regressive nature of taxation, and socioeconomic considerations in relation to that. If you come to the fundamental principle that the better-off people pay more for their alcohol in terms of quality wines and spirits, the second issue is the volume consumed, so the people who are consuming the highest level of alcohol are the people paying the highest level of tax—that is in quantum. However, when you look at it for the vast majority of the population—those people in the middle who, in general terms, would say and believe they are not involved in alcohol related harm—the tax levers are pushing people towards those sources of alcohol which are very clearly related to the highest level of alcohol related harm.

I urge the committee, on behalf of the Alcohol Advisory Council and the Australian community, to make a strong recommendation in relation to the tax policy as it currently stands, with no excise charged on wine and with the wine equalisation tax having very little impact in addressing that excise deficit as it applies to wine, and to very much focus on those two issues—that is, the tax and price associated with cask wine and the tax applied to light beer which does not provide the price incentive which we should be providing for promoting that as a viable alcohol consumption alternative.

Ms JULIE BISHOP—I would like to clarify something there. In one of your submissions there is a statement that this is a regressive tax system, and then it says:

It should be borne in mind, however, that the persons who pay the most alcohol tax are a) those in higher income brackets and b)those who drink the most alcohol.

Mr Slevin—That is right.

Ms JULIE BISHOP—Are you saying that is because the tax per standard drink is higher?

Mr Slevin—No. If you think about it in terms of what is paid, the tax applied to bottled wine is in the higher bracket. Bottled wine tends to be the preferred beverage of the higher income bracket.

Ms JULIE BISHOP—But not those who drink the most alcohol?

Mr Slevin—That is right. But because they drink more alcohol, they are therefore contributing more to the tax system.

Prof. Stockwell—To add to that, people with higher incomes do tend to drink more alcohol—there is a relationship between the amount of disposable income and the amount of alcohol. The one exception to the rule, which we have put in the submission, is that if you exclusively drank cask wine you would probably not be paying as much tax as somebody who exclusively drank low alcohol beer.

Ms JULIE BISHOP—I was going to ask you about that aspect.

Prof. Stockwell—The important thing from a policy point of view is the evidence that an increase in price has the greatest effect on the heavy drinkers compared with the light drinkers. In times of economic recession, heavier drinkers reduce their consumption to a greater extent, percentage wise, than do the lighter drinkers. So we have a strategy here which would impact most on heavier drinkers rather than light drinkers. There are many strands to the argument.

Ms JULIE BISHOP—Does that theory work with tobacco?

Prof. Stockwell—It does, yes. That is why the National Expert Advisory Committee on Tobacco has advocated so strongly for the change in tax policy that we now have. It has been put right for tobacco, and there is an opportunity to do it for alcohol.

Ms JULIE BISHOP—Per stick?

Prof. Stockwell—Yes. It is the same principle: a tax per unit of alcohol or a tax per stick.

Mrs IRWIN—On page four of your submission under the heading 'In relation to families' you suggest that some parents of illicit drug users are not assessing the support services or education groups that are available to them. This committee has heard from countless people that there are not enough services available. Are you saying that in some cases the services are out there but the parents are unwilling to use them?

Prof. Stockwell—I would ask the committee if we could address the submission on alcohol taxation first. I know it is confusing when we have presented you with two submissions. When

you have exhausted your interest or questions on alcohol tax, we can introduce our second submission to you, which is broader ranging. I am sorry.

Mrs IRWIN—It is all right. I will come back to that question.

Mr EDWARDS—In your submission you state:

Alcohol accounts for about 10% of Indigenous, compared to 3% of non-Indigenous, deaths. Among Indigenous people the percentage of bed for alcohol-caused conditions is 50% per cent greater than among non-Indigenous people.

You also talk about levels of tobacco use, and you state:

Levels of tobacco use are approximately twice has high among Indigenous than among non-Indigenous people ...

I might address this question to you, Dennis.

Prof. Gray—Again, this is from the second submission. Are you finished with the first submission?

Mr EDWARDS—I am sorry; I am talking about alcohol.

Prof. Gray—The second submission also discusses alcohol.

Mr EDWARDS—I will leave it until the second one if you like?

Prof. Gray—Yes please.

Prof. Stockwell—This discussion is specifically on the alcohol tax, I am sorry.

Mrs IRWIN—We will discuss the alcohol tax.

Prof. Stockwell—Get that out of the way; sort that out.

Ms HALL—It has been put to me that if we increase the alcohol tax on cask wines, that will push those people who can least afford alcohol into purchasing alternatives such as metho, et cetera. Could I have your comment on that, please?

Prof. Gray—We conducted an evaluation of liquor licensing restrictions in Tennant Creek, where one of the main restrictions was to ban the sale of wine in casks of more than two litres, which, in effect, forces up the price of alcohol. It was suggested when those measures were first introduced that there would be a swing to fortified wines and methylated spirits, for example. What we found was that the combination of restrictions in Tennant Creek reduced alcohol consumption by 20 per cent. But it is still twice the national average. There was some move to fortified wines, but it nowhere near offset the declining consumption that occurred through the banning of cask wine and there was no evidence at all that people had turned to methylated spirits.

CHAIR—Was that because of 'thirsty Thursday' or because of the different general consumption from containers?

Prof. Gray—It is a combination of a number of things.

CHAIR—I think it is 'thirsty Thursday', isn't it?

I**Prof. Gray**—They call it 'thirsty Thursday' there. On Thursdays, there are no front bar sales or takeaway sales. But there are other restrictions which apply all week, and I think, in combination, they have that effect.

CHAIR—A correlation between the size of the container and the other restrictions.

Ms HALL—Would those same restrictions and the whole of community programs be able to be instituted throughout the whole of the country if there were that increase in tax on cask wines? Would it be as effective?

Prof. Stockwell—It is a shame we need to have an either/or here. We have two examples there of things that would work very well. Tax can make a little difference across a large number of people and, collectively, that adds up to a lot of benefit. These restrictions and local interventions are really more supportive, if you have the tax structure right. We should not have to leave it just to local communities to have the initiative and know-how to put these initiatives into place. I think they need to be supported through having a rational system of taxation that encourages consumption of lower strength beverages.

Prof. Gray—The ban on the sale of cask wine in places like Tennant Creek, Katherine and Halls Creek in Western Australia is not because of the beverage itself; it is because of the price. By banning casks of over two litres, they are forcing up the price, which has the same impact as increasing the tax.

Dr WASHER—I need to declare an interest, being in the winemaking business. I totally agree with what you say. I am also a doctor, so I have got two hats on. From a medical point of view, what you say is absolutely accurate. The big problem historically in how this tax came about as it did is because the Winemakers Federation claimed they made greater than 90 per cent of the wine in this country, which is true, and 50 per cent of that happens to be cask wine. Sadly, their presentation comes from an industry presentation, and they were turning over volume rather than quality, and so we have a major problem in this industry. An argument from the industry point of view is, 'What are we going to do if you cut out the cask side of it?' because a lot of the industry, with irrigated grapes, et cetera in South Australia and other areas, produces volume and cask cheap wine, et cetera. The industry needs to move to quality, not quantity. To put a tax in that way is absolutely essential from a health point of view. So keep up the good work.

Prof. Stockwell—Just to add an observation there, cask wine is an Australian invention, as I am sure you know.

Ms JULIE BISHOP—Like the Hills hoist.

Prof. Stockwell—Also alcopops—we gave these to the world as a consequence of the tax breaks given to wine. The purpose of the excise tax breaks given to wine was to encourage exports, and to encourage our excellent wine industry, which it has done with great success—exports have skyrocketed. But what it has produced in our backyard is an enormous problem, with alcohol misuse of cask wine. It has a devastating effect.

Ms JULIE BISHOP—Your submission does say that you believe public opinion would support tax increases on alcohol as long as the increases were not just for revenue raising, and they were used for preventative or treatment measures. What is the basis for the conclusion that the public would support increases in tax for treatment and prevention? And what, in your opinion, would be a publicly acceptable rise in taxation on alcohol?

Prof. Stockwell—The first point is very important. There have been public opinion surveys conducted. The Alcohol Advisory Council engaged in one. We enlisted AGB McNair to do a sample of the four major, most popular states. It was very clear that about 70 per cent of the population supported a ‘small increase’ in the price of alcohol if the proceeds were used for treatment and prevention. The Northern Territory Living With Alcohol program showed that a rise of five cents a standard drink was well supported. It probably has to reflect the level of concern in that community, about what seemed to be a reasonable response. It hits you between the eyes in Darwin and the surrounding areas that there is a problem with alcohol. Five cents a standard drink would be great from a public health point of view. It might be politically harder than two or three cents.

Mr SCHULTZ—Are you guys going to advertise to that extent?

Prof. Stockwell—What I would say is that it might actually win votes rather than lose votes. If it is explained that it is used for prevention and treatments, the public seem to support it.

Ms JULIE BISHOP—What do the studies say about the issue of increasing the taxation anyway—the reverse of it? Why is there such resistance for taxing alcohol for general revenue raising, such as we do with tobacco?

Mr Slevin—Could I have a shot at that, and partly answer your last question about what is an acceptable level. The first point is to articulate a sensible reason or intellectual framework for the tax structure. I realise that as people come through the doors of your electorates that does not become the primary source of the discussion—it comes down to dollars and cents. But it is important to articulate that, and the current system is unjustifiable.

Secondly, in terms of the quantum, I think there is a general acceptance of the differential in price and the quality gradients that Dr Washer referred to. But when it comes down to that argument about whether it goes towards programs specifically related to alcohol related harm, the Alcohol Advisory Council’s position is clear: in the first instance, it is important to get the tax policy right. In addition to that, the council would certainly advocate that some of those additional resources—not all, necessarily—would go to addressing some of those alcohol related harm problems. So, when it comes down to the quantum, a well thought-out tax structure will vary according to each individual component. The question was raised earlier: ‘Are we going to advertise that broadly enough?’ There are a large range of health organisations that would be very happy to strongly support the kind of position we are arguing today, and it

has occurred in the past; for example, the organisations that supported a campaign in relation to the advertising of standard drink labelling on containers which occurred in the mid-nineties. So there is, clearly, that preparedness to invest. Are those organisations as resourced as, for example, the Australian Brewers Association and their campaign? Of course, the answer is 'No, not a snowflake's hope in hell,' but I think there is recognition amongst people within the industry that the current system is not viable. It does not help Australia in economic terms, and it does not help Australia in health terms. There would be no shortage of people around this country prepared to put that argument to support a government policy change along these lines.

CHAIR—Was there any response in the recent, almost current, brewers campaign? Was there any response from—

Mr Slevin—From health organisations?

CHAIR—Yes.

Mr Slevin—I wear a variety of health related hats and, if I can—

CHAIR—We are very aware, because we had these semitrailers circling Parliament House.

Mr Slevin—We do not have trucks.

CHAIR—We did not see the medical professions in their ambulances going around there, that was all. We appreciate your help, though. Sorry, I am being flippant.

Mr Slevin—No, I understand your point, and it is a very important one to look at in the context of your task in this exercise. We do not have the resources to run such campaigns because we do not have the financial and pecuniary interests to run such programs. And if we were to, the only source we would get such funds would be from the public purse. Would that be an acceptable investment of public dollars? The experience of the Alcohol Advisory Council is, 'No.' Will governments support organisations like ours to make the points we make about changing government policy? No. That is why the organisation remains a very small organisation with, in relative terms, a weak voice. However, across the organisations that you are talking about, I have every confidence and the council has every confidence, of bringing on board—and this is consistent with their current policies—the Australian Medical Association, the Public Health Association of Australia, the Council of Churches and the College of Physicians; all of the organisations that, I guess, deal with the pointy end of the problem. So, no, we are not going to have trucks circling Parliament House—

CHAIR—Just a couple of ambulances.

Ms JULIE BISHOP—How do you answer the statement that the reforms you are proposing could inflict hardship—negative consequences— upon those in society who can least afford it? How do you counter that?

Prof. Stockwell—I think what we are having to do is balance the anticipated consequences of different options. I have heard that cask wine is being maintained as cheap as it is to prevent Aboriginal people hitting each other with bottles. The argument is that they are much softer;

they cannot be used as weapons. I think that is such an argument of despair: when these people are wrecking themselves and their lives, and there is talk about the contribution to violence of some other weapon. We have to recognise that there are very real consequences of the high levels of consumption of alcohol. There may be some problems in adjusting to a change in the pricing of different products. I would imagine—and Dennis's evidence supports this—that turning to 'meths' is very unlikely and there would be a controllable outcome: it would only occur for a few people. What you have to understand is that a lot of the drinking that goes on in groups like this is that they will drink to a budget: they will pool their money and they will drink until the money runs out. With a changed tax structure, when the money runs out they will not be quite as drunk.

Ms JULIE BISHOP—You do not see any negative consequences from your reforms, then?

Prof. Stockwell—There may be some negative consequences of this but they would be swamped, they would be drowned, in the amount of negative consequences we are currently experiencing.

Prof. Gray—Can I just follow up on that? At least in terms of Aboriginal people, I think throughout the country there is major concern amongst Aboriginal people and Aboriginal organisations about the cask wine issue. The newly formed National Indigenous Drug and Alcohol Research Organisation is one of the groups that is pushing for a change in the alcohol taxation. And at a local level, as I have said earlier, places like Tennant Creek, Halls Creek and Derby, Aboriginal people have been looking for a ban on cask wine to reduce this level of consumption.

Mr Slevin—Can I just throw in one quick thing. There was a paper from Scotland in 1983 that I am sure people at the table are more familiar with than I, which looked at precisely this issue. While people who are on low incomes are, on your argument, potentially more adversely affected because of the cost factor, they are also more vulnerable to the tax changes and the cost per unit of alcohol and it results in a disproportionately higher reduction in their alcohol consumption. So the people that you are suggesting are more harmed by the policy are those—

Mrs IRWIN—I am not suggesting it; I am suggesting it has been suggested.

Mr Slevin—Sure, but that argument suggests they are also the people who have the potential for the greatest benefit in relation to this policy change because they are more price sensitive.

Ms JULIE BISHOP—Is there an Australian study on that? You are talking about 1983, Scotland: have you got something 2000, Australia?

Mr Slevin—It is not an easy natural experiment to conduct—

CHAIR—We should move on a bit, because there is a lot of interest but we have got another submission and we are going to run out of time. So just be alert that we want to do justice to the broader issues as well.

Mr EDWARDS—I just want to make one point, Dennis. It is interesting that you have raised the level of concern amongst Aboriginal communities. This committee has just conducted a

very comprehensive inquiry into indigenous health and, from the best recollection I have got, the issue of cask wine was not raised by one community or one single submission.

Prof. Gray—I cannot explain that. But, as I said, the National Indigenous Drug and Alcohol Research Organisation has raised it and it has been raised at a local level in various communities around Australia. As I said, in places like Derby, Halls Creek and Tennant Creek, people have been pushing for it, and at the moment there is a big debate going in Alice Springs about whether it should be reduced there.

Prof. Stockwell—Can I just suggest that there is a community awareness issue about this as well, but, where there has been a move in a local community, a cask wine restriction is one of the first targets in these areas. So the local people know it is a problem.

CHAIR—Okay. I have got Alby Schultz, Julia Irwin and Mal Washer on this. I know they are going to be very quick with their questions and there will be a quick answer.

Mr SCHULTZ—Just a quick comment before I ask the question. We heard from a member of the Aboriginal community yesterday that cask wine is as cheap as lemonade, but their experience has shown that if they remove one problem such as alcohol from the community they swing across to things like methylated spirits. So there are issues that you guys need to think about as well.

Prof. Gray—I think again we have to look to the evidence, and I think that, like non-Aboriginal people, some Aboriginal people have opinions about these things, but when you look at the evidence from Tennant Creek, for example, there was not that change.

Mr SCHULTZ—I am not expressing an opinion as a non-Aboriginal. I am expressing a comment that was made by an Aboriginal indigenous Australian. I am just putting that to you.

Prof. Gray—What I am saying is that people have opinions, whether they are Aboriginal or non-Aboriginal, which may not coincide with what the evidence shows; that is all.

Prof. Stockwell—I would just like to add that we are not proposing that this tax is going to remove the alcohol problem, and of course it will shift drinking patterns and people will selectively drink more beer or they will drink more something else.

Mr SCHULTZ— That is a point, yes. Your submission recommends an inquiry into alcohol taxation aided by research and public discussion to determine an optimal alcohol taxation system. What would be the focus of such an inquiry, what benefits would an inquiry of this type have for Australia and what body is best placed to conduct such an inquiry?

Prof. Stockwell—The focus of the inquiry I think ought to be on the public health and safety impacts of the present system and looking at ways of addressing that. I think it should also question the current basis of government policy, which is really, as has been indicated, heavily on the advice of the Winemakers Federation, which really represents disproportionately three or four very large multinational companies which happen to make cask wine. So I think one needs to look more broadly at the bases of alcohol policy.

I would hope that you would have a special hearing or a special session of your committee to look at this. It may be that you decide that a national inquiry is required. I have heard rumours and hints that the government may be prepared to look at this issue again. If we had to wait three years for a whole inquiry to proceed, that would be regrettable if it could be achieved within a couple of months.

Mrs IRWIN—Alby actually asked the question that I wanted to ask. It might be better if we moved on to the other submission.

Dr WASHER—Just to reinforce this, you still agree that the principle is that people will tend to drink a lower alcohol product or less of a product if the price goes up according to the charge for the alcohol content. The positives that I have personally received back—and I want you to comment on this—is that most people accept that as a pretty reasonable proposition in the community, even the people who drink alcohol on a regular basis. You would agree with that too?

Prof. Stockwell—Yes. The research shows people favour that.

Dr WASHER—What I am getting at is that your gut feeling is, from a political point of view, that as a measure this would not be that unpopular.

Prof. Stockwell—That is the easiest part to sell: reducing the tax on the low alcohol beers. I agree with the brewers circling Parliament House on one thing, and that is the fact that tax per unit of alcohol is highest on the lowest strength beer. The next highest tax is on mid-strength and the lowest is on regular strength. In order to keep the price advantage, one relies on the state governments to chip in with subsidies. It is madness; this is meant to be administratively simple. I think that they have just overreacted to the brewers' overenthusiastic lobbying and are throwing out the baby with the bath water.

Mr Slevin—To add one quick comment, a policy which gives a tax advantage to a low alcohol product encourages industry to invest more research into producing commercially viable low alcohol products. This was clearly and very successfully demonstrated with low alcohol beer in this country. One wonders whether a similar outcome could be achieved in the wine industry.

Prof. Stockwell—Low alcohol beer is an Australian success story.

