COMMONWEALTH OF AUSTRALIA

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Substance abuse in Australian communities

THURSDAY, 23 NOVEMBER 2000

MELBOURNE

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Tuesday, 21 November 2000

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

Members in attendance: Ms Julie Bishop, Mr Edwards, Ms Ellis, Ms Hall, Mrs Irwin, Mr Lawler and Mr Wakelin

Terms of reference for the inquiry:

To inquire into and report on:

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

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

WITNESSES

Committee met at 8.32 a.m.

JUDD, Mr Ray, Assistant Director, Drugs, Food and Health Development, Department of Human Services

SEVERINO, Mr Bill, Assistant Commissioner, Victoria Police

CHAIR—I welcome Mr Judd; it is good to have you with us again, and I welcome Mr Bill Severino. This is the fourth public hearing of our substance abuse inquiry. The minister referred it to us in March last year and the normal procedures have occurred. We have been to Perth, Adelaide and Melbourne and back some months ago, so we are starting to get up a head of steam. This morning we are taking the Victorian government as our first witnesses. We do not swear in witnesses, but I am obliged to simply advise that these proceedings are the legal proceedings of the parliament and warrant that same regard. Mr Judd or Mr Severino, would you like to make an opening statement and then we can get into a general discussion about the issue.

Mr Judd—I will commence and, as you suggest, Bill will follow up. First of all, thank you for the opportunity to appear before you in what we in the Victorian government regard as an important inquiry, given the significance with which the government regards the drug issue. Perhaps I should formally introduce ourselves and provide some context. I am the Assistant Director, Drugs Food and Health Development for the Department of Human Services. The Department of Human Services is the department which has designated lead role responsibility for drug policy and management strategy development across the Victorian government. So that explains part of my role. We met yesterday while I was moonlighting doing another job, but that is another story.

Assistant Commissioner Severino has responsibility within Victoria Police for drug policy and strategy as well as a range of other responsibilities. As I will explain later, we are both members of an interdepartmental committee that seeks to hold our operation together. It is not my intention this morning to talk in any detail about the submission which was provided to you, rather to talk about some of the policy and strategy underpinning that. But we are obviously more than happy to take questions from you about the materials provided.

As I said to you earlier, the Victorian government regards drugs as a key priority issue. It is one of the most significant social policy issues on the government's agenda. The reasons for that are in the submission in terms of the health, social and economic consequences which drugs have—and they are fairly stark. Certainly the Victorian government is acutely conscious that drugs are having an increasing and devastating effect on many people in the community by dint of their direct use and impacts across families and, as a result particularly of changing patterns of illicit drug use, the public nuisance which drugs are causing.

Victorian government policy is clearly underpinned by a commitment to harm minimisation. That frames all of the strategies which we develop and has been a principle shared nationally as part of the National Drug Strategy. But I think it is important to formally note that the Victorian government continues to strongly support harm minimisation principles. The Victorian government also strongly supports an approach which maintains an integrated drug policy incorporating both legal and illegal drugs. That is important to us in principle but also as a

practical issue given the increasing poly-drug use which is evident in Victoria. It is not just alcohol and the illicits, we also want to record concerns about the misuse of pharmaceutical products which has, in our judgment, grown as a problem in recent years but does not get the focus of attention given the highlighting of heroin. But for reasons of principle and for practical reasons the Victorian government seeks to maintain an integrated approach to drug policy.

The current Victorian government has given particular emphasis in its first 12 months to tobacco control and illicit drugs. On tobacco control it has introduced a range of legislative and regulative measures designed to further reduce tobacco use, with particular emphasis on strategies designed to reduce sales to minors and to decrease environmental impacts of tobacco smoking in public places. I will briefly comment on that again if people want to follow that up in questions later. I am more than happy to do so.

Over recent years Victorian governments have paid particular attention to drug policy and there are a number of key initiatives that I want to highlight in a range of many things that have happened over recent years. For the purposes of this introductory comment I note four today. One is the introduction of a new and integrated approach to school drug education following an inquiry four or five years ago now recommending quite significant shifts in the way in which drug education was provided, basically arguing that it should be a core part of the ongoing school curriculum, that it should be provided by ordinary ongoing classroom teachers and that it should be part of a whole school approach—not just adding a segment on drugs to a particular classroom. All schools should have an individual drug strategy that deals with the curriculum content—a skills component, the welfare element and an overall school policy.

Effectively, all state schools have an individual school drug program, as do virtually all Catholic schools and many of the independent schools. Evaluations suggest that with 2,000-odd schools involved there is a variation in the quality but there is quite substantial feedback that this represents a quite important development and one which provides a base for many of the prevention initiatives that we think we can now move on to. Drug education in itself probably does not have a dramatic singular effect but we now have a platform that we can build on and, again, I am more than happy to talk about that.

The second initiative of some significance in Victoria in recent years was the creation of the Youth Substance Abuse Service. Six years ago there was almost no specific infrastructure targeted at young people and drug use in this state. They were expected to either not use services or the services were those designed for adults and demonstrably that was failing, and the Youth Substance Abuse Service, and a range of other youth services, have been built in recent years. The Youth Substance Abuse Service has several elements, the first of which is a group of outreach workers on the street, in areas of heavy use, targeting very vulnerable young people and seeking to provide support assistance and to draw them into treatment.

There are specific youth drug treatment services now for those people who want to be drawn into treatment and a major investment in training of youth workers of the more generic kind to give them competence to deal with drug issues in a way that they have not. This is a multimillion dollar service. It has only been in existence three or four years, but early evaluation suggests that it has made a major difference and, again, it has built a platform from which we can continue to build.

The third major initiative is around providing much better support to courts in terms of giving them confidence. If they want advice about people's drug use where there is drug related crime, or if they want to use treatment as part of a court order, that treatment will be provided in a systematic fashion across the state. Again, this is a piece of infrastructure that simply did not exist in Victoria several years ago. It is an important service in its own right, but it now also provides a platform from which Commonwealth and state governments are jointly collaborating to develop the drug diversion program. This is the fourth major initiative that has come out of Victoria with leadership from Victoria Police, which Bill might want to talk about. It has been picked up as a national model.

They are amongst a number of initiatives that have been taken in recent years and I have pointed to them because I think they are important. On each occasion, I have said that they build a platform for the next iteration of development. One of the key messages that we want to get across today is that the Victorian government is absolutely clear in its understanding that we have got a long way to go in addressing and tackling this problem. But we have got some important infrastructure in place and some new initiatives emerging.

To put all of that in some context, it is worth saying that the Victorian government now spends some $67 million directly through what I would call an identified drug budget. That represents a quite substantial increase over recent years, but also effectively understates the outlays. Much of the government's outlays and the community's outlays on drugs do not come through the dedicated drug budget and it is kind of misleading to focus simply on that budget.

Much of what Victoria Police does, much of what goes on through hospital systems, child protection systems and so forth, makes a contribution to tackling the drug problem. It is very difficult to tease out those expenditures to get a genuine understanding of where the effort is and how significant it is. Clearly the $67 million in the dedicated budget is a growth but it is also a small percentage, and we would argue that one of the challenges for governments over the next few years is to better understand where their outlays are and what returns they get for them. At the moment governments by and large do not fully understand how much they are spending on drugs and where that expenditure falls and what they get back for it.

The Victorian government has put an extra $9 million into services in the last 12 months and that has gone into a range of prevention initiatives, some treatment services and a range of crime prevention projects. In addition to that $9 million, the Commonwealth and the state have jointly announced their commitment to the diversion program, which I have referred to. The Commonwealth will contribute in Victoria $23 million over the next three years and the Victorian government will complement that specific initiative with another $13 million. I think that is unusual for the state to have put not dollar-for-dollar matching but direct matching contributions to expand the national diversion program. It is a reflection of the fact that it was piloted here. We think it is a critically important service and the Victorian government is prepared to invest to back it up, not only because of its significance in its own right but also because of the potential that, if it works, we can have significant benefits across the corrections court system. So it is an investment strategy not just a commitment of funds.

In some ways it is slightly unfortunate that we are sitting here this week and not next week, in that the Victorian government, having received the Drug Policy Expert Committee report, will announce the next stage of its drugs strategy next week. I know that it will involve a

commitment of in excess of $70 million in further new money over the next three years, and I have got a sense of where most of that money will go. About five items are awaiting cabinet decision next week. I am, therefore, effectively barred from discussing it in this forum but will be more than happy to provide you with all of the detail of what the government does announce next week and can pass that through to your staff. We can possibly talk about some of that.

I guess there are a number of new initiatives—a very major commitment to prevention. The government is very clear that, when you reflect on what has been done in the past, with the exception of school drug education, we have failed to systematically invest in a range of prevention initiatives. Current knowledge of prevention, brought together in an effective manner by the Drug Policy Expert Committee, which you are aware of, gives a framework that government can use to develop those. There will also be major new expansions in treatment and revisions in the court structures and arrangements. My comment at the beginning about the importance of drug policy is reflected in the commitments to COAG and this new announcement.

There is a clear set of machinery in Victoria to manage government drug policy. There is a cabinet subcommittee, which is drug policy crime prevention and corrections committee. That is a clear attempt to keep a number of intersecting issues before a single cabinet committee. That committee also has a subgroup that works specifically on drug strategy. That is chaired by the Deputy Premier and Minister for Health, and that committee meets fairly frequently, working very closely with the interdepartmental committee that has reps from all of the relevant agencies within government, including the Victoria Police.

The government has before it and is likely to respond very positively to a recommendation to create a new independent advisory authority so that there is a mechanism of high level strategic advice flowing to government, independent of the bureaucracy—hopefully, not in competition with the bureaucracy. But there is a recognition that, by definition, as skilful as we may be, we have a perspective, and the government needs access to a broader perspective.

Victoria has, in national terms, an unusual situation in that, effectively, all of our services are provided by non-government agencies. There are no drug services. There are police as a government agency providing a drug service, but almost all of the rest is provided by non-government agencies. Our culture is one that is very clearly linked to working collaboratively with local government and with a range of agencies.

To conclude, there are a number of key challenges in front of us, one of which I have already talked about: to develop a considered, planned and long-term approach to prevention that involves schools and communities and that mobilises support for the community to be engaged in the issue. When I use the word ‘prevention’ I use it fairly broadly to include early intervention type services.

We need to do more and better at supporting the range of housing, health, community services and employment agencies that are involved in working with people who are drug affected, because those agencies are increasingly suffering as a consequence of the diversification and the broadening of the type of people using drugs. We must commit money to a strategy for saving lives. Overdose levels are far too high, and they are substantially preventable. You would be aware that the Victorian government has considered the introduction

of injecting facilities; it is unlikely that that will receive parliamentary support. The government will move to develop a saving lives strategy that can be implemented within current legislation. That is focused on high street drug usage and puts more people into primary health care and on-the-street outreach roles.

Before I hand over to Bill to talk about some of the law enforcement developmental challenges, the last one I want to mention is the creation of a more integrated and effective treatment service system. We have got a very substantial methadone program, which has been growing at about 20 per cent a year for the last couple of years. It is now at the end of its capacity to grow in its current configuration—the number of doctors and pharmacists involved is overloaded—and we have got to do some major redevelopment of that program in its own right, and also to create a better service network connecting methadone providers and people using methadone with the range of other treatment services that we now fund.

Mr Severino—Thanks for the opportunity to join with Ray in presenting some of the Victorian government perspective. Of necessity, I will restrict my comments to the law enforcement background and role. I am aware of a lot of the things that Ray has mentioned there, and Victoria Police are partners to a great extent with other government departments in Victoria. I would have to say at the outset that we have a very good partnering arrangement, which we enter in a spirit of very positive cooperation. I think that has proven to have some major benefits over the years.

Very briefly: the Victoria Police role is not much different from the roles of other law enforcement agencies in Australia on a state basis. Obviously, the Australian Federal Police have a fairly different role, apart from in Canberra, where they are involved in community policing. But we all are still the first response, front-line, 24-hour answering service in the community and for that reason we still get calls in regard to anything which the community requires assistance in. Regardless of whether we are the appropriate combating agency, certainly we are always the coordinating agency. The area of illicit drug abuse certainly forms a major part of our planning and consideration of the application and deployment of police services in Victoria. We are not only involved on the local community and state-wide front in illicit drug abuse strategies but also, of necessity, in the national framework in regard to pursuing that framework on the three-tiered basis: demand reduction, supply reduction and harm reduction. In that role, not only are we represented in national fora, but we actively participate in intergovernmental and interdepartmental working parties, and in the operational sense in joint operations with the AFP, the NCA and other agencies, including state agencies, as the need arises.

Over the last three or four years we see the philosophy of policing changing substantially from a strict law enforcement role, as in charging people when they break the law and commit an offence, to being more selective in our direction and our focus. Chief Commissioner Comrie has made it quite clear that the Victoria Police focus, currently and in the foreseeable future, is to target the major aspect of drug trafficking operations. That does not mean that we ignore lower level use, but of course the diversion aspects that Ray mentioned have come into play at the lower level and we do not target lower level drug abuse or drug use or offence. I think there is a combination of reasons for that.

One is that it is in pursuit of the harm reduction tier of the framework. The other is that we would prefer to put the monetary underpinning and the effort more into the return on investment

of the deployment aspects of policing, which one could say are never to the degree that the community would perceive as adequate. The community would always see that we need more police, and who would deny that we could always use more police? So we have to judiciously apply the deployment of police to the areas of best effort and best return. In that sense, over the last few years Victoria Police has targeted trafficking to a very large degree. Unfortunately, when you talk about trafficking you meet a blur of offence, use and possess, and trafficking. It is acknowledged that a lot of users traffic to be able to use, and there is very much a mix in that area.

As far as major operations are concerned, we have seen in the last two years, particularly, major operations run in areas of high community concern: suburbs around Melbourne, the central business district itself. As we speak here, the debate is raging in the Victorian media in regard to the way the city streets are becoming with the obvious drug trafficking that takes place. We have never subscribed—and generally throughout Australia, law enforcement has not subscribed—to the zero tolerance philosophy which was espoused in New York City and which was claimed to be responsible for cleaning up New York City. We have actually had people study the operations that took place there, and one little-known fact is that there had been an injection of about 6,000 extra police just before they started that project. Our police numbers here are 9,500 sworn members, so if you had an addition to almost double what we have got, I dare say we would make a big impact on a perception basis, if nothing else.

We have opted to go for support of the harm reduction aspect, along with targeting the major aspects of drug abuse, particularly the trafficking. We have a very good record in shutting down clandestine laboratories, but unfortunately they are by nature a backyard operation and it is very intelligence and resource intensive to shut them down. At the other end of that scale, we have world best practice at our Victoria Forensic Science Centre in regard to the handling and transfer aspects of amphetamine laboratory products. In all of those things we would probably be on a par, to a greater or lesser degree, with other police forces throughout Australia. We all seem to be heading in the same direction.

I think the future direction of Victoria Police operations in regard to illicit drug matters here will more than likely concentrate on our entry into the community through a project, which we will turn into the force's philosophy of operation, called local priority policing. Members of the committee would have no doubt heard the term 'community policing' bandied around over the years, but nobody ever quite put a definition on what community policing is. Of necessity, all policing is community policing. But we have adopted the term 'local priority policing' to indicate that the basis of this philosophy is engagement of the community.

Chief Commissioner Comrie has made it quite clear that local priority policing will inform police planning on a force-wide basis and it will inform deployment at the local level. We will be, in the initial stages, chairing what will be called local safety committees, involving government groups at the local level. People on that committee will be expected to have decision making capacity so that they can represent their organisation at that forum on a decision making basis. There will be some interest groups involved. I have quite often drawn the example that, if you were running a local safety committee in St Kilda—the renowned red-light area in Melbourne—you would probably want somebody from the prostitutes collective on that committee, because they do represent a significant policing issue. I guess that does not mean to say that the squeaky wheel gets oiled along the way, but certainly there would be

considerations of the policing needs throughout the community. Of course, that will differ from country to city, to various areas across the state.

We are hoping that local priority policing will encompass the considerations that we have to apply in the drug abuse operational sense. We cannot say whether the major operations that we have run in the city and around the suburbs have had any real effect. There is an argument that it really is a displacement issue. You would think that, if you could displace often enough and, I suppose, consistently, eventually you would have to have some effect on shutting trafficking down, but we would have to agree that displacement does occur and we do not know to what degree we have actually had any effect on shutting down the drug trafficking trade. In other aspects, it is a bit early to tell in any case.

We have benefited from funding from federal and state government perspectives—I have three people employed within my department on Turning the Tide funding—and a number of projects have been funded by that. We also benefit from national funding through the National Drug Law Enforcement Research Fund and the Victorian Law Enforcement Drug Fund. We are very involved in research in various areas in the technical sense and in the operational sense.

To summarise, I think Victoria Police's direction from here on in will be as part of the national operational aspects and as part of the national drug and alcohol policy aspects, through the chief commissioner's involvement in the Police Commissioners Conference drug subcommittee. He was a member of the board of management of other forums that have run at the national commissioners level. I think the future is for Victoria Police concentration on the diversion program; as Ray said, Victoria's trialling of that served as the COAG model which is now being rolled out in all other states and territories of Australia. The direction, quite clearly, that Chief Commissioner Comrie is espousing is early intervention. It is to do with education of people at very early stages in their life. It is do with diversion of people at very early stages of drug use so that we take them out of the judicial system and perhaps get them into accessible care and treatment at an early stage, taking them out of the cycle.

Down the line, the only way that Victoria Police can contribute any more significantly will be in the community sense. Until we get community mobilisation—we would hope to get a substantial degree of that through our local priority policing input—we do not see that policing can achieve anything on its own. I think I speak for all law enforcement people when I say that we would rather have nothing to do with the drug scene at all if we could avoid it, but we are still the 24-hour front-line service which, of necessity, meets that head on. The perception of community is that the police should do something about this, and that is a very frustrating thing for us because we just cannot have police every 10 metres along certain streets in Melbourne. We can mount major operations but we cannot sustain them, and unless you can sustain them to the degree that we have seen occur in overseas experience, I do not think you will have the effect of the saturation aspect of police operations.

I support what Ray said and I would like to reiterate that in Victoria we have excellent intergovernment department cooperation and, particularly, Victoria Police and the Department of Human Services have formed an exceptionally strong partnering bond over the last two or three years. We are very proud of that in Victoria. Thank you, Mr Chairman.

CHAIR—Thanks, Bill and Ray, for those comprehensive presentations. I will mention two or three things before we go to questions from around the table. Ray, the Commonwealth-state issues are ever present and you have given a pretty good oversight of those. What are some of the weaknesses in the last few years in terms of the relationship? We like to think they are improving, we like to think that there is a more targeted approach with the jurisdictions, but what have been some of the problems and the weaknesses in the Commonwealth-state relations where we might have done a little better?

Mr Judd—I would have to say that, at government to government level, the last three years or so have represented a period of significant improvement in terms of collaboration between all jurisdictions, law enforcement, health and other players. I would want to put it on record that nationally that has been very positive. However, we face a number of issues that are testing all of us and that we are not dealing with nationally as well as we might.

If I may put it somewhat colloquially, the arrangements for dealing with drug issues nationally feel a bit like a cottage industry as compared with the scale and extent of the problem. So our issues in providing good policy advice to governments across the nation and also in implementing good strategies on governments' behalf are compromised by the things we do not know. There is a very modest investment in research of the kind which will influence practice. There is quite a lot of research going on, and you as a committee I hope will form a judgment about that. It is my view that there is not a good strategic framework underpinning that research effort that is designed to influence what happens on the ground in prevention, treatment or law enforcement. Good things are going on but probably, as a proportion, there is a substantial under-investment and a non-strategic investment in a number of areas. Similarly, there is some effort going on nationally and in jurisdictions about work force development, but again, given the scale of the issues we face, that piece of the infrastructure is seriously underdeveloped.

On monitoring and evaluation—I speak as someone who last week resigned as Chairman of the Monitoring and Evaluation Committee for the National Drug Strategy; I resigned because I am moving on to another job, not for any other reason, I hasten to add—my sense is that we dramatically underinvest. Again, it is because we are still thinking as though drug and alcohol issues were fairly minor and marginal for government, with marginal and minor outlays. That is no longer the case. The national arrangements are under pressure because the infrastructure is not there to support good quality national policy making. There is certainly an environment of willingness to collaborate, and some positive developments are being put in place by each of the national committees. It takes longer than any of us would like because we are all busy in our own jurisdictions, and the quality of what we do, without reflecting on the competence of any of the individuals, is less than it might be because the infrastructure underpinning the effort is not commensurate with the issue.

CHAIR—With so much of this work and, as you say, the 'cottage industry approach' relative to the scale of the issue and the need for a strategic approach to interpreting the research—it seems to me that you really have to have very strong evidence based policy—if I am reading and hearing it right, greater investment in research and understanding will give us stronger policy and better outcomes.

Mr Judd—Evidence based policy is absolutely critical because this area is full of myth, assumption and emotional decision making which lead to service provision decisions that are not necessarily well founded if we do not back them up with evaluation and monitoring. So it is a front end and back end issue—that we have to do more to convince ourselves that we have well founded approaches.

CHAIR—Do we have much academic research on addiction itself?

Mr Judd—On the issue of understanding addiction itself, we do not do have all that much in Australia. But there is a choice to be made about where a small country like Australia should invest its research effort. In developing a research strategy, you have to make choices about where to invest; you have to look at what is happening globally that you are linked to and therefore able to benefit from expeditiously.

On the causes of addiction, in my judgment we would do better to monitor what is going on in the world and be prepared to accommodate that, because it is fairly expensive research in the context of Australia. In developing a more sophisticated strategy, I would advocate that our interests will be better served by that very active monitoring and collaboration but putting our money into implementation orientated research with a shorter time frame in terms of benefit. That is not to say that addiction research is not important and that some of it ought not to be supported in Australia but, in balancing a national framework, I would want people with more expertise than me to contribute to those choices. My instinct is to say, without denying the long-term benefit, that we have a much more pressing short-term need to know about practical implementation strategies that work.

CHAIR—I have one quick question to Assistant Commissioner Severino—and when I ask it you will see that I am referring to very approximate figures. We have been told that perhaps between 40 per cent and 80 per cent of police resources is going into the direct and indirect result of substance abuse in all its forms. Would you have a view about that, and would you care to comment on the dilemma that must be there for administrators, medium-term strategic approaches to community policing, the work of the state police forces, particularly in Victoria, in this case? Would you have a view about that commitment of resources in this area?

Mr Severino—Certainly. I am glad you prefaced your question by saying that they are very rough estimates, because one of the frustrations for law enforcement and other organisations in this debate is the lack of substantial statistics and the lack of a true picture. In a sense, all of the drug matters that we enter into are police initiated. It is victimless crime, in that people do not report the drug offences that we become involved in, and so it is all police initiated. We do not know the degree of unreported crime relating to drugs. We do not know the degree of drug abuse that we do not come into contact with. We do not even know what some of the foundation causes are for entry into the illicit drug scene, other than to say that they are socioeconomic, in the sense that we may see more people involved in it from some areas than from others.

To get back to your point: exactly as Ray said, there is a lot of legend and urban myth in some of the things that are talked about in the drug debate. One of them is the degree to which crime is attributed to drug abuse. It is fairly well grounded, I think, particularly in Victoria Police, to say that something like 70 to 80 per cent of the people that we deal with in the criminal sense are drug affected or drug linked in some way. Certainly in our watch-house situations, where we

hold people for periods of time from hours to days, we are now seeing around 70 per cent of people requiring some medication or some consideration as to their involvement in drugs. They are drug affected people. It is bandied around nationally that 80 per cent of crime is attributed to drug abuse. We cannot substantiate that.

One of the frustrations is that we have not quickly enough got a national picture. To go back to Ray's point: we do not have an overall leadership focus. We do not have a minister for drugs in Australia, and maybe it is time that we did. Maybe it is time we had a portfolio level that looks specifically at this and says, 'We need to approach this on the same basis as we approach a lot of other things that affect the community.' Until we get a consistency of approach across political bounds, we are probably not going to get that sort of thing quickly enough. My frustration is the speed, or rather the lack of speed, at which things occur. There are literally hundreds of research groups and institutions in Australia all doing good things, all being very positive and all well based, but the results are not coming together. Therefore, I cannot really say whether what you are saying is correct or not. To put it as 40 to 70 per cent is a good way to put it, but I would say it is the higher end of the scale. But we cannot substantiate that, and that is the frustration. Not being able to pin down the problem frustrates police terribly. We are very much problem oriented people. You give us the problem and we will go out and fix it. We cannot nominate the problem with drug abuse. That is one of our frustrations.

CHAIR—Thank you very much.

Mr QUICK—Should we set up a national clearing house, where all this research could be collated, so that with modern communications people can react to whatever the latest research states? We had a presentation yesterday from Melbourne University. City councils, medical professionals and community services are doing research; each of the states is doing their own thing. Do we give it to the Australian Institute of Criminology and say, 'Here's an extra bag of money. You're the national clearing house.' Rather than your trying to find 10 positions in Victoria Police to collate all this data, with modern technology you do not need them. We can collectively fund it. Would that be a lot better?

Mr Severino—I am sure that is on the right track. I do not mean this facetiously, but we are all still colonies in this country and we still very much operate as colonies unfortunately. I make the joke that we did not get the railway lines right until the sixties, so we have not moved on much from that. But we really need a non-political focus, which will carry the consistency of bringing the research together and informing the people who are then involved in the front-line sense, such as human services and policing. It is just not happening quickly. It is happening, I know, but it is not happening quickly enough to inform the debate.

Mr QUICK—We have done it with cancer, heart, kidney and so on. There seems to be a national recognition that, it does not matter where it is based in Australia, you have a coordinating body. Along this line, how frustrated are you two people with the media driving some of the agenda? Obviously, you have got an agenda. You have got a yearly budget and you are planning things. And then, for whatever reason, the media suddenly decides to highlight something on the front page or the second, third and fourth pages, periodically putting community pressure back on you people, when you have got long-term strategies that are very effective. In fact, I would like to compliment Victoria on what they are doing. But it must be very frustrating to suddenly have this out of left field focus putting the pressure on you.

Mr Judd—It is dangerous territory for a public servant to comment on the media. I think I can safely say that I regard it as a two-edged sword. On one hand, the policy-committed person in me says I would much appreciate the media playing a more proactive role in a positive and substantive informing of the community of the complexities, the issues and the opportunities for engagement. That does not happen sufficiently. There have been some outstanding examples in Victoria in the last few years; the media in Victoria has by and large been more responsive to communicating more effectively. We have looked with interest at the much greater difficulties that New South Wales has had with the media, because the debate has been better covered here.

On the other hand, I would also have to say, pragmatically, as a bureaucrat, it is the sensational media that keeps this issue in front of the public and influences the level of support and resource which has been made available so that it is about capitalising on what is on the face of it an unhelpful story to move the political—and that is 'political' in a small p sense—bureaucracy forward in tackling the problem.

CHAIR—Mr Severino, did you want to comment?

Mr Severino—I will just add a little to that. I think Ray is right—we have by and large very good cooperation from the media, but when it comes down to the bottom line of the media getting a story to the 6 o'clock news, sometimes along the way the true reflection of what we would like to see does not occur because of the speed with which the news has to be gathered and put on TV and biases come into things from various people who write articles. But that is not to say that it does us a lot of damage. I think the damage is that it takes time to answer some of the things that we have to answer because the media has raised them, but we never get the right of reply as fully as the initial dramatic headline. That is a frustration to everything that becomes public or is media news, as you were referring to before about the first three pages headlining the current problem or the perception of the problem in the CBD in Melbourne. We will not get the chance to answer that on the front page. We will not get the chance to say, 'These are all the things that we are doing. These are the long-term things that we are doing, which will help bring this back, and these are the immediate things.' We do not get a chance to say that because it is 'snap' news. It is like that.

CHAIR—And even the ethic of saying, at the end of the day, that these are community based issues and the community must own them along with the media. You must accept some responsibility as well, rather than lumping it on Mr Assistant Commissioner or Mr Politician or Mr Bureaucrat. That is another weakness that I see.

Mr Severino—Exactly.

Ms ELLIS—As a visitor to the city, it has been interesting to see one of the local daily newspapers in the last two or three days. Again today there was a magnificently sensational headline: 'Battle begins to reclaim city heart.' The ones of yesterday were even worse. The concern that I have, and my colleagues would probably agree with me, is that it is not constructive. I take the point that Mr Judd made that at least it is keeping the issue up. I am a politician and I can be a bit more provocative than a public servant. It is turning the whole issue into a blame issue, into a downward pressure issue and when you read some of the suggestions—just to labour on it for a moment—such as 'How to fix it: experts give answers.' One of these so-called experts says, 'The recipe: tough and permanent crackdown on crime,

begging, drug dealing and anti-social behaviour ...' None of that is suggestive of help. It is all suggestive of blame and 'we don't care where they are, as long as they are not where they are now'. And I think that is the downside of that sort of reporting, and you would probably have to agree.

Mr Severino—I do agree, and it just perpetuates this confrontational aspect all the time. There is the problem. We want the police to get on the street today and actually smack it right on the nose.

Ms ELLIS—No sympathy at all comes through to me from that particular article.

Mr Severino—No, none at all. I add a comment about an article in yesterday's *Herald Sun*, which you may have seen.

Ms ELLIS—Yes, we did.

Mr Severino—The irony of the whole thing was that there was a page there with the top part devoted to an article on 'Open trafficking in Springvale Road in Springvale; the problems that occur'. It is an open area renowned as a drug trafficking area. The bottom part of the page has an article indicating that a woman charged in regard to a $2.5 million ecstasy haul had been granted bail. Whether that is right or wrong, where is that consistency for the community to look at that and ask, 'Isn't something out of whack here?' This is where the media could play a role in being more balanced in what they present.

Ms ELLIS—Absolutely, and more accurate probably in the synergy of the whole thing. I will just get to a couple of quick questions that I have. Bill, you made a comment earlier on—and I will try and reflect it as accurately as I can—in relation to police numbers and police efforts, and how we would all love to see more police around. You said something like, 'We would be able to do more if we could keep the numbers up like it has been done elsewhere.' You made some reference to that. Is there some other part of the world that you are aware of where there has been greater success due to resources at your end of the process?

Mr Severino—The only example I know of is the one I referred to in New York City. We have looked at the experience there and you cannot get away from the zero tolerance argument, and there are a whole lot of things behind that that I do not have time today to go into. Everybody would agree that more police would help the problem, particularly when we are talking about drug abuse. But, again, there is a balance. We are state-funded organisations. You cannot devote all of your state funding to a police force. We cannot saturate to that degree and the funding to support that would be unrealistic. This government is currently in the mode of funding 800 additional police, and that is an exceptionally good thing for us to achieve over the next three years. That will be tremendous. But in the whole scheme of things, they will seep through the whole of Victoria Police, and they are not 800 people dedicated to drugs. I am not suggesting that you could or would want to do that either. But certainly to appoint more, in a sense, could achieve more results.

Mr Judd—Can I just add something, given the discussion about New York, and I am not asserting this with absolute confidence but my understanding is that the application of what happened in New York would not work here, even if we had the resources. Manhattan Island

has been dramatically changed, and having been there 12 months ago, it was a very comfortable place to be in. It has been changed by the injection of police and by zero tolerance. But New Jersey is fundamentally a different place in its political and policing environment, because it is contained.

Victoria, having an integrated police force across the states, simply has the displacement issue. You cannot manage zero tolerance when you have a statewide responsibility within a small population in the space of Victoria in the way that you can when you have a highly defined political and geographic space to manage. The politics of America simply never translate into picking up the problems that now exist in New Jersey. It is possible because the political domains and the operating police domains are much more defined, albeit that there is a huge population on Manhattan Island.

CHAIR—Struggling to call that a satisfactory solution in many ways.

Ms ELLIS—My last question is on a completely different subject. In the government submission you mentioned the percentage of adult smokers in Victoria having declined from the early sixties to about the mid-nineties. Since about 1995 it has gone up again. Can you refresh my mind as to what regulations or laws there are in Victoria for the consumption of tobacco in public and other places?

Mr Judd—We have just introduced new provisions that went through parliament in August that will make smoking in restaurants and eating places of all kinds illegal as from 1 July next year. It has not come into place yet. That provision will apply in hotels and gambling facilities in spaces where the predominant activity is eating. It is a sort of compromise position to cover the difficulties in those places. The legislation will also make it illegal to smoke in designated shopping centres and, at this point, almost all of the large enclosed shopping centres in Victoria have nominated to be covered by that legislation.

Ms ELLIS—They have asked to be?