CHAIR—That is very interesting and very valuable. You have seen the comment made, of course, that the government is only interested in perpetuating tax on cigarettes and grog because it benefits so well, as if we are almost personally benefiting as politicians. You know the political line. It would seem to me—and I may well be wrong but I want to canvass it with you—that the costs on health from alcohol and cigarettes, but of alcohol particularly because that is our subject today, would be far outweighed by a long way by any revenue collected in terms of federal tax.

Prof. Stockwell—Absolutely.

CHAIR—I am flying by the seat of my pants here because I have not got the evidence. The question is: do you have the evidence and what research has been done by any of your people in terms of the revenue in and the costs out? You have got some figures in here, I know, and you might be able to point me to where in your submission it says that. I could not quite get the analysis where we could make the clear case.

Prof. Stockwell—Probably the clearest case is in the Northern Territory where our own research has shed some light on it. The costs were estimated to be in the region of $150 million a year in total. They were reduced to about $120 million a year with the levy. I would not put all of that reduction benefit down to the levy. The levy revenue was $18 million over the four-year period. The estimated total savings were $124 million.

CHAIR—I am coming at it from a slightly differently angle. I take your point and I read that part of your submission and it was quite valuable. The point I am endeavouring to make in a whole of government sense, in a national sense, is that there are revenue collected costs to the community. I put this over to one side because that is just about immeasurable in many ways but, in terms of revenue in and expense out, I do not know that anyone has done the work.

Prof. Stockwell—Revenue in—I can check this and I can send it forward—is in the region of $1 billion to $1½ billion. I think it is in that field.

CHAIR—That is right.

Prof. Stockwell—The estimates of the total cost are outdated. One of your recommendations could be that we need another Collins and Lapsley exercise. The last one was in 1992, using 1989 data for a lot of its calculations. They estimated $4.5 billion.

CHAIR—Do you see what I am driving at: that the data is weak? We do not have it and I think that is something that we need to address.

Prof. Stockwell—Actually, it will not have changed that much since 1992 but that is the ballpark figure. They are hugely different.

CHAIR—But it is not a big issue; it is not in the public mind. There is this rather simplistic political view which says, ‘The pollies are in for their cut again on beer and tax.’ There is a wonderful Parliamentary Library heading: ‘Cigs and beer up.’ It is automatic. I am challenging it, and we need to do better in getting that message across. There is a very significant deficit on the cost side as to the revenue side.

Prof. Stockwell—That is where the hypothecated tax works. You can say all the money is going to treatment prevention, and everyone thinks that is a good idea.

CHAIR—We agree that we are weak in our evidence, in our data.

Prof. Stockwell—It needs to be updated. It is significant evidence; it is quoted all over the world. The Collins and Lapsley study is famous, but it needs to be updated.

CHAIR—My own view is that it is weak in presentation in terms of the public mind.

Prof. Stockwell—It probably is not conveyed to the public. There is a job to be done.

CHAIR—Which is our job, our role. It is not your role, but you can help us. That is all I am saying.

Prof. Stockwell—Indeed.

CHAIR—We need to move to the next submission.

Prof. Stockwell—I do not want to labour the point, because we are probably running out of time. My colleagues would like to speak briefly to their parts of the submission.

Prof. Loxley—I think it might be better if we just took questions at this point.

CHAIR—We are ready to go on that.

Prof. Loxley—I know there is a question here about parents of illicit drug users.

Mrs IRWIN—I had two questions on that submission, which I found very interesting. We will go first to page 6 of the submission and to the heading, 'Interventions to reduce the risk of harm of illicit drug use'. You outline a variety of costs associated with the current prohibition of cannabis. It recommends the adoption of a combination of infringement notice schemes and cannabis cautioning systems. Would you outline for the committee exactly what reforms you are proposing and what benefits you expect to flow from this.

Prof. Loxley—Perhaps I should preface my remarks by saying I am speaking on behalf of my colleague Simon Lenton, who is unable to be with us today. The reforms that he has proposed are outlined in detail in this monograph, which forms the basis of a report that he made to the Victorian parliament. That reference is in the submission. In brief, Simon and a group of other people nationally have been involved in a series of studies, which, among other things, have looked at the social cost of a cannabis conviction, comparing a state like Western Australia, where they have had prohibition prior to cautioning, to a state like South Australia, where they have had infringement notices for some time. They found generally that there were very high social costs associated with a cannabis conviction related to such matters as future employment and travel prospects and family related issues. They found that prohibition in the form of a criminal conviction for a cannabis offence did not appear to make very much difference, between those states that did criminally convict people and those states that did not, to the amount of use or harm associated with that use.

I should point out that the majority of drug related offences are minor cannabis offences; something like 80 per cent in Western Australia of drug related offences are minor cannabis infringements like possession and use. Therefore, rather than criminally convicting those people found guilty of a minor cannabis offence, an infringement notice system would appear to be better at reducing the harms associated with conviction. In addition to that, in Western Australia we did then bring in the cautioning system, which appears to be a good way to put people in touch with an education program about the harms associated with cannabis, possibly identifying

and picking up early heavy users of cannabis who are those most at risk of going on to harmful use of other illicit drugs. We combined infringement with some cautioning such that on a first offence one would be formally cautioned and streamed into the education system.

On subsequent offences one would be given an infringement notice but given the opportunity to work that out in an educational treatment program instead. It is a kind of diversion system as well. At any rate, that no criminal conviction would follow from either of those two infringements would seem to us to be preferable to a system where convictions are given to people—particularly young people, since they are very visible. They are out there on the streets and more likely to come into contact with law enforcement. They are more likely to be found in possession of cannabis. They are very much more vulnerable to being caught offending with cannabis than people who are more off the street and in their own homes. That seems to us to be a better approach. Does that answer your question?

Mrs IRWIN—We are going to page 4 of your submission now and that was in relation to families. I will just repeat the question. Your submission suggests that some parents of illicit drug users are not accessing the support services or education groups that are available to them. This committee has heard from countless people that there are not enough services available. Are you saying that in some cases the services are out there but the parents are unwilling to use them? If that is the case, why?

Mr EDWARDS—Just before you respond, my question is on exactly the same point. If they are not accessing the services, what strategies should we be looking at to get them to access them?

Prof. Loxley—There are a number of different things going on. One is that there undoubtedly is a dearth of services for parents of illicit drug users. The perspective that I have come at this from, the research that I have done, has been looking at parents as victims. I am not now looking specifically in terms of parents as educators or counsellors for their children so much as parents and families themselves experiencing really very serious stress and distress related to the fact that their family members are using illicit drugs. So it is accessing services for themselves, basically, rather than getting their kids into services, which is another angle which probably needs to be considered as well.

In some cases there are services and parents do not access them because they do not know they exist, they do not know how to find them or they feel too much shame to go and tell anybody in a public forum, or in an agency, that they have got a child in their family who is using illicit drugs. The shame aspect is very salient for an awful lot of parents. They actually do not want anybody to know that they have got a kid on heroin, that they have got a kid using amphetamines or that their child is ripping off their family and stealing their money because they are opiate dependent or whatever. So the shame thing is a very large aspect of parents' reluctance to become involved in programs. I have to say much of this is anecdotal rather than evidence based, that we do know from anecdotal experience that, when parents get into parent self-help programs particularly, they feel enormously relieved because they suddenly realise that they are not the only people out there whose kids are using heroin or whatever and that not all parents with opiate using children are bad parents. That is a major issue, the fear that the community will regard them as in some way responsible for their child's drug addiction.

You ask me what we should do about it. I think we should do a number of things, but I think one thing we should do is somehow get across to parents that it is really good for them to get themselves involved in support programs like the Tony Trimmingham parent self-help programs, some of which happens in other places. Somebody mentioned ADIS earlier. ADIS has a line called PDIS, which is the parent drug information service. It is an excellent line, but I think we need to make that telephone number much bigger, maybe in our local papers every day saying, ‘If you’ve got a kid with a drug problem, ring this number.’ Even if we do all of those things and even if we build many more services, there will still be parents who are very reluctant to become involved in formal health related services. I think what we have to do about that is be very creative in the ways that we go about developing those services: put them through schools, put them through health agencies, put them through community health, put them through all the sorts of different places that parents could go. We need to get the community talking about the fact that a parent with a drug dependent child is not a bad parent, because that is a major concern for an awful lot of parents. Apart from the fact that their lives are turning into disaster on a daily basis and they have to deal with that, they also have to deal with all the guilt that says, ‘Somehow or other, I’ve raised a kid with a heroin problem,’ or whatever. It is a major issue for them.

Ms HALL—I will ask you first what was going to be my last question because it flows on—

CHAIR—Excuse me, Jill. I need to see the mayor, who has been so courteous to us, and I am just going to ask Graham Edwards to be acting chair, though he is heading somewhere in a minute. As a matter of courtesy, can I just say that I need to leave you for about five minutes. I am sorry about that.

Ms HALL—My question is to do with families and the systems approach to dealing with the problem of drug abuse in a family. Have you done any studies on the systems approach to dealing with that problem: looking at the family, at the drug user, at what happens once they become drug free, the maintenance, the impact on the family, the changes that need to take place in the family, the issue of housing and of work, and how it all comes together and impacts on the person? I know it is an enormous question, but I asked it as quickly as I could.

Prof. Loxley—The short answer to your first question is no, we have not done that research, in part because we are working at the other end—we are looking at it from a prevention perspective, in terms of what are the early things that can be done to assist families at the earliest point when distress starts to become a problem. Some of the answers to your question are in a sense later, further back in the system, once the young person particularly gets involved in the treatment system and so on, and that is a bit beyond where we are looking. That is half of the answer.

The other half of the answer is that we have actually attempted to get funding to do much more detailed research with families, and with parents in particular, looking at it from the perspective of parents as victims. Unfortunately, so far we have not been able to get that research funded. So, no, I have a strong interest in families but I have not pursued it at this point beyond what is in the submission.

Ms HALL—Fine. I notice in the submission that you have identified that you are doing a longitudinal study on naltrexone or that you believe there is a need for that.

Prof. Loxley—Naloxene—to reduce opiate overdoses.

Ms HALL—Okay, I am sorry, forget that question. I would like you to make a comment on the needle exchange program. And I am sure I read in the submission about the need to look at the infection rate of prisoners. You may like to comment on the two together.

Prof. Loxley—I will indeed. Prisoners is not an area that we have specifically researched. I know the prison literature—

Ms HALL—It was in the submission.

Prof. Loxley—Certainly. I put it in the submission because it is a concern. It is not an area where we have done specific research ourselves. Because we have an interest in blood-borne viruses and injecting drug users, we keep ourselves very much informed as to what is going on in the prison environment. I would refer you, though, to the excellent work that has been done at our sister centre, the National Drug and Alcohol Research Centre, where there have been some specific programs of prison interventions and, in particular, an evaluation of prison methadone maintenance treatment. I am sure you have either heard from that group or you will be hearing from that group.

In terms of needle exchange specifically, our general point would be that needle exchange has been demonstrated to be effective against the transmission of blood-borne viruses, particularly so in the case of HIV-AIDS. The prevention of an epidemic of HIV-AIDS among injecting drug users is now quite evident in Australia. In terms of hepatitis C, that is much more difficult because a very large pool of infection existed before the virus was identified and so it has been a much more difficult epidemic to limit. Nevertheless, there is some evidence now that infection rates in hepatitis C are falling. The best evidence seems to suggest that, in part, this is to do with the provision of needles and syringes to injecting drug users.

Can I just add—you may have heard this from WADASO this morning—that needle and syringe distribution and provision programs are not all exchanges. In Western Australia the majority of needles and syringes are sold through community pharmacies. That is a very efficient system. They are sold at very low cost in FIT packs, which are disposal containers. We have demonstrated in WA that it is quite possible to get a very good supply of needles and syringes out into the community without necessarily giving them away for free and without necessarily having needle and syringe exchanges everywhere. So there is a variety of programs available to distribute needles and syringes to drug users; they are not all exchanges.

Ms HALL—Your research supports needle disposal units as being an effective way of handling them?

Prof. Loxley—Absolutely. Needle disposal units are 100 per cent necessary, as are FIT packs, which are the containers in which needles and syringes are sold. Every kind of means must be made available for people to dispose appropriately. Having said that, I know there are people who will not; nevertheless, we have to give them every opportunity we can to dispose of their needles and syringes as appropriately as possible.

Ms HALL—I have two other quick questions. If they are outside your area of research, by all means say so. Have you done any research on assessment and screening before people are accepted into any programs?

Prof. Loxley— No, because we do not do treatment research at all. Again, can I refer you to NDARC. That is their area of expertise.

Ms HALL—Have you done any research on addictive personalities, behaviours, and linked it into drug and alcohol use and also gambling?

Prof. Loxley—We do not do research on gambling. Tim might want to comment on the addictive personality issue. Speaking from the perspective of illicit drug use—and perhaps it is clear to you that injection drug use has been one of my major areas of concern; we have somewhat expanded beyond injecting in the last four or five years, but that is really where we came from—I do not find the notion of an addictive personality very useful when I am looking at behaviours like injecting. My major concern has been to say, 'We have a person here who is injecting. Firstly, are there some things we can do to make sure they are injecting more safely; and, secondly, are there some things we can do to prevent the injecting in the first place?'—that very pragmatic way of looking at the behaviour. I do not personally find the notion of addictive personalities particularly useful. Perhaps my colleagues would like to comment

Ms HALL—I am just throwing in a bit on poly drug use too.

CHAIR—We will need to wind up there.

Ms HALL—It is all in the same question.

Prof. Loxley—Poly drug use is a thing that everybody talks about and understands exists, and then we all tend to behave as though it does not. We focus on heroin, in particular, these days, because people are dying. One of my major concerns is benzodiazepine use, which is injected by injectors and which underlies almost all episodes of use across, say, a week or a month for most injecting drug users. They will use benzodiazepine; they will use opiates; they will use alcohol, of course; and they will use tobacco. Poly drug use is the commonest pattern of drug use—some legal, some illegal.

Prof. Stockwell—You are probably aware that many heroin overdoses are associated with concomitant use of benzodiazepines or, more often, alcohol.

Prof. Loxley—Or both.

Prof. Stockwell—It is a question as to whether they are heroin overdose deaths or alcohol overdose deaths, because you can overdose on alcohol as well.

Ms HALL—I thought you were going to comment on the addictive personalities as well.

Prof. Stockwell—There is a huge amount of research over decades. There have probably been about 50 different addictive personalities identified. Some wise person summarised it by

saying, ‘If you look at any personal attribute or personality characteristic, an alcoholic or drug dependent person has more of it or less of it than the rest of the population.’ It is not meant to be totally flippant, but it is so hard to disentangle what is fundamental and intrinsic in the person, as opposed to what has happened to them in the course of their drug using career. I do not think these studies have been terribly productive.

Mr SCHULTZ—On page 6 of your submission, in the second sentence of the second paragraph under the heading ‘Interventions to reduce the risk and harm of illicit drug use’ you say:

There is ample evidence that needle and syringe program are effective in preventing HIV infection without being associated with a rise in drug use.

You go on to say:

The availability of clean needles and syringes in Australia appears to be—

and I emphasise ‘appears to be’—

reducing hepatitis C incidence.

Yet on page 27 of your submission, the last sentence in the second paragraph states:

There are approximately 10 000 new cases diagnosed among IDUs per year.

There does not appear to be any comment there with regard to the cause of that. Finally, the fourth paragraph on the same page—and you use 1995 figures—states:

The latest results from an annual monitoring system established through selected needle and syringe programs around Australia, provide some evidence that the prevalence of hepatitis C among IDUs is declining: for example, from 63% in 1995 to 50% in 1995. However, some marked geographical differences were found in this study and the authors concluded that the prevalence and incidence of hepatitis C among NSP attendees remained high.

That seems to be contradictory. It appears to me that it is totally out of date with what is really happening today. That also appears to me to be misleading because of the use of words such as ‘appears to be’, and I would like your comments on it.

Prof. Loxley—The ‘1995 and ... 1995’ on page 27 is a typo and I apologise for that. I think the second set of figures should be 1998. This is based on a long-running study at the National Centre for HIV Epidemiology and Clinical Research in Sydney which is monitoring the prevalence of hepatitis C and HIV among people who attend needle exchange. It is finding that the prevalence is dropping, although the demographics and so on of the populations appear to be very similar. The authors of that study are concluding that it appears to be that the prevalence of hepatitis C is reducing among those who attend needle exchange—the study has it reduced from 63 to 50. The reason they say ‘appears to be’ is that it is somewhat soon to know whether this is an absolute decline or whether this is a blip, if you like, in the landscape that may reverse. We would need probably five years data before we would be ready to say that hepatitis C prevalence is declining. That is the first thing.

Mr SCHULTZ—Can I suggest to you, just on that point, that there is a danger in using words such as 'there appears to be' to come to a conclusion about what may be the case in two or three years time. That is misleading to the public; that is the point I am making.

Prof. Loxley—I think the use of the term 'appears to be' reflects the current situation: what appears to be the case at this time.

Mr SCHULTZ—I understand that.

Prof. Loxley—The difficulty with hepatitis C is twofold. One is that, as I said before, we had a very large pool of infection before the virus was identified, before HIV and so before needle and syringe exchange. We had a great big pool of unidentified hepatitis, called 'non-A non-B' in those days, which has since been identified as hepatitis C.

The best estimates of the rates of infection among injectors range from 50 to 80 per cent; in some populations—methadone clients, for example—80 to 90 per cent are infected. You cannot demonstrate prevention in an epidemic where so many people are already infected. What you can hope to do is look at infection rates among younger people who are not yet already infected. Our own work shows that the prevalence of hepatitis C is so strongly related to duration of injecting—this is four years old data—that once you have been injecting for about four years you have about an 80 to 90 per cent chance of being infected. So what you have to do is start to look among the early initiates to injecting. And it is that evidence that is slowly coming to light that suggests that we may be beginning to get this epidemic under control. It is a very difficult battle. It is a very large epidemic, unlike HIV.

Mr SCHULTZ—Thank you for that. I just wanted to make the point that it is subjective. Nobody has been able to give me any scientific proof, based on outcomes, that the needle syringe exchange program has been instrumental in controlling hepatitis C. I get a little concerned because when we introduced the needle syringe exchange program into this country in the mid to late eighties to control the spread of HIV-AIDS, which at that time was publicly espoused as being at two per cent—we used the excuse that the exchange program would keep HIV-AIDS under control—we have seen a massive explosion in the distribution of needles, from 1.2 million in 1998 to over 12 million in the year 2000 in my state alone, and, at the same time, we see figures about HIV being at the level of three per cent. When you raise those sorts of figures with people and you ask them to respond by supplying you with the scientific proof of what they are telling you, you cannot get the figures. There has to be some argument against the selective use of figures and data when just that incident alone indicates that there is a one per cent rise in the level of HIV-AIDS.

Prof. Loxley—I am not aware of a one per cent rise in the level of HIV-AIDS and I am not aware of the figures you are referring to. I would suggest that the National Centre of HIV Epidemiology and Clinical Research, which do hold the national Australian figures, would be the best people to give you that data. I do take your point about the massive explosion of needles and syringes, and the only thing I can say to you in terms of hepatitis C other than what I have already said is that, if we did not have needles and syringes distributed to injecting drug users, I think this massive epidemic would have been a titanic epidemic. We are beginning to get it under control. Injecting with a clean needle and syringe on every occasion is the only way we are going to limit the spread of this disease, and we have to get that equipment to people. I

am very sorry that so many people in this community inject drugs, but it is a reality with which we have to deal, and hepatitis C is an epidemic we have to try and control.

Mr SCHULTZ—There is always a reality that the issue of needles and syringes has, in my view and many other people's view, involved a lot more people injecting today than were injecting last year and the year before. What I am saying is that we also run the risk of creating further problems in terms of heroin addiction in this country because we are making implements more readily available for people to use. We are not only doing it at that level; we are doing it in an environment where there is no age barrier to people getting the needles and syringes in some states.

Prof. Loxley—I would like to make a final point on that. I would like to table some evidence, if I may. There is evidence for the efficacy of needle and syringe distribution programs. It refers to a range of international and national studies demonstrating that there is as yet no scientific evidence that the distribution of needles and syringes raises the prevalence of drug use or injecting.

CHAIR—Thank you very much. We will include that in the evidence. There being no objection, it is so ordered.

The document read as follows—

Ms JULIE BISHOP—The focus on this inquiry is on the social and economic costs of substance abuse. You have referred to some WA research by Lenton and others about the relationship between crime and injecting drug use. I am talking about page 20 of your report. I was surprised that it found only a very small proportion of injecting drug users were involved in drug dealing or other crime as a form of income. Can you describe this study exploring the relationship between drug use and crime? Have there been comparable studies or different outcomes from other studies?

Prof. Loxley—The point about this particular study is that there are not any comparable studies. The aim of the study was to try and access drug injectors who are not normally able to be brought into the kind of research that we do. Simon Lenton, my colleague, did this study in part as a response to the range of things that the rest of us were doing in accessing drug injectors in normal ways, by which I mean through needle exchanges and treatment agencies and networks on the street. Simon actually went to community pharmacies, he wrapped questionnaires around FIT packs and he offered an incentive to users: if they brought the questionnaire completed back to the pharmacy, they could get a free FIT pack. He then engaged the support of a range of community pharmacies right across Western Australia to help to distribute these questionnaires.

This is totally original research. As far as I know, it has been done only once before in a very minor way in the UK. Nothing on this scale has been done in Australia and, as far as I know, anywhere else, or repeated. What Simon found was that the group of people who answered his questionnaires in this research were completely different in very many ways to the drug injectors we normally get into research. They were much more stable, they were much more part of the community, they were much less likely to be involved in crime and they were much less likely to have been in treatment. They did share needles more frequently. They had a range of things about them that was very different. In fact, he published the study under the really nice title of *Citizens who inject drugs*, because what he said was that in many ways these are citizens in our community who are living at home injecting drugs. A lot of people do not know anything about them or about their drug use.

Ms JULIE BISHOP—So the questionnaire was distributed with the needle pack and then people posted it back or something?

Prof. Loxley—They brought it back to the pharmacy. They could post it back if they wanted to, but they could bring it back to the pharmacy. It was totally anonymous. It had a relatively low response rate, given the number of questionnaires that went out. But, as I say, because this kind of research has not done before, we do not know what an appropriate response rate for this kind of research would be.

Ms HALL—What was the response rate?

Prof. Loxley—It was something like 27 per cent, overall.

Dr WASHER—On the law enforcement side of the whole issue, how do you feel the WA police force is performing? What constructive suggestions would you have to help the situation?

Prof. Loxley—I do not think I could comment on the behaviour of the police in terms of illicit drug use policing, except to say that we have recently been involved in evaluating a community based drug law enforcement project which has two Western Australian sites, a site in Victoria and a site in New South Wales. It is a national project, in which we have been involved with the University of Melbourne. Richard Midford and I have both been involved in evaluating the WA sites. These are police projects in which project officers have been employed to work with the community to look at community based, harm minimising drug law enforcement. In that context, working with the police was a very supportive and good operation. But the police did find themselves having some structural and organisational difficulties, which made the notion of harm minimising policing somewhat difficult for them.

I draw attention very briefly to one of them. One of the notions about harm minimising policing is that police could use discretion in whether or not to arrest a person or to issue a caution, or whatever, at the point of apprehension. In Western Australia, particularly, we found that the police have some difficulty with the notion of discretion. They believe it puts police officers in a very untenable position, and that is based on previous experiences within the WA police service. I believe that is something police will have to address if they are going to look seriously at the national harm minimising policing. The WA law does not necessarily support harm minimisation as the first priority for drug law enforcement policing. Nevertheless, some kinds of harm reduction and harm minimising strategies do exist within most states as secondary or tertiary priorities.

Mr Midford—One of the things that was done in that particular project was the education of police. It was quite interesting to see that, before they got the education in harm minimisation, they did not have a good appreciation of it. Education is really important. It did give them an understanding of what harm minimisation is. They could integrate that in their practice—look at how they could use elements of it within their practice. If police are going to take on harm minimisation, an education process is fundamental to that.

Dr WASHER—The perception I am trying to get across is that, to me at least, the criminality of it is necessary—in some ways—to hopefully reduce the use of illicit drugs. But there is the catch-22 of having that sometimes delay treatment and access to the proper facts. It is undercover. Can you comment on the dilemma there?

Prof. Loxley—That is exactly right, and that is what the national move towards diversion programs is all about. Clearly, diversion has the potential to be very effective in bringing people out of the criminal system and into a helping system while, at the same time, not taking away the fact that the community does not tolerate that particular behaviour and sees it as criminal. Drug courts, particularly, are a very good way to demonstrate this to people. WA has just recently announced its drug court, and you would know that. But, like my colleagues at WANADA—and like most researchers—I would have to say that all of those kinds of mechanisms need very careful evaluation. We need to be absolutely certain that there are not unintended consequences of the range of diversion programs that have been put in place. I am not suggesting that there might be; I am suggesting that we should, as a matter of course, do that evaluation to reassure ourselves that things are working the way they are intended to work.

Prof. Stockwell—Can I add that, in terms of the overall resource allocation of police across the range of substances, the implication of Simon Lenton's work—which we mentioned

earlier—is that it is probably desirable to move towards the decriminalisation of cannabis, which takes up a lot of police time. An argument has been made for separating those markets and having police concentrate their attention on the more harmful drugs, and for dealing with cannabis use under a system of civil penalties. There is a case to be made for that.

Mr EDWARDS—It is interesting that, in my experience as a minister for police some years ago, the coppers out on the beat had a very strong view that that is what they ought to be doing, but of course the hierarchy, who are so much closer to policy, would not have a bar of it. Do you have any evidence or any idea of what percentage of crimes that are committed may be drug related? Have you any research or any evidence on that at all?

Prof. Loxley—Certainly in the Drug Use Monitoring in Australia study—which, as you know from my submission, we are involved in and which looks at criminals in the police lockup in four sites—we are finding that a very high percentage of those people are users of illicit drugs, most of them cannabis. But that is not to say that the crime that they committed is in any way causally related to the drug that they are using, other than in the case of a drug offence. The majority of people coming into the lockup are coming in for violent offences, traffic offences, drug offences and an awful lot of warrants and of misconduct and those sorts of offences, and there is a general high level of illicit drug use across that group. The one area where there is very clear evidence that there is a causal relationship or a very strong link and one would assume it was causal, is between opiate use and property offence. There, there have been estimates that as much as 80 per cent of property offending is related to opiate use.

CHAIR—Thank you. We are right down to bare bones here on time. Dennis Gray, your work that indigenous women are nearly 40 times more likely than non-indigenous women to be victims of spousal violence is fairly thorough—you are quite competent in that analysis?

Prof. Gray—That was not my work. That comes from work that we did summarising work. I will just tell you a little about our program first. We have the only dedicated Aboriginal drug research program in the country and we do both primary and secondary research, so that we have got a database which contains details on 320 indigenous intervention programs throughout the country and has 700 articles to do with drug use amongst Aboriginal people. The other side of what we do is first-hand research in conjunction with communities.

Those summary figures came from a review that Sherry Saggers and I did a couple of years ago for a book in which we compared indigenous drug use in Australia, New Zealand and Canada. We reviewed the literature fairly thoroughly for that and were quite confident—

CHAIR—It is pretty overwhelming; it is pretty staggering number. I come from an electorate which has got this issue. I am interested and I may talk to you privately at another time, if I could.

Prof. Gray—Can I suggest, if you are interested in going further on that, that one of the best organisations to talk to would be Tangentyere Council in Alice Springs, which is an umbrella organisation for the town camps there. They are mightily concerned about this problem.

CHAIR—Thank you. On addiction, you talked about personality. Western Australia has been somewhat of a leader in this. Where is it going, where are you up to in the study of addiction

and what do you think it is at? If you had three wishes, what would you advise the committee about addiction?

Prof. Stockwell—I take that question to mean the whole field.

CHAIR—Yes.

Prof. Stockwell—My immediate response is that addiction, as we usually understand it, is a significant part of the drug issue but it is a small part. A useful classification is: problems of dependence, problems of regular use—which can be long-term liver cirrhosis or whatever—and problems of intoxication.

CHAIR—Where would you take research?

Prof. Stockwell—We are developing a research agenda. The Commonwealth government's—

CHAIR—NHMRC?

Prof. Stockwell—There are so many different avenues that we need to develop. There are two things I would stress. The first is the need to correct the imbalance of funding in relation to illicit drugs. With deference to my colleague on my left, there has been very little research—and funds available—on alcohol issues. The other is prevention and policy, as opposed to treatment. Treatment is very valid, but we need more attention on prevention.

CHAIR—We are indebted to you. Thank you very much.

Proceedings suspended from 1.26 p.m. to 1.52 p.m.

SIRR, Mr Peter William, Executive Director, Outcare Inc.

CHAIR—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 proceedings in the House of Representatives. Mr Sirr, would you like to give a short opening statement?

Mr Sirr—Outcare is a crime prevention organisation that has been around in Western Australia for about 37 years. Our primary goal is to work with offenders, ex-offenders and their families. In the course of doing that work, we come into contact with a significant number of offenders. The reason I am here today is a bit by default; the person involved in this is on holidays and I have picked up the rod as it were.

One of the major reasons that we put in a submission to this committee was that, certainly in the last 12 years while I have been involved with Outcare, we have seen the issue of drugs, drugs in families and drugs with offenders take on a proportion much larger than we ever anticipated would happen. Certainly in 1989, when I started, drugs and substance abuse were problematic with our client base, but it would have perhaps affected about 20 to 25 per cent of our clients.

In the last 10 years client contacts that have gone up from about 28,000 client contacts per year to over 130,000 client contacts per year, albeit with almost the same amount of resources that we started with 10 or 12 years ago. The major issue that has come out of that is, certainly in the last five to seven years, the issue of drugs—drugs in prisons and drugs within families visiting prisons. It has taken on a proportion that we have found incredibly hard to deal with. We had a submission for a drug counsellor sitting on a shelf for some six years waiting for funding to come along. When the resources were made available a couple of years ago, that was an ideal opportunity for us to get in there and start providing some services.

It has actually got to the point in our organisation where we are starting to think that we need to become solely a drug agency rather than an agency working with ex-offenders. Something like 80 per cent of our clients now come to us with some substance abuse problems. Considering that a lot of our services were geared towards things like stable accommodation, providing employment and working with families, we have very clearly found that, if we do not start dealing with the drugs issue as the first and foremost problem, we are never going to get anywhere.

We currently have one drug counsellor on board, and we have exceeded the outcomes in that project by about three, because the demand was so high. That project goes into the medium and minimum security prisons in Western Australia and engages people who have substance abuse issues before they get out. The whole idea is that getting them out and helping them into transition into the community gives them a much better chance of accessing proper support and not reoffending. We have found that, with the amount of work that was presented to us, we could have four or five counsellors on board and not even touch the sides of it.

One of the major issues that emerges for us in dealing with government agencies, particularly the Ministry of Justice, is that they have a substance abuse unit which is meant to provide services within their structure. One of the issues we have with regard to that is that it is a very small unit, and at the end of the day they can in no way fulfil their mandate to provide substance abuse services to offenders before they get out. From our perspective, the problem is not being tackled in any serious way. Outcare sees itself as one of the sole providers of working with offenders with substance abuse issues, although obviously generic drug agencies are picking up most of the offenders. We are attempting to provide a service in a fairly holistic manner, but that holistic approach is not going to work unless we can deal with those substance abuse issues right from the word go.

We put in a fairly short, sharp, sweet paper, due to the time constraints that we had. I had intended to highlight some of those things on the way through, but at the end of the day, as it is at the end of your inquiry, I might be repeating stuff that has been said many times before. Does the committee instead have some questions about our particular slant on things, being an ex-offender agency? The issues are fairly clearly and simply articulated in this three-page document. It is obviously not an academic sort of paper; it is purely an anecdotal collection of evidence from our experience. We do not come to you as a specialist in the field; we have only just started providing specialist drug counselling services. The list of issues that we have raised here have become very clear to the organisation, and we think a significant number of them are fairly important and need to be addressed in a substantial way.

One of the problems we are experiencing as an organisation is that we perceive from all our performance indicators and a lot of the other services that we provide—some on contract to government and others on a grants and funded basis—that we are going to have an increasing difficulty in performing those contracts, because of the drug issues that our clients are now presenting. As an organisation, that is quite a serious thing for us: if our performance starts to lag purely through something that we cannot resource properly.

CHAIR—Could you remind me of the number of people employed in your organisation, and what sort of structure you have.

Mr Sirr—We have about 35 staff—it goes up and down a bit. It equates to about 25 or 26 full-time staff. We have a couple more projects, so it will probably go up to 28 in the next couple of months.

CHAIR—What is your main source of funding?

Mr Sirr—The main source of funding would be through state government departments. The majority of that is now on contract and tenders. A small proportion is on preferred provider status. An increasing proportion is starting to come from the federal government, particularly through the drug program—we are looking at getting involved in national suicide prevention services as well.

CHAIR—One simple proposition was put to us the other day by a young woman who said she would like to do a trade apprenticeship; yet the continuity of be able to go on with that was a restriction to her. Is that part of your work, in terms of negotiating employment opportunities and that type of thing? How would it work? If someone is trying to do an apprenticeship and

they have some difficulty—apart from stabilising their life, et cetera—what sorts of services do you offer in that range?

Mr Sirr—We actually offer an employment service which is purely for offenders and ex-offenders. So we would engage that person before they got out of prison—generally. It would be unusual for a woman to be doing an apprenticeship in prison, because the opportunities just do not exist. Say a person in prison is part way through trade training, we would actually pick them up and go and negotiate with an employer perhaps to carry that on, in conjunction with the training and education services in the prison. If the woman had a substance abuse problem and she was in there for serious substance abuse, that would be complicating her world quite significantly. Generally, people tend to revert back to substance abuse patterns when they get out of prison. Certainly, if she managed to get a job immediately after prison—which is very hard to do—or get into some sort of further training, the third and fourth months after exiting prison would be quite dangerous for her.

CHAIR—That would be a very high-risk period?

Mr Sirr—Yes: a high risk of reverting.

CHAIR—Just about all the young women were saying that, and the point was made to us that they go back to partners who are, in all likelihood, into substance abuse themselves and therefore the pressure is significantly higher and it is quite difficult to break the cycle.

Mr Sirr—The whole issue about peer group and relationships that push you back into substance abuse is quite strong. Most substance-abusing women have substance-abusing partners. In fact, it generally starts with a male who is a substance abuser, who then engages the female. That is certainly our experience. At the end of the day, women coming out of prison are behind the eight ball; they are actually forgotten in the system, because of the numbers. Currently, the muster at Bandyup is about 135 out of over 2,600, I think, in the prisons at the moment. They do not figure strongly in terms of being noticed in the system. It has got better in the last couple of years, but it still is not well resourced. We actually run a separate program purely for women, because of that.

CHAIR—What is the recidivism rate?

Mr Sirr—Again, it is a bit hard to estimate; but current knowledge says that about 71 per cent of people going to prison will re-offend again. One of the major issues with that, and particularly with substance abuse issues, is should we be starting to look at substance abuse as a health issue rather than a justice issue. A lot of people are in there for relatively minor offences, because they basically have what could be a mental health or a health issue.

CHAIR—Are the male and female percentages similar?

Mr Sirr—That is a global percentage. I am not too sure—

Mrs IRWIN—On page 3 of your submission, I have actually highlighted a section. I have got three things I want to ask you, and I find it very unreal. I am going to quote from your submission and I will take it one step at a time:

The prison system is unable to appropriately address health care and mental health problems associated with the substance abuse activities of inmates.

Why is this? Have they not got the resources? Can you explain? It is under the section on crime, violence, including domestic violence, and law enforcement issues.

Mr Sirr—The major issue there is that there is a will within the Ministry of Justice to deal with these issues. The major problem is that they do not resource it. As I earlier said, there is a substance abuse unit there, I think, which has about four staff in it. They are expected to service 14 or 15 prisons around the state with pre-release substance abuse programs. It is a total physical impossibility. They have been going around doing prison inspections in the state. One of the things that keep popping up in those reports is the fact that this unit does not do its job. It is not that it is not doing its job. It is because it is not resourced to do its job.

Mrs IRWIN—A lack of money really.

Mr Sirr—Yes, at the end of the day. The public health versus prison health is a big issue. There is an argument that the public health system should be running the health services within the prisons. It gives them a lot more accountability and there is a lot more transparency. There has always been a concern that legal prescriptions within prisons are a means to prison management. There is a possibility of overprescription of legal drugs, which is really just substituting one problem for another at the end of the day.

Mrs IRWIN—What legal drugs are we talking about here? Can you name them?

Mr Sirr—The Valium and the—

Mrs IRWIN—Serepax.

Mr Sirr—Yes, those sorts of things for anxiety and stress that prison brings on. A person who goes into prison with a serious substance abuse problem prior to going into prison needs a very intensive amount of mental and physical health management, certainly within the first few months of going into prison. There have been some gains made in terms of naltrexone programs being introduced in some of the prisons. I am not clear at the moment as to whether or not they are actually doing methadone programs. I think they were going to try them in a couple of prisons, but I am not sure.