Mr Judd—Yes. The government said, 'We have come to power with a policy on tobacco control that says restaurants and eating places will be covered, excluding hotels and all other public places, at this point in time.' We ran a consultation designed to basically engage with people about that and the other underaged smoking provisions. At that point we identified that the key stakeholders—hotel, gambling and shopping centres—were keen to be covered in part. It went beyond government policy and that only became clear through an extended negotiation consultation process. The government left a space for people to opt out but most of the shopping centres are opting in and will be covered by the legislation.

Ms ELLIS—Are you aware of any international or Australian research which shows the end result in tobacco usage as a result of those sorts of regulations?

Mr Judd—I cannot quote it for you now but there is research out of a couple of states in America that attributes the decline in smoking rates to measures which include those kinds of passive smoking measures. California is down from 25 to under 20.

Ms ELLIS—Thank you.

Mrs IRWIN—I have two questions to Mr Judd following on from Annette Ellis: one is to do with tobacco, the other one is to do with heroin. In your submission on page 3 on the Victorian smoking and health program, in the last sentence of the first paragraph you went on to say:

It is anticipated that the Government will provide a significant investment to assist local government efforts in tobacco control.

Does this mean more money for local government? Would they be the ones that will be policing hotels, restaurants and shopping centres? What do you exactly mean by that?

Mr Judd—Yes, it does mean that to some degree. In order to enforce the new laws, the government has made $2.9 million available in this financial year. That money will be shared between local government and the department. Subsequent to this submission being written, the legislation being passed, and discussion, it was agreed that the best way to tackle the sales to minors part of the new legislation was to have specialist enforcement teams who would develop skills and basically focus on that in a way that local government environmental health officers could not do, both in workload terms and because of some of the sensitivities that local government faces in dealing with traders at this tough end. Whilst it was not anticipated earlier in an agreement with local government peak bodies, the Department of Human Services will now employ six people to form the core of that team. The rest of the money—approximately $1½ million this financial year—will be distributed to local government to enable them to more effectively enforce both the existing tobacco control laws and the new laws. That $1.3 million to $1.5 million will grow next year because it is only a part-year effect this year. So the contribution to local government is substantial.

Mrs IRWIN—Most probably because of the local tobacconist. Is there a very big concern here in Victoria with chop chop being sold widely?

Mr Severino—There is a growing concern about it. I do not think that I would regard it as being sold widely but we do know that, through tobacconists and some of the weekend markets, chop chop is increasingly available. Some of the recent efforts of the tax office and so forth have highlighted that for us. I do not know about local law enforcement. I do not think it is a large problem, but we do acknowledge that it is a growing problem. In our legislative package, we have specific new provisions around the state having the power to deal with chop chop, knowing also that the Commonwealth has already acted in a way that we think is probably more important. We now have a good intercepting set of powers that both jurisdictions can use.

Mrs IRWIN—Regarding heroin, on page 11 of your submission, you stated that:

In the 1999 Illicit Drug Reporting System study, 42 per cent of injecting drug users reported using injecting equipment after someone else in the past month, for example, spoons, filters.

What do you think will be the policy implications of these findings?

Mr Severino—The policy implications are clear—that we are investing. We have made a small effort thus far and will announce a larger effort over the next week on what we are calling ‘heroin overdose prevention’. It is designed to be a package to inform and engage drug users using peer education strategies to again renew and reaffirm some of those messages that are out there. Also, possibly very early in the new year, the government will announce some new

strategies, specifically around needle and syringe exchange, to further improve the resources within the needle and syringe services and to put particular emphasis on retrieval strategies. The more used equipment we can get out of the system, the better. We have very high retrieval returns on a percentage basis now but, given that we distribute over five million needles, even a 95 per cent return rate leaves, in absolute numbers, an awful lot on the street. The needle and syringe services will be more targeted about that in an information sense and a retrieval sense, working with local government. New resources will, I expect, be given to local government to facilitate retrieval. Our 'saving lives in heroin overdose' strategies—about the risks—will work more directly with users.

Mrs IRWIN—Is it correct that the safe injection facility that is ready to go ahead at the Wesley Mission is not going ahead?

Mr Severino—The government came to office with a commitment to having five sites. Wesley was never identified. The government never got to the point of identifying the agencies that would run an injecting facility before the opposition announced that it would block that legislation. The legislation is currently in the upper house and it is my expectation that it will not pass. So we will not have an injecting facility, I expect, in this term of parliament, and possibly longer.

Mrs IRWIN—That was the problem with the Wesley—it actually set up the building prior to the legislation being passed.

Mr Judd—Yes. And the legislation required a sophisticated planning process in each of the five municipalities that chose to operate one before they could select an operator and recommend that operator to the Minister for Health. It is my understanding that, had the legislation passed and had the Melbourne City Council decided that they wanted to participate in the trial, they would have had at least one other agency coming to them to consider being the site. So, even if the thing proceeded, Wesley might not have been the site, but we simply cannot know that.

Mr Severino—I want to add something about needles and syringes. Victoria Police has two policies which support the harm minimisation aspect of that. One is that when people call an ambulance to a drug overdose, particularly a heroin overdose, we do not automatically or arbitrarily charge all the people if police attend at that scene. We know that there was a hesitation by people to call the ambulance because of a fear that when the police turned up, as we usually would, they were going to get locked up for 'use or possess'. So we have adopted that policy and we stick to it.

We also have a policy of not targeting or unnecessarily frequenting areas of needle exchange so that we do not deter people from using the facilities We are nowhere near as advanced as perhaps Switzerland, where police vehicles act as needle and syringe exchanges—they actually carry boxes of equipment and act as exchanges. I am not suggesting we should go to that, but that is something we have seen overseas. They have gone to the extent of street-side needle exchange boxes and sharps containers, and the police actually say they will act as a conduit as well.

Mrs IRWIN—I think that was good. A couple of my colleagues did a walk around the city last evening and visited a few laneways. They lost me on the way, so I decided to walk the streets on my own. It was very interesting. I met a young boy who had already bought some heroin. I asked him where he shoots up and he said he finds a laneway. He was going up to the church that I think is on the left-hand side of Collins Street. I asked him, 'Why do you go to a laneway? Why are you heading up to the church?' He said, 'Because I feel safe.' I said, 'What do you mean you feel safe?' He said, 'If something goes wrong someone will see me.'

Mr Judd—Yes, that is right.

Mr Severino—The other aspect is proximity to the deal. This was raised in the debate about supervised injecting facilities and having five in the city of Melbourne. The view of police was that people will not travel any distance to use what they have just dealt. That is a fact of life. There is disagreement in some circles about that, but we say that is a fact of life.

Mrs IRWIN—What type of training do the police get on how to handle an ethnic community? Do you have, for example, Vietnamese speaking policemen?

Mr Severino—We do have a group of people who loosely deal with the Asian community in a concentrated sense through crime department activities. A number of our people avail themselves of Victoria Police training courses in the Vietnamese language. As you would understand, in a lot of ethnic background areas one language does not suit because a number of dialects can come into play. Yes, we do have some people who speak Vietnamese, but, on a wider scale, we have over 500 people out of 9,500 in the Victoria Police who can speak up to 44 different languages.

With regard to our formal training, our training of recruits specifically to deal with ethnic background people is done with input from people from those communities. We have interchange aspects where people come in and we have our ethnic advisory bureau people who participate in that as well. Given that Australia is the second most multicultural country in the world, it is a significant thing for us to address in training. Whilst you could always say you could do better and do more, I think we do have sufficient training in place for people. We actually have on board, working for us, some people from ethnic backgrounds such as Asian backgrounds, and Aboriginal or Koori background as well.

Mrs IRWIN—Thank you.

Ms HALL—Yesterday we were given some figures for the budget expenditure in Victoria in the area of drugs. My understanding is that 68 per cent of all expenditure is on law enforcement, and then the rest covers the areas of education, health, community development, et cetera. Is that correct? Is there any sort of move to have a greater expenditure in the areas of health and education, given that the philosophy of the government is harm minimisation?

Mr Judd—My view is that that figure is as reliable as it can be and that, given the interchange between the chairman and Bill about police costings, it is a necessarily uncertain estimate. Parts of the drug budget we know down to the last dollar, but vast amounts of it we do not. As to the second arm of your question, we have the new investment in the COAG diversion program, which is a collaboration with Victoria Police and Victorian courts, where most of the

money goes into treatment to enable diversion to be made effective and with the new initiatives that are yet to be announced. Most of that is in prevention, treatment and the building of the infrastructure, the capacity building areas. Little of that goes into policing, although, as Bill as also said, the government has committed to funding an additional 800 police over the next three years. So I think we see a balanced strategy being grown across the board.

Ms HALL—So there has been a shift?

Mr Judd—Very clearly, if you count back. Perhaps an easy statistic to give you as a indicator is this: when I first became involved in this field in a bureaucratic sense, in 1995, the then treatment budget was just a touch over $25 million. When the government makes its announcement next Tuesday, and when those moneys are fully committed—so three years from now, before the growth phase is complete—the treatment budget will be well in excess of $80 million.

Ms HALL—So that is an enormous growth?

Mr Severino—That is an enormous growth. We have done less well in terms of growing prevention, up to now. There has been some growth but it has been marginal, in my judgment. But in excess of $9 million will come as well. The investments in the non-law enforcement side are growing at least in parallel, and probably more quickly.

Ms HALL—Thank you. I have got a couple of policing questions and then one on education, but I will start with one on people who are suffering with both substance abuse problems and problems of mental illness. What sorts of facilities and strategies are there in Victoria for coping with people that are suffering both from mental illness and from drug and alcohol and illicit drug dependency?

Mr Judd—We have spent probably an amount of the order of $750,000 over the last 2½ years specifically on training for people who work in the mental health system, to give them greater skills in dealing with people who have a so-called dual diagnosis. The mental health system is by far the largest service system when compared with drug and alcohol treatment. Much of the skill base had been eroded in recent years, and we have been trying to put that back, particularly for the outreach teams, the crisis response teams that are on the street and the mobile services. I cannot yet comment on the effect of that, other than that the feedback I get that is positive.

Secondly, we have developed a joint program, based in the western region, which brought together staff out of both the mental health service system and the drug treatment service system, put them together and developed a joint program designed specifically to work with people who have both problems. The assessment of that is that it has been a very effective response. Both the mental health program and the drug program will make commitments—to be made public next week—to expand that by an additional three services so that we will have a capacity to provide that. Each service will be based in one of the metropolitan regions but will have outreach capacity. So we are beginning to put together both a more competent mental health service system and a specialist response for those people who need it.

Ms HALL—I constantly hear reports of people falling through in both areas. They cannot be classified as just having mental health problems or a drug or alcohol problem. Of course, they do not fit into a neat little box; they are pushed out of both systems.

Mr Judd—I think that is a fair summary of the circumstance in a number of places in Victoria. Some mental health services and some drug and alcohol services do a fantastic job in meeting those people's needs; others, given they have got pressures and feel very uncomfortable that they do not have the skills to deal with the dual diagnosis, have sought to avoid it. We put a reasonable amount of money into training to try to bring skills back to people to say, 'You can deal with this.' We are now trying to develop specialist joint services that effectively sit on top of that and directly deal with the hard cases, if you like, but will provide their expertise back, in a secondary consultation sense, to the drug and alcohol and the mental health service systems.

Ms HALL—In Victoria I am sure that students are expelled and suspended for drug use. What strategies or alternative programs are in place in this state to pick up and meet the needs of those students who are placed outside the education system?

Mr Judd—Yes, it is true, although the development of the individual school drug education programs, as I said in my introductory remarks, is about having programs that are designed to ensure that people are neither suspended nor expelled without some alternative plan. In recent years we have developed a service system called the 'school focused welfare service'. It is not particularly essentially a drug program; it is about saying that lots of kids in schools have problems. Initially it came out of some of the thinking that was done by a suicide task force in this state. It is about marshalling the forces of the welfare service system. It sits outside the school but is managed in collaboration with school principals and pupil welfare services. Clearly, young people who are at risk of being excluded, or of excluding themselves, are linked to that service.

The state government has also taken two initiatives in the last 12 months to reinforce, if you like, the 'in-school' capacity to hold kids in and to support their transition, one of which is the creation of school nursing positions in secondary schools to do non-traditional health related programs, including this sort of activity. It has also spent $12 million—I think it is—replacing student welfare coordinators in schools, many of which were lost under the previous government. So a range of initiatives has been put in place over the last couple of years to really strengthen schools' capacity. It is also worth noting that we have recently had a major review of postcompulsory education in this state—the upper end of the school system and the TAFE system, in particular.

The recommendations made by that committee are being acted on. The government has committed, I think, $61 million over a number of years to address the transition points from school to higher education—whether it be TAFE or university—or employment. That is one of the goals of a new series of clusters of education facilities, and this money is particularly tied to those young people who fall out of all the systems. At the present point, in educational terms, no-one has responsibility for every student or ex-student, and the goal over the next few years is to change that. Again, none of that came specifically from drug policy; it was informed by drug issues in the way we have tried to develop drug policy: to say that the main game is in the social infrastructure—to use words that are in the Drug Policy Expert Committee's report. We have

got to reinforce those bits of the system, and this government is seeking to do that through the kinds of mechanisms I have talked about.

Ms HALL—I have two questions on policing. With diversionary programs, how do the police feel about the fact that they sometimes have to make subjective decisions in directing drug offenders to these programs? Also, what is the relationship like between the Victorian police and the Federal Police? Does it work well, and is there need for improvement in any areas?

Mr Severino—Your second question is probably a little hard for me in the sense that I do not have direct contact with the AFP, but I am aware of joint operations and I am aware of the relationship that we have in an organisational sense. I do not think there is any problem with that—as always, everything could be improved. Certainly, at commissioner level there is excellent cooperation. A lot of things in Australian law enforcement are in any case done by the group of commissioners per se, as the commissioner's conference, so they share everything they do in respect of the major focuses that they take. In answer to your first question, a large part of policing is the use of discretion. That is why we have not legislated or accepted legislation in regard to diversion, because you do not need to. A large part of any police officer's duty involves the application of discretion. There is a common law basis for that, in that we take an oath of office and are therefore individually responsible for our own actions as a constable of police. We cannot be told to do something unlawful by a senior officer. That is an example of the use of discretion in the strict legal sense.

Our people are trained well enough not to have a problem with applying that discretion. From conversation with some people I know there was a little concern about how they could trust police to make a subjective decision about who should or should not be diverted. But we have enough criteria for people to comply with and, if they went either way, we would start to pick it up as a trend and then reorient or retrain people. We run a very short training program in regard to the diversion aspects, and it is basically just the procedural part of it. When people enter Victoria Police—and other police forces—a large amount of the training revolves around the fact that discretion is something that has to be applied at all times, either positively or negatively. Whether they do or do not take action is a matter of an individual's choice at the time. I do not think diversion creates any more of a dilemma for frontline police than anything else would in that respect.

Mr EDWARDS—Firstly, Ray, I congratulate you personally on the work that you have done. What I have seen here in Victoria is probably better than any strategy I have seen in any other state. The work that is being done here is going to set up a long-term response to what is one of the most vexing problems that confront Australia.

You touched on one of the things that we are quite interested in teasing out, and that is the need for some national leadership. I know that the police through the IGC, the police minsters, the police commissioners, the NCA and the AFP collectively share and generate intelligence. However, it seems to me that, outside of law enforcement, while there may be good cooperation between state and Commonwealth there does not seem to be the same level of cooperation in non-enforcement areas between the states. Ray, you might care to comment on that. How do you gather intelligence and information from the other states—what works and what does not work?

Mr Judd—One comment is that the need for cooperation is in some ways less. Police are dealing with organised crime, which knows no boundaries, whereas most of the people we deal with are residents in our states and territories and, therefore, our service responses are not targeted. But, as you say, our national arrangements are outdated and undervalue the necessary effort. The suggestion of a clearing house and the use of new technology which makes that much more possible is also a valuable one. There is a proposal around developing a data management system using Internet based technology to communicate.

In terms of what we lack, a clearing house is a baseline, but there is an awful lot of information out there at the moment which is not disseminated in ways which are influential. The people who know things know things, and some of them are informed by that. Without wanting to be critical, a clearing house, for me, has a passive imagery. It is a repository and it makes information available. What we know in drugs, and in other parts of my responsibilities in health, is that there has to be a proactive dissemination strategy that gets that learning into place, both in terms of policy formulation and in terms of changing the way practice is delivered.

We do not have either the will or the resources to design the research strategy at the front end and set the priorities that will inform our action to effectively put that in place when the results are out there. We are not capturing in a systematic fashion even that which is currently being well done. There is good research; there are good evaluations of programs being done jurisdictionally. Victoria has a mountain of them. We routinely circulate the documents but, as I have said, I do not regard that as an influential dissemination mechanism because too many people get too many documents passing across their desks and they simply do not have the capacity to absorb what is there. So the clearing house, supported by various mechanisms nationally and a much more focused attempt to get the best value for money, is one of the fundamentals of the next stage of the national collaboration.

Mr EDWARDS—I have some policing questions. Bill, given your comments about purchasing drugs and then using them fairly instantaneously, were the police opposed to the safe injecting rooms?

Mr Severino—No, we were not opposed to them, on the basis that anything that would have some value and would assist, particularly in the harm minimisation role, would be of value. We maintained all along that police would like to see legislation which underpinned any implementation of supervised injecting facilities because—going back to the question about discretion—we thought that we needed to be quite clear on the aspects of, in effect, creating a place to do something legally which otherwise would be illegal. We were in a quandary about how we would take action because, remember, we are still responsible for enforcement within every building and place within Victoria. So you would have to nominate the premises and say, 'This does not create an offence if you do it in here,' and we would keep out of it because it would be government legislation that would underpin it. So, no, we did not oppose them per se, but we maintained all along that there were certain requirements which we would like to see in place before we would, in effect, agree.

If legislation is enacted that requires us to do certain things, we will do them, as the law enforcement agency is required to do. I might add that we based our proposal on a visit to European cities where we saw injecting facilities. Two of us travelled and had a look at those,

and we perhaps confirmed the idea we had previously had that legislation would be desirable for us.

Mr EDWARDS—Aside from policing and enforcement approaches, what is your own view about safe injecting houses?

Mr Severino—I do not call them 'safe injecting houses' because I do not think there is any such thing as safe injecting per se; I refer to supervised injecting facilities, creating a haven, if you like, as per the experience of 'where do you go to inject?' Personally, I think there is value in them from the aspect of saving lives albeit the fact that there is the perception that there are a lot of lives being lost with heroin overdoses—and that is not reality, but if it is one life, it is too many. There is a potential to save lives. There is a great potential to access people to be able to divert them into care and welfare. In some places overseas, we saw that very effectively done where there was a clinical nurse on deck. There was a facility for people to hand in their clothing for it to be washed and returned to them the next day. There was always the possibility that people may have been able to get out of their drug scene by having been accessed through care. I think, for that reason, they would be of value. In the Victorian and the Melbourne metropolitan aspect my concern would be that, unless they were very close together and there was a lot of them, you would not get those effects to any great degree.

Mr EDWARDS—Good points. You commented on engaging the community and said that in setting up your safer community based bodies there would be a level of decision making that would be required by these localised groups. What sort of decision making?

Mr Severino—Decision making on the basis that, firstly, policing up to this stage has by and large said, 'We will give you the service that we think we should give you.' That is being very brutal about it. Now we are saying, 'You are our customers and we serve you. You tell us what sort of policing deployment and resourcing activity you require to make your community safe.' To that extent that will inform our planning. You have to bear in mind that we still have planning requirements that will come from the top down through government, and whatever.

The reason I mentioned people attending those committees who can make decisions is that people will say, 'We have kids in the long grass behind the high school doing certain illegal things. We want the police to get out there and fix it.' We might say to the education person, 'If you get the grass cut at the back of that fence, you take away the ability for these kids to sit there and hide in the grass.' So it is not necessarily a police problem. We would want somebody at the committee to say, 'I will get a guy with a tractor and a slasher tomorrow to go and do that.' It is the potholes in the footpath, the broken streetlight—those sorts of things—about which we would say, 'They are not all police problems. As the head of that group, you could fix that tomorrow for us, and then report back to that committee on a whole of community basis.'

Mr EDWARDS—I certainly endorse that sort of approach. The need to spread the responsibility to other than just the police or the government is a vital strategy in the fight against drugs. One of my colleagues might be able to help me here. I thought we were told yesterday that, when a needle exchange occurred, the police were sitting off, and following up some of the people who were getting the new needles.

Mr Severino—I suggest that would only occur if we had a complaint of some sort. I am not aware of that, and my group is usually made aware of anything like that from the operational perspective. We have had experiences where, in the provision of a welfare situation, we had a complaint about dealing with drugs. We put an operative in. We mounted surveillance and we did in fact charge people for dealing in drugs out of that situation. Without knowing the circumstances, I would suggest it would be that we have had a complaint of some sort from a member of the public or otherwise and we would react to that. It would not be the norm, though..

Mr ANDREWS—Ray, I have a question about education, prevention and programs involving parents. I noticed that in the submission, under 'Future Directions', the government talks about reducing risk and enhancing protective factors for young people, and education broadly in that context. In the latest Penington report there are references to programs for supporting parents. Could you outline what the government is doing, or envisages or may have in mind, in that regard. I am particularly interested in the variety of programs, such as Life Education Victoria or How to Drug Proof Your Kids, which seem to be chronically underfunded, looking for funds, in trying to provide this. Is it envisaged that there will be some universal approach to education of young people, particularly at the primary and secondary school levels, and what is envisaged in terms of programs that will help to support parents in their role of educating their children?

Mr Judd—With regard to children, the individual drugs school education process—which is in place in all government funded services, virtually all Catholic services and about 80 per cent of independents—starts in primary school. In curriculum terms, there is content material, resources, available and training for classroom teachers. That has been developed over the last three years; it is now, effectively, in place and is a maintenance and development operation. We have got, effectively, near universal coverage in terms of school education, starting principally with the legal drugs in primary school but working right through each of the year levels. That is supported by school infrastructure. In fact, a core part of the school education program is that schools which are doing their program engage in parents, and run parent education sessions as an integral part of that package. Over 10,000 parents, I think, in this state have chosen to attend those sessions in just under two years and will continue to do so. The school does that as a routine part of its activity. Not all parents choose to attend.

Since this document was written, the government has announced a number of further initiatives, one of which is a collaborative strategy with the Commonwealth government—a fairly low profile but important part of the COAG initiative. Victoria will receive $600,000 a year from the Commonwealth to run parent education sessions similar in kind to those which are run in schools but targeting parents out of schools, particularly in those cultural communities and socioeconomically disadvantaged areas where participation in the school structure is at a lower level. That will sit alongside the just over $1 million a year in new money that the Victorian government has committed and announced will, again, be part of the overall package that is announced next week, but it has already been announced for parents. It has three elements.

The first is a new telephone support service for parents, operated by parents and backed up by professionals. One of the messages we have got is that parents who have dealt with the problem in terms of raising their own children—some with drug problems and some without—are prepared and interested to support their peers, and parents would value being able to talk

through their issues and concerns with a parent. Where they are at the pointy end of having a problem with their children, that can be connected straight through to a skilled, trained counsellor; the volunteers will themselves be trained. That service will be operational early in the new year. We are training the volunteers at the moment and getting the system in place.

Also, we have put or are putting parent support workers on the ground in each of our regions, to link parents to the treatment system. As more young people are involved in receiving treatment, we have found there has been a gulf where parents have been cut out of that process—a fairly important experience for their child, and one which not only is important in its own right but can also be bridge building, where there are pressures in the child-parent relationship as a result of drug problems. These workers will be there to help at that point of pressure.

In addition, a little over half a million dollars will be committed to the generic family counselling infrastructure in the community, so that there will be people in those agencies with particular drug expertise, both to deal with cases and to support other family counsellors. Parents then can go somewhere where they do not have to own up publicly to having a drug problem in their family. They can be going to get family counselling on a very neutral and quite anonymous basis.

Where there is a drug issue, we know that that demand is not being well met because there is not enough staff on the ground and the staff that are on the ground do not have the particular skills. We are now getting to the point where there will be a fairly safe and anonymous parent telephone service, treatment interventions and a broader set of educational activities working back up from those with problems to those who are seeking to prevent problems by parent skilling activities as they come towards dealing with adolescents. We have a lot to learn about that as we get that system on the ground.

Mr ANDREWS—With the independent or semi-independent organisations who are providing services, is additional support for them envisaged?

Mr Judd—All of the parent education run in schools tends to be on the basis of cooperation between people in the school and people in drug related organisations. They have opportunities. In fact, we cannot do it without them. The Commonwealth funded partnering program and the other parent skilling activities, as I said in my earlier remarks, will be provided by non-government organisations. The government will not be a provider. It will be a question of when we call for expressions of interest, people will put them in. We will have the usual process of setting criteria and people meeting those. In Victoria, we tend not to fund an agency because they exist. It is about what we need done. The role of life education, which you raise, has obviously been affected by the fact that over the last three years we have moved from a point where schools brought in external agencies, whether they were Life Education or God Squad, to the point where it is now much more core business for the school. They tend to use external expertise less often than they did in the past. That is one of the reasons that there is pressure around life education in the state. We would have a very clear policy rationale for that shift.

Mr ANDREWS—I would like to ask about sentencing. I noticed in reading the Penington report that they seemed to have sidestepped the question of whether or not there ought to be more emphasis on diversion programs as part of the sentencing options. It said, in effect, that

there was some review of sentencing going on and that they would look at the COATS system. It seems to me that—in some other states at least—the idea of having drug courts and programs that are voluntarily entered into but then compulsorily attended as an option rather than, for example, imprisonment, seems to have received much more attention than it is receiving here or has received from the Penington report. I would be interested in your comments about whether or not that ought to be looked at further or whether you think my assessment of Penington is wrong, but it did seem to me that they have said, 'We'll leave that for another day.'

Mr Judd—It may be that that report is written in the knowledge—and I cannot tell you where it is referred to—that the credit program exists on a pilot basis in Victoria as a diversion at the point of bail. As part of the COAG drug diversion initiative, 13 further courts over the next three years will be funded to run a credit program. As part of our overall approach to diversion, the police program has received most of the attention, but we will have diversion at the point of bail much more widely available. There are more magistrates courts than that, but 13 will cover the major magistrates courts where there are drug issues routinely and systematically heard.

Mr ANDREWS—Penington says:

> The CREDIT pilot was subject to a review after its first nine months of operation, during which time 199 offenders used the scheme. The review found that there was little difference in the re-offending rates of those who used CREDIT and those who chose not to use it.

That suggests to me that something more needs to be done at that level if it is going to work. My question is not so much about diversion at the point of bail. It is about alternative sentencing at the point of conviction. That seems to be the course which some other states are taking in terms of drug courts. My question is: why isn't that happening in Victoria? Are there good reasons, for example, why that is not being considered as an option in a major review rather than saying that is a matter for another day?

Mr Judd—The Penington committee considered the issue of drug courts and, in essence, decided that they did not support that strategy. Their recommendation talks about the development of an integrated drug program within the courts. It then has a series of dot points about appropriate skilling of magistrates and supervision of people dependent on the level of complexity. It reflects a view that creating a specialist drug court is, at best, only a partial response to the problem and has the potential to draw resources away from the issue.

The magistrates courts in Victoria are routinely systematically dealing with people who have drug problems throughout the court system. The observation of drug courts, both in other jurisdictions and internationally, is that they are created and deal with a very small percentage of the population and consume both the best magistrates and the moneys that governments make available to courts. The Penington committee is basically saying to the Victorian government, 'Your court system is affected in general terms and, in a staged way, you must develop an integrated approach to helping the courts deal with that problem.'

At the top end there is no doubt that there is a small group of fairly recidivist people coming through the courts and causing significant problems, both for the court and the jails. You would want highly skilled magistrates, very sophisticated assessment and backup support and the ability of the court to use sentencing powers to effectively compel participation in treatment.

The recommendation that Penington made would enable that to happen in a staged way without setting up a separatist isolated specialist court. The government has not yet responded to that recommendation, and may choose to do something else, but that is the rationale for that recommendation which indirectly and insufficiently deals with the drug court issue.

Mr ANDREWS—My question is not about the establishment of a drug court as such. It is really about whether or not there is an alternative sentencing option at the point of conviction that can divert those who choose into effective treatment programs, rather than at the point of bail. At least on the evidence reported by the Penington committee it remains questionable whether that has achieved anything.

Mr Judd—The answer is that they have said that they are not sure whether a new, suspended or deferred sentencing power will help. There is a specialist sentencing review being commissioned by government in the course of their inquiry. That review should look at that question.

Mr ANDREWS—When is the sentencing review due to report?

Mr Judd—I am sorry, I cannot answer that. I don't know.

CHAIR—Just take it on notice. Can we be advised?

Mr Judd—Yes.

Mr Severino—Hopefully, we will be back. This is an ongoing thing; we are not going to solve it overnight.

CHAIR—We can come back next week. Thank you very much. In the random drug testing area is there much occurring?

Mr Judd—There is certainly growing interest in the topic. It has not been an issue that has been at the front of our mind in policy making terms in the last little while, but I think it will come.

CHAIR—Thank you very much. It has been a pleasant exchange and no doubt we will see you again.

[10.28 a.m.]

BRUNT, Major David, Territorial Director, Alcohol and Other Drug Services, and Manager, The Bridge Centre, The Salvation Army

DALZIEL Mr John, Territorial Director for Information and Media, The Salvation Army

CHAIR—Welcome. I presume you would like to make a brief opening statement and then we could have a discussion about your views on this vexed issue.

Major Brunt—I will make my opening remarks by saying that the submission was made on behalf of the Salvation Army Australia Southern Territory. I clearly say that because, in Australia, as an international movement we actually have two headquarters. One of them is based in Sydney; the other is based in Melbourne. In Melbourne, I have responsibility for the drug and alcohol services from Darwin to Melbourne. That sounds very strange, but I have the responsibility for five states and so the submission is based on our findings there.

In our submission we would re-echo the current climate and with it remind people that substance use is bigger than the American standards. It seems, particularly in the media at the moment, that the only issue is heroin. We have to remind ourselves that it is a far bigger picture than the heroin scene. With illicit drugs taking only a small percentage of the deaths in this country, we need to remind ourselves of the issues relating to tobacco and alcohol, as well as legally available pharmaceutical drugs.

When we wrote the submission, the Salvation Army was also concerned about the impact of all those substances, including heroin, on family relationships. Currently, in all of our work, the question of the cost to families is increasing rapidly. As we come close to Christmas, I guess we could say that the Salvation Army services are in fact stretched to the limit so far as support for families is concerned right across all of our states.

In our current program for women and children at Bridgehaven, which is based here in Melbourne, we have now seen third generation heroin addicts. Part of our program there, looking at families, is to try and break the cycle of addiction. We have a specialised children's program operating in that service, purely to try to do something about breaking the addictive cycle.

We responded in the submission to the question of crime, violence and domestic violence. We are concerned about the increase of domestic violence, particularly as it relates to substance abuse. It is another area which does not receive the amount of publicity that some of the other substance concerns have received.

We also raised the issue of road trauma, which was on the brief. We would agree with the recommendations of the Australasian Conference on Drugs Strategy which was held in April last year, particularly looking at the development of screening devices to assist the police and others in recognition of safety issues, and also the referral to treatment and rehabilitation programs. We would like to see them adopted as an essential part of the penalties for drivers.

We referred in our submission to workplace safety and productivity. Again we would believe that early identification of drug and alcohol problems, and referral straight from employment to rehabilitation or counselling, would be a great cost saving exercise for the community, rather than waiting for people to be dismissed from their employment before they can actually seek some help. There have been some attempts in Australia to have that looked at and different services have done it, but workplace programs have never been really supported in any great way.

We looked at the question of health care costs, using figures supplied by the Alcohol and Other Drugs Council of Australia. We were particularly concerned at the cost of this whole area.

The Salvation Army's response to all of this is in the development of programs, including preventative programs, development of counselling services, detoxification centres, and sobering up centres. The whole debate, I guess, has made the Salvation Army look at the question of harm minimisation and the redevelopment of our services. In fact, in Victoria the Salvation Army operates what is said to be the largest needle and syringe exchange in Australia. It is based in Melbourne and is one of the reasons why there has perhaps been more emphasis in harm minimisation in the Melbourne area of the Salvation Army than in others.

In this whole area we believe that the issue of families has to be looked at. Our concern, when we started looking at substance abuse in Australian communities, was to look very closely at families. I am reminded that in 1972 the Victorian government had a committee of inquiry into drug abuse, which was perhaps one of the earliest known major committees looking at illicit drugs. If you can find copies of that report, you will see that it found that there needed to be a greater emphasis on parenting skills, family support and so forth. I think that every committee of inquiry since has said almost the same thing, but very little has happened. I will leave it there and we are happy to answer any questions. John is our official spokesman for public relations. He may want to add something.

Mr Dalziel—The real reason I am here is that all the time we are having to answer questions in the media about the use of drugs, both legal and illegal. David thought it would be useful for me to be here on this kind of inquiry as well..

Ms ELLIS—Thank you both for being here. In relation to alcohol, you actually say in your submission you are concerned about an increase in the availability of alcohol. Can you tell us what you mean by 'increase in availability', and how is that happening?

Major Brunt—There are a number of issues there. Our domestic violence workers talk about the fact that alcohol is now available 24 hours a day in many places. At one stage we were looking at the delivery of alcohol in carton form 24 hours a day, and that was knocked back, I understand, by the Liquor Licensing Commission. We are looking at alcohol being available to under-age people in increasing numbers. We seem to be seeing more binge drinkers among young people, and we have done our own surveys on those. This is a concern for us.

The other thing that is happening with alcohol is that the alcohol scene is becoming almost pushed under the carpet. For example, you very rarely will see an alcoholic getting treatment at the moment because there are very few places for them in Victoria. The police often ask us

where they can take an alcoholic that they have picked up on the street, for the simple reason that most of our detox facilities are now primarily heroin based. It is a difficulty.

Ms ELLIS—I think you are also making a fairly consistent point in your submission that—and I do not wish to misrepresent you by paraphrasing badly—the alcohol problem is almost being overlooked because of resources being driven into illicit drug treatment and so on. Is that what you are getting at?

Major Brunt—Yes. This is an interesting debate. In Victoria, within the last few weeks the drug law reform commissioners looked at the question of sobering up facilities for alcoholics. Some of the background to that came out of the debate on safe injecting facilities. We were going down the track, seemingly, of having safe injecting facilities for heroin addicts, regardless of the rights or wrongs. It was about having a safe place for someone using an illicit substance at that time, while a person who had been using a legal substance would spend the night in the police cells. So the debate raised its head in that way and is being looked at by the Drug Law Reform Commission.

Ms ELLIS—Can I just quickly take you back to what we were talking about a moment ago in relation to the availability of alcohol. You mentioned in your answer that more alcohol is going into the under-age sector. How do you believe that is happening? Is it the retailers? Is it the older friend? Are they getting it out of the family cupboard? How is that happening, in your view?

Major Brunt—We have outreach teams on the street four nights a week, from St Kilda to the city, and the feedback they are getting from the young people themselves is that alcohol is there and they are using it readily. They can always get it. They get it by the cask; it is available to them. So we have this alcohol problem and we are now seeing that, coupled with the young people with the heroin problem as well. It is not two separate issues.

Mr Dalziel—The surveys that we have done, which are Australia wide, over the last 12 years have shown an increasing use of alcohol as a deliberate attempt to get drunk by under 18-year-olds as a weekend activity. It is not just something they do once a year, it is something they do once a week every weekend. We are talking of very significant groups of young people—for example, 40 per cent say they have gone binge drinking, and all of them are under the age of 18. It is not just that the alcohol is available; it is that it is socially acceptable to use alcohol in that way.

Ms ELLIS—It would be really useful for us to get your opinion on how they are accessing it. I do not wish to sound glib but is it that they are snatching it? Is it that they are getting it over the counter illegally? Is it that their friends are grabbing hold of it for them? In your view, which of the above—or others—are the access points?

Major Brunt—Most of it is legal. Usually the oldest person in the group or the person who looks the oldest buys the alcohol and then it is shared with the others.

Mr ANDREWS—As you know, our terms of reference relate to the costs, among other things, to family relationships. As you say here—as many other people do in their submissions—substance abuse has an adverse impact in terms of family relationships for many

people in many families. Is there an element of the other way around being true? Do problems in family relationships or dysfunctional families lead to substance abuse, in your experience?

Major Brunt—They do but not as a foregone conclusion. The young people that we are seeing in our centres come from a variety of families, from people who would be seen as intact families to people who have been multiproblem families. In that debate I think we tend to forget the impact of peer pressure on young people as far as substance abuse is concerned.

Mr ANDREWS—In your submission you say:

Many Australian families now live in poverty and the gap between rich and poor has been expanding in recent years.

Does that flow through in terms of the incidence of substance abuse, that is—to put it bluntly and I may as well be blunt—is there a greater incidence of substance abuse in families in poorer or less well-off socioeconomic circumstances?

Major Brunt—I believe so. Certainly the client group we are seeing in St Kilda would support that. These people do not seem to have the hope of other families. The school dropout rate is high, the chances of employment are usually considered to be low, and substance abuse becomes one of the ways of coping with that sort of situation.

Mr Dalziel—It is dangerous to say that in isolation. We are looking at a very complex series of reasons and to even suggest that a person going through stress is prone to use drugs is incorrect. That is a factor that makes it happen but there is a wide range of reasons why it happens, from seeing your parents abuse alcohol and therefore seeing drugs as a solution when you want to enjoy yourself, to being under stress—something has gone right, something has gone wrong, you feel that you are not loved—and all are contributing reasons that people will use drugs. We should recognise that one important reason is the increasing gap between rich and poor which brings about this feeling of alienation for those who do not have, and now that drugs are cheaper and alcohol is very much more available there is a quick-fix solution. I do not have to wait for a month to fix it; I can do it in the next half hour.

Mr ANDREWS—All these reports you read and the many submissions we have make general references to the impact on family relationships and family backgrounds and things like that, and you make reference yourself to the report of nearly 30 years ago making similar sorts of connections and saying that we should do something about it and noting, probably quite correctly, that nothing has been done about it. I am trying to tease out the causal factors because if we do not actually get down to the nitty-gritty, if you like, of what this range of factors is then I suspect we are simply going to repeat this cycle and say, 'Yes, that is a problem,' but never actually address it. What are the factors that we can address?

Mr Dalziel—The common factor is that people think it is okay to take some drugs to excess sometimes, hence the emphasis on alcohol consumption. We went through an interesting process in Australia where we started to say that drinking and driving was unacceptable. At the time when the process started, which is now more than 10 years ago, it was generally viewed as acceptable masculine behaviour to be able to hold your drink and drive. That is no longer the view. There has been a dramatic change and we all know the results. We would argue that it is possible to look at the total drug culture across the whole range of drugs—not just illegal ones

but legal ones as well—and talk about it being unacceptable to take drugs to excess. We need to recognise what drugs do to us.

Mr ANDREWS—I understand that. But the oft repeated reason for that change is that we have educated the population to a new way of thinking. I suspect that the major component of that education has been the law itself, and that it is not so much the campaign that says, 'If you drink and drive you are a bloody idiot,' it is the fact that you get pulled up by any police car, that any policeman driving around has a breathalyser kit in his back pocket, and you will find yourself without your licence, fined and off the road for anything from six weeks to who knows how long. From anecdotal experience of speaking to friends and associates, there is a chance that you can get pulled up and lose your licence. If that is true that indicates a fairly harsh approach which I do not think is possible to introduce in this area, or would it be acceptable in the general populace as well?

Mr Dalziel—I do not think that is true. It just so happens that I used to be the managing director of an advertising agency that developed the very first Transport Accident Commission advertisements so I am very well versed in what has happened. At no time has it been suggested that the campaign was the thing that turned it around, rather it was a combination. It did not work when we had police powers exercised by themselves; it did when the advertising came along. It does not work if you have the advertising by itself.

It is wrong to suggest it is only the advertising and the police. It is much more than that. It is the view expressed in the media, the view that is then picked up by young people who say it is unacceptable. I think it is one of the most exciting changes that has happened, and I think there is a precedent there. We are doing ourselves a disfavour if we say that an advertising campaign will fix it—it will not. We are also doing ourselves a disfavour if we say that the police can fix it with lethal powers, because that will not fix it—it will just make it more of a challenge for the young people who want to use that as a way of protesting about what society is doing to them. We need to have the wisdom to take what we have learnt in the area of road trauma and apply it to the area of drug trauma. But do not let us just get hung up on heroin trials and restricting heroin use. It is bigger than that, and the kids keep telling us, 'Mum and dad drink alcohol. I choose marijuana, or heroin,' or whatever it is.

Mr ANDREWS—What are the components? If we know that there has been a combination of these components in the past in the one area and we are drawing an analogy, and you are saying that it is not one component but a combination, what are the components that you say are the underpinning supports of this policy?

Mr Dalziel—We see a desperate need for more accommodation for people who are going through crisis. Some of those people are homeless; some are in need of drug rehabilitation; some are in need of hospitalisation, and we do not have anywhere near adequate resources in any of those fields I have mentioned. We need to be able to say when people are arrested for any legal or illegal drug related offences that they have the option of going into treatment. We do not have the facility to do that, as David has just been talking about, in the alcohol area at the moment because it has all be taken up by drugs, so there is enormous need there.

We need to have the law working with the non-government and government organisations to ensure that that happens. And then you do need to have a communication process that deals

with illegal as well as legal drugs and talks about this whole issue in a holistic way. In other words, it is applying the same principles we have just learned from and using that knowledge.

Mr ANDREWS—On page 5 of your submission, under the road trauma recommendations, you have made reference to the selective use of drug recognition techniques and roadside drug screening devices in relation to specific categories of road user. Are you suggesting that there should be some sort of ability on the part of the police to screen drivers for drugs other than alcohol? Screening for alcohol is fairly standard now. I think your reference there is to heavy transport operators, and we know the incidence of heavy transport accidents, but are you generally supporting that idea?

Major Brunt—Yes. Certainly overseas, at all the conferences I have been to, they are looking at what ways we can fairly quickly screen drivers to see whether they are under the influence of substances other than alcohol. There has been debate about the use of cannabis and heroin on the roads, but any substance that changes the way we think and feel and changes our space is dangerous on the roads and we need to make sure that there is some testing there.

Mr ANDREWS—Are you aware if there are any simple, efficient means of doing that? I understand that one of the major problems has been the inability to do it easily and effectively.

Major Brunt—There is difficulty with it, and certainly there needs to be a lot more research into it, but it needs to be on the agenda and kept going for the sake of people on the roads.

Mrs IRWIN—I want to get your views on harm minimisation. The reason I ask this is that there are some people within the Salvation Army who are promoting abstinence as the way to go. I am just wondering what your views would be on harm minimisation.

Major Brunt—It is an interesting debate. Strangely, there are those who would see them as two opposing forces: total abstinence on one side and harm minimisation on the other. Some of the total abstinence people would say that the harm minimisation people are about legalising everything and so forth. It is not that at all. We would see it as, firstly, reducing or minimising the harm that is going to happen to the person themselves and to their family. Total abstinence cannot be anything else but part of reducing harm, so there are some people for whom total abstinence has to be the answer.

The Salvation Army gets singled out on this. But it is interesting that, in Victoria, while it is part of our drug and alcohol policy from the government, when someone goes to court, particularly to the Children's Court, it is not unusual for the Children's Court magistrate and others to impose total abstinence on people. It confuses people if they are in that part of the debate because they do not know what is meant. They say, 'You're talking to me about harm minimisation, and the magistrate has now said that, if I want my children back, I must never drink again.'

I see it as a continuum. I often say to my Salvation Army colleagues that, if someone was drinking a slab of beer a day and, through counselling or rehabilitation, I can get that reduced to six cans, I have no doubt reduced the harm to their body, the harm to themselves and the harm to their finances. If they choose to become totally abstinent, that is their choice. It is the same with heroin. If someone is using three or four times a day, every day of the week, and then

chooses, after counselling and support, to continue to use but to use safely on the weekends, as some people do, then that also has reduced the harm. I do not see it as two opposing forces. The Salvation Army in its Southern Territory has accepted the policy that they are not two opposing forces.

Mrs IRWIN—Some people can go cold turkey but there are other people that cannot do that.

Major Brunt—Exactly.

Mrs IRWIN—I am trying to give up smoking, and I will admit that. I am working on it. I have cut it down to under 10 a day, with the chewing gum or the patches. Some people do need help. My last question concerns the Salvation Army's Major Brian Watters who, as you know, is the chair of the Australian National Council on Drugs. He is on the record as saying he would like to see those responsible for formulating drug policy in Australia be subjected to drug testing. Is this the army's position too or just a personal viewpoint expressed by Major Watters?

The reason I ask this question is that when we were in Adelaide on Tuesday, the Festival of Light came out with exactly that virtually word for word and they were just adamant that anyone in the field of drug rehabilitation should be tested. I made a comment to them—I had the pleasure of being in Sydney last week and I spent three or four hours with Dr Alex Wodak and the Sisters of Charity—and I said, 'Are you saying that the Sisters of Charity should have their urine and blood tested?' I actually discussed this with them and they said that there was no way they would do anything like that. I am just wondering what the viewpoint is of the Salvation Army.

Major Brunt—I believe it is Brian's own personal opinion. It is certainly not a Salvation Army policy. I have no control over whether my staff choose to have wine with meals or a drink or whatever. I have just come down from a conference in Wollongong and it was noticeable that my staff were the only ones who smoked cigarettes, so I will probably be reprimanded when I go back. But, no, it must be his own policy. It is certainly not an official policy of the Salvation Army.

Mr Dalziel—In fact, he did not put it over as army policy when he made that comment. He was having a long rambling interview and he said that as an off-the-cuff example of how important it was that people were responsible—and Brian is rather prone to that. But it certainly is not army policy,

Mrs IRWIN—Thank you.

Ms HALL—I think Julie has touched a little bit on what I was going to ask you about, but I will just take it a little bit further. Firstly, I should congratulate you on your submission. I was very impressed and it really changed my idea of the kind of programs I understood that the Salvation Army supported with your needle exchange and heroin trials. The stance that you have taken on all these issues is quite different from the one that I thought you would before I read your submission so I think you have developed a very sensible approach. Do you support the methadone program?

Major Brunt—Yes. Again, you would find that there are some divisions of opinion, but certainly we see methadone as a treatment and we would like to see more counselling done alongside of methadone. Last year we piloted for six months a trial just of our own where our own social workers were actually in the chemist shop for about three days a week, supporting those who were coming in for methadone and offering the same counselling that they would get in a drug treatment service and so forth. It was just an idea to see whether that would work. It could work in some pharmacies, but certainly it was a slow process because a lot of people do not want counselling there and then, but it did open the doors and we were able to help some people.

We would see methadone as a viable option, particularly in our women's program. It is certainly the drug of choice for pregnant ladies. Our Bridge haven program would have very close links with the chemical dependency unit of the Royal Melbourne Hospital. I believe it is about choice for the user, making sure that they have got the choice and then being there to help them. Traditionally over the years—and I was in a conference this week where I made the point—methadone suppliers generally do not see the successes of the Bridge drug-free type programs, and so there has been that sort of rift. But we, on the other hand, do not normally see the 'successes' of the methadone program, so there has been this sort of division of opinion that has come up in some centres. But certainly my concern with methadone is that in Victoria it is so hard to get on the methadone program. There are just not enough doctors prescribing.

I am concerned about the cost factor. We have spent a fair bit of money just directly at our centre. When I say a fair bit, it is probably a couple of thousand dollars. That is not much but it is a lot to us. We have spent it keeping people on methadone programs when they have run out of money and certainly our family support services would see people who are getting emergency relief of food parcels and fares because they need their money to pay for methadone. It is an awkward thing. When you challenge that, you are often told that if they were on heroin they would go out and score the money and so forth. We do not want them committing illegal activities simply so they can stay on a methadone program.

Ms HALL—How many alcohol detox beds are there in Victoria?

Major Brunt—Last time I tried to work it out I believe there were 87 in Victoria. I may be wrong on that figure, but there are certainly not enough. The system is strange in that most services ask the addict to ring them at a certain time and a telephone assessment is done. There is no bed so they are then told to ring again tomorrow. If a person kept this process up then they would not need a detox anyway because they would have detoxed themselves.

The other thing that happens is that, for some reason, the homeless alcoholic or drug addict is treated differently. If a person does not have a home or access to a phone, to be ringing a detox unit on a daily basis is an impossibility for some. Yet there is a system developed—and it is certainly not an official system—where the detox workers would not take the word of a case worker at a homeless persons' centre and things like that. They would expect the client themselves to ring no matter how difficult it would be for them to do so.

Ms HALL—When we were in South Australia on Tuesday we had some members of the Wine Federation of Australia come along and talk to us. I wish I had the information in front of me now. They argued that the lower end of alcohol such as cask wines et cetera should not be

subject to any special taxation treatment. They argued against a volumetric wine tax. I was wondering what the Salvation Army's feeling was on that issue.

Major Brunt—I understand that there is a drive to have a tax of some sort put across-the-board and for the money from that tax to go into treatment and rehabilitation. If that comes off we would probably support it well and truly. I have not heard any policy on that.

Mr Dalziel—The Salvation Army does not make statements on economic things like that. We restrict ourselves to welfare things. For instance, a precedence for this is the tax that is put on poker machines and other forms of gambling. The proceeds are used to help rehabilitate those addicted to gambling. We do accept some of those funds and use them, but we would much rather see a reduction in the number of poker machines and the amount of money that comes. Similarly, with wine and beer taxes, that is an economic situation. It is not something on which the Salvation Army wants to see things inflated. We are not arguing that drinking alcohol is wrong; we are arguing that drinking it to excess is wrong.

Ms HALL—In the Northern Territory in some communities they placed a tax on the cask wine or put money from that into the community. They found that it had a positive effect in reducing the consumption of alcohol. I think it is designed to attract the area where there is a high level of abuse. I just thought you may have had an idea on it. I was not trying to give you a trick question there.

Major Brunt—Certainly our people in Darwin support it. I know that for a fact because they see cask wine as being a real concern for them in the sense of the number of people coming into programs needing sobering up and so forth. The cask wine has been the cheapest thing available for people to drink up there. If it puts the price up it may cut the numbers down.

Ms HALL—Thank you very much. That is fine.

Mr QUICK—I have two questions and they are far apart. The first is: as a national organisation, what are your views on just how effective the spread of support organisations is? You obviously set your own priorities depending on where people jump out of the ground and who knock on your door and the like. There are dozens of NGOs. You have the medical profession, schools, state community services and the like. How do we ensure that the safety net is there, that it is strong and that fewer people fall through it? We have consultative committees. We have intergovernment departments. We have so many acronyms floating around that it is overwhelming, yet the numbers of people being processed are increasing and the amount of dollars expended continues to increase. We see greater social dislocation and family dysfunctionality. How can we do it better?

Mr Dalziel—I think it is important that we have diversity of service providers for two reasons. From the point of view of the client, it is important that they are given a choice. If they get disgruntled with an organisation, they can go somewhere else and get help. There is always going to be a problem with governments administering those kinds of services, because people fear that big brother is going to be after them. Therefore, it is important that there is a choice. But there is also another reason, and that is that the community gets involved when non-government organisations are involved. None of the NGOs can operate without community

charitable support, and that makes the community shareholders in the business and concerned about the outcomes. I think it is an important communication.

But to get to the really difficult bit of how you make sure the safety net always works, I think the coordination that takes place now in areas like drugs and homelessness, especially, is a good example of making that safety net work. I think there are other areas where it does not work as well, and they need to be improved. I would suggest that that coordination has improved a lot over recent years.

Major Brunt—I would also go one step further and say that we need to ensure that local government is actively involved for the local community. I have been privileged to be the chairperson of the City of Port Phillip's roundtable looking at the drug situation. In formulating their local strategies, they have involved every type of drug and alcohol service within the community. I believe in getting more of that involvement. I know governments are thinking that way in the sense of primary care partnerships. I believe in those sorts of structures but not in too many more committees.

Mr QUICK—The reason I asked the question is that each and every one of us, as federal politicians—and I would imagine the state politicians—has people coming and knocking on our doors. The manifestation of their problem could be through the education system when their child, for whatever reason, is excluded. It could be inadequate housing or the fact that there is no food on the table. They access a variety of agencies and now, through computers, the agencies say, 'You went to the Uniting Church last week. You cannot get another food voucher. You are on your own.' So where do they go? There are social workers in the housing commission, in the schools and in a whole range of organisations. They might come and visit you people. How do we ensure that people do not fall through the hole? Last night, when we were walking around the streets of Melbourne, there were half a dozen kids sleeping out rough.

Major Brunt—There will probably always be people who will fall through the cracks, unfortunately, and there always has been. I believe the emphasis that is currently being developed in many states on primary care partnerships, with the idea of one point of call for assessment and so forth—it is still in its infancy—is worth following up and looking at. If a person rings a particular number, they may need hospitalisation, detox or whatever, or it might be something as simple as immediate financial assistance. If we can develop something like these primary care partnerships through local government, I believe it is certainly worth seeing whether or not they work.

Mr Dalziel—On the issue of the kids sleeping in the streets, there is another good reason for that: there just is not enough crisis accommodation in Melbourne, or in Sydney or Brisbane for that matter. The Salvation Army, from our largest centre—just down the road from here—turned 141 people away in the month of October. It hurts when the Salvation Army has to turn people away. We are looking after hundreds of people a night in Melbourne, and to have to turn them away is dreadful. And the other centres are turning them away as well. That is why they are on the streets: there is not enough accommodation. All the partnerships in the world are not going to work if the cake is not big enough.

Mr QUICK—We heard the Victorian government today espousing the partnerships and all this innovative stuff, and yet we see another message being sent out to our young people that it

is okay, for example, in South Australia to go to Victor Harbour for the schoolies weekend, in northern New South Wales and Queensland to have a schoolies weekend. We turn a blind eye. In all the national newspapers and on television there is a glorification of this rite of passage for kids leaving high school and going to wherever they are going to go. In South Australia you can have your three marijuana plants, but in Victoria there is a different message being sent out. What message would you like to send to us, as people on a national stage, about whether we still have this colonial rail gauge mentality that only South Australians are going to stay in South Australia? We had an influx from Victoria to Queensland when economic times got tough; we gave the problem of next to 100,000 people to Queensland. Who is responsible for the message—every state?

Mr Dalziel—I think it is absolutely ludicrous that we have different laws on such things. We should have a national policy on homelessness, drugs and those key social areas. The fact that it is administered by the states is probably sound, but they have all got to get together and have a common policy, and have enough money to do it, too.

Major Brunt—When I look at it from a national point of view, one of the real concerns that I have is what we would call in treatment the 'catchment areas'. It is a great phrase. In a city like Melbourne it really just means a local region, and that is easy to overcome. But when I am talking about our drug programs in the Northern Territory and I am talking to the Northern Territory government, the insistence is, 'We only want our programs for Territorians.' Everyone who works in the drug and alcohol field would know that drug and alcohol users do their geographicals, no matter what age they are, and they travel this country as a very transient population. If you have got to move people on, without treatment, without help, simply because they do not come from a particular area, we suddenly forget that we are all Australians.

Mr EDWARDS—David and John, I compliment you on the submission. I think any organisation that provides support to over a million people in need over a period of time, as you do, builds up a lot of credibility and a lot of wisdom. I think there is a lot of wisdom reflected in your submission, particularly your encouragement for us to have a broad view about substance abuse. Having said that, however, I want to turn to two things, heroin trials and safe injection rooms. I am a bit like Jill: having read your submission, I formed a completely different view on your views in these areas. I actually thought that you were opposed to both of these things, yet I see that you are neutral, both on heroin trials and safe injection rooms. This whole issue is a great dilemma, not just for us but for the community generally. Could you tell us what the factors are that caused you to come to a neutral position on both heroin trials and safe injection rooms, rather than one opposing or one supporting them?

Mr Dalziel—We are very concerned that the debate about the treatment of heroin victims has got down to just discussing these two issues ad infinitum. If the trials happened, the effect would be relatively minor even if they were successful. To allow such an important issue to be hijacked onto this one tiny treatment thing is a mistake, we think. If the community decided that we should try it and they got rid of all the political problems, there is no way in which the Salvation Army would speak against it, because we think it is worth while to look at all possibilities. We would prefer to remain neutral on both those issues. Then we have the additional problem within our own movement of people who are vehemently against such things, yet we operate harm minimisation programs that make it very clear that that is the correct way to go. For that political reason, we are also taking a neutral stance.

Major Brunt—You also need to understand that in about 1988 the Salvation Army embraced the needle and syringe exchange programs here in Melbourne. That, in itself, committed us to a harm minimisation approach. Not everyone in our organisation would support needle and syringe exchange, but we certainly support the outcomes and we believe in the outcomes. The question I always ask myself about safe injecting rooms is that, if my son were a heroin addict—and I ask others, because I think we have to bring it down to that personal issue—would I want him to shoot up in a toilet block? The answer is no.

Mr EDWARDS—Of course there are lots of people in the community who say, 'If you are in a situation like that, if you are using drugs, so what?' I think your position is quite a courageous one, even though it is a neutral one. Hopefully it is one that will have some influence on the ultimate determination of the way that the whole direction will go. I know in many respects it is a small aspect, but it is one for which people are increasingly looking to politicians for answers. Hopefully your submission will bear a lot of influence on whatever those answers might be. It is an excellent submission and one that really does have a lot of credibility. Thank you.

CHAIR—We were talking earlier about collaboration and getting people from all the various agencies together. Can we talk a little about the effective voice of the non-government organisations. What might we do better to develop a more effective voice and more effective collaboration with our non-government organisations? What is your experience there?

Major Brunt—In Victoria, VADA has had lots of ups and downs as an organisation. VADA is our peak body as far as drugs and alcohol are concerned. Part of the reason for those ups and downs is that there has been very little support for it financially and so forth. I believe that, if adequate financial support were given to non-government peak agencies such as VADA in Victoria, NADA in New South Wales and others, you would have a group in each state that governments could actually liaise with and that would become a voice for non-government organisations. I am very concerned that the smaller drug and alcohol agencies suffer incredibly when money is tight. If VADA is not a strong voice, some of the smaller agencies do not get heard. I would support VADA all the way. I think that is a very important aspect to our whole treatment thing.

Again, with groups such as the Alcohol and Other Drugs Council of Australia and the development by the Prime Minister of the Australian National Council on Drugs, in a sense we end up with two peak bodies in Australia, which is a bit strange. Having said that, I think the Alcohol and Other Drugs Council is also limited financially. So there has to be some support if we want strong voices in the non-government sector, particularly for smaller agencies.

Mr Dalziel—I could just broaden that a little. All those things are good but the central thing we are saying is that we need to look at the whole issue. The Prime Minister had an initiative where he got business leaders together to talk about corporate Australia being concerned with welfare. There are some lessons to be learned from that. We could have community connection and involve in that the people in charge of the various welfare organisations, businesses and government, and have each of them appoint people who will actually do some work to make that connection work. We have not talked about the terrible problem that is happening with the lack of education and training. I believe that does have an effect on these drug related issues we are discussing today.

It is important that employment access, education failure and drug rehabilitation are all part of this one community connection that is headed by the leaders in the field who appoint people to do the work. There are some excellent examples of how that has happened in these peak agencies that David is talking about. They are areas that can get into more of the detail but we need to keep the big picture in mind. In the end we will solve the drug problem. We do not often talk about solving it but it is solvable when people's attitude change. I believe that is the only way it can happen.

CHAIR—You made a very interesting comment that it is possible to solve the drug problem.

Mr Dalziel—I think Sir Humphrey would call it courageous.

CHAIR—It has been occurring to me this morning that we are seeing these figures on the scale of things rising and a whole lot of other alarming statistics. You are making a suggestion to us perhaps courageously but I would hope correctly. We must resolve this issue to the best of our ability. We have much more work to do. I guess you cannot really add to the statement but you are clearly indicating you believe the issue is resolvable.

Mr Dalziel—Yes, it is.

CHAIR—There is the issue of the media. Like so many things in the world they can become scapegoats. They can drive you to distraction by the way they present the images to the public. What is your experience with the media? I would have thought the Salvation Army had pretty good press and image.

Mr Dalziel—In an interesting example this week in Melbourne the *Herald Sun* have run with a very strong, 'Lock them up and throw away the key' type approach. They did not want to speak to the Salvation Army. We put forward to them the kinds of things that we are talking to you about today. It was not the issue they wanted to put across. The other media, like the ABC and the *Age*, without reference to the *Herald Sun*, are speaking to organisations like ours and others in presenting exactly the opposite view. Both views sell papers. They get the ratings up. It is an important illustration of the need for a diversity of ownership of media in Australia. It is possible to make it work. I can make a phone call to the *Herald Sun* and get a knock-back. I can make it to the *Age* and the ABC and they will take up the issue.

You can use the media to play the game the media plays and make it work. It is important that we allow media people to have an influence on the way these things are shaped. There are some superb media people being well trained at the moment and coming through our universities. That is much better than when I was a kid. I do not think there is any point in trying to regulate the media. It is an unsatisfactory way of communication but it is the best way of doing it. It is a bit like democracy, isn't it?

CHAIR—The worst system in the world bar the rest.

Major Brunt—In the area of youth suicide, the media took on a very rational approach—after education and debate and lots of talking.

Ms ELLIS—After a lot of work.

Major Brunt—I think that that could happen if we could get them to talk to responsible people about the drug debate. I think we could get that. Certainly it did work. You do not see many sensationalised stories about youth suicide any more, and I think it is worth looking at.

Ms ELLIS—Did the Salvation Army actually attempt to speak to the *Sun* this week when these articles started to appear?

Mr Dalziel—Yes, we were on the phone within half an hour of my reading the front of the paper.

Ms ELLIS—And they said, 'Thank you, but no thank you?'

Mr Dalziel—Yes. The view we were putting was that the real reason we have all these kids on the street—what I was talking about before—is that there is no homeless accommodation for them to go to. If there were and they were still on the street, then you would have every right to say to them, 'What are you doing here? You've only got to go down to the Salvos and they'll put you up.' The Victorian government has a long-term policy. That is not good enough for now. It is good that it is coming but we need something now. So, Mr Lord Mayor and head of the retailers association, if you are really convinced that it should be cleared up, put your money where you mouth is; give us enough money for housing vouchers and we will locate those people in cheap hotels for you straightaway.

Ms ELLIS—Okay, that is good.

CHAIR—Thank you very much, John Dalziel and Major David Brunt. Major, on behalf of the committee, please pass on my thanks for the use of the church and community centre here at Brunswick. We are very appreciative.

[11.28 a.m.]

BURT, Mr Michael, Chief Executive Officer, Victorian Institute of Forensic Mental Health

MULLEN, Professor Paul, Clinical Director, Victorian Institute of Forensic Mental Health

PATHE, Dr Michele, Assistant Clinical Director, Community Operations, Victorian Institute of Forensic Mental Health

CHAIR—Welcome. Thank you very much for being with us today. The proceedings here are of the parliament and require that same regard. I invite you to introduce yourselves and to make a short opening statement.

Mr Burt—I signed off our submission to you and apologise that our organisation has a very long name. Because it has such a long name we have given it a trading name and we call it Forensicare. I will just give a very quick overview of this organisation and an overview of some of the issues that Paul will elaborate on in a moment. The organisation Forensicare is actually a statutory authority in Victoria created by the Victorian parliament in 1997, so it is a very new organisation. It is one of the service components of Victoria's public mental health system, but it has a special mandate, a mandate quite different from the rest of the public mental health system. That is to provide assessment, treatment and research services in relation to mentally ill offenders.

The services we operate as an organisation in Victoria are mental health services in prisons, in courts, in in-patient hospital services outside the prison system and in the community. So our clinicians see offenders in very large numbers in courts, in prisons and in the community every year. Indeed, in prisons in Victoria, our clinicians see every male prisoner who is received into prison in Victoria, whether they are going to prison on remand or whether they are sentenced, and that is over 5,000 each year. So our clinicians see a lot of offenders.

The issue in relation to substance abuse in the clinical picture of the mentally ill offender is a very significant one, as you will see from our submission. There are special problems arising from the mix of substance abuse, mental illness and offending, problems that are seen in terms of clinical assessment, treatment and care and in terms of risk of reoffence. In addition, there is a marked lack of both resourcing and expertise within forensic mental health services, but more generally within public mental health services in Australia, in relation to dealing with this problem. I will ask Professor Mullen if he could extend those comments.

Prof. Mullen—Our special area of interest is this overlap between mental disorders of various kinds and offending behaviours, so our remit is the assessment, management and treatment of people who have this double disability of offending behaviour and mental disorder. There has been an association between alcohol abuse and offending which is well documented back into the 19th century. What is new, in our experience, and what has dramatically altered both the work of people like ourselves, who deal with mentally ill people, and the work of those who deal with offenders in prison populations is the rapid spread of drug abuse over the last 30 years. This has had a particular impact on the mentally disordered.

If you look at the rates of substance abuse in this state, for example, among those with serious mental illness, it has been virtually doubling every 10 years and it is still going up. We are now running at rates—depending on how you calculate it—of between 15 and 25 per cent of all of those with serious mental illness having a serious problem with substance abuse at the same time. When you look at the mentally abnormal offender—those who are both offenders, often as a result of their mental illness, and who have a mental illness—then the increase is even more dramatic. The majority of the people we now see have significant problems with alcohol and substance abuse.