Mrs IRWIN—It says:

In prison, the health management of an addict usually involves chemical restraint—

Can you explain that to me?

Mr Sirr—Essentially you are managing the person by legally prescribing drugs. The terminology is unfortunate. I did not write this. It is more about using the legal drugs to put someone into a calmer state of mind. You are actually using the medical health system in there to manage behaviours.

Mrs IRWIN—With permission of the prisoner or the inmate?

Mr Sirr—An inmate will present with anxiety or a high level of stress which might be the result of him coming down from drugs prior to going into prison or the prison environment. The medical officer will prescribe things like Valium—those relaxants to deal with that issue.

Mrs IRWIN—I have put down that I virtually find this unreal. I find this hard to believe. The submission says:

Prison drug policy forces the sharing of needles for intravenous drug use, which increases the risk of blood borne viruses for prisoners.

Mr Sirr—Again it is do with the terminology. The argument is that people in prisons are going to use drugs. This came from some discussion in the state about whether or not needles and needle exchange should be made available in prisons.

Mrs IRWIN—In Western Australia, they are not?

Mr Sirr—No, they are not. The issue is that drugs in prison are a reality. We do not have a position one way or the other on it.

Ms HALL—Do you?

Mr Sirr—It is one of those things that I think about one way and I go back and look at it and I cannot make up my mind about it. Certainly, what happens is that people get forced to share needles. Needles do get taken into prisons. They get passed around from prisoner to prisoner.

Mr EDWARDS—If it was treated as a health issue, what would your view be?

Mr Sirr—If it were treated as a health issue, most of these people would not be in prison—a large percentage of these people would not be in prison. They would be able to get needles, I suppose. There are needle drop-off units around Perth. I am not too sure about the exchange. There are some organisations that will provide free needles. But the whole issue of legalising heroin, or whatever, is an incredibly complex one and I have not given it enough thought to be able to say one way or the other or to make a decision on behalf of the organisation.

Mrs IRWIN—On page 2 of the submission, it says:

Parents of substance users/abusers attempt to minimise harm to their son or daughter by attempting to stop or reduce their offences. This results in the parent developing enabling behaviours and increasing their tolerance towards their offspring's behaviour. Often the parent will pay for their sons or daughters drugs to keep out of prison. The offspring then commits more crimes in order to purchase larger amounts of illicit drugs.

Mr Sirr—What was meant here was recently in the press over here. That is not related to our comment here; we have experienced this elsewhere. An example in the press recently was of a mother who was buying drugs for her daughter to keep her out of contact with the system and to try to manage the problem somehow. Her strategy to deal with it was to say, 'I can rant and rave and do all sorts of things, but that is not going to be productive.' So she turned around and did other things. Our view is that even doing that is quite dangerous. Once a parent starts to

condone the drug use, the child is not going to make a change in their behaviour. They see it as being positively sanctioned, and it does nothing to encourage the child to look for ways to minimise the drug taking or to get off drugs.

Mrs IRWIN—Was the mother aware of the various counselling services that she could have targeted for assistance?

Mr Sirr—I do not know, in that case. It was just something that was reported in the paper; it was not a client that we were dealing with. But some parents do take on the role of saying, 'I need to protect my child and, in order to protect my child, I'll actually give them drugs.'

Mrs IRWIN—Part of my electorate is Cabramatta. Everyone has heard about Cabramatta in New South Wales, and I have heard cases of parents buying heroin on the streets for their children—because of the time frame of trying to get into a detox unit—which is very sad. Are you finding this here in Western Australia?

Mr Sirr—We have not found it so much recently. I know we had some difficulty, a year or two back, getting people into the Central Drug Unit. The only way we could get them in was to threaten to go public. We threatened to do a press release to say, 'You've really got to move this along.' In relation to access to services here, there have been some changes in the way detox services are run. Methadone is now being distributed through chemists, and certain doctors have subscribed to the program. The problem we have with that is that, if you do not go into the Central Drug Unit, where you can get it free, you have to pay for it—through your local medical doctor and the chemist—and I think it is $56-odd a fortnight. Most people in these circumstances are on social security benefits, Centrelink benefits, and there is no way in the world they are going to start pulling that money out of the system. It is just not there.

Dr WASHER—Peter, you said that there has been a major escalation in this problem in the last 10 years. Why do you think that is so?

Mr Sirr—I do not know. It keeps baffling me. Drugs are very easy to get. I live in a semiaffluent suburb, and I know the majority of people there smoke cannabis, up and down the street. It is not an unusual thing. There is a whole relaxation of attitudes. It is an industry, as you know, well and truly. There is a fairly well-established drug industry in Western Australia. Anecdotally, when ex-offenders come to us, there is some degree of cooperation between some government departments. Enforcement levels are not where they should be in some areas. There are those sorts of things. It is also very hard to catch some of these people and to pin the crimes on them. There have been some changes. Ten, 15 or 20 years ago, there was a shift from alcohol and cannabis to some of the harder drugs. If you look at it from the business perspective of the people who are involved in that industry, there are smaller quantities of things, they are easier to shift and you get a high price for them. So you are starting to deal with the powders and those sorts of things. There is a great return on your investment. If you start looking at it as a business model, you see that that is why there has been a push and why those sorts of criminal activities are pursued quite actively.

Dr WASHER—Regarding contamination through blood-borne viruses in prisoners, the impression that I have is that it is a major problem in a lot of prisons, particularly in women's prisons. Would you agree with that?

Mr Sirr—That is my understanding. That is the experience that we have had. I do not know about the medical analysis of it but we certainly are very clear that needles are being shared at a very high rate in prisons.

Ms HALL—Given what you have said today—and correct me if I am wrong—I think you are saying that the needs of drug dependent prisoners are not currently being met adequately. Is that correct?

Mr Sirr—Yes, that is true, in terms of rehabilitation services available to them.

Ms HALL—How do you think that these prisoners should be helped whilst they are in prison? What sorts of programs do you think need to be introduced to jails?

Mr Sirr—They have got existing programs which I believe are adequately addressing the problem where they can. It is a matter of resourcing; you cannot address problems unless you put resources in. My position is that there are just not enough resources within the Ministry of Justice to do that.

Ms HALL—So they need more resources. Earlier, you were mentioning treatment by the health department of drug dependent prisoners or prisoners with illnesses. Is that another thing that you would see—

Mr Sirr—Some of the arguments that come and go about health authorities versus prison health authorities include the argument that, if there were an external provider, their duty of care would perhaps be different—they would see their duty of care in a difficult light—whereas internal health services conform to custodial and management regimes that might preclude doing some of these things. An external health provider may in fact take a different view: they see the problem, they work at it from a medical and health model rather than a custodial justice type model and, hopefully, put in appropriate resources to deal with it.

Ms HALL—That is an issue that maybe we, as a committee, should investigate a little bit further. Would you recommend that?

Mr Sirr—Yes, I think so. The health model within prisons, apart from just the drugs, has always been contentious. It has certainly been contentious in this state for the last year or so. There has been a push and drive to privatise health, to outsource it—all sorts of things. There have been committees formed to try and force the public health system to get into the prisons.

CHAIR—I think it is an interesting and important issue. Who pays for health in prisons: the Commonwealth or the state?

Mr Sirr—Currently the state.

CHAIR—Because the Medicare agreement does not include prisoners—is that why?

Mr Sirr—I do not know.

CHAIR—Do we know that as a committee? I will put that on notice to all of us to check that out. I am very interested in some of the structural reasons. I remember, in previous indigenous inquiries, going into prisons and having this issue come up some years ago. You have just rung a bell in my mind about it. I will put that on notice.

Ms HALL—Are there any additional programs that you believe should be introduced into prisons—programs that are not there at the moment—to address the issue of drug dependency?

Mr Sirr—I am sure that there are different ways of dealing with those particular things.

Ms HALL—Share that with us, if you could.

Mr Sirr—I am a great believer in bringing the outside into prisons because you cannot take people away from the community and then say, 'We have got you here to teach you to belong the community,' when you set up a subculture. Part of our drug counselling program is actually about going into the prisons before people get out. It is all about transition. People fail when the transition fails. They will get out and there are a whole lot of pressures on them to reoffend, even if they were not substance abusers. Generally, if they do abuse substances, they will do it within those first few weeks because of the pressure.

I do not want to swing our own bat too much, but we believe there should be a whole lot more resources put into that transition, so you are capturing people before they come out, you are planning ahead, you are doing stuff with them about saying, 'You need to address these issues, and here is an action plan that we are going to put in place to help you get back in there and get back into the community without falling over.' Our particular problem with that is that we get 130,000 client contacts a year and a large percentage of those are on prison sites, and we are dealing with families there. There is substance abuse in the women visiting the prisons; a large percentage of the women turn up there with substance abuse problems. We should be dealing with that as well, and no-one is resourced to deal with that. And we are getting people coming out and, because of the sheer numbers, we cannot do that intensive case management stuff that is really needed in those sorts of areas.

It is fairly deep-rooted behaviour and it is linked in with a whole range of history and psychological factors within a person. It is not an easy thing. It is not like, 'We will take this away and you will be fine.' They are long-term plans. All the research shows that, if you want to engage someone and do it right, it actually has to be on a more personal level and it has to be enduring.

Ms HALL—That was really my next question—looking at the connectiveness and how prisoners are prepared to move from the prison environment to the outside environment and the continuation of programs that they commence. Even naltrexone was looked at yesterday. Also, so I do not take up too much time, what is the relationship between your organisation, probation and parole and the prisoner being released, in relation to their ability to succeed once they get out.

Mr Sirr—Our principle or our philosophy with this is to actually engage people before they get out of prison. If people turn up at the prison gate and walk out without that, it just does not work. You need to have a rapport with a person, which is all about time and resources yet again,

and you need to actually come to some mutual understanding of where are you going to go in that relationship. If you cannot do that, the chances are diminished.

Ms HALL—So you try and have a plan written up, or, if not formally written up, devised before they leave?

Mr Sirr—That is right, yes.

Ms HALL—And probation and parole?

Mr Sirr—They are now called community based services here. We have a fairly strong relationship with those. We deal a lot with community correction officers; a lot of our people in a whole range of our services like employment or in our accommodation or in our drug counselling programs. Again, we try to keep those links and forge those bonds so that at the end of the day you can negotiate if things start to go wrong or you can fix things up.

Mr EDWARDS—Peter, you say in your submission that substance abuse is the major underlying cause of crime resulting in incarceration in WA prisons. I think your figure was about 75 to 80 per cent. We heard some evidence this morning to suggest that those figures are wrong and that the true figure is closer to 30 per cent.

Mr Sirr—I had this debate with a journalist last week. They actually did an analysis of what was the major event that put someone in prison, and I think she came up with car theft—illegal use of cars, and motor vehicles and unlicensed driving. But the argument that we have, and talking to our clients is much the same, is that they generally have used drugs either in the commission of the crime or for the commission of the crime. They are committing the crime in order to get money or they have got a history of substance abuse. So our argument is that one of the variables that is very strongly behind people committing offences is substance abuse, and they commit a whole lot of acts either under the influence of drugs or for something related to drugs.

Mr EDWARDS—There is a certain amount of jurisdictional responsibility here with state governments, of course, but, in regard to the core group that is in and out of prisons, you made the comment that when they get out they tend to revert back, I assume to drug taking because they go back into that environment of partners and friends and the same place that they came away from. In your view, is there room for a nationally funded program aimed at people who are incarcerated, and, if there was such a program, what would be the major components of that sort of work program? What would be the things that you would really need to deal with to try to break that sort of revolving situation?

Mr Sirr—Is this within the justice system or internal or straddling it?

Mr EDWARDS—From within the justice system. From what you have said, you would need to start programs while people are still inside prison, because it is no good just starting something when they are out.

Mr Sirr—To deal with substance abuse, the major component is about shifting the way you think about the world: changing the way you think and why you need to take drugs;

understanding what you are doing; and dealing with the behaviours. Behind drug taking there is a whole lot of other stuff too. That is the issue. There are a whole lot of psychological factors involved; there is a whole lot of history that is quite damaging for people. I was talking earlier on—just before this—and the comment was made that, behind quite a bit of drug taking, there is sexual abuse—and that is quite true—or traumatic family backgrounds: domestic violence in families and a whole lot of dysfunctionalism at some point that triggers off a need to take drugs or a need to use drugs. So it is all about addressing some of those issues. To me, it is primarily a counselling issue. You are never going to change someone unless someone wants to change. You cannot change anyone: it is a matter of the person themselves getting to the point where they can actually make considered, solid decisions about where they want to be. That is pretty hard work.

CHAIR—That sentiment is exactly what we found in the female prisons on Monday. That sentiment: we have got to want to do it. Fundamentally, we have got to accept that, haven't we? I interrupted you, sorry.

Mr Sirr—Yes, you have got to see some light at the end of the tunnel for yourself. A lot of people get out of prison and say, 'What the hell. What is there here for me? I am unemployable, because I haven't worked for six to seven years. I've got all these problems. What the hell.' And they just drift back into it.

CHAIR—In your submission you talk about the young indigenous males moving from alcohol and cannabis to speed and heroin. Sadly—by the sound of it—it may be considered a rite of passage by some young Aboriginal people. Can you give us a little bit more on that.

Mr Sirr—Again, it is an observation through contact with our clients that it is that drift from alcohol and cannabis. Lately, there has been a lot more use of amphetamines, speed and heroin, which, culturally, eight to 10 years ago, was a real no-no. But all that has shifted. Prison is becoming a rite of passage for Aboriginal people, and the statistics are terrible when you look at the incarceration rates of Aboriginal people here. On a daily basis, the muster could be up to 40 per cent Aboriginal. I do not know if these stats still hold, but some years ago, 50 per cent of Aboriginal males between the age of 18 and 25—50 per cent of Aboriginal youth—would go into prison in their lifetime.

Ms HALL—I think it is higher now. It is higher.

Mr Sirr—Yes, it could well be. Drugs are part of the prison culture as well. It has just become more noticeable that the other drugs are more prevalent.

CHAIR—Why the shift, why the rite of passage? You said it was a no-no not that long ago, but now there is a shift. There is obviously something that has happened. There is that general acceptance in the society and more and more exposure to these kinds of drugs. There might be just one or two things that someone might have noticed in terms of why there has been a shift.

Mr Sirr—It is actually a very hard question.

CHAIR—I am sure it is. You might think about it and come back to us. Someone might come up with something.

Mr Sirr—When you compare indigenous people in Australia to indigenous peoples all over the world—to the Inuits in Canada—it is not an uncommon outcome. It is not a desired outcome, but we have people who are alienated, who have very little chance of getting into work. It is not that they are unemployable; it is just that people do not employ them. In terms of financial resources, they are on a much diminished level. I think in terms of our indigenous people, that is what drives a lot of that. There is powerlessness, there is a sense of alienation. That, to a significant degree, is what drives drugs and alcohol. They are the factors that are pushing it.

CHAIR—That need not necessarily be racially based, but this is just compounded in this particular instance. That might be the general principle—the lack of empowerment for so many people—but it is compounded in the indigenous situation.

Mr Sirr—Yes.

CHAIR—Quite an important point that you make in your submission is that you suggest setting standards for drug and addiction counselling. Basically, it is a good idea. How and why should it be done?

Mr Sirr—We are relative newcomers to the field in terms of specialist counselling, as I said, although we have had exposure to people with substance abuse issues for years. When we advertised for the position, we wondered what standards we should advertise to and what we should look for. It was very clear that there was no accredited training for drug counselling services. I know that one of the universities is setting up a volunteer training package, but there is nothing accredited, nothing that says, 'Look, I've actually gone through and got the skills in this particular area dealing with people with substance abuse.' To me, it is actually an incredibly specialised sort of skill that you need to have. People seem to pick it up by default. They start working with people with drug addictions, they get a few skills, they go and learn a few models from elsewhere and attach it to what they do. I believe that it is such a big problem that we should be looking at having specialist people trained and resourced in the area. How we do it, I do not know. Using ANTA or some of the national bodies to—

CHAIR—You raise an important issue, and educators and a team of professionals can build something from that. On Monday we came across the volunteer program and something like 600 people had put their names forward. Then it went through a process of getting it down to—I do not remember—40 or 50 people, something like that, to take on the course.

Mr Sirr—We actually access that, because it is very difficult to find people. We have got some good volunteers who have come through that.

CHAIR—One last question. Drugs in prison: how prevalent is it, how difficult is it to control, and how much is it contributing to the ongoing problem?

Mr Sirr—Drugs have always been in prisons. From the days when they used to pull it over the fence at Fremantle Prison in a bucket into the guard tower, to the days where it is going—

Mr EDWARDS—The guards in the prison?

Mr Sirr—The guards. It is an old story. It may be folklore.

CHAIR—I know the establishment.

Mr Sirr—It may be folklore, but drugs do get into prisons. At the end of the day I think the issue from a management perspective is to minimise it, because you are never ever going to stop it. There are just so many ways. Even though you have got a maximum-security prison, people will find ways. The issue for management in prisons is to minimise it. We run a couple of family centres at Canning Vale Prison and Casuarina Prison, and I think there are about 100,000 contacts go through there a year. A lot of females turn up obviously under the influence of drugs and obviously under pressure to export, import—or whatever the word is—through the gate. It is not a pleasant sort of relationship—those sorts of things that happen—because there is a lot of force and threats of physical violence on women.

A lot of women are very happy to get caught because they can then go to their partner and say, 'I've been caught. They are going to search me forever. Don't ask me to do it.' Generally, that response is reported to me quite often: 'Thank God I've got caught. Now all this pressure and the threats of violence will go away. His mates coming around to physically threaten me will go away.' I have forgotten the second part of your question.

CHAIR—It is contributing to the overall problem really. It is there—you have clearly established that—but how much is it contributing to the overall problem? If you cannot break the cycle, you are just perpetuating it. You said that 79 per cent are 'repeat offenders'. Where does it fit into the overall deal?

Mr Sirr—It is all part of that health versus justice model too. If you went to a doctor and he failed 71 per cent of the time, would you go back? If you went to a car mechanic and he failed 71 per cent of the time, would you go back? If you put people in prisons and 71 per cent of the time they fail, why send them back? Look at alternatives that work. It is an incredibly expensive option when you look at the cost of incarceration being $50,000, $60,000 plus a year. There may be better ways to do it. If you look at the long-term cost benefit analysis, there may well be much better ways. If we can pull some of this stuff out of political cycles and political agendas and put forward a good 20- or 25-year plan and say, 'We know our investment is going to cost this on our projections,' we could actually come up with something different. What that is, I do not now.

CHAIR—The challenge is to have a long-term plan there.

Mr Sirr—I think so, and it has got to be bipartisan.