What is the impact of this on the wider community? You saw in our submission that one of the things that we have been investigating in this state is how the three things interrelate: having a mental illness, being a substance abuser and offending. If you look at serious mental illness like schizophrenia, the majority of those who commit serious acts of violence, including homicide, have not only schizophrenia but are also drug abusers. If you take out those who are drug abusers, then the increased rate of offending is small or modest—it could almost be overlooked. But when you look at the impact of those with schizophrenia and substance abuse, you have a very major increase in serious offending. It goes through every group, even if you look at something like depression. People with depression, by and large, do not offend more than the rest of the population, but they do when they are also serious substance abusers.

There is damage not only to others; there is damage to the individuals themselves. Looking at people with serious mental illness, we have studied schizophrenia in some considerable detail, and the death rates in those with schizophrenia are far higher than in the general population. One in 10 of those with schizophrenia will kill themselves within the first five years of diagnosis. This is a massive mortality—many cancers do not have that level of mortality in the first five years—and a lot of that is connected with substance abuse. So if you combine schizophrenia with substance abuse, the chances of you dying increase dramatically. The death rate is not just from suicide; it is also from accidents and related illnesses.

So what we have is a significant impact on the health, the life expectancy and also the criminal behaviour of those with serious mental illness because of coexisting substance abuse. And that even leaves out of the picture the whole problem of substance abusers themselves who do not have coexisting serious mental illness, and they, as a group, have very high offending rates and, particularly for the drug abusers, horrendous levels of morbidity and mortality. Thank you.

Mr EDWARDS—Professor, could you identify the substances that you are talking about? Are they prescription, illicit, licit?

Prof. Mullen—When I started working in this area in prisons and with mentally disordered offenders 30 years ago, it was very straightforward—it was alcohol and everything else was trivial. You saw a bit of opiates, you saw a bit of cannabis, but it was alcohol. Now it is quite different.

Most of the people we see with serious mental illness and serious offending have as a minimum cannabis and alcohol. We often see a mixture of prescription pills, particularly the benzodiazepines, particularly in female offenders benzodiazepine abuse is rampant. We also see, in Victoria certainly, quite a lot of amphetamine abuse. We are not yet seeing much in the

way of cocaine or crack. It does not seem to be around in our community to a great extent, but in other communities overseas that is becoming a very big impact.

So the big ones for us at the moment are alcohol, cannabis, then come the opiates, which are less frequent but so devastating in their impact, the amphetamines. Although it is quite widely distributed, we see little or no use of ecstasy in our particular population. This is still an expensive drug indulged in by young professionals rather than by offenders, so that is not a group we see. But cannabis is a very big problem in our group, as are the opiates.

Mr ANDREWS—To follow that up, it has been said in evidence to us, and the comment is made from time to time, that cannabis has a trigger effect in some people. You have to excuse my lack of medical terminology, but this is my understanding of the argument or the proposition that has been put forward. For some people who are susceptible to or have the genetic predisposition to schizophrenia, cannabis can have a trigger effect. Can you comment on that?

Prof. Mullen—Yes, the interaction between cannabis and serious mental illness is complex. There is no doubt that people with established serious mental illness—and it is not just schizophrenia but people with severe tendencies to manic depressive illness, for example—who heavily abuse cannabis will exacerbate their symptoms. They will make the treatment more difficult and they will have longer more severe episodes of illness. So it certainly damages someone with established illness.

There is evidence that it may very well produce earlier onset of illness, so that those vulnerable to, say, schizophrenic or a manic depressive illness who are heavy cannabis users may show the first symptoms of their illness much earlier than they would if they had not abused. And that is of considerable significance because the earlier it starts the more devastating usually its social and psychological impact.

There is also an argument, which is quite hotly contested by professionals, as to whether heavy cannabis abuse can actually induce a schizophrenic like illness, which becomes permanent. The same argument is also held about other stimulants such as amphetamines.

The conventional wisdom is really that the evidence is not in. Clinicians vary according to their experience. My experience is that I have seen it so often I find it difficult not to believe that you do actually occasionally induce—well not occasionally, but you can induce—schizophrenic like illnesses which become permanent as a result of heavy cannabis use. That is my clinical opinion. The evidence is very divided and other clinicians would give you different opinions.

I think it is important to distinguish. One of the problems that we have run into with this whole area, particularly with cannabis and alcohol, is that we all know that for most people their quality of their life social interactions may be improved by one or two glasses of wine during an evening. No-one's life is improved by a litre of wine washed down with some port at the end of the night.

It is a bit the same with cannabis. When we are talking about cannabis abuse, we are not talking about people who have a couple of joints on a Saturday evening. We are talking about people who smoke 20, 30, 40, 50 bongs a day. They are consuming vast quantities. Many of my

patients, when they are in the community, will not get out of bed before they have their first bong. That is what they do when they wake up. It is by the side of the bed, just as the chronic alcoholic's bottle of alcohol is by the bed. So it is very important to not get confused. We are not talking about intermittent or casual use in this population; we are talking about massive use.

Mr ANDREWS—Let me follow up one more thing on this. It has been said to us, and I have read it from time to time, that there is a distinction between cannabis in its impact upon the body, because it is said to be fat soluble, and alcohol, which is water soluble. Could you say something about that for me.

Prof. Mullen—It is a very simple thing. If someone were to smoke a joint in this room now, they would 48 hours later, the day after tomorrow, still have half of that cannabis in their body. If they were to drink a glass of wine, two hours from now there would be no alcohol in their body. That is very different. The reasons are the absorption of the fats, the rates of metabolism and the rates of excretion. But it does mean it has a very different impact. You do not want something which you take on a Saturday night as a social drug, to improve your social interactions, to be still active on a Tuesday morning. Yet unfortunately that is the case with cannabis. It is not the case with alcohol, which is metabolised at a relatively constant rate. You metabolise a modest glass of wine about every hour.

Mr ANDREWS—Is there evidence from, say, post mortem examinations of heavy cannabis users of that impact having built up in terms of the fat deposits in the body over time?

Prof. Mullen—It is certainly there. What you are dealing with is a slow removal of cannabis. If you stay at a constant rate of consumption, you will eventually get to a constant blood level. That is the answer. In terms of its immediate physical impact on the body, most of the damage that is done by cannabis is more a product of the way it is consumed than of the drug itself. In other words, there are various ways of smoking cannabis which unfortunately produce quite extensive damage to the lungs, particularly things called chillums, which are very popular in Africa—fortunately, not here. They are wide pipes, where they suck the cannabis, including sparks, straight into the lungs. That produces great holes through the lungs. The impact of cannabis is social and psychological, primarily, rather than physical.

Mrs IRWIN—I would like to congratulate and thank you for an excellent submission. What I found of interest on reading the submission was the women's care program, which you stated is the first of its kind in Australia and one of the few internationally. Could you let the committee know a bit about this women's care program and what it is doing for women who might have a substance abuse problem.

Prof. Mullen—One of the problems within the special care of mentally abnormal offenders in Victoria has been that until recently we had no separate units for women. When a woman became seriously mentally ill in prison, for example, or when a mentally ill woman committed a serious offence, such as killing her child, the only place we would have to put her was in an acute psychiatric unit among mentally abnormal, offending males. Many of these males would be sex offenders. It was a grotesquely inappropriate situation. The first thing that just producing that unit did was provide a safe environment for the care and treatment of a very vulnerable group. The other thing that it has enabled us to do is to provide a much more effective backup system to the mental health services in our women's prison, which is a troubled prison currently.

The aim of this is that for the acute care the women are treated within the women's unit. They present various particular problems which are often not shared by male patients. The rates of substance abuse among our women patients are much higher. It is almost universal.

Mrs IRWIN—When you say 'much higher', is it cocaine or is it alcohol?

Prof. Mullen—The problems we have, first of all, are with prescription drugs, with very high use of benzodiazepines, often at levels which are quite horrific. We also have very high rates of opiate use among our female population. Cannabis is there, but it almost pales into insignificance compared to both the pills and the opiate use. This is partly because of the women that come into our prison system and partly because of the environment within those prisons. Substance abuse is an even greater problem among mentally abnormal women offenders than it is among the males.

One of the major reasons—in our state, and I suspect in most of the other Australian states—that women are in prison is related directly or indirectly to substance abuse—from crimes committed to finance their substance abuse or related to the distribution and sale of drugs to crimes, involving males, which were often around drug involvement of one sort or another. These women are coming into prison because of their substance abuse, substance abuse is complicating their mental illness and it is a real mess.

Mrs IRWIN—What type of treatment are you giving these women that are under the program?

Prof. Mullen—The women's program operates significantly differently from the men's programs. The women who come into our system very rarely present a simple straightforward problem of a mental illness complicated by drug abuse. They usually have long histories of social and interpersonal disorganisation. Most of these women have serious histories of abuse and dislocation during childhood. They often have symptoms which are a mixture of depressive, severe anxiety symptoms plus the problems of the impact of substance abuse, plus the impact of whatever specific form of mental illness they may have on the top of that. The approach involves a lot more of the counselling, psychotherapy and group approaches of trying to improve areas of self-esteem and social function. They are approached really as a very disabled and damaged population—which they are—in which are embedded the problems of substance abuse and the problems of their mental disorder.

We occasionally get women straight from the courts who, while depressed, have committed crimes such as killing children. They present a much more straightforward problem in that they do not have the drug abuse problems. Once the depression is solved, they are often reasonably well-integrated, functioning human beings. But with many of the women who come from prison the problem is really dealing with someone who has been devastated and abused from childhood through adolescence into adult life, and with the post-trauma symptoms, the anxiety symptoms and the depressive symptoms that are all associated with those experiences.

Mrs IRWIN—It sounds like an excellent program. Congratulations on it. You stated that there are 10 beds for providing psychiatric care and treatment. Is there a waiting list?

Prof. Mullen—Yes.

Mrs IRWIN—How many beds would you love to have, or how many beds would you need?

Prof. Mullen—One of the curiosities is that the only people who are getting the care they need are people who get locked up in prison, and that is not a good situation either. But just to service the needs of the women prisoners that we have in this state, ideally we would need to double the size of that unit. We would also like to have a much more functional system of care and treatment within the prison. It is important to move people out of prison that need to be moved out of prison, but it also important to be able to provide, particularly in the drug area, counselling for experiences of abuse and post-trauma symptoms. That should be provided also within the prison.

Ms HALL—It is interesting—just referring to your submission—looking at the 34 out of the 51 patients admitted and the cocktail of drugs that they were actually using. Patient 21—there was very little that he was not using. This brings me to the point of my question. If the needs of people with mental illness were adequately addressed within the community would there be the same level of substance abuse by people suffering from mental illness? Would there be the same level of imprisonment, particularly when you consider that most of our prisons are full of people with mental illness or intellectual impairment and then you put substance abuse together with that?

Prof. Mullen—We really have a crisis in the care and treatment of mentally ill people who are also substance abusers. For a variety of historical reasons there has been disassociation between the services providing treatment and support for alcohol and drug abusers and the services providing treatment to the mentally ill. Similarly, within the support services for the mentally ill in the community, very often very little or no priority, or even acknowledgment, is given to the problems of substance abuse. We really need to develop a much better service for co-morbidity—the mixture of having both substance abuse and mental disorder—and we are not doing that.

I think we have to bring back into the mainstream of mental health care much more sophisticated and effective approaches to managing drug abusers. If we did that, yes, I think that we would decrease offending in this group and, yes, we would decrease the number finishing up in prison. I think that community care, to be a reality, has to address the realistic problems of disabled and mentally disordered people living in the community—not the problems we would like them to have, not the problems we think they should have, but the problems they actually have. One of the important problems they have is substance abuse. There is absolutely no doubt that seriously mentally ill people are far more likely to abuse substances than their more fortunate fellow citizens. We have to address that.

Ms HALL—That brings me to my next question, about research into the relationship between the use of substances—drugs and alcohol—and people suffering with mental illness. It is the chicken and egg type approach, the difference between the use by people suffering from schizophrenia or effective disorder, for example.

Prof. Mullen—We have done quite extensive studies looking at the epidemiological connections between these various aspects and there is good research elsewhere looking at many of these aspects. In some ways I think that our research has advantages over that done anywhere else. We now know what the problem is. We may be able to refine the epidemiology a

little bit but we know there is a big problem out there. The next problem is what we do about it and how we assess the various treatment and management approaches. So the real questions now are not: 'Is there a connection?', because there is a connection; or, 'Is there a problem?', because there is a problem. The question is: 'What do we do about it?' How do we develop management and treatment services which minimise the emergence of this as a problem in vulnerable people like the severely mentally ill, and what do we do once it is established as a problem? These are the same issues in the wider community. How do we decrease this escalating prevalence of substance abuse and how do we address severe substance abuse in established addicts?

Ms HALL—Have you got any strategies that you would recommend to this committee?

Prof. Mullen—The research strategy is important because there are a number of approaches which are being advocated, all of which need systematic and proper evaluation. I think we need to increase the skills of mental health professionals in dealing with substance abusers. I think that the pulling apart of services for substance abusers and services for mentally disordered was an error—

Ms HALL—I could not agree more!

Prof. Mullen—and we just have to put them back. When I trained, I trained in substance abuse. It was an important part of my training. As a young psychiatrist I worked full time in substance abuse. Psychiatrists who have trained in the last 10 or 15 years in Australia will be lucky if they have had any experience in the assessment and management of substance abuse, and that is not good. It is the same with clinical psychologists and mental health nurses—it is just not part of their training or something that they feel competent with or is their responsibility.

So we have to change the education patterns and make substance abuse much more an important part of the training of health professionals. There are still a lot of doctors out there—and they are not all old—who are hopeless at doing a basic assessment on the impact of substance abuse on the patient's health. That has to be done. Then we have just got to start looking at the various treatment approaches. What do we do about drug abuse? We look on that as a moral question. It is very complex. We look at it as a political question, and I think it is unanswerable. We look at it as a pragmatic question, and I think it is actually answerable. It is getting down to simple pragmatic things—what works and what does not.

Ms HALL—We were talking about cannabis a little earlier and how long it remains in the body, doesn't the THC—the actual intoxicating element—leave the body within under 12 hours?

Prof. Mullen—It depends—and it is not necessarily the only one—on exactly what you are using in terms of the cannabis. Most people claim that they do not show intoxication, but you can still show the presence of cannaboids in the urine days afterwards.

Ms HALL—Michelle, I assume that you were trained recently—within the last 10 years?

Dr Pathe—I have trained within the last 15 years.

Ms HALL—Would you like to comment on that little bit about the training that you received in that area?

Dr Pathe—Certainly. Substance abuse training was essentially elective when I trained. We obviously had to know something about substance abuse to pass exams but we did not actually have any hands-on experience unless we elected to work in that area. That was pretty typical of training programs around Australasia.

Mrs IRWIN—This might be a yes or no answer. At the end of your submission one of your recommendations was:

An expert in substance abuse be appointed to work in the forensic mental health field in Australia. Alternatively, funding be made available for an Australian forensic mental health clinician to be trained in substance abuse in the United States. On return to Australia, this clinician to provide training to other professionals in the field.

Are you saying to this committee that we have not really got a qualified or trained person in this field in Australia?

Dr Pathe—We are looking at him.

Prof. Mullen—We actually allowed knowledge and training in this field to deteriorate in Australia to the point where we do not have any experts of international standing who can combine the knowledge of the treatment of the mentally ill and the treatment of severe and serious substance abuse. I would not say it necessarily has to be America—some of the British treatment approaches are very good, as well—but it has to be either Europe or America. We need to re-establish expertise, knowledge and experience in this area within Australasia—which is terrible.

Mrs IRWIN—Thank you for that recommendation. We will take that on board.

Mr EDWARDS—I did not get to finish my questions earlier. A recommendation has been put to us via a submission that the Commonwealth government should require all hospitals in receipt of any Commonwealth funding directly or indirectly to test all patients admitted with a mental health condition for use of illicit drugs. Could you give us a view about such a recommendation?

Prof. Mullen—It depends what it is for.

Mr EDWARDS—They say it is for two purposes: to record the results of such tests and to report annually the statistical results of such tests.

Mrs IRWIN—Publicly.

Prof. Mullen—I think that anything that improves the care and treatment of patients is reasonable to recommend. When you are doing something which is a pure research project of that sort that is fine as long as there is consent from the patient to gather that information. You can actually do it relatively simply. Some of the new technologies are very sophisticated. The hair analysis, for example, will give you quite a good guide as to what drugs have been used

over the previous weeks. That is a non-intrusive and simple piece of research to do and would be well worth doing. The thing that would worry me about that are one-offs to find out what level would seem very important and then one could perhaps monitor it as time goes by; if you kept it up as a constant recording from all hospitals, what would be its implication? What would you use it for? Would it be used to stigmatise? Would it be used to increase funding? If it were to increase funding—the more drug abuses you have got—is there a risk? There are some real problems about this.

Ms HALL—What about without the patient's permission?

Prof. Mullen—I do not think you should do that without the patient's permission.

Ms ELLIS—But that is the assumption, that it would be anybody—that a mental requirement to seek treatment would be tested mandatorily.

Prof. Mullen—That would be to stigmatise those who come for treatment with a mental disorder. There are a lot of people out there in the community who smoke the occasional joint, who use the occasional this, that or t'other. We would not want them not coming for fear that they were going to be tested and that somehow this would finish up in a database which might later be used against them. On the other hand, I think research with consent and identification might be very interesting. One of the things we still do not know is the extent of real drug abuse among people coming into prisons.

Mr EDWARDS—In the context of the submission, I might say, it received a fairly hostile reception from the committee. I was just interested in your views.

Mrs IRWIN—Would you feel that it would stop people from seeking help?

Prof. Mullen—Yes, it could potentially.

Ms ELLIS—I have quite a different question that I need to ask you. In your submission you refer to Victorian research which appears to show that people with mental health problems, who are also substance abusers, are more likely to commit violent offences—and we have talked about that. Is it possible that people who are suffering from a mental illness and drug problems are more likely to be convicted of a serious offence, not because they are guilty necessarily but because they are less able to defend themselves legally?

Prof. Mullen—That is a very important question and it is one that can actually be answered. If, in fact, it is ease of detection, you would expect the largest overrepresentation to be in the relatively trivial offences: shoplifting, minor thefts, minor violence, et cetera, and the least effect to be in something like homicide where we have virtually 100 per cent clear-up rates. In fact, it is the reverse. The highest association is with homicide and serious acts of violence. The lowest association is with the more minor offences. What we are almost certainly seeing is a selective process, not working in that direction but almost the opposite way. People are being diverted out of the system if they are obviously mentally ill and their crimes are not too serious. I am afraid the answer is that this reflects a real association not an artefact.

Mr ANDREWS—We have seen in the last couple of decades in all states—and probably not only in Australia but elsewhere, too—large-scale deinstitutionalisation of people with mental illness. To what extent is that a factor?

Prof. Mullen—That is an interesting point. We have just completed a study in Victoria which was published in the international journal, *The Lancet*, earlier this year. What we did was to look at patterns of offending in those with schizophrenia prior to deinstitutionalisation in 1985 to 1995, in the post-deinstitutionalisation era. We found no overall increase in offending among those with schizophrenia despite, interestingly, a dramatic increase in substance abuse. Our latest figures, which will be for 1998-99, look as though there is an increase and we think that is because the level of substance abuse now is just becoming uncontrollable.

But deinstitutionalisation of itself did not produce an increase in offending. Anyone who has been around long enough, as unfortunately I have, to remember the old institutions will know why this is. The people who went into institutions and stayed were not the young, bolshie, difficult, aggressive substance abusers, but all the others. If you had a young schizophrenic who kept on slipping off down to the pub, came back drunk and hit one of your nurses, you did not keep them—you discharged them. Much the same, although perhaps I should not say so, tends unfortunately to happen today. One of the things about deinstitutionalisation is that the people who came back into the community and the people who did not stay so long were not the group that present the big problem for offending, who are not the long-standing, chronic schizophrenics, the severe depressives, but the young, disorganised people. And they have always been in the community, I am afraid.

Mr ANDREWS—So we are effectively dealing with two separate groups: those who are deinstitutionalised—

Prof. Mullen—And deinstitutionalisation is largely a furphy. What is not a furphy, however, is the increasing substance abuse among those with serious mental disorder.

Mr ANDREWS—Presumably, from what you are saying, the real increase in schizophrenia and other mental illnesses in the community has been amongst the young rather than the older group that we have always had.

Prof. Mullen—Yes. It is the older ones who are much more likely to be there than they were 30 years ago.

CHAIR—I just want to ask a couple of things and then we will need to complete this section. The significant increase was a real revelation to me, but perhaps an even greater revelation to me this morning has been the absolute dearth of resource or expertise in this area—with great deference to yourselves, who are obviously well versed in it. I just find that quite remarkable when we know the issue is as serious as it is. That is the first point. My question leads on from that, but it could open up as many fronts as you want to come to. What is the interrelationship, particularly at professional levels, resulting from this information? What is the discussion like in your circle and in the universities on this subject, and where are we at in the community debate in this?

Prof. Mullen—I think there has been a dramatic increase in interest, internationally and in Australia, in the problem of the interrelationship between alcohol and drug abuse and mental illness. The added one of offending is a rather more specialist area, but broadly the so-called co-morbidity has become one of the major areas of interest in the psychiatric and clinical psychology literature over the last four or five years. It is not that it is not recognised—it is, and good research is starting and is well ahead in Europe and America. So I think there is at least now a very clear awareness that this is an important problem, it is a problem we do not know enough about and it is a problem to which we need to find solutions very rapidly. What is important is that Australia should share in the increasing knowledge and skills which are being developed to try and deal with what many would now argue is the central problem for mental health services, and is undoubtedly the central problem for forensic mental health services.

CHAIR—I hope that we might help you advance the recommendations that you made, which seem to me to be absolutely critical, essential. Thanks very much to the people of Forensicare.

Ms ELLIS—This has been so interesting that we could have talked with you for hours.

[12.12 p.m.]

CHALLONER, Mr Bruce Ronald, National Manager of Education and Counselling, Focus on the Family Australia

TYRRELL, Mr Peter, National Product Manager, Focus on the Family Australia

CHAIR—I welcome representatives from Focus on the Family Australia to today's proceedings. No doubt you would like to make a brief opening statement. The committee does not swear witnesses, but the proceedings are legal proceedings of the parliament and need to be regarded as such.

Mr Tyrrell—Before I proceed, I would like to apologise for Mr Glen Williams, who is the CEO of our organisation, not being here. As we speak, he is in a delivery unit with his wife, who is having their second child. He left yesterday afternoon in a hurry. He certainly and sincerely gives his apologies, but I think you will understand.

Focus on the Family Australia is an organisation that is dedicated to helping strengthen families in many different ways. We have a focus on helping families in their relationships with each other—personal issues. We have counselling that is done on site and also through the telephone. We have about 35,000 people on our mailing list currently, and we reach out through every part of Australia. The program we have here is How to Drug Proof Your Kids, and certainly that is what we have been talking about throughout the submission that has been made.

One of the things that we continually hear—and we all agree on this point—is that the youth of today, in fact all of us, have a choice with regard to drug usage. No-one would disagree with that. It is a choice made by the individual. Focus on the Family certainly takes this issue very, very importantly. On the issue of choice, we have a firm belief that parents have a big part to play in how they can help children, teenagers, youth, make appropriate choices for their future. You hear in the news all the time about our trying to help people who are chemically dependent. On the other hand, we hear very, very often from parents who are saying, 'What can I do? As a parent, I believe, or want to believe, that there is something that I can do in order to help my children.'

It was on this basis that the program How to Drug Proof your Kids was born. It was because of this need that was continually put before us: 'Help me, what can I do?' Many parents are being given a great deal of information about what their children are learning. They are being told a great deal about what drugs are and a whole range of things, but the one thing that seems to be missing in the whole of the strategy is the prevention aspect of strategies that parents can implement at home.

Mr Challoner here next to me has had extensive experience in writing programs with the RAAF. He spent many, many years as a counsellor and setting up counselling centres, and Mr Challoner, therefore, was commissioned as part of our organisation to prepare the program. So it is on that basis that we are saying that choice certainly is the central and democratic right of everyone to use or not use a particular type of drug. But parents can certainly do a lot at home,

and we are there to help the parents. That is our focus. You have before you the submission. If there is anything you would like to ask us, we certainly would love to answer it for you.

CHAIR—Thank you very much.

Mr EDWARDS—Peter, one of the reasons this committee addressed this whole task of substance abuse was because, collectively, we were finding in our own electorate offices that more and more people were coming to us for answers and direction. Of course, it is very difficult to often find the sort of agency or the sort of help to give parents, particularly when they suddenly find out about and confront the situation that their child is involved in drug or substance abuse. But you say in your submission that we must identify a common set of core values and principles to undergird any particular approach that has as its goal the reduction of the tragic effects in our society relating to drug abuse. I am very pleased to see that you are advocating greater responsibility for parents. I just wonder how you go about, firstly, identifying a common set of core values and, secondly, implementing such a set of core values.

Mr Challoner—Through reports that have recently come out—one here in Victoria—on drugs and youth, they look at protective factors and risk factors in relation to which way children will go with regard to drug abuse. Those protective factors are recognised in the report as valid, if you like, indicators that we should be moving to as core values—what the family unit should be introducing as protective factors in reducing the risk of their child using drugs. So my answer would be that those factors in the report would be what I would see as core factors.

Mr EDWARDS—Can you give us a definition of 'family'?

Mr Challoner—A family is a core unit. The simplest definition is what we all have come from.

Mr EDWARDS—What, in your view, are the most important ingredients in terms of bringing up children? What is the most important ingredient that that core unit can have?

Mr Challoner—Again, going back to those protective factors, they would be those things such as instilling community values for the children, saying, 'Don't go down to the shop and steal; it is not right to do those sorts of things.' There are core values such as acceptance for the child, that the child is loved regardless and, if the child does something wrong, I am not going to yell and scream to instil the wrong principles in my child. I will sit down and communicate with him or her so that there is open communication in the home. They are all basic core values.

Mr ANDREWS—On page 4 of your submission, you speak about training 750 facilitators and that these facilitators have reached over 300 six-week parent programs attended by over 6,000 parents. I was wondering whether you have done any evaluation of the effectiveness of it. How do you rate that?

Mr Challoner—This is a question that has come up a number of times. We evaluate in a number of different ways. Within every program that is actually run the parents themselves fill out information sheets about the program that tell us how the program went, whether it met their

expectations, whether the facilitator met their expectations, and a whole range of other questions. We bring those back into the organisation and tabulate them.

There is also a survey that is put down at the very start of the program. Since we have been going only 18 months, we are now at the stage of starting to collate all the information. These surveys ask a whole range of questions about the parents' view of the family at that particular point of time—this is before the program has actually started. At 18 months and then at five years we are planning to bring all that information together to see what changes have occurred from before the program started to a period after the program has started to see whether the parents have indicated that there has been a change in things like the communication within the family and their understanding and awareness of the drug situation. There is a whole range of questions as part of the research aspect of the program. So we will be taking that and looking at the results, and then we will do the evaluation based on that.

Mr ANDREWS—One of the clear themes which comes through your submission is that there is, for whatever reason, a reluctance on the part of those involved in providing programs—generally within the community and possibly within the school or education systems themselves—to incorporate programs which involve some parental involvement. Why do you think that is the case?

Mr Tyrell—If you take, say, the education departments around the place, their focus is on the children, as it should be. If you look at a lot of the latest information that is going out to the schools, it talks about whole community involvement. Certainly, whole community involvement is what schools should be looking at but, primarily, their focus is on the students within that school. So on a primary school basis they are going to be taking the children through a whole range of courses about how drugs affect them and choice—those sorts of things. When it gets into secondary school, again, they will go through a whole range of different activities, but they are very much focused at the student level. The people who seem to have the primary interface into the community tend to be the schools so they tend to have a school based view on it.

Parent programs have been run in the past, and I know that the Turning the Tide program certainly had a lot of information for parents which was very good. They have now introduced a new parent program which is going to be a lot more specific, looking at the environment within the school. That is good, but it seems to be a very slow thing to come around. People tend to be focused on teaching kids about the harm minimisation side of it: what is good, what is bad; what they can do, what they cannot do. But from the parents point of view, it has tended to be an information passing thing only.

I know that people such as the human services groups within local councils will be there as a support to parents should parents come to them. They will run some types of programs. I have been to some of them—and they are very good—but, again, they are more for information sharing. To actually get out into the fuller community, to the different organisations within the community, is when it becomes very difficult, because the focus seems to be on the children and doing what we can to teach them about the drugs and the issues. There does not seem to be a strong focus on getting to the parents and seeing what can be done to help the parents.

That is where our program is fundamentally different. You asked, 'Why would there be an issue with some of the other programs that are going around?' It is quite simple: we do not have

a child focus; we tend to have a parent focus. There is a fundamental difference there between the two.

Mr ANDREWS—Would you advocate government funding for organisations that incorporate or involve a parent focus?

Mr Tyrrell—Most definitely. If we are talking about prevention and preventative strategies then, to me, that is the way it should be. A while ago there was a meeting on the Australian National Council on Drugs. It was interesting to be at that particular meeting. People started talking about prevention, and they said, 'Yes, we have services where people can go for counselling or to talk or whatever,' but when it comes down to actually doing something which is a positive, proactive step to get to parents to help parents, that seems not to be there. Everyone talks about the whole issue of trying to prevent this happening, but it seems as though it is just a lot of talk.

Mr ANDREWS—Mr Challoner, Mr Edwards was asking you about core values and principles, I think, and you made some reference to protective factors. Are these the factors that have been identified by the Pennington committee—for example, a family sense of connectedness, feeling loved and respected, proactive problem solving, et cetera?

Mr Challoner—Yes. They are protective factors that have been re-evaluated from earlier studies and found to be clinically just as correct over the years; they have not changed.

Ms HALL—Could you tell the committee a little more about your parent focused drug education program How to Drug Proof your Kids?

Mr Challoner—The program is designed to equip parents with skills within their families to be able to deal with the issue of not only drug education but, when a child is found to be on drugs, how to deal with it in a way that in no way puts the child down but has the effect of getting alongside and supporting them. The emphasis of the program is to do a lot of skill work in educating the parents.

Ms HALL—What kind of skill work?

Mr Challoner—Skill work would be communication. In the first week we do an exercise in how to communicate successfully with your child. We give them an exercise to take home and a list of 30 questions—for instance, what is your child's favourite colour; what is their greatest fear; if they had permission to paint their room a colour, what colour would they choose? They are 30 very simple questions that are designed so that the parent can get to know their child better. It is with those strategies of education that we equip parents with skills so that they can better communicate with their kids. If that communication were happening and the issue of drug taking arose then there would be a more open discussion about it and not as strong a negative reaction to it.

Ms HALL—I want to get a little more information on your definition of family. I was not quite clear on what you meant by 'where we come from'. All of us come from different areas. Does it include all possible definitions of a family, or is it more the standard family of mother and father?

Mr Challoner—As we would know the standard environment, including single parents, where there would be a parent and a child and they would be biological—one of those would be the biological part of the child.

Mr Tyrell—In terms of where this whole thing is placed, we get a lot of single parents, de factos, grandparents and carers coming along to the program. The program does not target a specific group; it is there for people who want to help the children who are in their care in the broader sense of that. That is why teachers come along and a whole range of people. We do not get down to the point of saying, 'A family is this,' within the context of the program because that is quite irrelevant. It is getting down to the parents and the people who children are in the care of.

Ms HALL—I agree. Given that the focus of your program is to help parents develop the communications that they need to stop their kids taking drugs—

Mr Tyrell—For them to make a choice about taking drugs?

Ms HALL—Yes, to make a choice. Given that they may make the choice to use drugs, would your group then support harm minimisation for those young people—the needle exchange program, the parents still supporting those children and maybe methadone programs and safe injecting rooms? What is your feeling about those things and some of the other issues that have been brought up under harm minimisation?

Mr Tyrell—I will start the answer, then Bruce may want to jump in. The way the program has been designed—and this is one of the issues you probably saw come out in the document—is that we are not a zero tolerance group. People have tried to push us that way. We are not. We believe that there is a whole continuum of use here. Every parent—and I include people sitting here today—would say that they do not want their children to become chemically dependent. That is the fact. We do not. At the very start of the program we say, 'How can we set up a family environment in which children do not want to go down that path?' That is the first stage.

The second part of the program looks at how parents can identify if there is use and what they can do about it in order to help their children should they be going down that pathway. It does not make a judgement on them. It just says, 'Some children are going to make a choice and, if they make that choice, what can we do about it as parents? How can we handle it? Do we talk about it as a family, or do we not talk about it as a family? Do we put it under the rug? Do we go and do something about it?' We go through that whole scenario there.

Then there is the final part of the program, which says, 'Some people do become dependent, they recover, but then it happens again. How do you handle that?' By virtue of the program covering that continuum, it certainly acknowledges that a child or person could be anywhere along it and that, as a parent, our role is to help at some stage along there. That is our role; it is not to pass judgement. In terms of needle exchanges and that sort of thing, the question that comes up is: where are you in the debate? That is what everyone is trying to say to us. I am here to tell you that we are not in the debate. It is not our role to sit here and say, 'Needle exchanges are great. This is great, that's great, that's not good,' because that is an issue that the parent has to decide on. If they needed to do that to help their child, the parent would make that decision

based on the information they had gained from everybody around them. We do not talk about that in the program.

Ms HALL—You do not.

Mr Tyrell—No, we do not.

Ms HALL—Because you are working with parents, maybe that is an issue parents need to become aware of.

Mr Tyrell—It is a treatment option.

Ms HALL—Your program can give the very best support to parents. Given that a child from a very caring, loving environment with excellent communication can still choose to use drugs, maybe they are issues that parents need to have information on as well.

Mr Tyrell—They will get information on those issues. We provide all our facilitators with resources. With their programs, the facilitators provide a whole range of resources that the parents can go to. We get them to get in touch with local agencies to talk about that information. In the area that I come from in Melbourne, there are so many great services, but nobody knows anything about them. Our job is not to handle these issues with the parents. Our job is to say to parents, 'There are a whole range of agencies out there; there are a range of decisions you are going to need to make. You will need to speak to specific counsellors—drug counsellors and alcohol counsellors—that are in your area', and they are available. We put them in touch with those people. These are issues that they have to handle at that time to sort out which way they are going to go.

Ms HALL—Would your group continue to give ongoing support to the family?

Mr Tyrell—In any way we can, we do. We have parents who call us up and say, 'I can't find anybody to help me; where do I go?' We then say to them, 'Here's a phone number. You go to this person and they will help you in some way. They will be able to steer you in the right direction.' What we continually hear from parents is, 'I don't know what to do about this.' There is supposed to be a lot of information out there. It is supposed to be an information age, but the parents, when this happens, walk around and say, 'I'm being shunted around. I don't know what to do.' Bruce and the other counsellors at the office can provide on-site counselling. They can provide telephone counselling as well. But because of limited resources, we try to get them in touch with people within their own communities who can help them.

Ms HALL—Have you heard of a group called Tough Love?

Mr Tyrell—Yes, I have. That is from Tasmania.

Ms HALL—Tasmania and South Australia. We spoke to them about that.

Mr Tyrell—I have met the lady and that is about as far as it has gone.

Ms HALL—So you do not know much about that program.

Mr Tyrell—No, I do not, I am sorry.

Ms HALL—Thank you very much.

Mr Challoner—One of the misconceptions that is out there, and is very strong, is that, when we talk of 'harm minimisation', most people are thinking 'harm reduction strategies'. In fact, we go around government departments and we talk about harm minimisation and that is the question that is asked of us, 'Are you harm minimisation?' And the answer is yes. We base it very firmly on the Commonwealth government's strategies on harm minimisation. But the general consensus out there, when we mention demand reduction strategies, is that they tend to ask, 'What is that?' Their focus is very firmly committed to harm reduction strategies.

Ms HALL—Sixty-eight per cent of all government money in Victoria, which is a bit of a blanket figure, is—we were told yesterday—spent on demand reduction and law enforcement.

Mr Challoner—There are three areas: there is supply reduction strategies, harm reduction strategies and demand reduction. I am very surprised if it is in harm reduction and not in demand.

Ms HALL—Fair enough.

Mrs IRWIN—Thank you Peter and Bruce for that; your comments are now on the public record. You stated in your opening statement that youth have got a choice. There are some young ones out there who can go cold turkey; there are others who need help. I am happy to see that you encourage people. If a young person came to you, you would say to them, 'I know you can't go cold turkey. This program is not helping you, but the methadone program that you are on is.' So that is good to know. On page 5 of your submission, in the second dot point, you say:

> We have come to understand that there are some in our society who are opposed to what we are doing because they see it as a threat to their own service ... Some have extremely aggressive political agendas ...

Who in our society are you referring to and why do you feel this?

Mr Tyrrell—I think the second question is probably the most interesting. We have been to a whole range of different government organisations over the time that we have been working with this particular program. It seems that you get categorised very quickly as to which side of the debate you are on. It is as though people cannot believe you when you say, 'We are not out here to debate the issue. We are not out here to take a side.' It seems as though people would like to push you in that way. We have had it from a whole range of different government organisations, whether it be local government, education departments or health departments.

It has taken a lot of work to convince them that we are not trying to play some sort of political game here or that we are not trying to play some sort of a commercial game here. Because it happens to be a hot topic at the moment, some people think we are in it just for the money. It is as though people think that this whole idea of just trying to serve the community is

a noble thing that nobody actually does any more. We have had it from a whole range of different government groups: they try to put you into a particular category.

Aggression? Yes, I have had incredible aggression on the phone. I spoke to one group here in regional Victoria when one of our facilitators was told, 'If you have anything to do with How to Drug Proof Your Kids, we won't have anything to do with you.' Having climbed the tree, so to speak, as I did with the phone call, trying to work out where this was coming from, I found the person who was in charge of the region in Victoria and spoke to that person with regard to the skills program. To be given this verbal abuse because we were supposedly a zero tolerance program—

Mrs IRWIN—You have just stated that you are not.

Mr Tyrrell—I know. You can state that a thousand times, but it seems that, unless you work within the government sphere, what you have does not actually count for much. It makes it very difficult for people out there. All the people we have out there working as facilitators—just over 900 of them now—are volunteers. They give a huge amount of their time to do this program. They have one thing on their mind, and that is just to help the parents. They are not out there for commercial gain. They are not out there with some weird religious thing. They are out there just to help the parents help their children, yet they get these blockages because it is considered that they are with a program that is zero tolerant.

It is these sorts of things that do provide a real blockage to what we are trying to do. There seems to be this idea that, unless you have come from the government group, you certainly cannot have anything that is of much value. I think that is very sad. We talk about community partnerships here in Australia. If we are supposed to be a community partnership, where is the partnership and where is the community? I think it is very sad that we have gone down that track. I do not know if that answers your question, but that is how it has been.

Ms ELLIS—I have some general questions. I want to understand a little more about the organisation itself. How are you funded?

Mr Tyrrell—We are an associate of Focus on the Family in the USA. We are registered to use their name in Australia, and therefore they will give us some form of funding to help us.

Ms ELLIS—So they give you seed funding, do they?

Mr Tyrrell—That is correct. Basically, it pays for people to work with us.

Ms ELLIS—What is the origin of that group in the USA?

Mr Tyrrell—They are a Christian based group, set up by a guy called Dr James Dobson. We are a totally independent group. We do not in any way belong to that organisation. We are registered to use the name, and that is it; that is the sum total of it. We do not have to report financially to them. We do not run programs that they ask us to do, et cetera.

Ms ELLIS—Are they your sole source of funding?

Mr Tyrrell—No. Most of our funding actually comes from donations that are made by people all across Australia, from books and videos that we source internationally and locally, and as money we get from the program, with which we can then continue our work.

Ms ELLIS—You used an interesting expression just a second ago. I have no objection whatsoever to church based organisations when I ask this question, so it is not coming from a biased point. You said, 'They are not out there with some weird religious thing.'

Mr Tyrrell—That is correct.

Ms ELLIS—Remove the word 'weird' for me and tell me what sort of religious connection, if any, you do have. To what degree is there a religious component in your teachings of the program?

Mr Tyrrell—The organisation is a Christian based organisation. What does that mean? It means that we have a biblical view of things. That is the start, that is the end of it. There is no denomination that supports it. All of us go to a variety of different churches. We work with all sorts of churches. We even work with a lot of non-Christians. We work with a lot of Jewish people. There is a whole range that we work with.

Ms ELLIS—It is important for me to understand this because I do not know a lot about you. I have two other quick questions. Have you made or do you intend to make any measure of the socioeconomic groups of parents that you are accessing? I have got a reason for asking that. Whether it is a government program, a NGO program, a Christian based program, the Boy Scouts, it does not matter who we are talking about, there sometimes can be a problem in getting to some of the less well educated or lower socioeconomic groups. I am not suggesting that we do this in some insulting way, but it really is useful to know to what degree we reach out in different programs to different levels of the community. Do you make any of those sorts of measures? If so, how? If not, have you considered doing it?

Mr Tyrrell—The survey that we provide at the very start of the program certainly asks quite a number of different questions in regard to how many people are in the family, what the status of the family is, what family type it is—there is a whole range of things. That will be compiled into the research that we are doing so that we get a broad demographic of the people that we are actually working with. Also, our facilitators are a good benchmark. Remember that the program is a community based program. So where the facilitators are tells us a lot about the demographics that we are reaching. What we are starting to find as we are doing more and more research into that is that, say, in Victoria, in Melbourne, we have about two facilitators in the whole of the western suburbs. We have to try to reach more people in those suburbs.

Ms ELLIS—That was part of my reason for asking, actually.

Mr Tyrrell—That is certainly something that we are focusing on and that we are working towards. It is certainly in the front of our minds. In Queensland we are working with a migrant education centre to run the program for new migrants. It was asked that we do it. We are in the process now of rewriting the program to that particular—

Ms ELLIS—Is the program free?

Mr Tyrrell—No, it is not free.

Ms ELLIS—What are your charges, and how do you judge them?

Mr Tyrrell—The way the charges work at the moment is that the facilitator can make a charge. I think the cost of the program to them is $26—

Ms ELLIS—For what?

Mr Tyrrell—For the parents manual, which is a parents program.

Ms ELLIS—For the book?

Mr Tyrrell—For the book for the parents. We are looking at trying to reduce that through a number of different ways, but it is $26. The majority of the facilitators run the program for about $35 for the six-week period, including the manual. We ask all the facilitators to look at getting sponsorship within the local community, and so facilitators actively go out and talk to different companies to see whether they can underwrite the cost of the manuals to them.

Ms ELLIS—So it is up to the facilitators, wherever they are, as to how they actually finance it?

Mr Tyrrell—Exactly. You would find that a lot of the churches run it as something that they are doing for the community. There is a whole range of different ways that some people do it.

Ms ELLIS—The reason for asking that was not only to understand how you do it but also to see whether or not that is a way of getting a measure. What if a family comes and they are a welfare dependent family, dependent on the government income? Is that taken into consideration, and therefore is that giving you a clue as to where your families are coming from?

Mr Challoner—Yes, we have a policy in training that we say to facilitators that if, for whatever reason, the parent is unable to afford to come along, they cannot turn the parent away. They contact us at Focus and we will, through whatever funding we have available, cover that parent's cost.

Ms ELLIS—Do you have a program of ongoing monitoring of the facilitators—

Mr Challoner—Yes, we do.

Ms ELLIS—or are they sort of floated off?

Mr Challoner—No. We have continual monitoring on our system and evaluation every time they run a program. We do refresher training for them when we visit states and they can come along and gain new insights and understanding about the program. We are also presently talking with the indigenous population to make a program there.

Ms ELLIS—Nothing would make me happier in the whole wide world than if we could, in fact, drug proof our kids. I am not having a go at you in any sense, because I think you would probably agree, taking some of your earlier comments. You could move into a family unit and you could give them all of the education, support, knowledge and know-how in the world, but at the end of the day there are also elements of life outside the family—unemployment, peer pressure, a whole range of things. You can gear your kids to deal with those things better than maybe they were, but at the end of the day there are aspects of life outside of family influence. Given that we may agree on that, do you do any sorts of measures—I know Focus is only 18 months old—or are you considering putting into your measuring outcomes a way of knowing the outcome from the child's point of view? I do not mean you should not monitor the parent at all, but monitoring the whole family.

If the title of your program is 'How to drug proof your kids', nothing would be more useful, I do not think, than to know, a period down the track, whether or not the children have remained drug free, have come out of what they were in in the drug world and, if so, what other elements there were in play. I do not wish to make it sound complicated, but it would be a very interesting measure of your program. Was it unemployment or was it other issues that were relevant—not causal, because I do not know how you could determine that—to understanding that outcome measure? Have you considered doing that?

Mr Tyrell—We ask that information from the parent's point of view, but, no, we have not at the present time gone down to the stage of saying, 'Right, let's actually send something to the kids or get them in and let's talk to them about it.'

Ms ELLIS—Even if you asked the parents—have you asked the parents 12 months later?

Mr Tyrell—Yes, that is part of the two- and five-year research.

Ms ELLIS—So you are into the first phase of that at this point.

Mr Tyrell—That is right. We are just about ready to go through that now. So that is the whole reason for the two and the five years, to see whether or not it has taken and what changes are perceived to have been made to the family over that period.

Ms ELLIS—Could I be so bold as to suggest that it is not a case of saying at the end of that, 'Oh, so unemployment was the issue,' because we do not know in some cases how people think and why these issues have occurred. It would be useful to see the elements around particular outcomes, and maybe then some pictures could start to emerge that you could draw some conclusions from collectively. Would you agree with that?

Mr Challoner—Definitely.

Mr Tyrell—I agree. The most critical thing there, of course, is the funding to allow that to occur. That is always the big issue.

Ms ELLIS—I understand that. We got into that with some earlier people about research.

CHAIR—On page 5 of 11 in your submission, in dot point 1, you make the point:

It is the young person's choice whether or not they choose to engage in the harmful use of drugs and parents cannot help in their decision making.

That is the view of some drug educators. Are you familiar with that statement?

Mr Challoner—Yes.

CHAIR—How widespread is that attitude?

Mr Challoner—We are hearing that constantly from parents. As we do the program, we get feedback from the facilitators. We are getting that feedback from the parents who are saying, 'When we go along for help for our child who is taking drugs, we send them down to the local council to talk to the drug counsellor down there, or at the school.' The comment that is coming back from them as a parent is, 'They will make their own mind up about it. There is nothing you can do about it and, let's face it, the majority of kids take drugs anyway.' They are the general comments that we constantly hear. So it is widespread around Australia.

CHAIR—So it is widespread and these are general comments. Is it 50 per cent of these people saying that or is it 25 per cent?

Mr Challoner—We are not asking every parent; but in the programs that the facilitators give us feedback on, they would come up with a few parents every time they run a program who would come up and say to them that comment.

CHAIR—That parents cannot help in the decision-making?

Mr Challoner—They go along to a counsellor at a council in their area, and the counsellor's feedback to them is that there is nothing the parent can do: the child will make its own decisions, and you really cannot do much to help; and anyway, most people take drugs, so what is your problem?

Ms HALL—You will have to explain that a bit more. Who is saying that?

Mr EDWARDS—That is what people are saying to them; that is the feedback they are getting. I must say that I have heard the same sort of feedback—not as intensely or as often as you have, but I have heard the same sort of thing.

Ms HALL—How many people do your program? How many parents in each program?

Mr Tyrell—It varies. Some will have as low as five. Some will have up to 35. It depends on the facilitator. We believe an average is somewhere between 15 and 20.

Ms HALL—Do you have a brochure on your program?

Mr Tyrell—Yes. We are just about to go a reprint on it.

Ms HALL—It would be really good if you could send us a copy when you reprint it; and maybe if you have got a written outline of your program, that would be helpful too.

Mr Tyrell—Certainly.

CHAIR—Why do you think educators are saying this to parents?

Mr Challoner—I am not sure. I would love to be able to have the research resources to do a study on that. In my own personal experience in moving around Australia, I am discovering again that the issue in harm minimisation is that the emphasis of their thinking is on harm reduction and not demand reduction. So there is a sense of misinformation. The point I would like to make here clearly is that our statistics say there are a awful lot of kids not on drugs at the moment. We should encourage that and say to parents, 'Hey, you are doing a fantastic job out there.'

CHAIR—Whoever is responsible, we want to celebrate it.

Mr Challoner—Exactly.

CHAIR—I do not care whether it is an educator or parent or whoever.

Mr Challoner—But the message coming back is the opposite: 'Every kid is on drugs anyway, and you can't stop it.' That is detrimental to the many kids out there who are not taking drugs at the moment.

Mr Tyrell—One of our staff members went to forum last year in the eastern suburbs of Melbourne. There was a person from the education department who was doing a presentation to about 200 parents and he made that comment: 'Your children are going to try drugs. So what if they try a bit of marijuana? So what if they try a bit of something else? Only a small percentage of them are going to get hooked on the stuff, so do not worry about it.' I think that conveys a very different message to the parents from what we are really trying to do here.

Mrs IRWIN—Following from that, regarding anyone—a young person, or one of any age—that might have an addiction, even with heroin, do you feel it is a health, a social or a moral issue?

Mr Challoner—It is certainly a health issue.

Mrs IRWIN—That would be number one?

Mr Challoner—Yes. It is certainly a community issue. As for a moral issue, from my own personal view, that does not come into it. There are many other factors that we need to consider first before that.

CHAIR—Mr Tyrell and Mr Challoner, thank you very much.

Proceedings suspended from 12.58 p.m. to 1.44 p.m.

HAMILTON, Professor Margaret Ann, Director, Turning Point Alcohol and Drug Centre Inc.

CHAIR—Welcome. The committee does not swear witnesses but these proceedings are proceedings of the parliament and need to be treated in that context. We have met you before, haven't we?

Prof. Hamilton—Yes, you visited Turning Point and then I met you in conjunction with the meeting of the ANCD which your committee attended.

CHAIR—That is right.

Prof. Hamilton—Thank you very much for the opportunity to appear before the committee. I do apologise for being a little late. I made the mistake of not driving myself but getting a taxi, and I was dropped off about three blocks away.

Mr EDWARDS—We had the same problem yesterday, so we are very sympathetic.

Prof. Hamilton—In the light of my being a little late, it might be most useful if, rather than speaking at any length, I mostly responded to questions. The Turning Point submission did not attempt to focus specifically on your terms of reference, so we did not confine ourselves to just those points but, rather, tried to look at some of the important messages and themes in and around Australian drug policy and programs at this time. Yesterday you met with other members of the Drug Policy Expert Committee in Victoria. I am a member of that group and not able to attend yesterday, but a lot of my thinking has gone into that report and I am happy to enlarge on or extend any issues that might remain from that. As a member of the ANCD I am involved and have opportunities for policy involvement at a national level. I am also a member of the National Expert Committee on Illicit Drugs, which is meeting in Melbourne today—that is where I have just come from. In a similar capacity, I am a member of the alcohol group. So I am open to answer questions with any of those involvements informing me.

One thing I want to say is that drug and alcohol issues, but drug issues broadly, are beyond the specialist realm. They are now pervasive, not only in the community broadly, for residents, families and individuals, but also in all of our health, welfare and education services. We can no longer think of this as something that needs some special services somewhere or some special experts that we refer drug and alcohol matters to. We have to move from that to see it as an issue that all sectors must be able and prepared and resourced to respond to. If we were to keep expanding specialist services to the extent that we might need them, firstly, we could not afford it, and we do not have the workforce. Most of the important responses can be done by well-trained and well-intentioned people, and alcohol and drug treatments can easily be delivered by the generic health and welfare personnel in this country, with the back-up and support of a core of specialists. I do not think everybody has to go to a specialist.

CHAIR—Some of it is fundamental and, with commonsense and proper practice, can be dealt with.

Ms ELLIS—Thank you very much for being here with us. Can you discuss with us your view of the community's understanding and acceptance of harm minimisation?

Prof. Hamilton—It is very mixed. There is certainly a group in the community who in recent years have come to misunderstand, in my view, harm minimisation to mean free rein for drugs, legalisation, let everybody take whatever they like, or variants on that, as one extreme. That is certainly not my understanding of it. It has become, in a sense, so generic as to now lose some of its value as a concept, but I believe that harm minimisation, in my understanding of it, is still vital to our approach.

For me, it is the difference between treating drug users as citizens and treating them as excluded or different or in some way unusual. Harm minimisation speaks to me not just of minimising harm for individual drug users but also of how as a community we can reduce the harm, for all of us, of those people using drugs. I think there is variable understanding. It is not an easy concept to explain and to define. It does not lend itself to a slick, readily grasped definition. It has probably been manipulated by many of us in all sorts of ways such that it has become a very stretched notion and no longer clearly identifies what we mean.

Ms ELLIS—I understand that Turning Point has been involved in a pilot program, particularly helping survivors of heroin overdose who may be at a high risk of dying from a subsequent one. Can you talk to us a bit about that?

Prof. Hamilton—Yes. That is a program we call DROP. It is federally funded, through the Tough on Drugs strategy. There are about six people who experience an overdose for every one who actually dies of an overdose, so there are very many more incidents of heroin overdose experience to add on to those who die. The program was an effort to think through logically that this group must be very high risk for overdose death and, if we can reach out to them and somehow make contact with them, perhaps we can do things that will prevent another occasion of overdose. It is very much geared toward harm minimisation. We knew that, were we to make contact and start talking about stopping using drugs, it was unlikely we would engage them.

Ms ELLIS—Is that program finished?

Prof. Hamilton—The program is ongoing. We have had an interesting experience with the program, and it is perhaps a salutary tale. Often, when we are trying new things, new programs, innovations, we have to accept that it is learning in doing. The logic of it was that we would get ambulance officers to have a card that they would hand to the person they had just attended and urge them to make contact with us. We also had an arrangement, potentially, where the ambulance officers could alert our workers, who could actually attend. What we have found is that it is extremely difficult logistically to actually do that. And then, when a user is handed that sort of material, the last thing they want to do at that moment or even in the next few hours is actually ring up and have to speak to somebody else they do not know. So the logic at one level was reasonable, but it was the practice of it that showed us that maybe it was not the way to go. We have now recast that program and we are trying to look at it as a locality based program, where we have got the workers involved in this out on the streets with part of our outreach team so that they are much more readily available. They get to know a group of current users and are much more likely, therefore, to be able to intervene or be involved if someone has an overdose experience.

Ms ELLIS—Have other services tried this approach?

Prof. Hamilton—Western Australia has tried a program in which they respond to people who are brought into accident and emergency departments. The protocol in Western Australia, as I understand it, is that ambulances bring all of the overdose people that they attend into the hospital. It gives them a very valuable reference point in that sense, but it is a very expensive intervention to do that. We simply could not afford to do it across the country. We could not afford to do it here in Melbourne. But they have had a program going there where they have actually been running with some volunteers. They have paid staff and then they have volunteers who make contact with people who come in and talk with them about the experience, and talk with them about reducing the risk of a subsequent overdose experience.

Ms ELLIS—In your submission you say that there are associations between the use of legal products such as tobacco and alcohol and the uptake of illegal drugs and that, if we want to stop young people from starting to use certain drugs, perhaps the place to begin is to stop the uptake of cigarettes. Are you suggesting that the use of certain drugs leads to the use of others? Is it not possible that some young people are simply less risk averse than others and will experiment with anything anyway? Can you discuss that with us?

Prof. Hamilton—Yes. I do not want to promulgate what I think of as the crude gateway theory, which is 'leads to'. So I am not really suggesting 'leads to'. But we do know there is a strong correlation, particularly between people who take up smoking when they are young or who engage in heavy binge drinking when they are young and the subsequent uptake of heroin, probably for the reason that you suggested, which is that they are less risk averse. But when you ask young people how we can prevent drug use, many of them are able to talk about the big difference between smoking something and injecting something. We do know that the transition from smoking cigarettes to smoking cannabis is a small step for most young people: they come across both of those substances, they are offered them and they are available to them. The fact that one is legal and one is illegal has some impact on some, but on a very large group it does not particularly. But the transition via a smoking route of administration is an important one because it is such a small extra step.

Where we have got heroin increasingly inexpensive and strong such that the smoking route of administration becomes attractive and not terribly expensive, we are now seeing some heroin users who commence their heroin use through smoking. So my comment is in part about the route of administration issue: if someone has never smoked, they are less likely to smoke anything. If they have never smoked tobacco cigarettes, we have some evidence to suggest that they are less likely to get involved in cannabis use or, when they do, they are older. In terms of harm minimisation, the later the uptake of these drugs the less likely it is that they will be particularly harmful or problematic. Anything we can do to delay the commencement of smoking tobacco cigarettes is likely to have a flow-on effect in delaying the uptake of smoking of other substances. It is much more complicated than just one leads to the other.

Ms ELLIS—It is really good to get that information. Thank you.

Mr ANDREWS—In the Penington report there is a recommendation about education information support and skills development for parents. What did the committee envisage in that area?

Prof. Hamilton—We did not have a specific set of programs or messages or a 'curriculum' in mind. Rather, we were wanting to affirm the work that has been done through schools in Victoria over the past four years and, while encouraging the continuation of that work, to perhaps make more effort to engage families and parents. Personally, I would take it further and say 'adults in the local community' because I am concerned that parents are left with the burden of our next generation. Increasingly, we have a number of adults who do not have children, and I would like to think that they would also be willing to share the roles and responsibilities of ensuring that the next generation are sound and resilient. I would take it a little further and talk about engaging adults in the local community.

Mr ANDREWS—In your submission you say:

... research from other countries suggests that it might be resources and effort applied in the very early years of a child's life that offer most promise. It is important that we conduct our own research in exploring these findings over time.

Can you elaborate on what you were getting at there?

Prof. Hamilton—Yes. There is increasing convergence about the antecedents or the factors that contribute to all sorts of social health and behavioural problems that include drug use, youth suicide, mental health in general, juvenile crime and even the propensity to have accidents of all sorts, whether they be accidents in the school yard, accidents in cars, accidents in the workplace or accidents at home. There is some evidence there.

What we are starting to see is a pattern of vulnerability for all of those things coming together, such that prevention programs in those different areas are starting to suggest, with evidence from overseas, that it may well be that pouring the effort and support into young families—forming families—works best. So when couples are having their first child and when children are in those first early years of life might be the most cost-effective times for prevention we can engage in, because that is the era of life where people really develop their strongest risk and vulnerability, as well as strong resilience. It is always hard, I think, for governments to fund those services because you are looking at very early intervention and you are wanting to prevent things that might not be seen for 15 or so years.

As a result, most of the research we have about it comes out of the United States, and some comes out of the United Kingdom. But I think it is promising research. I think is also promising that we now have, for example, a national crime prevention framework—which is the report called *Pathways to prevention*—which goes through and documents these and ticks all the sorts of programs that have evidence for effectiveness. They are very similar, in my reading, to the primary prevention for drugs. So I was really talking about the need to look at those very early years, not to think that something, for example, like drug education in schools is a particularly effective primary prevention strategy. We do not have strong evidence to say that it us. There are good reasons to do it, but we should not see it as 'this is how we stop people using drugs'.

Mr ANDREWS—Would those primary prevention programs of the type you are suggesting be built around the protective factors that were identified earlier by the Penington committee?

Prof. Hamilton—To some extent. I think there are more thorough and more clearly articulated—and certainly more sophisticated or extensive—reviews of that literature in other

places. We have in a sense summarised those and brought them forward. But yes, generally that would be right.

Mrs IRWIN—Thank you very much for an excellent submission. I actually want to discuss three sections of the submission that you had in all separate areas—harm minimisation, treatment and involving families. Firstly regarding harm minimisation: I found this very interesting. With regard to the adoption of an alternative model or approach of more active regulation, mediation or management of drug markets, you suggest that Australia would first need to be a better informed community. What exactly do you mean by this? Do you mean that we are not educating the committee?

Prof. Hamilton—Yes.

Mrs IRWIN—How would you like to do that or how do you feel we should be doing that?

Prof. Hamilton—I actually think that political leaders have got a crucial role to play because the media obviously are always very interested in political leaders' views on controversial subjects. The drug one, as I am sure this committee has come to realise, is vast, it is complex, it is contradictory, it is very confusing and it is quite hard to be right in. I never pretend to be right. Yet many with perhaps less knowledge, I dare to suggest, are clear that they are right.

Mrs IRWIN—That is a very good comment.

Prof. Hamilton—So I think one of the important things is to actually take the community with us on the journey of understanding, exploration and dialogue. We have not been good at that. I think from time to time we have rather polarised the community over what is right and what is wrong or we ought to do this and we should not do that. This is a field where that can be quite dysfunctional and potentially destructive. I say destructive not just because it is another word to talk about dysfunctional but because one of the things that concerns me is that we must have a community who believe in our capacity to respond to and deal with the issue. To the extent that the committee feels impotent, disempowered, unable to respond or lacking in understanding and is just saying, 'I do not know what to do,' this decreases our capacity to build the next generation as confident, resilient young people. If we as adults say, 'We do not know what to do,' what sort of message is that sending to the community at large and to the next generation? I think in that sense it can be quite destructive that the community in the end sometimes feels that no-one knows what to do, they do not know what to do and they do not know what the answer is.

That is different from saying that these are really hard issues and that there isn't a right and there isn't a wrong. We must look to ways of proceeding that we can gain agreement on. When we are talking about the need for trying new initiatives we must do that very carefully, we must explain why we would think of trying new initiatives, and try and take communities with us on that journey in a careful and considered manner. I find the community generally is terribly distressed and sometimes fatigued by the insistence that there is a right answer and a wrong answer, or—and this is even more distressing—that there is somehow a secret menu of options that experts are hiding. You often have the community saying, 'What we're doing now doesn't work, so what can we do?'—as though there is another set of things or a blueprint somewhere that we have not tried or accessed. I find the community often falsely assuming that what we are

doing now does not work and calling for new things but, when you tentatively suggest trialling or trying some new things, very reluctant to allow the opportunity to try those. That is where I think we need to have much clearer leadership that makes a commitment to taking that journey.

Mr EDWARDS—I want to ask about that in relation to the current campaign in the local paper.

Mrs IRWIN—I was going to go on to that. I have written down the words you just said 'take the community with us on that journey of understanding'. That is so spot-on. I think what Graham was going to ask is: do you feel that the media are doing a lot of damage? The reason I am asking this, and a number of other members have asked this of other people, is because of what was in yesterday's *Herald Sun*—

Prof. Hamilton—And today's.

Mrs IRWIN—Do you think they are not getting the right message there, that it is just about selling papers?

Prof. Hamilton—You are the experts in what the media thrive on. They thrive on difference, division, fight and conflict. Sadly, that is quite negative in the drug area. My experience has been that, regardless of political affiliation, if I get an opportunity to speak to a group of people we end up with an enhanced knowledge on my part and on their part and, usually, some sort of mutual understanding that we are actually on about the same things and that, with that shared knowledge, we could do all sorts of things. The media like the high profile, provocative, emotive pictures—drug users in the streets, people injecting, injecting equipment—and all of those things increase the anxiety of our community.

Melbourne is actually a very safe city, one of the safest cities in the world—as are all of the Australian large cities. And yet if you ask most people in suburban Melbourne, 'Is it safe to be in Melbourne?' they would be very tentative about saying yes. That is part of what I was talking about before—it is an extension of that issue of having a community that no longer feels competent or that it is in charge of its city. That is contributed to largely by the media. I walk in and around the city at night, I go to public toilets, and I suppose I feel a little more confident because I am not too fussed by bumping into drug users as I see them regularly—and they are there. But that sense that 'it is dangerous' is one of the worse things we can do. It certainly will contribute to increased mental health problems, and that is independent of the drug use. Just the fear and anxiety, the decreased sense of being able to walk and talk and do your business in public space, is a major detriment and one of the reasons people would not want to live in cities that take on that image, even though it might not be real. And the media is a big part of that.

Mrs IRWIN—I know people say there are always two sides to every story. I am like you, Margaret: I have got Cabramatta in my electorate and I walk the streets like you walk the streets of your loved city. I might go up to people who have just injected and say, 'Why are you taking drugs?' 'Because I'm hurting.' 'Why are you hurting?' Some say they were sexually abused; one women, aged 28, said it stopped her pain about her four-year-old who died. But those stories do not get out. Why are they taking drugs? What is there to help them? So thank you for sharing that.

You say that there are many families eager to be involved in helping to prevent the uptake of drug use, but you also say such families are vulnerable to quick fix programs, some of which are very expensive. Can you give us a few examples of quick fix programs? I have been speaking to people who think: naltrexone—this detox—is absolutely wonderful. We visited George O'Neil's clinic in Western Australia—he was not there at the time; he was in America. There was a naltrexone clinic in my electorate, which is no longer operating. The charge was $6,000 or $7,000 for treatment. Are these the sorts of quick fixes that you are talking about?

Prof. Hamilton—Those would be examples. Sadly, this is not an issue and heroin dependence is not a condition that there is ever likely to be an easy fix for because there is no easy explanation of how someone gets into it and they do not get into it overnight. It would be foolish for us to think that a quick response will be able to reverse what is usually six to 10 years worth of difficult life circumstance and all sorts of things happening.