CHAIR—And different.

Mr EDWARDS—It has got to be bipartisan.

Mr Sirr—Absolutely. The theory is that for every dollar you spend now on crime prevention and on dealing with problems up front you will save $7 down the track. There has been some very substantial research done overseas. For instance, the Sherman report looked at all the justice department programs in the States, and looked at what works. The primary thing that

came out of that was that, if you can nip problems in the bud, you can do a lot of primary prevention. If you get in and work with families, women, single kids, and people from low-income areas, not only do you reduce crime at the end of the day but you reduce a whole lot of those things that stem from that, which is lots of violence, lots of drug taking and all those sorts of things.

CHAIR—We do not hear of too many threats against your staff. If this violence is targeted at partners, targeted internally, how much does it flow over to your people? I do not know why I ask that; it just seems to me to be an issue around violence and how it is directed.

Mr Sirr—I would not want to put it out of proportion, but it does sound bad when we hear women reporting that their partners are threatening them or that pressure has been put on them to smuggle drugs. As an organisation, I actually think we have an incredibly low threat rate against us. I can think of only two circumstances in 11 years where I was a bit uneasy. It was mainly because of someone who had a history of drug abuse and who had a mental health problem as well. It is that combination of things that is pretty hard to manage.

CHAIR—In a sense that is encouraging, without wanting to overstate it. I am interested in how people direct their violence and if it is directed in a particular way.

Mr Sirr—People work with us because we volunteer to do it. It is an altruistic sort of organisation. We are non-profit, non-government and non-threatening. We get people angry with us quite often. That is not unusual.

CHAIR—We can understand that.

Mr Sirr—That is mainly to do with having limited resources in terms of the material and financial support that we can offer. Generally, they are people who have substance abuse problems who want us to theoretically fund something; but generally they want the money to go down the path of buying drugs, or they just want to grab the money and run. There are a small number of hassles every week, but they are not a lot.

CHAIR—Thank you very much, Peter. It is much appreciated.

[2.41 p.m.]

FARISS, Ms Nova, Director, Mofflyn

MacLEAN, Mrs Vivien Jennifer, Administrative Officer, Mofflyn

NEMARIC, Mrs Sandra-Sue, Family Care Worker, Mofflyn

ST GEORGE, Ms Carole Ann, Coordinator, Intensive Family Services, Mofflyn

CHAIR—Welcome. As you heard my general words of guidance about witnesses, I will not repeat them. I invite you to make a short opening statement.

Ms Fariss—I would like to introduce Sandra-sue Nemaric, Carole St George and Viv MacLean, who are all representing the work that we do at Mofflyn and will put different aspects of our presentation to the committee. I will make a brief introduction. We have actually carved up between us particular areas of interest to present to the committee, and we will be keeping them brief so that you can ask some questions. Firstly, the material that we have sent through to the committee indicates that Mofflyn is a Uniting Church agency and it has a long history of residential child care. In the last decade or so we have moved out of residential child care into intensive in-home work with families where children are at risk of harm or abuse, at risk of being placed in out of home care, or where children are in out of home care and strategies are being put in place to see if it is possible for them to be reconnected with their families. That is partly funded through the state government.

When we saw the invitation to make public submissions, we realised that this was an important issue for us as an agency, and Carole will go into that a bit more in terms of the increase that we have seen over the last decade in the number of families in which substance abuse is presenting as a significant factor when considering the wellbeing of the children. Also, and this is another part of our submission, there is the impact of substance abuse on the workplace and on individuals who work in Mofflyn, where staff members have had direct involvement through being exposed to substance abuse within their own families. Viv MacLean is going to present her personal experience in that regard. She is an employee of Mofflyn. She has worked with the agency but has also experienced directly the trauma of substance abuse within her family. We thought that was a case that involved Mofflyn as an employer and a staff member as well.

Without further ado, I would like to introduce Carole St George. Carole was acting as Coordinator, Intensive Family Services, for a few months. During that time we did snapshot research on the issue of substance abuse in our families and what that meant for our work. Carole and Sandy are going to present different perspectives on that, which you can follow up with some questions. Is that okay?

CHAIR—That is great. Just out of curiosity, what does Mofflyn mean?

Ms Fariss—Mofflyn is an old Methodist family from Western Australia. When Mofflyn was established as the Methodist Homes for Children in about 1920, several families were very involved. One was the Mofflyn family and I believe there was also a Lyn family. The other version of the story is that the Mofflyn family did not want to be known as 'the' family behind it so they wanted the spelling changed.

CHAIR—So it is in recognition of great supporters and historical links?

Ms Fariss—Yes. We now come under the national umbrella of Uniting Care but we are an autonomous agency of Uniting Care.

Ms St George—We organised a survey of the families that we had in the services, in particular the intensive family services area which is the program where we work intensively, as Nova explained, with families experiencing multiple problems. We felt at the time we decided to do this that a lot of the families that we were working with were experiencing a lot of drugs and that the children were being exposed to parents who were using drugs. The repercussions of that seemed to us to be quite serious. So what was behind this was for us to look internally, as an agency, at what we would be doing about that and how we needed to address that.

The survey has been quite significant for us in revealing the extent of the suffering that children experience, particularly as a result of their parents' drug use. We knew about it, but when we actually did the research on it we were quite surprised to see the severity of it. You have got the paper on this. There are things like premature birth; young babies going through psychological withdrawal—we work with families where that is the case; children who have severe developmental delay, which is the result of the parents' using drugs and not being able to be available to children to give them a normal upbringing; and some children also having hepatitis C as a result of the parents having hepatitis C. In families where there is a lot of drug use, poor nutrition is the result of often not having any money to provide for the children—that is fairly self-explanatory.

We see a lot of physical and emotional abuse and neglect as a result of that as well. That is also associated with families having multiple problems like physical violence. You see a lot of that with these children. Neglect is a major issue because of parents just not being available as they are so much more interested in using their drugs and are totally focused on their drug habits so that their children are left pretty much to do what they can. We see a lot of that; Sandy will talk a bit more about that. We have malnutrition as a result of it. We have seen babies with brain damage. Foetal alcohol syndrome is fairly common.

We see a lot of very severe behavioural difficulties, with the children acting out, and we spend a lot of our time working with those children and families. The children have various degrees of learning difficulties, and in the agency we spend a lot of time working with schools with those children. A lot of that is the result of drugs.

We also took a note during the survey to look at how many children are using ADHD or ADA medication. It was noticed—although I think this needs to be looked at separately—that this medication is quite prolific in the children we see. Their behaviours are acting out behaviours, medicos see that and prescribe the medication for that, and parents are very happy to go along

with that. We have quite a major concern about the dependency that these children have on that medication. That was one of the major impacts of the survey.

The other effect which we knew was there but which the survey highlighted was the intergenerational use of drugs. We asked during the survey for the number of families where grandparents had been using drugs. So, if you consider the children who were using ADHD medication as well, there is a combination of three generations using drugs within the families that we are working with. We found 30 per cent of the cases with grandparents currently using drugs as well.

I guess they were the two major factors that came out in terms of our concerns, really, as an agency as to how we would address that. As an overall view of it, we felt that at the moment, certainly in Western Australia, there is some research around as to how to deal with drug issues but certainly we as an agency have not had a lot of training in terms of how our workers deal with drug abuse. We have some but we are not specialised in working with that even though 50 per cent of our clients are using. We are currently looking at developing training—and linking in with training with state government as well, hopefully—and increasing our skills so that our agency can deal with this issue. I am sure that that is a much broader issue than just with Mofflyn. That is about it as a summary.

Mrs Nemaric—My name is Sandy and I am a family care worker at Mofflyn, which means that I work hands-on in the home with the families. As Carole has already said, we did a survey back in May with 84 children that we were currently working with and over 50 per cent of those were in homes where medication was a common theme. For us, there is a huge impact on children just because of that statistic alone, because of what it means to them. As workers, we know that there is a lot of hurt and a lot of pain but for us we have to come up with the new strategies and the role modelling of positive behaviours. We have to encourage responsibility. We have to try and get families participating and into the community again and network them into positives. For the children who, quite often, are left isolated in these homes—and, as Carole says, we do work in the schools—we find that even in the schools there is a lot of self medication, especially of the AD and the AH medications with these families. Okay, they go to the doctor and get the medicine but it is not exactly a matter of just going in and getting it. They then medicate the children according to what is going on for them at the time, which is quite frightening.

Mr EDWARDS—Does the 'H' in AH stand for hyperactive?

Mrs Nemaric—Yes. Again, there are a lot of excuses that are used for these children who are behaving badly in the community. They are excuses. It is because of the long-term ways. For us, there has not been any programs with competency skills for parents of substance abusers. There has not been enough research done on it. It is hit and miss so you put up with lots of strategies, because it is like a rollercoaster ride for these families. Every day is a struggle for them, whether it be for money, whether it be for getting the kids to go to school or whether it be for role modelling the idea of doing homework—and that when most of these families have not had a job before and maybe, like we said, grandparents have also been abusers of substances. There are often more complex issues also involved with these families.

Ms Fariss—Finally, I have made some statements in our submission regarding the impact on the workplace for people who are struggling with this issue within their own families. I will not highlight any of those comments—I think they were fairly clearly summarised in the document. But I will introduce Vivien now to provide you with a more personal story.

Mrs MacLean—If you bear with me on this, I had to type it out because it is the only way I will get through. My daughter passed away five months ago. I wanted you to have a view of the addict as well as what you are dealing with. If someone had asked me five years ago my thoughts and beliefs about drug addiction, my answers would have been very different from today. I nearly backed out but then said I would do it, because if it would help anyone gain even a little insight into this, then it would be worth it.

My daughter was a beautiful child, she was an articulate young woman, she had dreams and hopes for a future. She loved sport, children, animals, and she completed a beautician course successfully. She was involved in modelling. She was also very sick with an addiction of heroin and prescription drugs. When you add this last piece of information to the initial description, most of the initial part is lost and people get the stereotype of someone who is addicted to drugs. Everything else becomes irrelevant—they are just a person who is a junkie, a user, an addict, a druggie. That is the vision that is conjured up.

I had two children and they were both addicted to heroin, but their uses were different. My son used it because he enjoyed it, he had employment, he was able to finance it and most of the time no-one was aware that he used. The only real giveaway was that he never had any money to spare, even though he was earning a very good wage. My daughter became involved with drugs when she was about 15. This began with curiosity and experimentation which led to full-on drug addiction of heroin and prescription drugs. At the beginning I had very little understanding and even less knowledge of these drugs and the environment surrounding them. At the time of her death, only five months ago, I could recognise all of her prescription drugs, tell you what effect they have on you and what drugs they interact with. She used heroin because she found she could forget pain and she could hide anything she needed to. She was abused at the age of 11 and she never recovered from that. But when she used, she was free of memories. When she stopped using, they all returned—the nightmares, the voices, the self-hatred.

She hated using and she hated the lifestyle needed to use and to survive there, but she hated dealing with reality even more. She had been on methadone for many months, but she was still using prescription drugs. She was gradually weaning herself off these and very proud of this. It was taking a lot of hard work. She set herself goals and was reaching them. She found a new partner, she was going to change her name and she was leaving the past behind. She moved into her own flat only three weeks before her death, but something went wrong. She was also on the naltrexone program but, when she died, she had no naltrexone in her system which means that, for some reason, three days prior to dying she had chosen not to take it. I had not been able to contact her. I had a locksmith break into her flat and that was where I found her. The hardest thing is that you do not know what happened, whether it was an accident, or whether it was just too hard to handle.

That is a summary. What I will do now is address the areas that you said you were concerned with and my viewpoint on them. Family relationships are totally strained as you try and protect

yourself from the addict, you try and protect the addict from the family and the family from the addict. You isolate yourself because you do not want anyone to know about it but, by doing this, you lose all the support of the people who love you. All relationships are strained because, as a mother, I would never give up trying to regain the children I knew—not the children who were affected by drugs, but the ones that I knew. I always used to say that I had four children—the two that I raised and that I knew and loved and the two who used drugs, and that is how I kept sane. My 86-year-old mother questioned me one day and asked me if I still liked my children because I never spoke about them. She was relieved when I finally told her the truth, and that was after about four years.

Christmas and special occasions are hell. If they are there, what will they be like? They are hell if they are not there—why weren't they there? You do not ask people to visit because you cannot predict how they are going to behave. I lost my partner of four years when he could not cope with anything anymore. Relatives visiting from overseas are given excuses as to why they do not see them. The money I used on them over the last five years was everything I had. I kicked them out of home and cried. I took them back and cried. I would say, 'This is the last time,' and then I would go down the same road again and again, hoping this time it would be different, looking for the smallest sign that things were really changing—having my head information fighting with my heart, trying to keep peace between family members, learning about drug rehabilitation available, finding the refuges when she could come home, paying rent and bonds, paying all the other bills, getting belongings out of hock shops, fixing cars that were smashed, visiting her in houses that I would not put an animal in: not wanting her to live this way, but unable to offer anything else. I would take off in the middle of the night to sort out each crisis. I slept across her bedroom door to prevent her going to the dealer. I drove to Kalgoorlie and back in one day to bring her home after she hit rock bottom at 17. When I arrived home I could not find anywhere to take her: she was too young they all told me. Fremantle Hospital was the only place because she was talking suicide and she went through cold turkey there as they had nothing they could give her.

Five years ago there was very limited information and even less understanding. We talked for hours to try to sort things out because she really wanted to change. The hardest thing of all for me was that all her life I had been able to fix things but this time I had no control, no ability to change anything, and was frustrated with systems which are not adequate to cope with these children; dealers who, even when dobbed into police, walk free within hours; and doctors who give out repeat prescriptions of addictive drugs. She was doing well on the naltrexone program and helped convince her brother to go to the clinic too. After his detox session between Christmas and the New Year, I saw the millennium in by his bedside at Sir Charles Gairdner Hospital where he was so ill. He vomited nonstop for four to five days, losing 14 kilos in weight. I slept at the hospital with him. The staff were tremendous and conceded that they had learned a lot from treating him. The recommended dosage of Valium for an addict can be likened to giving someone a jelly bean for a broken leg.

I mention this to try and highlight the levels of frustration felt by myself and by the medical staff as they treated my son—not to mention his frustration. After all this I then kicked my son out of home because he was using again and I had to go and find him when Amanda died and bring him back. He returned home a week before the funeral and I told him I would support his drug habit until after the funeral but then it was over. It took two more detox sessions before he was able to stay away from the drug. The first one was the morning after I buried my daughter.

Crime, violence and law enforcement: I learned how to deal with collection agencies, what happens when you get evicted and how to cope with police calling at my home about the criminal system. I believe the so-called drug dealer has been caught—these are mainly people who sell to support their own habits. The ones who really need to be caught never will be. With road trauma I lost count of the accidents Amanda had. Looking back, most of them—probably all of them—were related to her prescription drug use. In terms of workplace safety and productivity, after reading our submission—because I have been off work and have just come back and found this was happening—I realise even more how my situation affected other people who I worked with. For the first three years I told no-one because it was something you could not discuss. I also think the isolation I created, because I had children who were addicts, was one of the hardest things. When I was in the lunchroom and drugs became the topic I would leave. I always remember one comment from a fellow worker who was totally unaware of my situation. She said, 'Junkies should all be lined up and shot.'

I believe even on my worst days I was aware of the parallels between my own life and that of the families I worked with. My experience with drugs sometimes gave me a different perspective from other workers about these families. The ability to recognise signs and symptoms of drug use developed very strongly. I know there were days when my work came second—when I would spend the time talking to Amanda on her bad days and when I had to leave to put money in the bank for her, go to see her after distraught phone calls, go to hospitals, attend doctors or visit her in rehab. Holidays were taken around her needs and never around mine—mine were not considered. After her death I had to have time off work. During that time counselling was offered to me and I took it. Even though I am now back at work and try my hardest to concentrate, some days it is impossible because she is all I can see. The support and understanding of my colleagues and my employer have been tremendous. I could not manage without them. Going back to work was my reality base. I needed something that was concrete, because nothing else is.

Regarding health care costs, Amanda was on a disability pension. Both mentally and physically she was unfit to work. I myself had her committed to Graylands twice to prevent her committing suicide. The second time she was put back on the same drugs that she had just spent three months detoxifying from. That was the day that she went back in there. She was hospitalised on three other occasions for suicide attempts, one involving an ambulance call-out. She was hospitalised following three massive seizures while in the Central Drug Unit. These were connected with withdrawing from prescription drugs. I attended different doctors with her and questioned the amount of drugs they had prescribed. Her tolerance level of prescription drugs was unbelievable. Her blood pressure was so low that she would have blackouts and seizures, but they still prescribed her Valium, Clonidine, Doloxene, Serepax, Rohypnol and others—prescriptions of 50 at a time, with up to six repeats. When she died she had a stack of prescriptions that high in her bag. Some were from the same doctor and some were from different doctors. The naltrexone program alone cost me hundreds of dollars and that still is not paid off. She was hospitalised twice after her detox treatments. I have just completed my tax return and the receipts—those that I kept, and I did not keep them all—totalled over $2,500 for this year.

To close, I would like to acknowledge the support that I found, and still have, from all the people involved in the naltrexone clinic, which I heard closed today. The other support that I am using is a group that Palmerston run in conjunction with Mareena Purslowe for parents who

have lost children through drugs. It is an exceptional group that I believe needs more recognition and promotion to people at a time when they need understanding without restrictions. It is a very special place. Unfortunately, I think only five of us have attended.

I also believe we need a central computing system of some description to help stop the ability to doctor shop. The community needs realistic education about addiction and the needs of addicts when they are trying to stop. Try to imagine if someone told you that you were not to see anyone you knew or go anywhere you knew or do anything you had been doing for the past few years but were just to go out and begin a new life. Even with the skills and knowledge that each of you has that would be an almighty task. But this is what we ask of the addict. I believe there needs to be some type of re-education system for them to learn to live again in society because they do not know how to live in society if they have been an addict for a few years.

People do not usually die from heroin use alone; there are other drugs involved. Statistics only show a combined drug related death or a suicide or a car accident or death by misadventure. Heroin does not show up in true numbers when you are recording deaths. I do not justify or excuse the behaviour of addicts but I do remember they are all someone’s child who did not start out this way. No-one, regardless of their circumstances, should ever believe it will never happen to them.

CHAIR—Thank you for the courage to come and give us an insight into the reality.

Mrs MacLean—That was my daughter. She was not the stereotype of the junkie that you see portrayed in the news and on TV and anywhere else. That was two weeks before she died, when she was healthy again and getting there. They are the pictures that people do not see when they think of drug addiction. It is not just heroin; it is not just illegal drugs. Her prescription drug addiction was as bad, if not worse, and it was harder to get rid of. There is no naltrexone to get rid of that. That is why I am here.

Mr EDWARDS—Vivien, thanks very much for that. It has helped remind us of what we are about as well. We took evidence this morning from the National Drug Research Institute who are doing a lot of work in this area. They made the point that parents can be seriously distressed by the use of drugs—and particularly illicit drugs—by their children. Obviously, you have reinforced that. They say their research has shown that parents need more support but that few access support services. I would be most appreciative if you could comment on that statement as to whether you see it to be true or not. I might then like to follow up with a couple of questions.

Mrs MacLean—I think it is very true because, as I said, for the first three years I told no-one about it, even my parents or brother. Nobody knew. What do you do? Do you say, ‘Hey, my kid is an addict’? You do not do it. I believe people are beginning to access more because people are beginning to realise it is an illness that these kids have. It is not just that it is an illegal thing they are doing. It is something that affects people. You can talk about it more. I guarantee that, if you mention it, there will be at least one person in the crowd that you mention it to that says, ‘I know what you mean because I have got someone too.’ That is the sad part. It is at epidemic proportions out there. I get the feeling that Perth believes that it does not have a heroin problem and does not have a drug problem. People do not talk about it. It is like there is a shame connected to it.

Mrs Nemaric—I too have a son who is an addict and I have done an addictions course. You will find that the mothers are the ones that go to these or try accessing these groups. I have done a lot of volunteer work at the naltrexone clinic and the carers are usually the mothers, the sisters or the aunts; very few men stay in the clinic. They walk outside and stay away until the detox session is finished. So what does that say about what is going to happen when the hard part starts when you leave the clinic?

Mr EDWARDS—It is an excellent point, and I must say that in my own experience, in my own electorate office, when parents come to see me it is the mum that walks in the door, not the dad as a rule.

What sort of services do you think the federal government should be directing its resource support towards in order, firstly, to assist parents to get a better understanding of the issues and the realities of drugs and, secondly, to support families that are caught up in a drug situation?

Mrs Nemaric—It is hard; it is a catch 22 because no-one ever thinks it is going to happen to them, and even with all my work experience you know absolutely nothing until it is in your own home and your own feelings are caught up. I do not think anybody ever thinks they need an apprenticeship to deal with what is coming, so I guess often for me working with families is almost therapeutic because it just reminds you of the daily struggle. You are looking at a mirror almost but it is actually quite good for you in a lot of ways because you are not alone. There by the grace of God go I as well, except I was more fortunate perhaps with support and my child probably got a lot more support. These people are quite isolated, so for those people as parents in our client base, I do not believe that many of them—they struggle so hard—are actually going to access groups that could be beneficial. I know Holyoake has some really good parent-child groups running at the moment, but it is really hard to plug people in. Even as an agency, if you plug them into those things, when you stop working with them I guarantee they do not continue going. So the motivation is very different before the event until after the event, because it is such a struggle once the event arises.

Mrs MacLean—I think it has to be somewhere where the whole family can be accepted. One thing I found about the naltrexone clinic was that it did not matter who these kids were, what they looked like, what they said or what they did, they were accepted as a person and they were accepted as a person with worth, and that is something that has gone from an addict’s life. Usually you might have mum hanging in there but even mum gets frustrated and angry; kicks them out, takes them back and all that. But it needs somewhere where they can learn to live again and they can learn to like themselves again. These kids do not want to use—they hate it; they hate everything about it. You cannot explain the power of this addiction. You cannot explain the power of a death on you. You cannot explain childbirth. I mean, you can write as many books as you like, you can read as much as you like, but until you actually experience it and it is right up your nose you just cannot; it is so hard. They wake up wanting to use and as soon as they use they want the next one. It is the scheming—it is a way of life that you have got to break. You can stop the drug with the naltrexone but it is the head stuff. It is almost like needing to put them somewhere where they can learn to live again and they can learn how to think and reason. I just do not know.

Mr EDWARDS—Vivian, obviously you have a fairly high opinion of George O'Neil's clinic. Did you come into contact with any of the other state government funded organisations like, for instance, Next Step?

Mrs MacLean—I have had limited contact with Next Step. I have had contact with Palmerston, Bridge House, Cyrenian House—with most of them.

Mr EDWARDS—With the naltrexone clinic, you mentioned that you were struggling to pay the money. Do you still have to pay whatever was outstanding? Or has that been—

Mrs MacLean—My son is still alive so he still has a debt there; but it is a matter of principle for me. That was her chance at life and I do not know why it went wrong, as I say, but that gave her the best shot; and I believe in what happens there. I believe that it is only part of what they need, though. The detox is the beginning. Although is it horrific—I do not know whether any of you have ever seen it; if you want an experience, you should watch someone being detoxed—that is the easy part. The hard bit comes after that, when they then have to get off the drugs that get them through that and then the prescription drugs.

Mrs IRWIN—I have to commend you for your courage, what you have done today. I think you are doing a lot of this for all the Amandas that are still out there, crying for help.

Mrs MacLean—You have that right.

Mrs IRWIN—I noticed what you were saying about naltrexone: how long had Amanda been going to the clinic? Did you mention three months?

Mrs MacLean—No, no. I cannot remember: she had been going six months, and she slipped up in March and had to be retreated, after an ex-partner attacked her in Perth with a knife. She went off then, and she came to me straightaway. We took her down and she was done again and she was fine. So she had probably been there about six months.

Mrs IRWIN—And you had felt that that was the best possible treatment for Amanda? You say that she was on methadone.

Mrs MacLean—Methadone has its place, I believe. Methadone is very constricting, inasmuch as that, to be able to afford it, she needed to go into the methadone clinic. That meant travelling every day. Travelling on transport was very difficult for her—although driving cars was even worse. When she finally got to go to a chemist for it, the indignities that he put her through to actually get it she did not want to know about, so she went back to the clinic. A lot of chemists are really good with it, but some are just horrific to them. They really do have a go at them.

CHAIR—Could I understand that a little better? What might a pharmacist say? What might a chemist say?

Mrs MacLean—They are requested to give the methadone out. They get paid to give it out, and everything else, and they give a measured dose and that is it. Amanda would go into the chemist and there would be three people there, and so she would wait. Three more people would

come in, and he would make her wait until there was no one in there, and then he would make a big thing of giving it to her. Or if she said, ‘Look, I am really in a hurry,’ or whatever, he would say, ‘You are only getting methadone; you can wait.’ It was that sort of attitude. They have worked really hard to get off the heroin to get to that point. They have gone through a lot to get there and, then when they get that shoved in their face again, they think, ‘Why do I bother? What is the point? I get no recognition for anything I do. I may as well go back.’ Plus, with methadone, they can still use—and that is very detrimental to their health. It rots their teeth. She had just had four hours of surgery on her teeth two weeks before she died, to have them all put back because they had all rotted—and I mean down to the gum. So while it has its place, I do not believe it was as effective.

Mrs IRWIN—Going back to the Subiaco detox clinic, earlier today we heard from the Western Australian Network of Alcohol and Other Drug Agencies. I am looking at my notes, which refer to when they were talking about the clinic. They felt that the clinic were not screening people properly. Can you tell me, when Amanda went to the clinic, whether there was an initial interview.

Mrs MacLean—Absolutely.

Mrs IRWIN—You were with her?

Mrs MacLean—Yes.

Mrs IRWIN—Could you explain, if you do not mind, how they actually screened her? How did they say, ‘Yes, I think this program is good for you’?

Mrs MacLean—She had actually been in before, and backed out, and did not go back. Then we went in and we had an interview with one of the doctors. We looked at her history: what she had tried and what had and had not worked. I cannot remember all of it, but that was what was looked at before we went in there.

Mrs Nemaric—That usually happens on the Wednesday before they are treated on a Saturday, or on a Saturday when they are treated on a Wednesday. They are made, sometimes, to wait for quite a long time, and that is why sometimes they do not wait, because there is not an appointment. You turn up and sometimes lately there have been up to 39 people waiting—you are not going to get in. An addict has not got time to wait around for an appointment, and that is another problem. But they are screened quite thoroughly. They are weighed—all those things are done.

Mrs IRWIN—So they are weighed, their blood pressure is taken and everything is done.

Mrs Nemaric—Yes.

Mrs IRWIN—Regarding her medication, her naltrexone tablets, she was getting those from Next Step—is that correct?

Mrs MacLean—Yes.

Mrs IRWIN—She had no problems with Next Step, going and getting them?

Mrs MacLean—No, Next Step are very clear. If you are late for an appointment, it is just not on. You have to be there on time for your appointment, and that sort of thing.

Mrs IRWIN—If she was late for that appointment—because we are getting different stories here regarding Next Step—would she just be told to take a seat and wait until the next available appointment should come up, or would she be told to come back in a couple of days time?

Mrs MacLean—She was never late. That tablet was too important; that was her bulletproof vest, as far as she was concerned. I think another appointment was made. My son was late once, and he was very lucky because they had had a cancellation. But normally they would have to come back for another appointment, which is like signing a death warrant to these kids.

Mrs IRWIN—Not the same day, it could be a couple of days later?

Mrs MacLean—Yes. This is the other problem that you encounter: when they are ready to go and see someone and to do something about it, they are ready then. You phone, and it is like, ‘We can give you an appointment in three weeks time.’ I remember when she was abused, I phoned SARC, and they said, ‘We can get her an appointment in six weeks time.’ She had just disclosed to me now—and they said ‘six weeks time’! It was like, ‘We can give her telephone counselling until then.’ Sure, but it is timing; it is lack of resources, I believe. With respect to the families that we work with, you try and tee them into things, and it is that waiting period. I know it sounds very selfish, but when someone is ready to do something it has taken a hell of a lot of work to get to that point, and they want it now. There is a fear that if they do not do it now, they will not do it.

Mrs IRWIN—I hope you do not mind me asking you this, but do you feel that the system let your daughter down, when she was crying out for help?

Mrs MacLean—At times, yes. The day that I brought her back from Kalgoorlie, I phoned everywhere—and she was too young. We ended up at Fremantle, because Central Drug Unit would not take her. She was only 17, and they would not take her. They said, ‘We won’t put her in with the others.’ I said, ‘But if you don’t see her now when she is 17, she won’t be here when she is 18 or 19, when she fits your criteria.’ They could not help me.

CHAIR—What was the right age?

Mrs MacLean—I think she had to be at least 18. I was very lucky inasmuch as she did get in and she got fast-tracked to Palmerston farm. But even that has a waiting period. They go down, they spend the night and then they come back. There are all these little gaps in between. There is not that continuity and it is very hard to keep a handle on them because they are powerful.

Mrs Nemaric—The other thing to remember is that a lot of these kids—and they are not all kids; some of them are adults in their forties—are also going through the legal system as well. They are not just dealing with the health system; they are dealing with the legal system, they are dealing with the welfare system and they are dealing with all of these things. With my son, who is 23—I still believe an addict has to have some consequences too—one of those things for us

as a family was to have him imprisoned. I tried and tried to get that to happen because he was a danger to the community, not only just to us. He had been on naltrexone and had been clean for a long time. He went to prison and what did he do first time? His only way of managing things is to shoot up. So he went to Casuarina and shot up within hours of getting there. So then we were back to square one. That went on and on and on. These people do not just deal with the drugs in the way we are all talking about; they are dealing with it in many ways and with the stresses and the pressures that most of us take for granted every day. The families deal with those, if they have the support of families as well, but there isn't any support there for families.

Mrs MacLean—I think it is the unfairness that they see. If they do something wrong, they get thrown in jail. But they know that higher up the chain things are happening that are being ignored, that are being covered up or that people are getting away with. We say we do not know who is doing all this. You ask any addict on Hay Street—he will tell you. He will tell you who they are. I walked down Hay Street one day with my daughter and within 200 yards it was, ' That is a dealer, that is a dealer, that is a pick-up shop, that is a pick-up shop, there is another dealer.' They cannot get away from it. And the people making the money will never be touched.

Mr SCHULTZ—Can I just say how much we all admire somebody with your strength to come in and talk about it, and you too, Sandra. I want to pick up on the point that you just made there. I find it very difficult as a person who comes from a rural area of New South Wales to know that I can do exactly what you just described and pick out all of the dealers in the home town that I live in and in some of the towns that I visit, yet I do not see any charges for dealing and using in the towns among those very same people. I have grave concerns about just how far the drug trade as we know it has infiltrated our communities. I just want to revert back to the concerns that you raised about the very freely available legal drugs that seem to be prescribed by some doctors. I just want to ask you, given that your daughter was in that sort of situation: how much did that prescription for or the giving of legal drugs by doctors neutralise the detoxification process that your daughter was endeavouring to go through with naltrexone?

Mrs MacLean—The naltrexone was almost separate from the prescription drugs she was taking. All the naltrexone does is to block the receptors. When I say she took prescriptions drugs, she could take 20 Valium and walk down the street, or she could take four Rohypnol—enough to put an elephant down—and sit here and talk to you. She could take any of those. Weaning her off those was a lot harder than the heroin. We had a regime. I had one of those seven-day packs and we used to put out what she needed for the day each time of the day with a couple of spares at the end.

Initially, it was one day at a time, so I could go back to work. She would phone me at work before she took them, she would write down what time she took them and then, when I came home, we would check that she had the right amount left. That was how we did it, to the point that there would be two days, three days and four days. She cut herself down. She knew she could go to any doctor and get them. She knew what to say. She could take the medical board on and she could tell them what they were about. She knew every drug there was. I have a knowledge of drugs that I never thought I would have.

Mrs Nemaric—Addicts trade drugs, pills, as well. That is how they get their next hit, if they have rohies in particular. That is what my son was hooked on—rohies—as well as on heroin.

They could get those anywhere and trade for Temazepam. That was the next one that he got hooked into, because they were not as available and they were also cheap.'

Mr SCHULTZ—I understand what you are saying. Yesterday, at George's clinic, I talked to a very attractive young lady who was going through a detox program. She had been a prostitute since she was 14 years old. Her mother was a heroin addict and overdosed. She was telling me that she did not have any problems getting anything off doctors: she just walked in there, winked and gave them a lovely little smile. If I were a doctor sitting behind the desk and were confronted by that very attractive young lady, I would probably do the same. But it does not make the system right—that is the point I am trying to make.

Mrs MacLean—There are certain doctors that you go to.

Mr SCHULTZ—Yes.

Mrs MacLean—That is the other thing. That is the really sad thing.

Mrs Nemaric—They are spread right across the metro areas, so they are quite accessible whether you drive or do not.

Mr SCHULTZ—And the addicts get to know where they are.

Mrs Nemaric—Of course they do.

Mrs MacLean—I went and argued with one of these guys one day. I said, 'How can you possibly prescribe those for her, knowing what her history is?' And he said, 'They won't hurt her. I saw someone take 150 one day and he is still alive.' I said, 'Excuse me, I am trying to get my daughter off these and you're giving me that sort of stuff.' The addict will hang on to that and will say, 'The doctor said that and the doctor prescribed them, so they've got to be fine.'

Mr SCHULTZ—So what I hear from you is that there is obviously a very real need for us to consider the protocols of what controls governments can introduce—and these would be over and above what are already there—against the overprescription of legal drugs that are creating or compounding the problem that we have in the community from illicit drugs.

Ms HALL—You suggested a central register. I think that is an excellent idea.

CHAIR—We need to move on. Mal, any questions?

Dr WASHER—This is more a comment. The impression you certainly get is that unfortunately there are people for whom we do not have an answer as to how to treat them. That is a worry. Being a doctor, I find that a frustrating thing. We just do not have the answers and, to reinforce that, we need a lot more research. It is a tragedy to lose kids like this. It does not matter what you do; there is no one drug or magic bullet to stop it. You give all the psychotherapy and the genuine help but that does not necessarily win the day either. You have to do that, you have got to keep trying, but you do not always win. I guess there are a lot of areas that I think it reinforces. There is a lot of research to be done as we do not have the

answers to this problem. We do not also seem to have answers to why it is an escalating problem. There is the availability, but drugs have been available since time immemorial. This has now become an increasing problem for reasons we do not really comprehend. I have never heard anyone tell me the logical reasons.

Ms Fariss—We could not tell you why, in the families that we are working with, we have had such a significant increase in the problematic use of substances. In fact, I would say that the difficulties associated with substance abuse are now more significant than those associated with alcohol abuse some years ago.

Dr WASHER—What it all highlights is this: we have been playing with ideas in Canberra for a central register of all people with all prescription drugs and the big problem we have to overcome is the Big Brother connotation, but I think it is time Big Brother did something. Big Brother has to take some responsibility.

Ms JULIE BISHOP—Do you mean privacy considerations?

Dr WASHER—Yes, that is the problem. A register has been thought about a lot. We have the facilities to deal with it. We have the technology to put it in place tomorrow if we felt the public would accept it. It makes us seriously think about the fact that sometimes there are bigger issues than just a bit of privacy; you are talking about people getting killed.

Mrs Nemaric—You are also talking about politicians and it being an uncomfortable area for them if they want to keep their jobs as well.

Mrs MacLean—The other thing that I would say is that when you do this research and you do everything, ask the addicts, ask their parents, ask the people that it really affects—if you want the real answers. It is like reading a book on childbirth and thinking you know about it. Until you get the real gut stuff, you cannot get the answers because you do not know what they need. You can only assume you know what they need. Until you talk to them, you really do not know what they need.

Ms JULIE BISHOP—What is the priority, Vivien? After your experience, where should we be directing our efforts in terms of priority?

Mrs MacLean—For me, I would like to see the stigma go from it so that it can be treated openly. Get rid of the shame and everything that goes with it. Treat it openly. I heard you talking before about the drug related people in gaol. If you take it back a step, you will probably find there is a lot more. It is on a peripheral of so many things. These are kids that do not want to be there. Heroin is a drug on its own. It is so unlike the others. It has a life of its own. It has a power of its own. Any heroin addict will tell you that—that you can use any of the other drugs and you can drop them. Heroin—no. You need it to live a normal life once you start taking it, and that is the difference.

Ms HALL—Thank you once again for coming along and sharing your experience with us. I am sure we all have learnt a lot from your contribution. It seemed to me that you coped and you were able to find the resources to go through the detox process, either with the heroin or with the legal drugs. But what happened after that? Was the support in place to help your daughter

and to help your son now to get back into a normal life? Were the services there? Do you think that we should be concentrating on making sure that we look at the whole process—that we look at the work, look at the housing, look at the support that the addict needs?

Mrs MacLean—You cannot take a part of it because, if you change one part, it changes everything else anyway. It is the complete thing. That is what I was saying before about the taking of the naltrexone as the beginning—the dropping of the addiction as the beginning. It is that lifestyle thing that needs to be addressed after because these kids do not know how to live. They lose it.