I think it also occurs in the prevention area. I am always very loath to criticise any groups with good endeavour that are out there, and I will perhaps need to explain myself a little bit once I name them. A program like 'How to drug proof your child' has a very catchy title and is very attractive to parents who are desperate to drug proof their child, but it is a little misleading to suggest that there is a way to drug proof your child. That program and the people who work with it have made a lot of endeavours to make it relevant and make it local, even though it has been imported from North America. They have certainly consulted with me, and I had some concerns in their early days about two things. The materials they were using were very much focused just on illicit drugs and did not at that time deal with alcohol and tobacco particularly well. I understand they have now included some material—on alcohol, particularly. I also worry a little bit about the sales pitch and the apparent promise that you can drug proof your child.

What happens to those families if their child gets involved in drugs? How much more of a failure? I do not know how to drug proof my children. I have a 17-year-old, about to turn 18, at schoolies week this week, and I have a 14-year-old daughter about to turn 15. What I have done with them—again, trying to live out my rhetoric—is try very hard for them not to take up cigarettes. They have older stepsisters who smoke, and that makes it difficult because they are big, positive, desirable role models. Thus far—touch wood—neither of them are smokers, and I feel that if I have got James to the age of 18 and he is not a smoker, that is a help. For me that is an important part of drug proofing him.

But if we are really talking about drug proofing, the things that we need to be enforcing are the valuing and the connectedness, spending time and effort to communicate with our children to indicate to them that we do care about what happens to them and that we do care when they are in trouble—and that we also care when they are doing well. It worries me that sometimes people get falsely focused on the drug specific components rather than the big effort on those broader messages. I know many families who have a lot of knowledge about drugs. I have many colleagues who have been working in and know this area very well, and some of their children take drugs. If you can have all that knowledge and still have your own children taking drugs then I do not believe there is a way to drug proof your child by training. I am not wanting to say that that program has no value, but I think that sometimes programs can promise much and it is difficult for them to deliver.

Mr ANDREWS—A title which is catchy—in a world of advertising, jingles and trying to get people in—is obviously designed to attract people to it. I have sat through that program, and what it seems to me to be about essentially is communication between parents and children, which I would have thought was a good idea.

Prof. Hamilton—I think it is. That is why I am saying there are a lot of elements in it that are positive and quite worthy. My view, quite strongly—and it is based on evaluations of a range of programs—is that the best drug prevention programs are actually delivered through usual institutions, usual service providers that young people come in touch with, rather than extra special or different ones. In that environment, the more successful drug prevention programs have the usual teachers in schools, the usual group leaders for youth groups or religious leaders for people who have a commitment and affiliation with a religion, rather than some of the special add-ons. It is partly out of that, I would have to say.

Mr ANDREWS—Aren't they mostly aimed at children and young people? What about the involvement of parents?

Prof. Hamilton—Many of them increasingly include parents or are working to include parents. One of the dilemmas and difficulties is that some of the families who are perhaps vulnerable but least vulnerable are the ones who are most likely to engage in programs that are directly advertised as drug programs. I would say that in an ideal world we might want to look at how to involve parents in education and at ways in which schools can work harder to engage parents in an overall joint partnership with a commitment to educate and nurture young people into adulthood. As a part of that we might include drug education, rather than having a situation in schools where the children are dropped off, do their education and go home, and every now and then the school runs a drug program and invites parents in. In a way, we end up with compromises on that.

Mr ANDREWS—Isn't that what is happening, really? The more the drug education is brought into the mainstream curriculum in schools, the reality is that parents have less involvement.

Prof. Hamilton—I do not believe that. I could not be absolutely sure. That is why I said 'believe' rather than 'evidence'. One of the things I do to drug-proof my daughter is to serve at the school tuckshop once every term. That is one of the strongest and most important roles I have got even though I am a full-time worker. Going to the school tuckshop for a day may be more important than my going to a parent information night about sex or drug education. In that day I get a real feel for where the school is at, what the community of young people are doing, who they are, what they like and dislike and how polite or otherwise they are—because when you are on the end of the tuckshop line, you cop it. It is those sorts of engagements and involvements that may be more important in facilitating that kind of supportive, caring, connecting community of concern around young people than specific curriculum programs.

Mr ANDREWS—I am just expressing a concern that what is coming through to me is a sense of excluding parents one way or another. Whereas what we are trying to do is to say that this is a holistic approach, and the more parents can be a part of it, the better. If you go back to your point about trying to do things in the early years, we are talking about five years or so of a child's life before they will even go near a school.

Prof. Hamilton—I very much agree with you. Anything that excludes parents is bad.

Mrs IRWIN—There are some parents who are not interested too.

Prof. Hamilton—That is true, but some of that is our lack of sophistication in understanding what interests parents and our ways of approaching them. I do not think I have ever really met a parent who does not actually care what happens to their kid. It is our inability to better understand how to engage those parents who seem hard to engage.

Mrs IRWIN—A very good point.

Ms HALL—When I was down here last time and visited Turning Point I was really impressed with the work that you do—the level of research and dedication of all your workers.

Prof. Hamilton—Thank you.

Ms HALL—I have read your report. I read it then and I have skimmed through it again this time. What is the most important message you would like to give us, a federal government House of Representatives committee, in our considerations of this issue?

Prof. Hamilton—The importance of us evolving and celebrating an Australian approach to the drug issue. We too often look for derivative solutions from other places, be they European cities, the Netherlands or the United States. I am fortunate and privileged to meet people from other countries, who, when they visit us, say, 'We find it extraordinary that you can sit in the same room or at the same table and work out policies between health people and police, for example—that you can see the continuity, linkages and complexities, of tobacco, alcohol, benzodiazepines that have been subscribed, benzodiazepines that have been sold on a black market, heroin, cocaine, cannabis, et cetera.' There are grand opportunities for leadership in the country. Rather than saying, 'Look at what's happened there, look at what's happened there; we should try a bit of this, try a bit of that,' we should look to what our capacity is and our understanding of our own citizens.

The two words that, over time, have come to help my thinking are 'humane' and 'pragmatic' responses. I did not hear him speaking, but I understand the Prime Minister yesterday was talking about some of the values that he wants to promulgate about an Australian approach to things, and I think he used the phrase, 'the Australian way'. I hope that he might apply those same values and ideas to the drug area, because in this country none of us want to exclude drug users, because they are our children, our brothers, sisters, fathers, uncles, cousins and so on. We also know that, if we can assist and support someone and keep them alive, they do stop using. That is the humane bit. I think the pragmatic value is very much the sort of Australian attitude of problem solving—find a solution, there has to be way of doing this, let us have a go.

I am affected a little bit by my own history, which was in rural Victoria. I can always remember that on the farm you were often in a situation where you did not have the right bit to fix the tractor or whatever it was, but I never, ever had the attitude put into my schema that that meant you had to wait until you could go to town and get it. What it meant was, 'Okay, what have we got out here? What's in the tool box? What's on the trailer? Can we cobble together something? Can we find a way through here—can we find something that will work? Let's

forget for a moment the theory. What might work? Let's give that a go.' And you soon knew whether it worked or not. I regard that as an enormously valuable component in my resilience. That is something I would like to see us celebrate, because historically, certainly, Australia has been built on those values. It would be very sad if we did not somehow celebrate that and use it to help inform us as we progress. The sort of evidence in that circumstance—of whether the tractor got going or not and whether you could get back to the shed and so on—would let you know if it worked or not. But if it did not work, you did not say, 'Oh well, nothing I can do.' You had to try something else.

That is why I am quite committed to trying things—trying them with caution and with care, but with a bit of innovation and a bit of flair—and then trying to evaluate them to see if they work. If you get good evidence that they work, then you would do it again. And if it did not work, it would just mean you have to try something else. That would be my message: we should look to ourselves and our capacity, using all the information, all the tools and all the bits in the tool box that are available to us—not reject any of them, but find our own solutions and celebrate them. We have done actually very well, notwithstanding the ongoing problem that we have. In an international environment, we compare very favourably with other countries when it comes to drug policy. There will never be an era where we have fixed it. It is an issue of persistence, and I think about it when I think about working with indigenous programs. I do not know that there is a right way to do it, but the important commitment is to persist. It is through that effort and doing that that we might find better ways, rather than, 'I'll wait until someone tells me that's the menu that you go to and you select that one and that'll fix it.'

Ms HALL—What do you think the biggest threat is to achieving this?

Prof. Hamilton—Probably the matters we were talking about before: polarising the community and providing false hope that we can get rid of drugs or that we can get to a situation where we do not have a drug problem. I think that is entirely unrealistic in an era of global trade, communication and travel. I just do not believe that will occur in my lifetime. So I think it is false promises and false information and polarisation around drug issues rather than a feeling of coming together.

Ms HALL—In the area of dual diagnosis of people suffering with mental illness and substance abuse, how are the services here in Victoria and what do you think needs to happen? I notice in here you mention training of staff, and I am sure that is one of the issues.

Prof. Hamilton—The co-occurring conditions or co-morbidity is a huge issue for us in the drug treatment area. Drug issues are a huge issue for mental health and physical health services as well. I believe we have gone beyond the time when we can section this off and say that this is a specialist area. The figures vary everywhere: from 10 per cent up to 80 per cent of mental health service clients who have significant drug and alcohol issues. A significant proportion of them, and I think it is a majority, are also smokers. I would add that the workers in mental health and in drug treatment are also more likely to be smokers than workers in any other sector in our community, other than perhaps the cigarette industry. The issue of taking things in response to, or as a part of, those conditions is very much a part of those worlds. Those conditions certainly occur.

In terms of services, we have probably gone down a track of almost overspecialisation, but there is now a realisation that there really needs to be some better cross-linkages. For the last few years here in Victoria we have seen efforts at developing common protocols and referral mechanisms, for example. I would just say that I think they are inadequate, sometimes nonsensical, and their sustainability is very limited. That is as someone who has written them, worked very hard and been in there. That is because the best results you get are while you are working on them. You get a lot of coming together, say, between mental health and drug treatment, while you are doing them. You put sometimes years of effort in and then you get this nice document that defines the protocols and then those staff move on and the protocols stay on a shelf. The best collaborative work that went on was while you were struggling with the protocols. It is the effort to do them, and not the product, that actually counts. We have not got this right and, I think, the structure of funding of health services more broadly is complex.

Perhaps one of the issues I would raise for this committee is the complex web between Medicare paying general practitioners in our community and the state being responsible for most of the direct drug treatment services. Our most successful treatment for heroin dependents is the use of methadone. Methadone in Victoria is supposed to be delivered through GPs and GPs are paid for by the Commonwealth. So over the last few years, when people from the Victorian government got up to describe drug treatment services, they had a complex chart with all the specialist services, but GPs and methadone were not on there. Many of the drug treatment services have ambivalent attitudes towards methadone. I respect people who choose not to use methadone and successfully manage drug treatment without drugs, and I certainly would want to affirm that very strongly—as someone who has evaluated Narcotics Anonymous, for example. But I think it is unfortunate that we have that thinking division, where one of the major treatments that we ought to be making available is not seen as part of the state's drug treatment program in people's minds. It is partly because of the different funding arrangements. Similarly, in hospitals here in Victoria, we have seen a decrease in the commitment of hospital based services to people with drug and alcohol issues over the past 10 years. That is partly due to the funding arrangements that we now have.

Ms HALL—Taking it a bit broader, I suppose it comes to the linkages between the federal, state and local governments all working together in partnership to achieve a good outcome.

Prof. Hamilton—The necessary beginning point is for those levels of government to come together. I am very pleased that local government has very recently been invited to construct a committee to participate in national drug policy deliberations. I think that is a positive and constructive step. I think that there are still all sorts of complexities about our levels of government and who is responsible for what. An immediate one that confronts us all is the place of some of the new pharmacotherapies. I know that we have had calls from many sectors for naltrexone to be put on the PBS. Buprenorphine, which has just been registered as a drug and which I think holds great promise, will only be a valuable drug if it goes onto the PBS. There are strategic policy issues associated sometimes with decisions that often feel, at a local level, so far away as not to be able to connect with or influence them.

Ms HALL—Yesterday, we met with a group. One area of research that they said was inadequate was foetal alcohol syndrome. Do you think that there needs to be more research in this area? What do you know about this syndrome? How widespread is it? It was put to us that it was extremely widespread within the community.

Prof. Hamilton—I call it a contested condition. It is not a readily diagnosed condition. I believe it is probably underdiagnosed in Australia. Our official prevalence rates are actually very low in comparison with, for example, the United States of America which has very high prevalence rates, particularly in American indigenous communities and in poorer communities. I do believe it is an issue for us. In fact, it is currently on the agenda for consideration of the National Expert Advisory Committee on Alcohol for that reason. I always have concern about a condition that sounds as though, looks like and may be differentially diagnosed in some subpopulations more than others. I think it is one that we must approach with great care and caution to avoid it becoming a stigmatising diagnosis for Aboriginal Australians. I think that population is vulnerable to it. It is likely that there is a higher prevalence in those communities than in the total population. I think that requires a good deal of sensitivity in how we approach it.

I would say simply, yes, we do need to think about it more. We probably need more research but I would like an opportunity for that alcohol group to bring together what is known before we presume that there is not enough and we rush off to do more. We need to be careful about different country comparisons because it is a condition that is contested. You can ask two doctors to have a look at a baby and diagnose it. One will say, 'Yes, this is definitely foetal alcohol syndrome,' another one will say, 'No, it is definitely not,' and, if you brought in a third, they might talk about another condition called foetal alcohol effect, which is having a little bit of it but not all of it. It is not an easy one to just take the figures off a shelf and study them. I think it needs quite a deal of looking at. We certainly need to do that.

CHAIR—Professor Hamilton, I have just a couple of quick questions. You mentioned the general service area—this is the training issue—and that you need a vibrant and competent specialist sector.

Too often this aspect is forgotten or left too late. As a result it is extremely difficult to recruit appropriately qualified and experienced staff in this sector currently.

Then you go on to say:

Various National and State level needs analyses have been conducted and reported on. Their recommendations appear hard to implement; possibly because some actions required cross traditional domains and/or Departmental boundaries. Whatever the reason, unblocking them is essential.

Perhaps we could touch on the cross-traditional domains and/or departmental boundaries, which may give us a couple of clues on what recommendations we should make and how we might assist.

Prof. Hamilton—Certainly, and I appreciate a chance to speak briefly to that. It arises out of my experience over many years of having provided advice, or been a participant in, working groups who have written things about what we need to improve the work force. I note that without exception those work force recommendations have always been the last ones to be considered by governments. Whether it is in time or amount of money—and it is usually both—they are very much the dag end of the whole affair. It is sometimes because we have departments that are responsible for, and fund, education and training, but they are usually not the departments where the main impact of the drug issues is felt. So then you get, say, justice or law enforcement and the health and treatment sector with huge needs. It seems to take an

awfully long time to bring the right people together to get the funding constructed in a way that can be made available.

Also, we generally underfund training programs. We have engaged in this country endless one-off, itsy-bitsy programs, saying, 'Throw a bit of training at it; that will be a good thing to do.' We just cannot keep doing that. If there are not proper career structures for workers, we will never have a good drug and alcohol work force. So it is absolutely essential that we work hard across some of the key professions to see what is necessary to have a critical mass of well qualified, trained and committed people, and to keep them in the sector. You do not do that by recruiting them at a junior level, throwing an odd day of training here and there at them, letting them burn out and then saying after five or 10 years, 'Well, there are no more jobs for you.' And that has been our history.

It requires quite a lot of considered thought. I am not a medical doctor, so it is not my profession I am arguing for, but medicine is key in terms of status and capacity—it must be supported to develop a specialty in addictions. We have doctors who are committed, but if they want to ever be specialists, they cannot afford to stay in this area at the moment. I am advising some of our most experienced medical practitioners at Turning Point Alcohol and Drug Centre to get out. I do not want to have to, but for their own careers that would be the advice. So I think medicine is key, and professions such as social work, teaching, psychology and nursing are critical. We have to comprehensively look at it, not just when people are in the jobs. We have to go back to curriculum and accreditation of university courses. There have been reports written about this, so I will not try to repeat all of those.

The federal government's initiative some many years ago to fund what was the CADEMS program—Coordinators of Alcohol and Drug Education in Medical Schools—was critical in giving us a bit of a lead in this area over the last 15 years. Sadly, that is no longer funded, so that is one I would encourage some reconsideration of. Again, not because I think doctors are the best and the beautest, I just think that if you have not got that profession well trained generically, you are not going to have general practitioners, gastroenterologists or psychiatrists who at the end of the day care about, let alone understand, drug related matters.

CHAIR—Thank you very much. No doubt it is quite complex, but could you give us a brief insight of cultural differences. You have touched on the Aboriginal situation and you have also mentioned Vietnamese communities. The assistant commissioner this morning said, I think, that 500 of the 9,000 police officers of Victoria have more than one language. Is there something significantly different around the substance abuse issues of certain cultural groups that we could be a bit more aware of?

Prof. Hamilton—Yes and no. Let me do the yes bit first. Yes, in that many of our specific ethnic groups are recently arrived migrants and some of them are refugees. We know historically that social and behavioural trouble, and drug trouble in particular, are much more likely among the most recent arrival groups. It is partly the kind of post migration experience and the trauma, loss and grief and so on. I think there is increased vulnerability as a result of the cultural dislocation and all that has gone with that as well as individual circumstances that have often been quite traumatic and pretty dreadful.

There are also sometimes cultures of origin, beliefs, attitudes, knowledge and experience that make it more complex for us to take these communities with us on the journey that I was talking about before. I just see that as a different version of still needing to do the same thing. I have had a truly privileged opportunity to speak a couple of times at the North Yarra Community Health Centre events, and most recently at their annual general meeting. They, for me, personify the effort. When I speak there I am told before I come that I will be speaking to a mixed language group and they always have between six and 10 simultaneous translators in a space even smaller than this. I am given notes if I wish to use them to prepare. They go to extraordinary lengths to include their community in their deliberations and meetings. I spoke there recently. You speak for a sentence and then you wait. All around the room you have people with a cluster of others sitting around them explaining, talking and engaging in dialogue.

That is the no part of my answer. It is just a different version of needing to take those communities with us. In doing that we need to recognise that sometimes those differences are quite strong and profound. They are based on a mixture of belief as well as knowledge and information. We have to recognise that and it will take considerable information and dialogue for us to understand their experience and for them to understand ours.

CHAIR—Thank you very much. As ever we are deeply indebted and appreciate what you have done.

Prof. Hamilton—Thank you very much for the opportunity. I wish you well. This is a tricky arena. I do not expect and would not ask you to come up with the answers. I hope that you have heard me say that there are not any, but do join us in this effort.

[2.43 p.m.]

HANNAN, Ms Ainslie, Co-ordinator, Eucumenical Migrant Centre, Brotherhood of St Laurence

HOUSAKOS, Mr George, Manager, Brotherhood of St Laurence

KYRIAKOPOULOS, Ms Angela , Tenancy Worker, Rental Housing Support Program, Brotherhood of St Laurence

POWELL, Ms Margie, Manager, Rental Housing Support Program, Brotherhood of St Laurence

SIEMON, Mr Don, Social Policy Co-ordinator, Brotherhood of St Laurence

CHAIR—Welcome. The proceedings are legal proceedings of the parliament and need to be treated in that context. If you would like to make a brief opening statement we will then discuss the issues.

Mr Siemon—I will give a very quick introduction. I thought it probably needed five of us to replace Margaret Hamilton, from Turning Point, because of her enormous knowledge. We are very impressed with Turning Point, which is a near neighbour of the Brotherhood's head office in Fitzroy. The Brotherhood, as you probably know, is a Melbourne based agency. We have a budget of about $30 million a year and we operate a wide range of services: community services, children's services, different forms of residential and community care for older people and people with disabilities, tenant support services, material aid, some family support services, early childhood learning services and a range of employment services, including the JPET, CSP and Job Network services.

The thing that is most distinctive today is that we are not a drug and alcohol agency. We are not an organisation that has direct service experience in the drug and alcohol area; neither are we engaged in research directly around drugs and alcohol, even though we have a longstanding and, in terms of non-government welfare organisations, quite extensive research history. In fact, one of the interesting comments that Margaret made was that some of the boundaries in this area are shifting, and we have chosen, for the first time in a long time, to share the experience of our services regarding drugs and alcohol in ways that previously we would not have. We do not, for example, have an opinion on things like: is methadone a particularly helpful stepping stone away from heroin, why, or for whom? But we do have a number of services that have worked for a long period of time with people whose lives have been deeply affected by various drugs, legal and illegal, and that see various types of illegal drug use in their communities. We thought that might be of interest to the committee.

All the staff here apart from me are engaged directly in those services. The key point to make is that the services that we spoke to in preparing our submission were those we knew had direct experience, particularly of some of the illegal drug use. While some of the numbers that our staff have come up with are quite striking—for example, some services saying that a majority or

even, in some cases, 100 per cent of their clients have significant drug issues in their lives or have been impacted in very damaging ways from substance abuse—those are not representative of all our services, nor are they representative of community services more generally across Victoria. The reason for making that point is, of course, that we do not want to build up or contribute to too much of a climate of fear around those issues. At the same time, we certainly do not want to play down the real hardship which is out there in particular communities and particular parts of Melbourne.

There are two very strong messages coming from our services that I want to emphasise. The first is that there is a pretty well-held view among our service staff that the growth in substance abuse, particularly illegal drug use, can at least in part—and, probably in their minds, very largely—be sourced to the hopelessness that is associated with poverty and lack of opportunity, and that addressing those problems is at least as important as more directly drug related interventions. The second is the observation that it is often the people who are at the most vulnerable point in their life, or are vulnerable for other reasons, who in practice are the one dealt with by the criminal justice system. It is the people who are homeless who tend to be the ones injecting publicly and tend to be picked up by the police. We need to ensure that our responses do not make life worse for those people in a selective and quite unfair fashion. There has been reference to the *Herald Sun*'s front page yesterday. We certainly would have concerns about the extent of that type of representation of the problem for those reasons. Thank you.

Ms Hannan—I would like to make a comment on the last question you asked Margaret Hamilton. I addressed it in the submission but I would like to make a point about it. The relationship between diversity and substance abuse I believe is not in itself to do with ethnicity but with the known lack of opportunity and experiences in certain populations in relation to taking up certain settlement opportunities in Australia. That is a very important point. What we need to do is think about the high levels of unemployment within new arrival communities—up to 78 per cent in refugee communities, with many of those people having overseas qualifications. We need to think about the fact that 28 per cent of all young people in juvenile justice come from Cambodian, Vietnamese and Malaysian backgrounds and 100 per cent of those problems are drug and alcohol related.

The point I want to make is about the data collection system. The Commonwealth is doing a very good job under the Charter of a Culturally Diverse Australia of looking at indicators for diversity so that we can map appropriate responses in our different program areas. At the moment the Culture of Language Indication Program is in its implementation phase. This will inform the whole of the Commonwealth and also the ABS data collection system, which government rightfully takes as its major planning tool. But there is no collection for ethnicity. There is language and country of birth, but no ethnicity. This means that second generations cannot be tracked. This also means that sizeable populations of Assyrians, Chaldeans and Kurds cannot be tracked in terms of what instances there are of drug and alcohol abuse and what a pragmatic response could be. This is a severe limitation.

CHAIR—In terms of the overall issue of substance abuse we heard earlier about a belief or an optimistic hope that we can do better—and we know we can do better. Perhaps we can start turning it around. What signs, if any, do you have of this issue being able to be turned around? Do you have anything there that is showing us a positive light? Is there anything that you know of within this whole issue?

Mr Siemon—It is clear that in terms of individuals' lives there are programs that do make differences. George might want to say something about a couple of employment related programs, JPET and CSP, that people may be familiar with. JPET is really for young people who have very deep disadvantages, homelessness particularly, as predominant factors. The CSP, Community Support Program, is really a bit of the Job Network for people who are deemed by the system as not being able to benefit from intensive assistance because of complications in their lives. The effectiveness of those programs is in stabilising and helping people take the time to rebuild their lives. The key question though is the extent to which that experience at an individual service level—in this case models which are focused on employment but also acknowledge and deal with some of the drug issues—can accommodate the large numbers of people that are entering the high need group.

Mr Housakos—What we see, in particular with the JPET program, which was originally a federally funded employment and training program—it has significantly changed now to be a support program for young disadvantaged people—is that the support we give these people over a two-year period is actually affecting the drug issue.

What we are experiencing is that, in forming a relationship with these young people, we are actually entering into their subculture in a way that we have not been able to enter before in any other employment based program. In doing that, we are actually submerging ourselves into their world and, in essence, once we become part of that world of being able to support and lead people into rehabilitation—the issue of sending someone off to detox is fine from a referral point of view, but it does not work—unless we stay with that young person and give them a pseudo community to feel part of, then our work does not let us get them away from the drug issue.

CHAIR—This is unrelated but it might connect slightly. Wasn't it the Brotherhood of St Laurence who did some historic demographic work showing areas of poverty and, over the years, the impact or those things that were not able to impact on this level of historic poverty. Are you familiar with that study?

Mr Siemon—There are studies that we have done over a number of years, but I am not clear enough on which one you are talking about. You are not referring to the Jesuit Social Services and Tony Vinson's work on indicators of disadvantage?

CHAIR—Yes, that is the one.

Mr Siemon—Yes, Tony Vinson. That was really doing a different sort of indicator of disadvantage based around social problems rather than getting measures of economic disadvantage.

CHAIR—I remember it very well, because he brought it to Canberra and sat down with us and worked his way through it. I just wondered whether we were able to make any useful connection with some of that work.

Ms HALL—I must leave. I am disappointed that I cannot hear the rest of your submission, but I have read your report. You do great work.

CHAIR—I am just drawing out the degrees of poverty and disadvantage.

Mr Siemon—One point which is very clear from the distribution of our services—and Angela might want to comment a little bit on this—is that in areas where we know disadvantage is high in a number of indicators, not surprisingly, you see some pretty intense concentration of drug problems. In a way, this is almost stereotypical. Angela works in Dandenong, working particularly with people who are either in public housing or are seeking public housing, but also in the context of a broader community advice bureau environment, and her insights from the ground may be useful. They are pretty striking. I guess that the key point is the pretty horrific extent to which prolonged poverty, prolonged unemployment and the concentration of those people in particular communities—which is what we have done through our public housing policies, in part, but which also happens because of the way the private rental market works—plays out in drug use.

Ms Kyriakopoulos—I work on the main drag of Dandenong—Lonsdale Street. I work from the old town hall in the Dandenong Citizens Advice Bureau. We see over 15,000 individuals per year for emergency relief and crisis. I am one of the co-located workers there who works with public tenants within the Dandenong region. For nearly the past three years, it has been enlightening for me to see the way the drug trade has escalated. It is fine the way that the media portrays it and all that, but I see it from a different point of view. I see the issues of drug related poverty and how it affects people and their lives. I see a lot of my clientele, especially with drug related poverty, who have not got enough money to pay off their drugs and have to go and do illegal activities. Once they get caught for illegal activities, the police will put them through the court system and then they will go through the whole system. Once they are released, they are out back to the old support networks and, again, the whole system starts.

I am constantly seeing people die down where I am in Lonsdale Street. A lot of drug users cannot afford to eat, to pay their rent, to do anything. To survive, they have to do illegal activities, whether it be muggings, burglaries, car thefts or armed robberies. We always talk about support agencies. I think we need to start talking about the legal system and how we are approaching the whole issue of drugs. People can talk about methadone, they can talk about support and detox and all that, and, sure, a lot of your clientele go through all those. At the end, what happens? They come back to you, saying, 'I've just had a bit of a taste of something.' You think, 'Let's have a cup of tea and talk about how we can resolve all this.'

My issue is with the legal fraternity in particular. We keep on talking about heroin. We have got to start talking about amphetamines and how they are affecting our society. That is the most violent industry you can think of. The people who control the industry are not street dealers; they are the top people who manufacture. How do the courts manage the problem within the legal system? What type of sentencing do they dish out to people? It is no good saying to drug users, 'I'm going to put you away for six months.' Sure, they are going to get a free feed, a free bed and everything, when they come out they are clean and strong, and it is going to start again. So we have to start looking at issues and solutions and how to regulate some of the legal problems, in particular with the drug dealers. Maybe we need to enforce higher penalties for drug dealers. A lot of them go into the magistrates and they laugh. They adjourn their court cases three times. By the time it gets to the third time, the magistrate is not really interested.

I can talk about lots of issues and what is happening within the drug trade. The majority of my clients are involved in the drug trade, whether they are drug users or dealers or their families have been involved, the illegal activities—I can go on and on. But I think something needs to be done urgently.

Ms ELLIS—Angela, thanks for that. I would like to talk to you about the legal system a bit more. When you mentioned Dandenong, it brought back a lot of memories because I am a Melbourne girl and I worked at Dandenong High School for nearly 10 years—100 years ago!—so I know the region reasonably well. In your submission, you talk about the contradiction in the message that comes out to some of these young people in terms of treatment versus the legal system—for example, they cannot get access to methadone, there is a long list, or they cannot get access to detox, so they go through the courts. As you say in your submission:

> There is a concern that the current response sends a contradictory message to people surviving on low incomes. It is very difficult to access an appropriate service to assist them with their addiction, but if they are convicted of a crime and sentenced to gaol, that same person will have access to a methadone program, access to detoxification facilities, to shelter, food and company.

You have also just been talking about that, but can you talk more about the treatment side of it, which you did not mention—that is, the long lists waiting to get onto methadone versus what happens when they go through the system?

Ms Kyriakopoulos—When they go through the system, particularly if they are linked into the methadone program—and you know Dandenong quite well—most of our chemists are located where the drug trade is.

Ms ELLIS—Or is the drug trade located where the chemist is?

Ms Kyriakopoulos—They are located near McDonald's—that is what I can say. What I am finding with a lot of the clients, especially about the methadone program, is the issue of the cost. I know it is unrealistic to say that as they are only paying about $35 a week, but it is still coming out of their pension. What the methadone does is control their lives and makes sure they do not go into illegal activities—the thrill has gone. It is easy to go onto a methadone program—there is no problem about that. Within two or three days, you have been linked through your doctor, you get your photo done, you do your ID, it gets sent to Canberra and you are on the methadone program with a chemist—you are on the list. But the problem is that they need some type of support workers out there. It has to be more than just drug and alcohol workers. There have to people like community development workers who are trained to look at certain areas for them. A lot of dug addicts have a problem with cooking. Hygiene is the number one thing. They need new friends. It is hard to explain.

Ms ELLIS—What you are really saying—correct me if I am wrong—is that it is all very well to pick up the issue directly related to their addiction, be it methadone, detox or whatever, but we also have the person with the nutrition needs, the health needs, the housing needs, the support needs, the socialisation needs and all those other things that you cannot do just by merely dishing out methadone three times a day. There are all these other things to attend to as well.

Ms Kyriakopoulos—I will give an example of renting. It is fine to give someone a house to rent. How do they pay their rent? How do they pay their bills? How do they do anything? At the end, they will have a massive amount of rental arrears or antisocial behaviour. Most times antisocial behaviour is involved with a lot of drug related issues. They will be evicted. They will become homeless. Something has to give. Something has to be there for them. At the moment there is nothing. It is really tragic to see a whole family being evicted because mum or dad has a drug problem.

Mr ANDREWS—You have spoken about substance abuse leading to poverty which I think is well enough understood. I was interested that on page 4 of your submission you quoted from the study by Johnson and Taylor. You refer to poverty leading to drug taking—the reverse situation. I am just interested in teasing that out. What are the main causes of poverty that you would identify?

Mr Siemon—The most obvious one is the inability of people to get paid employment, whether that is reflected in unemployment more formally or people being jobless for other reasons. Clearly, the high levels of sole parenthood contribute significantly to poverty. In Australia, one of the interesting things is the extent to which some of those things overlap now because we have had high levels of unemployment and quite significant levels of quite long-term unemployment for a long period of time. It is a bit difficult to disentangle those things about what is an entirely cultural phenomenon, for example, in sole parenthood and to what extent it is household formation is influenced by job opportunities.

Underemployment is associated with that. There is not a simple divide between the unemployed and the employed any more. There are a lot of prime working age families that we have seen in our research where fathers lost their jobs in the recession of the 1990s and have never got back into the stable employment that they had managed to hold on to in the 1980s. That is a big part of it. If you talk about poverty in terms of poverty incidence measures against the Henderson poverty line, by definition some of it is due to inadequate social security payments. Poverty, as it is commonly understood in the community, is very largely driven by the difficulties of people getting the paid work that they want in sufficient amount to build their lives through that means.

Mr ANDREWS—In your experience, can you identify what proportion of poverty leads to substance abuse compared to substance abuse leading to poverty? Is there some breakdown that you could make a ballpark estimate about?

Mr Siemon—The comment which Margaret Hamilton made, which in part derives from research by people like Chamberlain and MacKenzie, particularly in terms of young people, is a good example. The risk factors for youth homelessness, youth suicide and teenage drug taking tend to be similar. Some of that is disruption in households; it may be things that happen within the families; it may be parental unemployment. You can identify those sorts of risk factors and the statistical connection with the outcomes you are worried about. They all tend to be rather similar and to play up differently when you look at life histories, when you do detailed interviews with young people.

We have done quite a bit of work in the past about youth homelessness: what helps kids stay at school, what the positives are and the resilience factors to counteract the risk factors. It seems

to me that we have a situation where we have had prolonged high levels of unemployment and quite sustained levels of poverty—however you measure it and describe it. We have concentrations where those are real problems, and they are clearly associated to some extent. Your point is absolutely right, and it is a point that can be made for gambling as well, and probably a lot of other problem behaviours. Gambling leads to poverty, but we also know that those people are at risk, having not much else to do, and so gambling is probably as good an investment as anything else. If they come from poverty, they have a higher propensity to throw their money down the pokies. The drugs are a bit the same.

The experience of working on the Rental Housing Support Program, more generally than any, probably gives a bit of that same story. Most disturbing is the extent to which we now have a very high level of very damaging drug use as part of their normal behaviour among particular groups of people who are very disadvantaged. We always had that with alcohol and smoking. We have now got not only heroin but also sniffing chroming stuff, with young people in care. Some of that is deadly. That is a bit more intense than it used to be, and that reflects the fact that we have not been able to wind back some of that poverty nearly as fast as perhaps we should have, and that is because we still have not really got on top of unemployment.

Ms Powell—As the manager of the public tenants support program across the southern region, which is one of the biggest regions in metropolitan Melbourne, I see the frustration of the tenant workers dealing with people who are affected by drug and alcohol substance abuse, in that they have a job to do. They are generic workers, which is to keep people in their public tenancy and also to get other people into public housing. Working with people who have been affected by substance abuse makes their job much harder. In a climate where you are expected to see a certain number of people and keep things ticking over, there is no appreciation or understanding of the way their jobs have changed. My concern is dealing with their frustrations of having to work in that climate. It is a bit of a cycle—a bit like Angela was saying—in that they get evicted because they stop paying their rent because they cannot pay their rent because of their drug use. There is that aspect.

The other aspect I am concerned about is that a lot of drug activity occurs on public housing estates, partly because they are large concentrations of low-income people. Therefore, public housing then becomes stigmatised and acquires a name, such as, 'They're all on drugs.' That is most unfortunate because then we have people who genuinely need to go into public housing being frightened of taking up that housing option. It is not fair on the very valid older communities of public tenants who have been there for a long time. Their lives are being disrupted. The policy of the segmented waiting list is that the people with the highest need are now getting into public housing. That has also got a huge potential for destabilising those communities. So it is having a very strong effect. That is about all I want to say.

Ms Hannan—We run the state program for Vietnamese, Laotian and Cambodians exiting juvenile justice—developing a model for the state. We are also part of the Reconnect national program, looking at the culturally and linguistically diverse program and looking at youth homelessness. I think the other indicator of poverty, as we have all talked about—including Margaret Hamilton—is family breakdown. We do consultations with Cambodian families on the issue of leadership and we are implementing a life choices program for young people around mentoring in business, with Rotary, to try to break some of the cycles of poverty that lead to substance abuse. The startling thing that one woman said to us is, 'We don't know what to

do'—this is through an interpreter—'We shouldn't have carried him across the killing fields. We should have left him. Now he is addicted. We don't understand the system. We don't know how to get into it.' There is a Cambodian expression, 'Just leave us his eyes'—and you try to work out the rest because 'we do not know the system and we do not know what to do.'

Mrs IRWIN—I have a big Vietnamese community in my electorate in south-western Sydney, in Cabramatta. I suppose you have heard about it.

Ms Hannan—Yes, I have heard of it.

Mrs IRWIN—I never tell the people on the committee that I come from Cabramatta. We are trying to teach the older people within the Vietnamese community that their children have problems, but they do not want to know. A lot of them turn their backs because they lose face. That is another expression—they lose face.

Ms Hannan—Yes.

Mrs IRWIN—We have got to try to get through to these communities through education.

Ms Hannan—Our experience is that the Ecumenical Migration Centre has a lot of connectedness with the different communities and does a lot of work with the gatekeepers in the community—actually within the Vietnamese and Cambodian communities. The Middle East community uses religious leaders and cultural structures to develop programs of family mediation and develops it from programs existing within those communities, rather than using a Western bloc model and trying to put a circle into a square—which I am sure they also do in Parramatta, too. It also asks businesses within the Vietnamese community to use traineeships. That gets back to the whole issue of life choices. People in those communities say to us, 'We don't want to have another employment program about how you write a resume. We want a job.' Many of those people in the communities have offered people mentoring programs without so much as a subsidised labour market program. There are not many opportunities. It would be unrealistic to think that there is no discrimination happening in terms of employment in those communities. That is why I think that one of our most successful programs is the Life Choices Program, which looks at partnership between businesses, traineeships, personal development and self-esteem—working with communities to break cycles. Unless you do that, you have a second and third generation of unemployment and poverty.

Mrs IRWIN—On page 1 of your submission, last paragraph, it says:

> We all highlight the importance of strong communities in reducing the risk of people developing drug problems.

In your view, what are some of the factors that lead to a weakening of these strong community relationships. How do you think the government can help to strengthen communities as a way of reducing drug related harm?

Mr Siemon—Australia has some well tried and, I think, useful approaches to this which, in a sense, have been a little overlooked because of governments tending to see services as things which are there and which should be seen as commodities in some way. So we have seen a move away from funding models at a state level, particularly in Victoria, which have focused on

how we can develop a better infrastructure in particular locations and how we can encourage the local community to be engaged in that way—to see services as providers that are funded almost as though they were a shop, except that the purchaser is sort of government rather than the individuals, although, in some cases, it is the individuals who purchase as well.

We have seen a drift away from funding community infrastructure and community ownership in the way that we have in the past. That is partly a change in government funding. At the same time, this happened when increased affluence and, to some extent, other things like changes in the media have tended to drive us apart a little. There is greater inequality, mobility and demands on people's time and the winding back of institutions which 20 years ago were still a bit stronger in people's lives. It seems to me that if governments are serious about rebuilding communities we have to be prepared to consciously resource them more, rather than rely on them to do it by themselves. Whether you are talking about at a local level or about a particular community identity, like an ethnic community, we have tended to do that with things like our settlement services—with recent immigrants, for example, we tend to rely on the existence of community bonds.

I do not see that building a strong community is a substitute for a good system of social infrastructure. I actually think that the two go hand-in-hand. So we probably need, in the case of Victoria, to be increasing again the amount of money we spend on community health centres, for example. We should not just set up local community management structures for the sake of doing them and because everyone feels that they are locally owned, but we should be genuinely trying to ask those institutions, 'How are you genuinely engaging with your local community?'

Margaret Hamilton gave the example of the North Yarra community health centre. We have seen within Yarra, which I know reasonably well, that some of those institutions which were there and were part of the community have been severely damaged by local government withdrawing its interest and by funding squeezes of various sorts and there is no longer the demand placed upon those bodies to really be reaching out into the community and building those connections. We know, if you look at stuff like youth homelessness, that one of the crucial predictors of whether a young person who becomes homeless, for whatever reason—good or bad—is able to hang around in school and actually continue to get an education and get some structure in their lives is to do with the extent to which there are people there that they can attach to. That is behind a lot of talk about caring communities.

We need those mainstream institutions, like child-care centres, schools, health centres and local doctors, to have a sense of themselves being part of a broader local network with local engagements that can provide those points of attachments for individuals or families who are in crisis. I think there are a whole range of strategies that we can use, partly going back to some of the funding strategies that we used the 1970s and early 1980s, and certainly there needs to be a recognition of the importance of communities trying to do things for themselves. I think it was a pity, for example, that we lost some of the local Skillshares as employment services. I am very sad that we see community based and owned children's services as a sort of inefficient competitor to the private sector child-care centres. I think it is a pity that we have told local government in Victoria that their business is to go back to roads and rates and to forget about human services.

Mrs IRWIN—Potholes.

Mr Siemon—There is a lot we can do and there is a lot of knowledge there. We are not starting from nothing and there are plenty of really useful small initiatives in every community that you can start with, and a lot of goodwill.

Mrs IRWIN—If a young person came to you and said, 'I have got a drug problem. I want to get off drugs. I am crying out for help,' what would be your first step?

Mr Siemon—I will start with you two for answers to that, I think.

Mrs IRWIN—Where would you start? Who would you phone? Where would you steer them?

Ms Kyriakopoulos—I have a few friends and colleagues who work in different agencies. I would ring up the Drug and Alcohol Council in Dandenong to see what is happening and to see if I could get the person booked in automatically for some type of counselling. Also, I would ask whether or not there was accommodation for the individual, especially with the youth housing who specialise in drug and alcohol. If that does not work, then I would have to start thinking, 'What am I going to do?' I have colleagues all over the place and I would start ringing around all over Melbourne to find out where I could get this person housed. Not all youth housing places will take individuals who are drug affected. That is one of the questions you get asked over the phone as well—about whether there are drug issues or not. I would also try to access housing establishment funds. Maybe we could not get the individual into any other type of accommodation for a couple of nights but we might be able to get them into a motel, so we would get a few dollars from there. Also, I would link them back into the drug and alcohol place to get an outreach worker to visit the individual as well. There are a few options, but it is time consuming.

Ms Hannan—As part of my job at the Ecumenical Migration Centre, I coordinate the counselling direct services section. We specialise in small and emerging communities across the state. We give advice to Human Services on protective issues. We would start to focus on where the resilience point within that young person was first, as a model, and look at what capacity there was within that person to act, what systems they had and whether the issue was actually relevant or appropriate to link into the mainstream sector. Fortunately, we are based in Collingwood, and there are a number of excellent people at the North Yarra and North Richmond Community Health Services from different communities, but that is not always relevant. If they were more linked in with their family, we might take a family approach to it. It is equally as much a service delivery response as a family-community capacity response that we would use.

If the young person was not able to go home, we would use other existing networks within the community more often than not, which would be often acceptable to the family because we run the family mediation service for the state for diverse communities. If that was not relevant—for example, for a young person from an Islamic background, if that is how they identified—if they were religious ,then they could go somewhere to a religious organisation, like the mosque. We have a mediation program with the Preston mosque. We would then link them with somewhere like the Gray Sisters because, across communities, there is a certain respect for certain structures and it is therefore appropriate. Within the youth homelessness program, a key indicator is to try to get families back together and to get that connectedness,

because we believe that within substance abuse that can enhance the strength in that community and that individual. That is the model we would use.

Mr Housakos—It is an interesting question because we experience it more and more now in employment services. We have more and more people coming to us saying, 'I want a job but, by the way, I am addicted to heroin.' The answer to your question, outside of all the processes that were identified, is the fact that the thing that keeps us alive is our strong links in the community with the other service providers. It is very important for us to sustain those links, even though a lot of our links are suffering the same way we are under competitive tendering and it is becoming harder and harder to survive. But without those we would not be able to refer people on. We would literally have to say, 'There is nothing we can do.' Even for ourselves now, funded to deliver employment services through Commonwealth and state funding, we are more and more having to address this issue on a day-to-day basis and realise that we cannot knock these people back.

CHAIR—I think we need to draw it to a halt there. Thank you very much. We very much appreciate your input, Brotherhood of St Laurence.

Mr Siemon—We have a report that might be of interest which we can provide to the committee.

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

The document read as follows—

[3.31 p.m.]

HOGAN, Mr Paul, Manager, Residential Services, Youth Substance Abuse Service

McDONALD, Mr Paul, Chief Executive Officer, Youth Substance Abuse Service

CHAIR—Welcome. While the committee does not swear in its witnesses, the proceedings today are legal proceedings of the parliament and need to be treated in that context. Over to you, gentlemen; I invite you to make an opening statement.

Mr McDonald—Thank you for the opportunity to speak, especially at this late hour of the afternoon. We will try not to numb your neuro-transmitters too much today. The Youth Substance Abuse Service, as outlined in our submission, is seen as Australia's largest and most significant use of a specific service for those with problematic drug issues. It is currently a state-wide service across Victoria and is working with some 1,300 young people with problematic drug issues per year. Some 25 per cent now are under 16 and some 90 per cent of those are heroin dependent. We put about 540 young people through residential withdrawal. Our submission addresses the problematic end of the youth substance issues. On the issue of the impact of drug use across the Australian community, from a large picture, around half a billion dollars is directed to Victoria, and some 61,000 admissions into Victorian hospitals are due to drug related injuries. We have now, for the first time in Victoria's history, surpassed the 3,000 figure in regard to prison population. Moving to young people specifics, some 85 per cent of those in juvenile justice centres are actually there for drug related issues.

In relation to one of the biggest social issues, I want to outline the 21 deaths that we have had in the organisation in its two years of service, to illustrate that the thinking about youth substance issues is not just about how we get young people to say no to drugs, but how to actually manage young people with problematic drug use behaviour. In the last two years, the Youth Substance Abuse Service has had 21 young people associated with its organisation die—all were under the age of 21. Two-thirds of these were male and a third were female. The age range was from 14 years—which was on the weekend—to 21 years. Of those who died, 51 per cent were under 18 years of age. A third died in public space, a third died in temporary accommodation and 18 died from direct heroin overdoses—with two asphyxiations from chroming. The loss of years in regard to these 21 young people who died from heroin overdose is, on average, 59 years per young person for every death. Of those young people who died, who were associated with the Youth Substance Abuse Service, 75 per cent had started their heroin use at 15 years or younger.

We would like to see young people with problematic drug issues readmitted into the society that you and I all enjoy. At a federal level, this requires a number of actions that we have outlined in our submission. National guidelines that standardise juvenile justice practices across the states need to be brought into train—national guidelines that see that young people with problematic drug issues are not demoralised, in a sense of not having in several states dual track systems for juvenile justice and adult clientele, which exists in only two states, and that convictions do not carry more than three years. A number of young people who we have experience with would be getting possession and trafficking charges, yet they carry these convictions right through their lives. These young people will go on and want to join the Public

Service, the youth alcohol and drug industry and other sorts of things, and we suggest that the conviction should not carry any more than three years.

The diversionary program should be expanded to accept people who have been in front of the courts for the eighth, ninth, 10th and 11th time for their heroin related issues and pharmacotherapies should be affordable. You may have heard this morning that Penington in the latest report recommended that no cost be associated for any young person under 18 on methadone. I outlined to you in the submission that the number of young people on methadone in Victoria under the age of 21 add up to around 1,300, which is in the vicinity of 15 per cent.

In regard to pharmacotherapies we would like to see not only the issue of income support addressed but also some encouraging signs that the trials with adults with buprenorphine and the other new pharmacotherapies start making their way into some good funded research into trials with young people. Of course, if they are successful, we would like to see all these therapies under the Pharmaceutical Benefits Scheme.

I would just also like to point out that the National Illicit Drug Strategy put $250 million into law enforcement. There is some research that is indicating—and it is our evidence—that young people in front of the courts are five times more likely to be incarcerated for drug related charges than for normal burglary charges. What we are doing is locking up young people for taking drugs. I know that sounds quite simplistic, but with the rates of incarceration, the impact or the cost of such incarceration—though we have not been able to measure it in year terms—certainly demoralises an already demoralised state.

Finally, I would just like to point out that YSAS's view is that we need a vision for disadvantaged young people. The majority of the young people that we would see at the Youth Substance Abuse Service would have had traumatised backgrounds. Our report '100% Dependent' which we alluded to in our submission interrogated the files of the first 100 young people coming for residential withdrawal and found that 80 per cent of those young people coming in for residential withdrawal were traumatised through disconnection with their original country of origin, sexual abuse or violence or dysfunctional families. We may have a vision for those in training and we may have a vision for those in school in regard to the drug issues. We would encourage in that sense the concentration on how to assist young people who have already fallen off or been derailed through no fault of their own on the journey into adulthood.

Our submission outlines further issues in regard to not only the ability to keep young people alive but also the provision of treatment. I would conservatively estimate that at this stage Australia could lead any other country in the world by five years in its development of youth and in alcohol and drug treatment. Victoria, in particular, has made significant steps in its approaches on this matter in the last three years, which makes it a world leader. We need to further encourage those approaches in regard to attracting young people into systems for the treatment of alcohol and drug dependence.

CHAIR—Thank you very much.

Mrs IRWIN—Congratulations. I think you are doing a fantastic job. The submission was very beneficial for me. The two areas I want to cover are crime and violence. On page 247 of your submission you state:

YSAS calls for a wiping of any recorded conviction in the adult court up to 3 years after dispensation of that order. We would suggest that the Committee look at the Queensland system whereby charges are erased after 5 years from the offence being committed.

Why would this be a positive move and would you recommend it as a general rule for other convictions?

Mr McDonald—I will answer it this way. You see police blitzes that go out onto Melbourne streets to get drug use off the streets. In the latest one, they issued about 172 traffic and possess charges, and 78 per cent or 150-odd of those charged were under the age of 20. The general community's attitude is: let's get the dealer, let's get the trafficker. I will tell you who is dealing out on the Melbourne streets: it is the young, heroin dependent user. They have three choices: they could prostitute themselves, they could break into yours and my homes and steal the videos, or they could do what would be deemed as the most minimising in terms of harm, and that is to deal. Our issue is that this is the better of three bad choices, and that to have trafficking and possession of a drug of dependence on their criminal record, when they have moved out of problematic drug use and when the view of the community is that any traffickers are bad, is just putting albatrosses around these young people's necks. They will have passport problems, overseas problems and problems with police checks which are now coming into all human service industries when you have these charges.

What we would like to see, rather than demoralising them for the rest of their lives by having to carry these charges, is that drug use is a 'here and now' condition. What we are suggesting in recommending giving a leeway of three years from the last charge would in fact encourage these young people in that they do not have to carry this baggage right through their adult years.

Mrs IRWIN—I thought that was a very good recommendation. I was touched recently to hear of a young lad who wanted to get into the Air Force but he had had a conviction many years ago and just could not get in because of that conviction. He would have given a lot by being in the Air Force.

I want to go back to the issue of family relationships. In your submission you say that support for families is either ignored or vastly underresourced. Why do you think this is so, and what sorts of services do you think governments ought to be supporting? Go for it—tell us.

Mr McDonald—I think the alcohol and drug sector, and also the youth sector, have never been good in engaging the family. From the research that we undertook at the residential withdrawal unit, we found that these are not just feral young people from statutory backgrounds running around without any family connection. In fact, 43 per cent of those seeking residential withdrawal who had heroin dependency problems were still connected and attached to their families. We think that families are doing the hard yards out there. There are several aspects we would encourage the committee to consider. For the first, I will use our service as an example. We are running a fairly significant state-wide Youth Substance Abuse Service across nine departmental regions, offering residential withdrawal, home based withdrawal and youth alcohol and drug outreach, and yet I have no funding for family support workers. You cannot create one without the other. The families, the parents, who are doing the hard yards, want to have a connection or association with the organisation that their young people are involved with.

The second thing is that parents like talking to other parents. We need to somehow encourage that aspect. The parents get a lot of strength from other parents. When there is a national social policy directed at, 'Let's go back to the family', I am staggered about the lack of initiatives, resources and promotion of resources for those families that are struggling with drug use and abuse within their communities. The other aspect is not only associating family work with treatment, but actually letting parents have some respite through having company of their own in those situations. We often say to parents, 'Get better informed yourselves, and the more you are informed the better you will be.' Within the youth industry, what we hear too much is, 'They're on drugs.' Well, what drugs? How often are they taken? Is this actually a problem or is this experimental? As we have pointed out, most young people come through adolescence into young adulthood without a drug problem. It is just the minority who do struggle that we need to concern ourselves with.

Mr Hogan—The point needs to be made—and Paul has sort of made it—that the need of parents is often a hidden one, because they are often embarrassed to either seek help, know where to seek help or even be able to say to anybody, 'My child is on drugs,' because the reaction they are going to get is going to be very negative. Sometimes the needs of families are ignored or overlooked because we do not understand what the demand is, because oftentimes families are literally embarrassed by the reaction they are going to get from fellow community members.

Mrs IRWIN—You are right. I have very dear friends who have lost their son through a heroin overdose, and they are heavily involved with the Family and Friends for Drug Law Reform. The problem was that during his time of addiction, when he was in rehab—and he was in rehab many times—they were crying out for help: 'How are we going to cope with him? How do we cope when he comes home? Are we handling it the right way? Are we saying the right things to him?' There was never that support network there for them in those early stages. There is support now for them, but the sad thing is that Patrick is no longer with us.

Mr McDonald—There is a twisted type of grieving going on for families and parents of problematic substance users: in grieving over death—though parents probably do not complete the exercise—some finality has resulted. Parents of problematic drug users grieve over their hopes, desires and wishes for that toddler when they were thinking they were going to be an adult. They are grieving over their own son and daughter, who are operating under rules that are completely incongruous or foreign to a family concept of rules—that is, stealing, lying and those sorts of things of a repetitive nature that families do not often see, and the great hopes and falls. We need to think about parents of problematic drug users in regard to grieving and about how we can support them through that. Even though they have not lost their son or daughter, they have lost the hopes and desires that they had for their son or daughter—temporarily, mind you.

Ms ELLIS—I want to take you back to an answer that you gave to Julia a moment ago in relation to the criminal system and the sentencing of young people. You explained very carefully the three options they have for existing. I have heard that opinion from you before, and I do not necessarily disagree with it. I have put that opinion to police authorities, not here in Victoria. Their immediate reaction was that they would have a concern at the probability of syndicating some of those young people to the control of more senior criminal elements in the dealing process that you have outlined. Can you give me your reaction to that.

Mr McDonald—My point is not promoting them to say, 'Let's get a club of well respected dealers.' Young people with problematic drug use who are dealing are making the choice of three lesser evils. This is the lesser evil to make the choice of. The difficulty is that illicit drug use is a public life. Thus, you are going to have reasonable behaviour in unreasonable circumstances. I am suggesting that we need to introduce some discretion in regard to our legislation about what is trafficking, using and possessing, versus what is major cartel dealing and trafficking. I do not think the community make the discretion. That is why, under legislation, we need to put those protections in place.

Ms ELLIS—It was really important for me to get you to elaborate a bit further, because when I put that view there was not an overreaction but a certain level of alarm as to how they would use whatever discretion they had in trying to sort out who would be acting in the way that you describe and who would be virtually coming under the control of other people. That does not rule out what you are suggesting, but it would be another consideration that would have to be woven into the equation of how to deal with it.

Mr McDonald—That is right. I think we have less work to do with police—who are making some very positive yards—and more work to do with the judicial bench, to understand that drug use is a relapsing condition. They are thrown up, as the expression is, to raise the tariffs: 'Listen, Johnny, if you come back here again, I'm going to suspend your sentence.' Of course, Johnny is going to come back next week or next month. We think that we can teach these kids lessons. They have gone through refugee camps; they have gone through dysfunctional families. There is a more superior rule to teaching lessons for problematic drug users, and that is maintaining your addiction and feeding that.

It cannot be just a simplistic approach to these young people—you cannot say, 'Well, I've exhausted all options. Basically, you've hit the end of the road. We'll lock you up.' What I am suggesting is that the point of change for young people with problematic drug use is usually at this point: the night before court, at the point of death or at the death of a friend. Those sorts of crisis moments—not after the fact, but predicting the fact. If we can understand that equation about what goes through the mind and about motivation, then we can say, 'Well, maybe an ongoing, continuous range of tariffs, rather than a downward spiralling range of tariffs, may have some impact in regard to our custodial numbers.'

Ms ELLIS—How important do either or both of you believe it is for us to have an education and information process—I do not wish it to sound bureaucratic, but just in general terms—in regard to the general public when we try to get some support out of the community at large about certain initiatives we have got in mind in dealing with this issue? For example, when we visited your residential detox unit, I was very refreshed to hear a description given to me by one of the staff there or one of the clients—I cannot remember which—where I asked them what they regarded as a successful process. The comment came back to me that it is not someone coming in here going through our residency and leaving, but maybe going through it two times, three times, five times, seven times—because they continue to be alive and they are continuing to seek assistance. When I have used that as a general example just chatting with some groups in the community, there has been, to my alarm, a raising of the eyebrows and a rolling of the eyes, as if to say, 'My God, they call that success! Seven times through! Surely to God, by then, they would have given up on them.' It really concerns me that that is not an isolated view in some parts of our general community. What would be your comment?

Mr Hogan—The first point that I would need to make is that these are young people who have the same sorts of dreams that you and I had when we were their age. They do not have dreams of becoming major drug dealers. They have exactly the same dreams as we have. They are just going through some difficulties. The majority of young people go through adolescence relatively unscathed and their families and the local community come out relatively unscathed. There is a small group—these young people are a part of that group—that have significant difficulties. Sometimes drug use is a symptom of the difficulties that they have already got. So I do not believe that when somebody who has a significant drug problem had their first drink or their first puff or their first injection were making the choice to become a drug user. It is something that overtakes them and it is something that actually offers them something—perhaps a bit of a break from what they are running away from.

We all know that adolescence is a fairly protracted period. It can last for a very long time. We have to see drug use in that context inasmuch as it can also sometimes last a significant period of time but that most people will, with a lot of support and help, get through it. So the mere fact that somebody is at least continually trying to address their drug issue is a better indication that they are actually going to come through it sooner or later, rather than having the one attempt, saying, 'It didn't work for me. I failed. I'm just going to give up.' I think that is the message that we need to give to the community: that, yes, most of them will get through it; that sometimes it is our attitudes that can make a person feel that they have failed; that it is our responsibility as a community to develop an attitude that is responsible to the general community; that it is also an adolescent response to a young person's problem and we have some responsibility to help them get through the problem and support them along the way.

Ms ELLIS—Thank you; that was very clearly put for me. In your submission you referred to a feasibility study for a recovery service which would look after people who have either just overdosed or been drug affected in a public space. Could you tell us a little bit more about this service? It appears to me that it would be addressing a pretty important need. What would you like to add to that?

Mr McDonald—This idea came out of the environment of when Victoria was contemplating supervised injecting facilities. The Victorian government was saying, 'If we go down this track, clearly under 18-year-olds will not be allowed to go in.' So we started to think about an alternative response to a supervised injecting facility that has some place. It is a comment on the general street injecting drug user community. My point is that traders go back to the shops, police back to their police stations and YSAS goes back to its YSAS treatment service, but where does the street injecting drug user go? Can we create a space? This is why I am saying that now is the time we re-admit these individuals—who are human beings too—back into society by creating this space.

The community is not ready to take the step of a supervised injecting facility, although we did point out in our submission that we interviewed 215 street injecting drug users across the five drug hotspots of Melbourne and asked them 40 questions. Eighty-nine per cent said they would go to a supervised injecting drug facility. They also said that the reasons why they would go would be: decreased public nuisance, decreased littering and increased community safety. We called the report *Not just for us—for the community*. Such initiatives were for the community, not against the community.

In light of that environment we developed a feasibility study that explored whether we could take young adults back to a service to recover from an overdose, because 78 per cent were getting into ambulances back to the casualty hospitals and were being administered narcan. The fear was that they would go off and whack up again. The common information that should be out there is: hang in there for a while—after an hour you will get stoned again rather than doubling up and thus being at risk of overdose.

The model for which we did a feasibility study was that mobile outreach overdose workers went to shopping centres and to the street, assisted people and 'specialled' them—that is, were with them for that hour and also created a space they could return to. That is still being discussed at government level. It is about trying to think about how you put services within a drug using behaviour and into a drug using community rather than what has been traditionally said: 'Let's not do much apart from needle and syringe exchange programs, and let's wait for the drug user to want to do something and thus move into treatment.'

Ms ELLIS—If we do not have it and it is available to us, would we be able to get the questions and the results of that survey?

Mr McDonald—I am happy to send you the *Not just for us* report and the feasibility report on a public space.

Ms ELLIS—That would be very useful.

Mr ANDREWS—You state in your submission:

... the current array of post-release or diversionary programs for 17-21 year olds is vastly inadequate ...

The latest Penington report, in the discussion about sentencing options, talks about the credit system and also the COATS system. But the Penington committee largely sidestepped the issue by saying: 'Let's have a look at this in the context of a subsequent sentencing review, but don't say anything about what should be done in this area.' Do you have any idea why they, in effect, sidestepped the issue and let it go for the time being?

Mr McDonald—Let the purchasing treatment go through the courts?

Mr ANDREWS—No, I meant other diversionary programs or sentencing options for magistrates, given that you have said that there is an inadequacy and you were critical of the magistracy in this context.

Mr McDonald—I do not know why they are sidestepping it. There is certainly a view from the judicial bench that there is a lack of sentencing options—and at the Children's Court level too—for young people with repetitive, problematic drug issues. I am not sure if I am answering your question here, but the likes of CREDIT and the likes of COATS—the purchase treatment—are still purchasing existing treatment options. I think you will find that, certainly in Victoria, there is no youth residential rehabilitation or program. There are very few day or activity type programs around this clientele. We are basically obsessed with the cued end, the front end—withdrawal and detoxification. The post-withdrawal programs are not there and the breadth of sentencing options are also not there. I am not sure if they are sidestepping: let

CREDIT keep ongoing and see how it goes or let the COATS system keep going and see how it goes.

I raise another point. I do not think we want to get to where the United States are—that is, that you cannot access treatment unless the court has directed you there. Two-thirds of our young people have legal dispositions. We are talking about 320 young people on any one day in YSAS with problematic drug issues, and around two-thirds of them will have legal dispositions. But they are all walk-up starts; they are all voluntary; they all actually want to be a part of it. Creating rehab options through court purchasing is a good idea. I am just a little bit concerned that the diversionary sector is not the tail that wags the treatment job, if I can put it like that.

Mr ANDREWS—The Penington committee also said, on page 145 of its review:

The CREDIT pilot was subject to a review after its first nine months of operation, during which time 199 offenders used the scheme. The review found that there was little difference in the re-offending rates of those who used CREDIT and those who chose not to use it.

Do you have any comments on why that might be the case?

Mr McDonald—Those figures stuck up with the drug court figures in New South Wales as well. The only comment I would make is in regard to the evaluation. Are we talking about an end result—did CREDIT influence this person to go into a non-drug using lifestyle or not? Having received our own CREDIT clients for the Youth Substance Abuse Service, I think the advantage is that there is some treatment that focuses on what an individual can do from bail to the court case. Giving some motivation in that period to attend four or eight times to look at your issues is encouragement for something whirring around your head. You might not see any action, but whirring around your head is: do I wish to continue my drug use or not?

CREDIT was created out of a frustration from the bench that we do not have any further options. What we have got to do—as far as we are concerned it is an evolving sector—is keep on trying different options. I think that CREDIT on a here and now basis—if I can put it like this—puts someone in a treatment system on a here and now basis. Evidence has shown, as research has shown, that within the orbit of a treatment service their quality of life will be improving during that phase. To get an end result that it actually cures their drug addiction, I only wish it was so easy. But to provide a better quality of life during the period between their bail condition and their final court has merit.

Mr ANDREWS—You also say in your submission:

Much of the reason for these increases in incarceration rates are due to breaching of community based orders for drug related crime.

How do you avoid that breach?

Mr McDonald—I have one quite clear recommendation for minimising the breaching of community based orders and thus resulting in prison, and that is to ask the Office of Corrections, which handle a lot of the CBOs, to start getting discretionary about their client group. I am making a generalisation here but, generally speaking, the days of the good old crim

have gone. It is now a population of drug related crime, and thus it presents you with a more challenging condition about relapse.

What I would suggest to minimise the breaching rate of community based orders is to have specific staff to deal with the 17 to 21 age group—the young at old age group—and start understanding some of the skills, the interventions and the approaches that that target group should have. They do not put an emphasis on that quality to minimise the breaching rate of some of these CBOs. Community based orders, then moving on to a worsening tariff of suspended sentencing and then imprisonment just goes to show that we are still treating it as a criminal condition rather than a health condition. I would suggest to you that the way to minimise breaches of the CBOs is not only to target specific staff to young adult services but also to provide repetitive and quick opportunity back into treatment. At the moment, demand far outweighs supply. At any one time in the last two years at our residential withdrawal unit, we would have had 30 young people ready and waiting to get into detoxification. It is not a matter of an individual young adult wanting to deal with their drug use; it is whether they have got opportunities to do something about their drug use.

CHAIR—So you would say we have got to provide the opportunities?

Mr McDonald—Yes.

CHAIR—It is not the ideal world you would like it to be at the moment but, if it were and there were opportunities there, should there still be an end point to that? At some stage, has the community, through the courts, got the right to say: we have given you X number of opportunities, and you have not availed yourself of them? If your answer is yes—and it may not be—when should it be?

Mr McDonald—We might need to distinguish between people with addictions who are just keeping their heroin use going and those using violent and other sorts of crime. Maybe the answer cannot come only into the context of a judicial response. Maybe the answer comes also into the context of our preparedness to understand what illicit drug use is all about and our preparedness to have the fortitude and strength, with Australia's best clinicians and scientists, to pilot other ways of managing illicit drug use.