Ms HALL—Is the support there for them at this time?

Mrs MacLean—When someone stops using, I would say no because they are very sceptical of any help offered. It is like, 'What do you want back?' or 'It is just another agency. They do not really care' or 'If you get involved with them, you never get away from them'—that sort of thing. It is finding something that they can relate to.

Ms HALL—What do you think we should do in that area? If you were making a recommendation—

Mrs MacLean—Get a heap of them together and ask them. Face them and ask them.

Mrs Nemaric—They still have to take some responsibility for themselves though. That is where I differ with Viv because I actually think they are people and they often know they have lived probably the majority of their lives not like what they are presenting as. They do know about responsibility. They do know about consequences. Perhaps that is what happens with families. They get too uncomfortable to be able to give those things. It is called hard love. I think sometimes that is what has to happen because you can feed them all the time you like, but it still comes back to them wanting to do it and wanting to change. They are responsible.

CHAIR—On Monday morning we did spend significant time with young female prisoners and that sort of message was coming through.

Mrs MacLean—They have to want it. You cannot do it for them. They have to want it.

Ms Fariss—That is also the issue with our families.

Mrs Nemaric—Particularly for my family, we needed a spiritual being as well. The physical part had fallen apart for us. That became very important to us, and still is to this day. Each day it is just a daily thing, but prayer is very important. My son also knows that he needs something more than just what can be presented physically. What George actually gave to him was the ability to understand what forgiveness really is all about and to trust and all of those things. We deal with that every day and we do not always trust him.

CHAIR—Thank you for that. Sandra, you touched on politicians. It is important that we see ourselves through your eyes and we want you to be totally honest with us.

Mrs Nemaric—I am actually related to Kim Beazley, so be very careful!

CHAIR—I think it is important in terms of the political will, the political debate. There is state and federal, there are people all over the place in this, but it is important if you could just give us a view about politicians and what you meant by that.

Mrs Nemaric—When you look out there at that bell tower, materialistic things come to mind. Banking people feel important for the wrong reasons. Our agency stands for caring about people, and that means you take them warts and all. You get to know people and you get to listen to people, and that way you are working at the grassroots of things rather than giving them things like that. That does not mean much to people, it does not mean much to my family, but I do need other things—I am not saying what they are, but they are not always material things. It is nice to know that you trust the person you elect or that the majority of your electorate elect to represent you, and, quite often, they do not hear what you are saying.

CHAIR—Yes. So politicians—

Mrs Nemaric—In general, I would not trust, no.

CHAIR—That is fine.

Mrs Nemaric—I just find them in a world of themselves. They get used to a lifestyle and the things that go with it—and all very well, we all do; but sometimes it gets a bit grandiose.

CHAIR—But when we have got serious issues, as we are talking about now, and when we look at the relativity between what we would all regard as serious issues and those other matters, then it is important to focus on what is important.

Mrs Nemaric—And not just talk all the time—there is always a lot of talk. It is following through.

CHAIR—We are very guilty of that.

Mrs IRWIN—More action.

Mrs Nemaric—Yes, that is right.

Mrs IRWIN—I am hoping you get that out of this committee.

Mr EDWARDS—One of the strengths of the parliamentary committee system is that there are people from all political parties. The strength of this particular committee, as we have shown in previous work that we have done, is the very strong bipartisan approach where we push politics well away from our deliberations and we endeavour to deal with the issues that are confronting people. I want you to have a bit of faith in that system, because it is important for us to believe in it as well. But the strength of this is the very strong bipartisan approach that we have to the task that we have got in relation to drug abuse in Australia.

Ms JULIE BISHOP—This is beyond politics.

Mrs Nemaric—Yes, of course it is. It is about people.

CHAIR—I would pick up Mal Washer's point, and he is much more qualified than any of us to know about medical and drug matters. We do not know the answer and that is why we are here listening. I want to stress that: we do not know and we are trying to learn.

Mrs Nemaric—For addicts, that is very important because they are individuals and therefore they need a range of options, which we do not give them at the moment. Even though I stand up for the naltrexone program because it worked for our family, I also accept that there are alternatives available which would work for other families.

CHAIR—Be assured that amongst this group there is great discussion about that. That is the debate in the committee and we reflect that in the same way—no different, no better, no worse. Vivien, I would like to ask you something in an anecdotal way. I am told that I am a walking disaster for a heart attack: I am overweight, I am this, I am that, the job I am in, all the rest of it—my family tell me that on a regular basis. But if I had a heart attack I would know that Washer might come over and help me out, call the ambulance or something—

Ms HALL—He says, 'Don't count on it.'

CHAIR—It would depend on whether I had been good to him on that day or I had given him the right red wine or something. But I know I would get treatment and I know that I would go to a hospital in an emergency situation anywhere in this country, without prejudice, without all the—what was the word we were using?— stigma that you were talking about. Yet if in the next few weeks I became a heroin addict and I was in a hopeless situation, I would not get that emergency treatment in the same way. What is coming through to us in this issue is that as much as possible—because we know we need the law, we need criminal sanctions and all the rest of it where it is appropriate, and that is where the debate will come—if we treat it more as a health issue without the stigma, that would perhaps be one small step in helping. I know I would get help straight away in an emergency situation. But if I were a heroin addict, I would not get it in the same way. Does that ring a bell in the way we treat health issues?

Mrs MacLean—I have to say, having dealt with Sir Charles Gairdner Hospital, that they have been brilliant. They have never made me feel uncomfortable. But that is because they also have an understanding. They are aware of the program and they are aware of the treatment that happens there. It is hard.

CHAIR—I am just searching for an understanding.

Ms Fariss—Is it more a matter not just of stigma but of the different medical services and of the medical system having the attitude that this place is the expert on that and this is the expert on that? With heart problems and many other chronic health problems there is a much broader range of access points. Is it possibly also a matter of appearing to be stigma but of actually being because people in certain emergency medical fields or other areas do not have the confidence or the knowledge to at least see the person first? When they see somebody with a heroin addiction or whatever and somebody coming in with a heart problem, there is this other

issue. It is compounded by their own anxieties and their own lack of knowledge or expertise. And we do carve up the specialist sort of approach in the community, which I think reinforces some of those problems.

CHAIR—That is what I as trying to get to. If we saw it more as a health issue, would that give us a better chance? That is all I am trying to determine.

Ms Fariss—As more of a general health issue, not just specialist issue.

CHAIR—Vivien is not sure.

Mrs Nemaric—We cannot even go to our local doctor because my son went there stoned out of his head three years ago. He now has a son in his own care and for him to have his immunisations we have to travel for miles because he is seen as a whatever they called him at the front desk and we cannot go there. And yet that is bulk billing. He has not got a job at the moment. That is quite a common story.

Mrs MacLean—I think there is a territorial thing too. Even with Sir Charles Gairdner they said, ‘We are going to treat him this way. We don’t care what Dr George O’Neil says. He is not the doctor here. We are the doctors here. He may be the specialist in this program that your son is doing, but we are going to treat him.’ When they were going to give him five millilitres of Valium every four hours, I just laughed at this doctor. I could not help it. I said, ‘Give him a packet of jelly beans.’ He ended up with medication from the cancer ward to stop the vomiting—whatever they use for that—and it still did not work. That was when I said that they had actually learnt from him and they conceded that, ‘Hey, maybe we do not know enough.’

CHAIR—So it is very much about knowledge.

Mrs MacLean—Yes, it is understanding. It is getting past this, ‘Oh, it’s a dirty addict,’ or, ‘It’s a junkie,’ or whatever. It is getting past that and seeing that it is a problem. If we do not face it and if we pretend it does not exist, it is going to get worse and more kids are going to die.

Mr EDWARDS—That is a very important point. I think we really have to, as a community, realise the size of the problem that we have to deal with. Until we can convince the rest of the community that there is a problem of that magnitude, it is going to be very difficult to deal with.

CHAIR—Ladies, is there anything you would particularly like to say?

Ms Fariss—Don’t lose sight of our families and their young children either.

CHAIR—That is very good. Thank you very much, we really appreciate it.

[3.52 p.m.]

DAUBE, Mr Michael, Chief Executive Officer, Cancer Foundation of Western Australia

SULLIVAN, Ms Denise Leonie, Manager, Policy and Tobacco Program; and Director, Target 15, Cancer Foundation of Western Australia

CHAIR—Welcome. I wish to point out that, while the 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 itself. Do you have any comments about the capacities in which you appear?

Mr Daube—I am also Chair of the Tobacco Issues Committee of the Australian Cancer Society.

Ms Sullivan—Target 15 is an antitobacco campaign recently set up by the Cancer Foundation.

Mr Daube—I have a brief opening statement, and I will run through that as speedily as I can. While I will be talking about tobacco, clearly I would not want to be construed as implying any criticism of action in any other areas. Tobacco is by far our largest preventable cause of drug deaths. It causes more than 18,000 deaths each year in Australia, which is well over 80 per cent of all Australian drug deaths. During your hearing today, smoking will have caused the deaths of 16 Australians. Those deaths caused by smoking start in the mid-30s. Those who start smoking earlier smoke for longer and are at the greatest risk of being killed by tobacco. Although we used to be leaders in this area, just under a quarter of the adult population still smoke. We had encouraging trends during the seventies and eighties but we had a plateau in the nineties. There were some encouraging indications from the evaluation of the National Tobacco Campaign but nothing like the results we need. Smoking among young people remains a cause for especial concern. More than a quarter of 16-year-old boys and girls are smokers, and the vast majority of smokers start during their teenage years, making them less likely to quit and more likely to die early from smoking. As far back as 1992, the total tangible and intangible costs of smoking to the community were estimated as being just under $13 billion. In the context of your terms of reference, there are clearly also immense personal costs to families.

As far back as 1992, the total tangible and intangible costs of smoking to the community were estimated as being just under $13 billion. In the context of your terms of reference, there are clearly also immense personal costs to families. For example, on Fathers Day we pointed out in an advertisement that over 1,000 Western Australian fathers will die this year because they smoke. There have been some encouraging results from the trends of earlier years in lung cancer mortality among men but, unfortunately, the epidemic of lung cancer in Australian women continues its upward trend. Of course, lung cancer is not our only concern. Smoking is a recognised cause of 14 cancers, and for that reason, as Denise mentioned, we have recently established in the Cancer Foundation the Target 15 campaign with the aim of reducing prevalence of smoking to 15 per cent by the year 2010.

I just want to talk very briefly now about what it is that we need to do. Our belief is that, despite the efforts and goodwill from governments and others, we simply are not doing enough. There is now evidence from around the world, including Australia, that a comprehensive program can bring about a dramatic reduction in smoking. The US Surgeon-General, David Satcher, wrote last month:

We have the tools, the knowledge and the resources to cut smoking rates in half by the end of this decade. The only question left unanswered is: do we have the will?

Our argument would be that individual measures alone will not resolve the problem. We need a comprehensive approach. This federal government has in fact obtained more funds for public campaigns on tobacco than its predecessors and I think deserves due credit for that, but we are still doing little more than holding back the tide. We need to spend serious money. We spend maybe 50c a head around the country on tobacco control, trying to reduce the 18,000 deaths caused by this addictive problem. Telstra last year spent $130 million on advertising, more than $7 a head. We are underspending in comparison with commercial advertisers and in comparison with other drugs. Dr Simon Chapman has pointed out that, while we raise over $10 billion[*] a year federally in tobacco tax, on our national tobacco campaign we spend $112 per tobacco death, while on illicit drugs we spend $118,000 per death. So it is time for a quantum leap in the levels of funding provided for tobacco control, and some other countries have started to take that route. New Zealand spends about $4 a head on tobacco control. In the US, last year Massachusetts spent $58 million on tobacco control for a population of around six million, and the results—and I can show you overheads on this—demonstrate dramatic reductions in smoking in Massachusetts amongst adults and kids in comparison with other American states.

So what we need is major public education programs funded at the levels commercial advertisers would find realistic. We need strong, graphic and frequently changing health warnings. The Canadians have done that—they have essentially taken over the pack. We need further and complete controls on tobacco promotion. We thought we had solved a bit of a problem when we banned most forms of tobacco advertising, but the companies will always find new ways of beaming in sponsorship, of PR, of the vast increase in point of sale advertising we have seen of late, and so on. Our argument would be that there is no case for any promotion of cigarettes just as there is no case for any promotion of heroin or ecstasy. The ban on tobacco advertising, promotion, public relations and marketing should be complete. It is illegal to sell the product to minors—it should be illegal to market it in any way.

We also need to control the toxic ingredients in cigarettes. We believe there should be mandatory disclosure of all toxic ingredients to governments, who should in turn provide that information to the public. Then we should be looking, as we can now, at mandating progressive reductions in the most toxic ingredients of cigarettes. We can talk about that more if you like, but it is clear that the tobacco companies know and can quite deliberately engineer the doses of some of the carcinogens. We think that smokers should be properly informed about what is in cigarettes and we believe that those ingredients should be regulated.

[*] Mr Daube subsequently amended this figure to approximately $5 billion.

We also know that there is evidence from around the world that regular and significant annual tax increases play an important role in reducing smoking and that larger tax increases have an especial impact on young people. We believe that there should be a 20 per cent pack levy to fund tobacco control activity. That would be similar to the annual CPI increase that smokers already face, so really it would not make very much difference to them. And all our surveys have shown over the years that there is popular support for tobacco tax increases when that money is used for worthwhile causes. A 20 per cent pack levy in Australia would raise about $240 million a year and we think that would be starting to talk the kind of realistic funding that should be put into tobacco control, together with the establishment of a national tobacco control authority.

We also would like to see better support for people who want to give up smoking. It is addictive; a lot of people find difficulty in giving up. There are now products on the market—nicotine sprays, gums, inhalers and the like—which, especially with GP support, can make a real difference. We should do much more to provide support for the smokers who want to give up to make the products more accessible to them, to subsidise some of their costs and to provide incentives and guides for doctors who want to help them.

There are a lot of other areas where we need to do more. We need to reduce exposure to passive smoking, particularly amongst young people and to the work site and so on. We need to do much more with and for Aboriginal communities whose smoking rates are still about double those compared to the rest of the community. We need research to support our programs. We need consistency across governments so that, while health ministers and departments try to reduce smoking, they are not undermined by other departments. We need efforts to litigate so that manufacturers carry a responsibility for the harm they cause. We need to support strong international action on smoking, especially through the WHO framework convention on tobacco control.

There is one other area that I would like to comment on for a moment, encouraged perhaps by Graham Edward's comments about the bipartisan nature of all this as an issue. We also need, I believe, political parties as a signal to refuse any funding from tobacco companies and we would urge your committee to make a recommendation in that area as well. It is a bipartisan issue. Both major parties still take tobacco funding nationally. It is inexplicable to us that this continues, particularly given the massive evidence that these same tobacco companies spend a great deal of time and money trying to undermine the work of governments while they are trying to promote a product which, if purchased by young people, is legal. So we would urge you to recommend that all parties refuse tobacco funding, just as they would automatically refuse funding from the vendors of other harmful drugs.

This inquiry addresses substance abuse and very properly addresses all forms of drug abuse in Australia. Unfortunately, the focus by governments and others in the community on drugs does not recognise the importance of tobacco as a prime cause of drug deaths. There is fascinating evidence coming through from tobacco company documents released through litigation. The tobacco industry seeks to promote concern about illicit drugs in order to take the heat off tobacco. Our argument is not that we should do less about illicits or alcohol and drug abuse, or whatever. Our argument is that we should do more about tobacco.

We spend far less addressing tobacco than we do on other drug problems. We are far tougher on the manufacturers of other drugs than we are on those who knowingly peddle a product that kills one in two of its regular users. They knowingly mislead the public and governments. They knowingly undermine the work of governments and health agencies, and all that, 50 years ago to the month since the first overwhelming evidence was published about the dangers of smoking in the *Lancet* on 30 September 1950.

So we do not argue that less should be spent on other forms of substance abuse, but we do urge that, in your discussions and recommendations, you place appropriate emphasis on tobacco as a drug that kills far more Australians than any others. We also urge that you make recommendations based on the knowledge we now have about what clearly works. That means spending much more money but, in our view, that is what the problem demands. Dr Satcher, the Surgeon-General said that we now have the knowledge to be able to recommend measures that could lead to halving our present smoking rates within a decade and that would do more than any other measures to reduce the death and disease caused by substance abuse in Australia. So I think we are talking about a quantum leap in the intention and the funding that is provided for tobacco and a comprehensive approach to this lethal problem.

Ms JULIE BISHOP—You mentioned a paper from 50 years ago: is that Sir Richard Doll's paper?

Mr Daube—Yes.

Ms JULIE BISHOP—Fifty years ago it was published in the *Lancet*. In more recent times, we have had health warnings, quit campaigns and some of those very graphic advertisements on television, and the like. Yet, I understand that, in some sectors, such as young people, tobacco consumption is on an increase, and in other areas, there have been some downward trends. Otherwise, you would have to say, whether it is 50 years on or 20 years on, we have still have not made the ground that we should have. Is it the case that there are some people who are going to smoke whatever the health consequences, however many times you tell them, however much money you spend on informing and educating them, they are just going to smoke, or is that being far too simplistic?

Mr Daube—It is being a little simplistic, if I may say so. I think you are right: we have had 50 years, first of all, with some pretty amateurish public education. The assumption was by the medical profession and others that, if you simply tell people about something, tell them that something is wrong—

Ms JULIE BISHOP—Put a little warning on the packet.

Mr Daube—Yes; but even the warnings on the packs came late, and you had the industry arguing and denying the evidence and confusing the community. That went on for a long time: the naive assumption that if you just tell them it is wrong they will do the right thing. We have really only had effective public education programs in fairly recent decades. What you find is that, the more money you put in, the better your results are. Even in this state, when we were putting significant amounts in in the 1980s, we were getting good results and then it started plateauing again. You are absolutely right; there are concerns about tobacco smoking among

young people. There are some age groups where there have been slightly more encouraging indicators, but where we still have very worrying concerns.

The thrust of what I am trying to say is that we have never actually had a comprehensive approach. We have never done it. We never put the kind of funding in that is necessary. If you are a commercial advertiser trying to sell baked beans or chocolates or whatever else, you would laugh at the kind of budgets that we have had. If you are an advertiser, you are trying to sell people something they want; whereas health promotion has been defined as the business of making people live miserably so they can die healthy. We are trying to sell people something, to persuade people to do something they do not necessarily want to do. We have got all kinds of hurdles to overcome and, until very recently, and even now, we have had the massive opposition from the tobacco industry. Even now, when my son watches the Grand Prix on television, he will see a racing car which has an advertisement for Play Station on the front and for Benson and Hedges on the back.

Ms JULIE BISHOP—It is about to be phased out. We passed the tobacco prohibition advertising bill in the House of Representatives the other day.

Mr Daube—But it will still be—

Ms JULIE BISHOP—It is slow.

Mr Daube—The case that I am trying to make is that, if we spend enough money, if we do enough comprehensively, then we will get those encouraging trends. Perhaps the best example of that is—I was going to spare you from slides but I might pass around copies of them—in Massachusetts, for instance, where they have had significant expenditure and a dramatic decline in smoking, as a result of that.

Ms JULIE BISHOP—In what age groups?

Mr Daube—In all age groups. I can show you that the line on the graph goes down for Massachusetts, and for the rest of the states it stays up. With kids, too, in comparing Massachusetts with the rest of the country, there is a decline: Massachusetts does massively better than the rest of the country. One of the experts in this area says that 'when you aim at an adult, you hit a child' with these campaigns. If you do enough, then you do get through to the community. So the answer to your question as to whether there are some people who will continue to smoke, come what may, is that we can catch them in all kind of different ways. We know that most smokers actually want to give up; and now at last there are products on the market that can help them. So my answer to you is that we can halve it. We cannot knock it off, but we can reduce it.

Ms JULIE BISHOP—I accept that there have been phases, if you like, in our awareness and understanding. The battles that have been raging with tobacco companies have varied over the years. So, if we start from 50 years ago and then come to today, of course there are people who have been smoking for a long time and whom you may never reach. My interest is in the young people, I must say, who have been born and grown up in an environment where we are much more sophisticated in our education and understanding of the harmful effects of tobacco consumption. People who are 14 now have grown up in an environment where we have always

had warnings on cigarette packets. There has been a much higher level of understanding of the harm and there have been much more sophisticated campaigns; yet they are still smoking. So what do we do with the young people?

Mr Daube—We have well-funded, major public education campaigns. Those young people do not see very much about smoking in the media. They do not see very many major campaigns. They do not see the kind of advertising that a commercial advertiser wants if they want to get through to kids.

Ms JULIE BISHOP—But they do not see the sort of advertising that we grew up with showing terribly glamorous cigarette smokers.

Mr Daube—No, but they are still seeing cigarettes being used and promoted by adults. There is no magic bullet here. It is a long-term process. With adults, even if we had kept putting in the same sort of money and the downward trends we had in the eighties had been continued during the nineties, we would be at about 17 per cent instead of around 23 or 24 per cent. That flows down to kids as well. Kids follow the example of peers. The most seductive argument that comes through from the tobacco industry is only focused on kids.

As you probably know, there are now about 30 million documents available on the web that the industry has to put up because of litigation in the US. It is fascinating to see the strategies they present. Their strategies are always focused only on youth and do not talk about adults. What they fear most are the kinds of things that we are recommending: major well funded public education campaigns, strong graphic health warnings and restrictions on smoking in public places.

The soft option is low-key education programs for kids because those do not work. They paint smoking as the kind of adult behaviour to which you aspire. Indeed, there is one lovely document where the industry set out the case for youth education campaigns on smoking. The case is that it will help to prevent the kind of action that they want to avoid. So the answer to your question in short is that there is no magic bullet but taking it seriously overall kids do respond to major public education programs of a kind that we need. We also need school education. There is all too little going on in that area but we need a comprehensive and well funded approach.

CHAIR—Thank you. You mentioned a $10 billion tax revenue per annum. I was not aware it was as high as that. Do you have the data there? I presume the data is from the Commonwealth Treasury data.

Mr Daube—Yes, we can provide that to you. I do not have it here but I can certainly make that available.

CHAIR—It seemed high to me at $10 billion.

Ms JULIE BISHOP—What were you thinking: $9 billion or $6 billion or something like that?

CHAIR—I was thinking about $1 billion to $2 billion. I am obviously a bit off the track. The World Health Organisation and the World Bank argue that a tax increase could be the most important thing to curb tobacco consumption. What sort of tax increase would your organisation recommend? I think you touched on it earlier; I would just like to reinforce what you were talking about.

Mr Daube—Firstly, I said that, although treasuries hate it, I would like to see something hypothecated for action on tobacco. Secondly, we need to see something that is regular and annual and more than CPI. I am not going to hang my hat on a particular amount but I think something significantly more than CPI.

CHAIR—If we are going to make an impact it would have to be better than CPI, don't you think? If you want to really give it a touch up you would be looking for a 20 to 50 per cent increase in tax to have an impact. Do you know of any of your sister or brother organisations around that are advocating a specific amount? You are not but are there others who do?

Mr Daube—What you have seen in other countries is that, when there are significant tax increases, cigarette consumption goes down and that particularly affects kids. If you wanted a figure just a figure to hang one's hat on, I would say that anything in the order of 10 per cent or more is noticed by the smoker.

CHAIR—Thank you.

Ms HALL—Thank you very much. I wanted to start off by making a couple of comments and asking you to comment on them. Firstly, referring back to what has already been said by Julie about some people smoking no matter what, doesn't that demonstrate that cigarettes are like all the other drugs that we have been talking about, such as heroin, amphetamines and alcohol? It is well documented that people know that they are dangerous and bad for their health and, in some cases, even illegal, yet they still use them.

Secondly, I have a comment about some of the antismoking campaign material. I find particularly obnoxious the one where someone inhales the cigarette smoke and you see it travelling through their body. The effect that has on me is that I turn away from the TV. I am not a smoker. Many years ago I was a smoker—over 20 years ago. I do not like to watch it and I block the message that is coming through. Do you think sometimes those types of messages and campaigns have more of a negative effect than a positive effect?

Mr Daube—I have three comments to make. First of all, you always offend somebody if you want to advertise graphically. Years ago, when we ran a campaign aimed at kids that had the punchline 'Only dags need fags', it evaluated very well, but then I had a phone call from a Mr and Mrs Dag, who objected to it. So you cannot win.

On the addiction issue, yes, that is important and, indeed, studies on American servicemen after Vietnam showed that they found it easier to give up heroin than to give up cigarettes. There are reasons of access, and so on, there as well. But cigarettes are an addictive product and it is very hard for some people to give up. Fortunately, now we do have the mechanisms with which to help them that we did not have before. But they are a drug of addiction, and that is why we are so concerned about any form of their promotion. That is why we need to do more.

I have to be a little unashamed about the advertising and say that graphic advertising does work and it does get through to smokers. That ad—for instance—tested well, it has evaluated well and it is having an impact on smokers. The only problem is that we are not spending enough and you are not seeing it often enough. You may not like it, as a ex-smoker, but our job is to advertise as graphically as we can. In answer to Julie's question, one of the problems we have had in recent years is that we have not had that kind of graphic advertising very much on television. It has not been there. Kids now are not growing up seeing the kind of shock-horror television programs about the dangers of smoking that we grew up seeing, because it is old news. We need more of that graphic advertising and I think the first in our series starts on 15 October. I will try to keep it out of your constituency.

Ms JULIE BISHOP—Just to pick up on that, do you mean those very graphic Quit ads? You are saying that you have stopped them, so you have a whole new market that you have to get to, as in the younger generation.

Ms Sullivan—Can I just comment on the ad that you are talking about. The ad is actually a part of a whole series that was developed for the national tobacco campaign, which is a joint Commonwealth, state and territory initiative. What came out of the research that went into that—in terms of talking to smokers—was that, while they understood smoking caused harm, they did not quite understand the mechanics by which it caused harm to their bodies. They wanted to be shown the sort of advertising that explains what is actually happening inside their bodies when you say that smoking causes a stroke, lung cancer, emphysema or whatever. An evaluation of that campaign, which came off air in May of this year, shows that it has probably contributed to a one per cent decline in the prevalence of smoking. While the ads can be quite shocking to some people, if you made ads that made people feel comfortable, you would not be having the sort of effect that you need, particularly when you are looking at an addictive behaviour that is also part of the way in which people socialise and live their lives.

CHAIR—Thank you for that. I have to excuse myself. Ms Julie Bishop will chair from now on.

Ms HALL—In your presentation, you discussed cutting smoking by half. How could you do that—advertising and what other methods?

Mr Daube—A combination. We need consistent, hard-hitting advertising. That is probably the crux of it. We need support, both direct and indirect, for smokers who want to give up. We need health professionals to get much more involved. GPs and others are probably aware of the evidence but often do not like raising the issue with their patients. So we need to get health professions and others involved. I believe there is an onus on governments to do more. There is also an onus on organisations like ours to contribute to that. The Target 15 campaign to which we have referred, which is the Cancer Foundation's campaign, is one for which the government here has given us matching funding. But health agencies need to be involved—restrictions on smoking in public places, strong health warnings, all of those kinds of measures. So we are really talking about a comprehensive program, rather than one-off bits here and there. Does that make sense to you?

Ms HALL—It does. My final comment is that I agree that smoking should be treated in the same way and given the same sort of funding as all other drug prevention usage programs. It is causing enormous health impacts in our communities. Good luck with your campaign.

Mr Daube—Thank you.

Mrs IRWIN—What is your feeling on what is happening with illegal tobacco, chop chop? I have heard a few of my constituents saying that it is quite widely available. Would you like to comment on that?

Mr Daube—It is a worry. It is a worry because, as with any illegal product, it becomes in some ways very hard to control. I do not pretend to have expertise in terms of how you would control that, but we would certainly see that that is an area where governments need to take fairly urgent action. It is probably the only area that we agree with the tobacco industry on.

Mrs IRWIN—Because they are losing money, because people are buying it a lot cheaper. Can you give me more details about Target 15? Is it solely in Western Australia? Is it a trial and if it works here you might do it in other states? I note that it aims to reduce a number of adults in Western Australia who smoke to 15 per cent by the year 2010. That would be great to do Australia-wide. Is it just something for WA?

Mr Daube—It is at present. That is because we are the Cancer Foundation of Western Australia and we decided that it was time to put significant resources into tobacco. We felt that it was not good enough just to go to governments and say, ‘You should do more.’ If we want to be convincing, then we should be putting some of our resources into that area. We have to do that in a way that will ensure that we can deliver all of the various other services we as a cancer organisation have to deliver. We went to the state government here and asked if we put up significant sums would they match it. Between us, we will spend about $600,000 this year. If that evaluates well, then we expect that to continue and develop. We have started with some press advertising. Our major television campaign will start after the Olympics—because we do not want to pay Olympic advertising rates—and we hope that that will have quite an impact on the community. We also hope it will be a little different. It will be a message coming from a slightly different source.

We picked the target of reducing to 15 per cent by 2010 for three reasons. The first is we think it is feasible, on the basis of the evidence from elsewhere. The second is that if the downward trend that started in 1984 and got halted in 1990 was kick-started now that is where we would get to. We have had that trend before, and we think we can kick-start it and get there again. The third is—and this comes back to Julie Bishop’s point—that we wanted to set a realistic target. We did not want to say that we can bring it down to zero overnight; we want to set a target that we know is achievable. Will it metastasise? Will it spread nation-wide? I would hope so. I think that will depend on how well it runs. But what we are also trying to do is set an example for other non-government health organisations and say it is time that we all got into this rather than just beating up on the government and expecting them to do it.

Mrs IRWIN—It sounds like a good idea. What age group are you targeting, because you are only saying $600,000 for the first 12 months?

Mr Daube—I think we will put more in. That is $600,000 to the end of this year. We are primarily targeting younger adults. Those are the ones we need to get through to. All of the evidence that we are aware of is that if we target younger adults we will get through to kids as well.

ACTING CHAIR (Ms Julie Bishop)—Numbers four through to seven of your recommendations, on the last page, relate to what you see as obligations and requirements of tobacco manufacturers. We are dealing with—whether we like it or not—legally operating corporate entities within Australia, who are dealing with a legally available product, and that brings with it most of the problems you are concerned with. Looking at your four suggestions, I can see one or two of them being within the jurisdiction of a government. But otherwise I question how viable it would be to require a tobacco manufacturer to reveal all their expenditures, for example, on promotion, marketing, public relations and incentives. I can understand the government getting involved in requiring them to reveal the constituents of their products, because we do that in consumer areas. Could you comment, in relation to recommendations four to seven, on how realistic you think they are.

Mr Daube—That kind of expenditure information is required in the US, for example: there are precedents there in terms of information on product content, the toxic ingredients and so on.

ACTING CHAIR—There is precedent in Australia for that.

Mr Daube—Yes, and you can find out much more about the candy bars that you buy than you can about cigarettes, and smokers do not know anything like enough there.

ACTING CHAIR—Number six says the federal government should have the responsibility to control the design of tobacco packaging, et cetera. Is there a precedent for that?

Mr Daube—The Canadian precedent is a really nice one. This is the Canadian cigarette pack, which I will pass around. That is now essentially best practice. The Canadian government has mandated it. That is an example of Canadian health warnings. The health warning on cigarette packs should not be a matter for negotiation between governments and tobacco industries. It should be a matter of governments saying, 'This product is killing 18,000 Australians; it's up to us to mandate what is on the pack.'

ACTING CHAIR—Do you know how this came about, in terms of the Canadian government legislating to require that? Was it a push from the medical profession? Who designed it? How did it come about?

Mr Daube—Through a huge lobbying and campaigning exercise over many years. There was monumental opposition from the tobacco industry, which is always the best indicator that you are on the right track. And then there was quite a lot of market research to identify the most appropriate health warnings. I know the federal government is currently doing some market research in this area, and there are some very positive things that the federal government is currently doing. But then it boils down to the government having the political will to implement it.

ACTING CHAIR—We have a very strong antitobacco campaigner in our minister for health, so that is a start.

Ms HALL—I would never buy cigarettes with that on the packet.

ACTING CHAIR—Your final recommendation is that the government devote a minimum of $10 per head of population to public education programs. Could you restate for the committee what you base that $10 per head minimum on.

Mr Daube—Essentially, best practice internationally. That is taken from Massachusetts, where they are spending just under $US60 million internationally for a population of six million.

ACTING CHAIR—Massachusetts not being a tobacco manufacturing state, I assume. What about other states in the US; are they following?

Mr Daube—To varying degrees. It is also fair to say that there is money coming out of tobacco settlements in the US, and so there is more money available. Far be it from me to say that most of it seems to be going to lawyers—and governments, to be fair, are spending it on other activities as well. If we have best practice, then that is something that we should follow. And what we are seeing from Massachusetts and what you see from the graphs is that that is bringing good results and there is no evidence of saturation. There is no evidence of marches in the streets because people think too much money is being spent on that; so it really is based on best international practice. Even if we followed trans-Tasman harmonisation, they are spending $US3.30 per capita equivalent in New Zealand now, so we would be spending a good bit more than we are at present.

ACTING CHAIR—We could take Massachusetts as the high-water mark, if you like, and do an analysis of what it is that has enabled them to spend that, whether it is money coming out of tobacco settlements or what. I take your point. They have contingency fees over there. Their litigation is far more advanced in terms of where they are at with settlements and the like. I wonder if it would be useful to do an analysis so that we could come up with an amount per head—and I do not know whether we should just accept your $10 per head at face value or whether there is a lot more behind it—and, if the search were directed in that area ,whether we would come up with a minimum and then take it from there.

Mr Daube—I will make two or three very quick comments. One is that any figure used like that is an arbitrary figure—$10 or $8 or whatever. What it is saying is that we need a quantum leap from 50c or thereabouts a head. The second is that, of that Massachusetts funding, about one-third goes to media and about two-thirds goes into other areas as well: assistance for smokers, and other such tobacco control activities, and so on. One could probably do a fairly sophisticated analysis that would keep quite a lot of economists going for a while; but, for us, the crunch is that the quantum just needs to be a whole lot greater. I would not be too worried about whether it was $5, $7 or $10, so long as it was a heck of a lot more. It is not for us to say where that should come from—whether from litigation or whatever else—because that sort of funding is still relatively small in comparison with the amounts we spend in other areas and, as I have suggested this afternoon, it could be raised just by putting another 20c on the pack. If you

add a lot more than that, more could be raised—which would give the government lots of money to spend on other things.

Ms HALL—Do you think that your argument would be strengthened, though, if you did have a more scientific breakdown of that $10?

Mr Daube—We could give you a breakdown of how that money is being spent in Massachusetts. We have also tried to give you a comparison with other commercial advertisers, if we wanted to be in the same sort of ballpark as McDonald's—who are trying to influence kids and spend $60-odd million a year on advertising—or as Nestle, who spend $75 million a year on advertising in this country. All the science in the world would probably bring you a figure of ideally somewhere between $5 and $15.

ACTING CHAIR—It has to be targeted, though, hasn't it?

Mr Daube—Yes.

ACTING CHAIR—McDonald's is trying to appeal across the board. You are just trying to target those who are smoking or the younger people who are likely to take it up.

Mr Daube—Ours, as I said, is the more difficult task. We are trying to target all smokers; we are trying to target potential smokers; we are trying to target people who may influence smokers. So we do have a pretty big target, and my worry about further analyses is that they can always be used as further reasons to postpone the action that we need. I know it is not that in your case, but I know that what we are looking for is action now, and the sooner the better. I would be more than happy with economic analyses if they followed the addition of a significant amount of money.

ACTING CHAIR—Is there anything that you wish to say by way of a final statement?

Mr Daube—There are three things. First of all, I am very conscious that, with what you and your colleagues on either side have said, we are speaking with people who are sympathetic to the issues that we are trying to raise, and we do appreciate that. The second is I would like to thank you and the secretariat for enabling us to make this presentation and adjusting your initial schedule. We really do appreciate that. The third is that the single major message that we want to get across is that we need a new lift for the campaign on smoking. It is 50 years old. It has become a little tired. We are not spending as much as we did.

ACTING CHAIR—Complacency?

Mr Daube—There is complacency. Certainly, when we had our ad ban here in 1990, we sat back a bit. We need a new lift. We need new funding. We need to sit back and look at some of those documents that the industry is now revealing and realise just how nasty and evil an industry this is. Some of that is new evidence. The way that they have operated is quite unconscionable. We need a new recognition that this is an industry that needs the toughest of controls. We are requesting you as a committee to make some recommendations that will give a new lift, recognising the good things that are being done by the federal minister and others. We still need a new lift to this campaign and that is what we seek from you.

ACTING CHAIR—Thank you very much for attending today. Thank you for the contribution from the Cancer Foundation. Is it the wish of the committee that the three slides provided by the Cancer Foundation be incorporated in the transcript of evidence? There being no objection, it is so ordered.

The slides read as follows—

Resolved (on motion by **Mrs Irwin**, seconded by **Ms Hall**):

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

ACTING CHAIR—I now declare this meeting adjourned to our next gathering in another capital city. Thank you all for attending.

Committee adjourned at 4.38 p.m.