Although it is commonly said that the federal and state governments differ over only two small issues, one of them is a heroin trial, and that is no small factor. While young people and young adults choose to use this substance and while our death rates spiral as they have been doing in the Youth Substance Abuse Service over the last 18 months, why are we not compelled, along with changing our judicial system and making it more user friendly, to change our health system and our treatment system to actually get closer to this community and give them some relevant care and relevant treatment options?

My answer to you is not only about changes at the judicial level and how many times is enough times. As Paul has just indicated, each time one is back is usually a good news story, not a bad news story. I am saying that you need to move it for a range of different ends. It is an ability of the bench to understand that a person in front of them for the eighth time is as motivated to move into treatment as they were the first time; it is an ability of the bench to have

patience and tolerance and say, 'Okay, let's do treatment again.' We should be heading down this track unless we want to build more prisons.

CHAIR—The attitude out in the community, which is what Annette was referring to, is that there is a limit to the number of times and that we have got to draw a line somewhere.

Ms ELLIS—No, I was not agreeing to it.

CHAIR—I know you were not agreeing to it; I am saying you referred to that being an attitude in the community.

Mr McDonald—But this is the challenge, and this is the debate. The challenge is this: the drug using condition is a chronically relapsing condition. This is the difficulty about us, ourselves, and the bench and police, coping with this behaviour—families. What we have to understand is that this is different human behaviour. This actually is driven by somewhere else, by a different set of rules. At the moment our rules about how we are handling it and the rules they are operating are just increasing our prison numbers. What I am suggesting is to understand the chronic relapsing behaviour of the addicted drug person and to move some legislation and some sentencing options that reflect that chronically relapsing behaviour.

Mrs IRWIN—That is a very good point. I actually use a legal drug: I am a smoker, and have been for many years. Annette referred to a young client of yours that has been back for five, six or seven times. At least that young person is still alive. At least that young person is still coming back. With my addiction to cigarettes I have tried so many times, and I am getting there slowly but surely. I have got the assistance of some members of the committee. I have cut my habit in half, so, hopefully, I will probably end up losing that.

I have one quick question about something in your submission that I found very interesting and had not realised. You suggest that skill and knowledge levels of GPs and pharmacists in relation to methadone could be better. I have never really looked at the training that doctors or pharmacists might get. What sort of training do doctors and pharmacists receive before they are able to dispense methadone? I hope you are not going to tell me none.

Mr McDonald—No. They are all trained, because they have to register as methadone prescribers. The issue is about the numbers of methadone placements, which you have probably heard evidence about. I think last week you could only get in to three GPs in Victoria for available methadone placements. The training issue is often at a pharmaceutical level with the pharmacists as well. Our experience is that there are some very good chemists that are responding very caringly towards the methadone prescriber, and then there are some other chemists that probably need some improvement in regard to how to view the individual. With regard to the training in relation to the cross-counter care—if I could put it like that—at a pharmacy level, it would be our observation that young people, especially, who do get impatient, do get a little bit feisty, only need one negative experience at a pharmacist's and they will not return.

The three obstacles in regard to methadone for young people are price, relationship with the pharmacist and the discipline of picking up every day. In a technology where I can go to any ATM and pull out money from my bank account anywhere in the world, I do not know why we

cannot have smart cards for methadone prescribers such that they can walk in, flash the card in front of any chemist and pick up their methadone anywhere in Australia or, in fact, in Victoria. We have got the technology; it is whether we are wanting to actually make life easier for people who have had heroin addictions. I am questioning whether we do want to make life easier for people who want to move into treatment.

CHAIR—I have a quick question on the road issue, drug driving. You mentioned UK experience. Do you have any recommendations here?

Mr McDonald—Yes. In regard to club drugs and drug driving, looking at some of the work that is done in the United Kingdom and in Europe, especially about club drugs and about people's information about what drugs they are taking and going into these dance parties and rave parties, a very simple harm minimisation strategy that we would be suggesting in regard to club drugs is actually having a transport system that is operating at four, five or six in the morning to ferry these young people home.

When I was around it used to be radical for pubs to close at 3 a .m. Now you have rave-after parties that are going to 5, 6 or 7 a.m. People do not get there till 1 a.m. Our public transport system has to move with youth culture to understand that it is peak hour in certain spots at about five in the morning for young people, to reduce the drive home factor. United Kingdom statistics in regard to drug driving—I would be happy to furnish the committee with some of that research—indicate that a number of people leaving these rave parties are jumping into their own cars and driving home, where quite easily an adequate public transport system for young people might be able to minimise that.

Mrs IRWIN—The culture has changed. When I was courting, in my younger days, I would be picked up by boyfriend at 6 o'clock. My daughter is now 24. I remember that, when she was 18, 10 o'clock or 10.30 would come and I would say, 'Rebecca, where are you going?' 'I am going out to a party.' And it is true, the culture has changed.

CHAIR—That is very interesting. Paul McDonald and Paul Hogan, thank you very much. Your evidence has been very valuable and we appreciate your attendance here today.

[4.17 p.m.]

BROUGH, Dr Rodger John (Private capacity)

CAMERON, Mr Donald James Gray, State Director for Victoria, People Against Drink Driving

COLLINGBURN, Mr Brian Laurence (Private capacity)

CHAIR—Welcome. We have now come to that section of our public hearing where we are inviting three-minute statements from 13 people that have indicated they would like to make them. I intend simply to go for about 2½ minutes and just give a tap on something. That will mean you have got about 30 seconds to go. I invite Dr Brough to offer us his three-minute statement.

Dr Brough—Thank you very much. As a rural based alcohol and drug worker with nearly 20 years experience in this field, I would like to draw attention to three of the most pressing and urgent issues that I see. Firstly, and in terms of something that I suspect may not often have been brought to your attention, the absolute necessity of having a rural voice heard in policy development, planning and implementation of alcohol and drug services and programs needs to be acknowledged and addressed. Solutions that address urban needs and substance specific responses are often relatively ineffective or irrelevant in rural areas for three reasons: the often fundamentally different epidemiology of rural and regional alcohol and drug problems is not appreciated; often, the hot problems and subsequent research and interest generate urbocentric solutions and their relevance and importance in rural areas are rarely actively considered; and the impact of the realities of rural living is just not appreciated. The issues are, but the impact of them in terms of alcohol and drug service delivery is not.

Secondly, the still rising toll of heroin related deaths is of considerable concern to many members of the community. The political reality is that this persisting public health problems needs to be tackled much more vigorously, in ways that will produce results and will be politically acceptable. In reality, this means encouraging more addicted users into long-term treatment with substitution therapy or into stable long-term abstinence. The largest single obstacle, in my experience, is treatment associated costs—which Paul was talking about—for clients. The cost of accessing life saving treatment for heroin addicted Australian citizens is far too high and too often results in inaccessible treatment or pressure to continue illegal activities to sustain some tenuous involvement in treatment. Methadone, buprenorphine and possible Naltrexone urgently need to be made affordable, particularly to the growing numbers of young people, rural addicts, who often have high transport costs added to their methadone dispensing costs, and couples.

Thirdly, the evidence for persisting high levels of alcohol related problems in the Australian community in general, and in rural and regional Australia, in particular, has been increasingly ignored in the heat of the debates over injecting rooms and heroin trials. The success of the Northern Territory's Living with Alcohol program provides a model for action which, since the High Court decision in 1997, has been denied to state governments. The Commonwealth needs

to revisit the issue on behalf of long-suffering communities and families, and ensure that the alcohol industry shoulders a more substantial responsibility in regard to addressing the pervasive problems related to alcohol. Thank you.

Mr Cameron—The aim of People Against Drink Driving is to try to save lives on Australian roads. It knows that over this coming Christmas time, holiday period and summer months ahead, men, women and children will be tragically killed and seriously injured on our roads—some maimed for life. The costs of the personal tragedies amongst Australian families are incalculable. One of the main causes of these avoidable deaths will be alcohol and there are huge monetary costs resulting from that. We know that here in Australia many thousands do not realise that alcohol is in fact a drug. This toll has happened every year with sickening regularity since 1965, when I first began to study the role of alcohol on the road toll. I do not have to be a prophet to know that it will happen again and again until we, the public, do something about it.

What can the public do about this problem which, PADD believes, is threatening the fabric of Australian society? Firstly, we have to recognise and widely promote the fact that alcohol is a far greater killer drug than heroin—see the coroner's figures for Victoria in recent years. Secondly, we have to advertise widely that alcohol is a drug which, on a global scale, as a cause of death is second only to tobacco. Thirdly, before my days of PADD involvement, I organised a petition for random breath testing throughout Victoria and was overwhelmed by the public support received. I presented a total of some 12,000 signatures to the then secretary of cabinet, and the legislation for random breath testing was enacted in February 1976. In hindsight, I believe RBT has been credited with saving hundreds of lives. There could be a lesson to be learned from that—namely, that if it has had some effect in curtailing the use of alcohol by drivers, it has had a beneficial effect.

I am also concerned about the NHMRC recommendations that alcohol has a tendency towards protection of persons from middle age on. It occurs to me, and I have evidence to support it, that if you are middle aged and your body clock is running down, you are presumably having some medication. Australia is the highest pill-popping nation on the globe. Therefore, when I began to research the effect of medicines inimical to alcohol, I found that 25 per cent of the most commonly used 250 medications should not be used with alcohol. We have got this interactive problem and many dead drivers are found with drug mixtures in their bodies.

CHAIR—Thank you very much. I invite Mr Brian Collingburn to speak.

Mr Collingburn—Firstly, I wish to make an amendment to my written submission. After 'public schools' please add 'and poorer Catholic Schools'.

Increased drug abuse, depression and suicide are all symptoms of a society malfunctioning. We have a society where many young people pass through a trial by ordeal no less than those of the medieval, where the crime is belonging to the wrong socioeconomic group or having parents who only value a trophy child. It is where males are emotionally crippled by pressure to become predatory and moral cowardice is rewarded. It is where the ruling culture is 'you scratch my back and I'll scratch yours' and families on $60,000 are persuaded that they are battlers.

When thousands of teenagers are denied any economic support, the government is aiding and abetting illegal activities. One-year subsidies to take on apprentices who will be sacked after 12

months are cause for depression and substance abuse. As inbred products of the overfunded elite schools are so inadequate that they have to import overseas experts to manage their assets, and Australian research and inventions must go overseas, adequately funded schools with adequately trained science and maths teachers are required for the hoi polloi in the technological age. This is not happening. It is very depressing—reach for a bottle or a syringe.

In a few years, bacteria will be totally resistant to all known antibiotics. To prevent cross-infection, hospitals—which nurses now refer to as 'filthy'—will have to revert to the intense scrubbing and disinfecting of 50 years ago or become the death traps of pre-sterile times. Already in Queensland, there have been a significant number of infections of flesh-eating bacteria after relatively minor operations. Perhaps this is the case in other states. But resources are being stripped from public hospitals. Will Caesarean operations again be killing mothers? To reduce substance abuse, we need to reduce the motives for substance abuse. We need business and political leaders with moral courage. I ask: have we got them?

CHAIR—Thank you very much, gentlemen.

[4.26 p.m.]

FETHERSTONHAUGH, Mrs Deirdre Marie Anne, Research Fellow, Caroline Chisholm Centre for Health Ethics

GAWLER, Mrs Isobel Claire, Honorary Secretary, Drug Advisory Council of Australia

GYSSLINK, Mr Paul, Professional Issues and Research Officer, Pharmacists Branch of the Association of Professional Engineers, Scientists and Managers, Australia

CHAIR—Thank you very much for joining us. Over to you, Mrs Fetherstonhaugh.

Mrs Fetherstonhaugh—Our submission focuses specifically on the abuse or misuse of prescription and over-the-counter medications, and the effect on people's health and on health care costs. Statistics show that up to 10,000 people a year are being treated in Victorian hospitals for drug overdoses. Most of those seeking treatment have not overdosed on illegal drugs but on prescription medications such as tranquillisers, antidepressants and analgesics. Over the past few years, the number of people overdosing on these prescription medications has risen steadily.

The Health Insurance Commission has estimated that savings of up to $31 million a year would be made by reducing the waste in both Medicare consultations and PBS prescriptions generated by doctor shopping. While doctor shoppers can now be identified more easily because of the Commonwealth Government's 'Doctor Shopping Project', we must find out why these people are requiring such large quantities of drugs, and deal with their problems appropriately.

Studies have shown that approximately half of the drug related hospital admissions were considered possibly, or probably, preventable. The definitely or possibly avoidable admissions included those for non-compliance, predictable adverse drug reactions, prescribing errors, contra-indicated medications and known drug allergies. The monetary costs of drug related hospital admissions in public hospital costs alone is around $350 million annually, and this does not include the human and social costs of such admissions.

One strategy that could be developed to reduce the number and cost of adverse drug reactions would be the establishment of a national pharmacy Intranet or a linked computer database. The Intranet would improve the timing and quality of communication between pharmacists, prescribers and public funding in regulatory bodies. All prescribed medication for a particular person would be known, and this could prevent drug-drug reactions. If other information about the patient were also available on the pharmacy Intranet—such as their age and weight, the existence of any known drug allergies and whether they have any other diseases or organ failure—then fewer mistakes would be made. Interfacing with other health care professionals would allow verification of prescriptions, and communication with pharmaceutical manufacturers and wholesalers would allow online queries about drugs. An Australia-wide Intranet may improve control of medication abuse and misuse and reduce costs to the community because there could foreseeably be a reduction in drug related hospital admissions.

The increasing use of the Internet by people all round the world has opened up other avenues for obtaining drugs, both prescription and non-prescription. There needs to be appropriate regulation so that there will not be abuse, either intentionally or unintentionally.

Increasingly, there are bacteria that have become resistant to certain antibiotics and which can cause potentially fatal infections and increase health care costs. Antibiotics are useless against viruses which cause most upper respiratory tract infections, but people attend doctors and these doctors prescribe antibiotics. This unnecessary overuse of antibiotics has contributed to the development of antibiotic resistant bacteria. The public needs to be educated about the causes of infection so that they do not unnecessarily request a prescription of antibiotics, and doctors must learn not to feel pressurised into giving them one.

CHAIR—Would you like to make a statement, Mrs Gawler.

Mrs Gawler—I am speaking on behalf of the Drug Advisory Council of Australia. I have sat here since 8.30 this morning listening to many words of wisdom, and what I must say is that I believe that the time has come for us to urgently reassess what we are doing with our overall approach to drug use in Australia. I think that we need to reassess what we are doing. We are noticing, every one of us, that things are getting worse, not better. There are other countries who have proceeded as we have. We are, in fact, following old policies, not new policies. I do not believe there is a particular Australian way. We are all human beings on the face of this earth, and drug addiction affects us all in just the same way, even if there may have been slightly different sociological factors.

I would say that we should do an about-turn. I think that to introduce heroin trials is unwise in that most drug users are poly drug users; therefore, we would need to introduce trials of every illicit substance known to man. If we had trials in every substance so that they were available to those who choose to use them, we would find that the drug barons would invent new substances for people, just to keep up their money making market.

Injecting rooms are impractical. The widespread use of mind-altering drugs is apparent. For example, there is the use of cannabis and ecstasy at rave parties and significant IV heroin use. This organisation believes that this development is a consequence of harm minimisation. Abstinence is politically appropriate to use as a form of harm minimisation and is, in fact, obviously the best form of it. Harm minimisation is the basis of the national drug policy, which has been in operation for the past 15 years. I think we should look at abstinence.

I believe there is an urgent need for a review of the whole concept of harm minimisation because, fundamentally, it promotes the concept of the tolerance of drug use. All the evidence regarding heroin trials and the transmission of infectious diseases indicates that we should not be encouraging the intravenous use of any drug. The needle distribution centres have, in fact, perpetrated this mode of taking mind-altering, highly addictive drugs. For example, 76.5 per cent of young people under 20 tracked at the needle exchange at Kings Cross—having started hep C free—were found to be hepatitis C positive after being involved in that program. So, obviously, we are expanding the drug using population by means of facilitating use. We have normalised drug use by institutionalising it and we have created a ‘honey pot’ effect for drug dealers at the needle exchanges. In fact, we just need an urgent review. I call upon the

government to please reassess abstinence programs, as has Sweden and the United States, and let us have an about-turn.

CHAIR—Is it the wish of the committee that the document from the Drug Advisory Council of Australia, provided by Isobel Gawler, be incorporated in the transcript of evidence? There being no objection, it is so ordered.

The document read as follows—

CHAIR—Mr Gysslink, please make your presentation.

Mr Gysslink—The pharmacists branch of APESMA represents the views of 5,000 employee community pharmacists. We welcome the opportunity to expand on our written submission with the following six points. Firstly, we propose that an economic analysis of substance abuse in Australia be done by health economic experts, for example, Collins and Lapsley. Secondly, we support the retention of the present system of scheduling of drugs which restrict access of some medications to prescription only, while others are available through pharmacies, so that consumers receive the necessary information and appropriate products after consultation with the pharmacist. We support the recommendations of the Galbally draft report into the review of drugs, poisons and controlled substances legislation.

Thirdly, the legislative system of schedules and permits for drugs of addiction allows pharmacists to identify and refer patients who may be substance abusers. Pharmacists are the health professionals most in contact with people who abuse prescription and non-prescription medications. We encourage government to adopt a national training program for medical practitioners and pharmacists in their local geographic areas so they can simultaneously undertake alcohol and drug training programs. This training should be in conjunction with representatives from local alcohol and drug agencies so as to improve the cooperation, working relationship and skills of those involved to assist the patient with the treatment of their drug abuse.

Fourthly, the third community pharmacy agreement provides funds for medication management programs. These programs, using a collaborative approach between the pharmacist, GP and other health professionals, will be of benefit primarily at this stage for older patients. We support the introduction of these formal reviews widely in the community as people may be helped to use their medications appropriately and thereby reduce the risk of future abuse. Opportunities may exist for pharmacists to be employed by GP practices to give all patients the option of at least annual medication reviews and, in some circumstances, more intense follow-up.

Fifthly, we support the introduction of electronic health records with adequate safeguards that would record all medicines consumed by patients—that is, prescription, over the counter medicines and complementary medicines—so that misuse and abuse of particular drugs would be detected. However, given the system will be voluntary to ‘opt-in’ it is difficult to see drug abusers will become part of this system.

Sixthly, we urge the government to divert a proportion of money spent on the law enforcement component of the drug strategy into providing adequate services to assist with the treatment of drug abusers. Law reform and debate on issues such as supervised injecting facilities and heroin trials should be addressed to treat drug abuse as a medical condition and support the harm minimisation approach to reducing dependence on illicit drugs.

In conclusion, drug abuse is indeed a complex issue with no easy solutions. If past strategies have not worked then debate must occur with all options on the table so that society may decide to take some risks and try new strategies to address this problem. The problem is too great for ideology to control the outcome.

[4.38 p.m.]

HOCKING, Ms Barbara Mary, Executive Director, SANE Australia

HOSKING, Mr Michael John, Resources Manager, Teen Challenge (Vic) Inc and Drug and Alcohol Counsellor, Intouch Medical and Counselling Centre

MUEHLENBERG, Mr Bill, National Secretary, Australian Family Association

CHAIR—Thank you for joining us. We have agreed on three minutes. Mrs Hocking, would you like to start?

Mrs Hocking—I am with the organisation SANE Australia which is a national charity helping people affected by mental illness. What I want to do now is reinforce what I have said in my statement before about the special needs of people with mental illness for special consideration in this whole drug debate.

Drug abuse, both licit and illicit, is a major problem for people with a mental illness. It is often the presenting symptom for people with depression or an anxiety disorder, but my comments are mainly focusing on people with psychotic illness—that is, illnesses such as schizophrenia or bipolar disorder. There are two major issues here: first of all drug abuse is very increased in this population; secondly, that very drug abuse complicates greatly their treatment for their mental illness, so it is really a major issue.

Most people are using non-prescribed drugs to ease the distress of their symptoms or to counter the side-effects of medication, so it could be said that they are often used in a very appropriate way, but that same use does, in fact, complicate the whole treatment. There are certain drugs, for example, marijuana, which are now showing quite good evidence that, for people with an existing illness, they do trigger symptoms or recurrence of the illness.

Some figures just to reinforce the use of street drugs: almost 50 per cent of people with psychotic illness are reporting use of illicit street drugs such as marijuana, heroin, amphetamines and tranquillisers. The use of alcohol is also enormous and it causes great problems. Tobacco is probably one of the most important issues to consider as well, because there is three times the use of tobacco within this population than in the general community. When we consider that tobacco is considered to be the greatest killer, these folks are disadvantaged again and again. The point of my statement is just a plea to say: don't forget this population as an important target audience. There is nowhere in the world I can point to where there are model programs going on. What we really need are some good pilot programs to look at ways in which we can educate and provide appropriate treatment for people with this dual problem.

The other major issue is that both the mental health system and the drug and alcohol abuse system run in parallel. People often fall between the two. There really needs to be much more effort and focus put into trying to look at ways in which both systems can work together for the

very special needs of this quite large group. If we are looking at psychotic illness we are looking at three per cent of the population, which is about half a million people.

Mr Hosking—I am a drug and alcohol counsellor with about three years experience operating in the eastern suburbs of Melbourne. I represent Teen Challenge and also the counselling centre Intouch, at Doncaster. Apart from my comments in my written submission where I emphasise the danger of marijuana, which I have seen bring on psychosis, paranoia, bipolar disease and schizophrenia, I want to say that most the addicts I counsel—about 90 per cent—started their drug career smoking cigarettes. Nicotine appears to be more addictive than all the other drugs. After the addicts have started off with nicotine they moved on to the heavier drugs. I realise that government is trying to curb this problem, but the advertising needs to more strongly emphasise the cost to the individual and the dangers that this particular drug, nicotine, can have for their future.

Most long-term addicts of heroin and marijuana suffer from low self-esteem and even self-hatred caused by rejection, neglect, abuse and overdiscipline in their formative years by parents and other people. I would say 70 per cent have suffered abuse by their fathers and some by their mothers during their formative years, causing them to retreat into drugs to cover up their emotional pain. Programs like methadone do not always get people off drugs, as most methadone users I know are also using heroin. Parents, especially fathers, desperately need short courses in how to understand the benefits of good parenting to bring honour in their homes and also to help understand drug prevention in the home. It is just not happening.

For a long-term addict there is a simple equation that needs to be presented to the committee, and that is: long-term drug addict equals long-term rehabilitation. There is no other answer, in my experience. It sounds expensive; however, not when you compare it to 75,000 heroin addicts using a daily dose of methadone, which is actually harder to get off than heroin. It is just as debilitating, although not as dangerous. Some people are on it for years and years, and the damage to their digestive systems, their brains and their confidence is almost beyond repair.

I believe there are three steps to recovery: first, counselling; second, detoxification; third, rehabilitation. Many people think that might be simplistic. But I had a 21-year-old man in my office last night who has detoxed 15 times and he is still taking heroin. The reason underlying his addiction to drugs has simply not been properly addressed. Only long-term—12 months—rehabilitation will help the addicts focus on the healing process and establish their self-confidence again.

Existing rehabilitation services that I am aware of in Victoria are doing a fairly good job, but the majority of those residents are already there on sickness benefits and that pays half their cost anyway. If the methadone program was scaled back and eventually phased out, that would cover the other half of the pension payment to cover their total rehabilitation costs. Church groups are doing a good job as are the Salvation Army, Teen Challenge and others, but they need more government support and backing to maintain and increase their services in this particular area of abuse.

Mr Muehlenberg—Perhaps I can introduce this by saying that for about three years I was fairly heavily involved in the drug culture myself. A lot of my friends did not make it, so I am very grateful to be here today. The more or less official policy of both Commonwealth and state

governments on the issue of drug abuse for about the past 15 years has been what is known as 'harm minimisation'. During these 15 years there has been a marked increase in the problems of drug abuse—all the indicators that we all know about. One might argue that there is an association between policies of harm minimisation and the crisis we face today. In fact, the AFA would argue that harm minimisation has been tried and found wanting.

If we looked at several related social problems and applied harm minimisation principles to them, we might perhaps see the connection. Cigarette smoking has long been a problem. In the last 30 years we have tackled it pretty severely, and we have seen about a 30 per cent drop in cigarette use. We are doing all we can to deter people from using cigarettes. However, if we applied the harm minimisation approach to cigarette smoking, what we would be doing is telling our young people, and not so young people, about things like filters, low tar and nicotine levels and teaching them how to smoke safely. Again, the principle here of harm minimisation is: people will do drugs, we cannot avoid that, so let us try to reduce or minimise the harm. That is what we are doing on drug policy now. If we applied it to something like cigarettes, we would come up with those kinds of solutions as well. However, I am not aware of anybody making those proposals at the moment because they seem to be fairly unhelpful to the problem of cigarette smoking.

Take a similar problem: drink driving. We all know people are driving while drunk. We could throw up our hands as we do in the drug debate and say, 'We're always going to have these kinds of people, so let's teach people who drink and drive to do it safely—perhaps give them classes on how to drive or concentrate better while drunk, or maybe step in even more radically and provide sturdier cars that will not so easily succumb to crashes.' Again, I am not aware of anybody making those kinds of suggestions. In fact, we say that people should not drive if drinking.

There is a bit of schizophrenia in public policy on some of these issues. On the one hand, we have a very strong 'say no' approach: we do all we can to deter people from taking up those activities or to get them off when they are on. But on the issue of drugs we seem to be taking a very different approach. We put our hands above our heads and say, 'We surrender. You're going to do it anyway, so let's try to make it safer.' We at the Australian Family Association would argue that harm minimisation has in fact not been working. It is a failed policy, and we need something new. Policies that stress harm prevention or harm elimination would be the way to go, and we have seen successes overseas, notably in Sweden. We ask the government to rethink its current approach to drug problems.

[4.50 p.m.]

NOLA (Private capacity)

CHAIR—Welcome, Nola. Over to you.

Nola—We are living in this beautiful country in peaceful times, with housing, education and health so much improved and life and the world so exciting, so what is it today that is missing that makes our children turn to drugs? You have to wonder if there is a lack of spirituality in our culture and a lack of guidance in example. I would like to focus on marijuana—the abuse of which is causing the most tragic waste of potential in so many lives of young people—and its associated heartache for the parents. Marijuana, the so-called soft drug, is a mind altering drug, which causes loss of ambition and initiative and which mangles memory. Marijuana is very dangerous. Unlike alcohol, which usually leaves the body within 24 hours because it is water soluble, marijuana is fat soluble, which means that the psychoactive chemicals attach themselves to the fatty component of cells, particularly in the brain and the reproductive organs, and can be detected up to 30 days after initial use.

Extensive research has indicated that marijuana impairs short-term memory, slows learning, interferes with normal reproductive function, affects heart function, has serious effects on perception and skill performance—such as driving and other complex tasks involving judgment or fine motor skills—and greatly impairs lung and respiratory function. A marijuana cigarette contains more cancer causing agents than the strongest tobacco cigarettes. Every organ of the body is affected by the accumulation of cannabinoids in the cell membranes. These include the brain, the female reproductive system, the male reproductive system, the lungs, the immune system and the heart. Addicted people on marijuana rave about how wonderful the drug is. They cannot see their irritability, their volatile moods and their paranoid hostility. They will not admit that they have dropped out of further education and sporting interests, and are losing out in the work force. In fact, the changes in an addicted person's whole life and loss of interest in normal activity are marked.

Drugs are such a worry out there, and they are affecting people in society, and it does feel very hopeless. I am in contact with a whole group of people who have children on drugs, of which heroin is the biggest problem. However, you would be surprised how often marijuana is used, either as the main drug or sometimes with a cocktail of various other things—really weird things, sometimes. But even if that person manages to get off heroin, they still smoke marijuana. A lot of young ones mix heroin and marijuana together, and that is extremely dangerous. That is very common. Australia should go the way Sweden has with its strict laws prohibiting street drugs. Law enforcement has made it difficult to obtain heroin and cannabis. Education on the dangers of all drugs could start even in kindergarten with stories, tapes, videos and cartoons that also include other ways to be relaxed and enjoy life without having to be on drugs.

CHAIR—Thank you. You are welcome to table that, if you like.

[4.55 p.m.]

TOOMER, Mr William Frederick (Private capacity)

CHAIR—I invite Mr Toomer to address the committee.

Mr Toomer—My submission confronts a fundamental difficulty with controlling the illegal importation of drugs. I would like to make the point that it is not intended to use this forum to simply attack any institution for any other reason.

My written submission brought to light the ill-treatment carried out by government agencies, a past ministry for justice and the Attorney-General's Department against an individual who reported occurrences of illegal heroin importation. The Attorney-General's Department is known to be overtly antipathetic towards whistleblowers who, in the public interest, report serious wrongdoing. Curiously indeed, the question is why.

Wittingly or not, the Attorney-General's Department is seen to be a facilitator at times for selective criminal endeavours and has on serious occasions given deliberate bad and misleading advice to government ministers. Introspection and a reappraisal of the Attorney-General's Department's proper role in advising government and departments is long overdue. It remains a long way from the model litigant which it claims to be. One basic problem is that the Attorney-General's Department has long supported the Kafkaesque priority known as the public service ethic—that is, an abiding loyalty above all else, including the national interest, between senior administrative public servants. Hence the protection given to the National Crime Authority, even when criminality is involved. For some government officials this mind-set will lead to corruption.

This misplaced loyalty or worse has resulted in the ludicrous situation whereby the Attorney-General's Department protects and legally represents criminality and public service malfeasance in the courts. Those individuals who report serious drug offences find themselves pitted unequally against the public funded resources of the Attorney-General's Department. Under such circumstances it is hardly equitable nor fair for government ministers to abrogate their responsibility to protect individuals acting for the common good by reporting heroin importation.

The specific example within my submission refers to the politically well-known Skrijel case, in which the government curiously considers it appropriate for the courts to resolve the matter in a grossly unequal conflict. Mr Skrijel should have been the crown witness when prima facie evidence first established that there was considerable probative value to his allegations. I refer to the Quick report. The Attorney-General's Department should be protecting such an individual who bravely reported illegal heroin importations, instead of being his adversary in court proceedings.

It is a matter of community shame that the national media corporations have mostly allowed themselves to be silenced on this story, which cries out for a royal commission because the problem affects us all. This current government is shamefully content to accept the defensive

advice of officers within the Attorney-General's Department not to pursue the Skrijel findings. Much of the harm which has been done and still is being done to both Mr Skrijel and the community arises from the fact that 'good' men are willing to turn their backs. The NCA was born out of urgency to direct the Costigan commission's attention away from a drug syndicate which was far too close to the highest office of past government. Little wonder that Operation Noah, which invited citizens to report serious drug activities, was not bona fide but simply a device to assist a drug syndicate with needed information.

In 1974 an unheeded advance warning was given by royal commissioner Justice Athol Moffitt that international organised crime syndicates would infiltrate this country, fashioned for concealment and apparent respectability in influential positions. It remains a matter of public speculation as to why the NCA parliamentary watchdog, the PJC, did nothing while the Skrijel matter developed, nor since. The PJC is fully aware of the Skrijel case, which both makes a mockery of the Australian justice system and stands as a case study as to why a new agency to replace the NCA is still needed. The NCA, with Attorney-General's Department assistance, is still covering up its criminality in the Skrijel case. Three years ago the secret Harrison report was made available to the Attorney-General's Department. The report disclosed corruption within the Australian Federal Police relating to drug law enforcement. It is reasonable to accept that this report was sanitised by the Attorney-General's Department, as was the Quick report, which supported the allegations of Mr Skrijel.

The Skrijel case has provided poignancy to the Costigan commission's indication that 'crime bosses can afford a mantle of protection'. Why has there not been any attempt to lay criminal charges against NCA officials in the Skrijel case? It would appear that heroin use has not peaked, stabilised or declined. It would seem that there is so much of the stuff around that criminal groups are prepared to be quite brazen in their attempts to smuggle it into the country. That is what Mr Skrijel was drawing to our attention.

A royal commission now into the Skrijel case, with a modest budget, would be a cost-effective measure in providing the greatest impetus to sound drug law enforcement and a reinvigoration of public confidence and cooperation. It is well past time to uncover the cover-ups. Overall it is a significant warning that Whistleblowers Australia Inc. has been unable to find any authority to which people can now turn with confidence to redress an obvious wrong.

CHAIR—Thank you very much, Mr Toomer. I thank everybody for those presentations. It was one way of dealing with a great deal of interest. I thank you for your patience and tolerance, particularly those who have been with us all day. I hope that it has been useful to you. Thank you, Melbourne, for having us here.

Resolved (on motion by **Mr Wakelin**, seconded by **Ms Ellis**):

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

Committee adjourned at 5 p.m.