
COMMONWEALTH OF AUSTRALIA

# Official Committee Hansard

# HOUSE OF REPRESENTATIVES

## STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

**Reference: Substance abuse in Australian communities**

TUESDAY, 21 NOVEMBER 2000

ADELAIDE

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

**INTERNET**

The Proof and Official Hansard transcripts of Senate committee hearings, some House of Representatives committee hearings and some joint committee hearings are available on the Internet. Some House of Representatives committees and some joint committees make available only Official Hansard transcripts.

The Internet address is: **http://www.aph.gov.au/hansard**

To search the parliamentary database, go to: **http://search.aph.gov.au**

**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 8.51 a.m.**

**PAGE, Ms Stephanie, Director, Student and Professional Services, Department of Education, Training and Employment**

**PAGET, Mr John, Chief Executive, Department for Correctional Services**

**STRATHEARN, Mr Graham, Chief Executive Officer, Drug and Alcohol Services Council**

**VAN DETH, Dr Arthur, Executive Director, Metropolitan Division, Department of Human Services**

**WHITE, Mr Paul, Assistant Commissioner of Crime, South Australian Police**

**CHAIR**—I think we all know who we are and what we are here to do. The House of Representatives Standing Committee on Family and Community Affairs is looking at the issue of substance abuse. We have been to Western Australia and have done some work in the national capital. We are going to Melbourne in the next couple of days after our hearing in Adelaide. I almost feel that we have met before. We certainly know Graham and Paul. I welcome the representatives of the state government.

I wish to point out that, while the committee does not swear in witnesses, the proceedings today are legal proceedings of the parliament and as such they warrant the same respect as the proceedings of the House of Representatives. That said, welcome everybody and thank you for your help yesterday. We had a great day yesterday looking around as part of some informal proceedings.

I am sure you will have an opening statement, after which we will get down to some general discussion. I am not sure who would like to lead off.

**Dr van Deth**—I am here to represent the South Australian government's position. I work for the Department of Human Services as the Executive Director of the Metropolitan Division, which includes a whole range of primary care areas of service delivery.

I want to begin by thanking you for this opportunity. It is my intention to give a bit of an overview of how the South Australian government sees substance abuse in this state, highlight some of the statistics and then provide a fairly high-level overview of the approach we are taking to dealing with substance abuse across the whole spectrum. The first and obvious point to make is that the impact of substance abuse on the South Australian community is extremely widespread and clearly ranges from health issues to behaviour, aggression, mental illness, communicable diseases, road trauma, workplace safety, drug related crime, organised crime, family and social dysfunction, et cetera. The cost is borne by the whole community, not just those people directly affected, and through issues such as insurance premiums, diversion of money from the legitimate economy, a huge impost on health care and welfare systems and the cost, of course, of law enforcement.

I will provide a few selected South Australian statistics to put it in perspective. In 1998 there were more than 1,900 deaths as a result of alcohol and other drug use. For the same conditions

there were 21,000 hospitalisations. If you break that down, out of those 1,900, 1,500 deaths were due to tobacco use, 300 to alcohol use and 150 to other forms of substance abuse. So it is worth always keeping that in perspective, that alcohol and tobacco are the big areas of substance abuse.

We estimate that the South Australian economy is impacted on to the extent of about $1.5 billion per year through substance abuse. If you look just at heroin overdoses, we had 45 fatal overdoses in 1998. That is a significant number and it represents an increase of 25 per cent over the previous year. In any one year, six per cent of South Australians are physically abused by someone affected by alcohol. If we look at complications arising out of legitimate pharmaceutical drug use, which I know is slightly outside this topic, we see a range of issues, such as adverse reactions, dependence, traffic accidents, accidental or intentional self-poisoning and, for example, hip fractures from people losing their balance due to the drugs that they are on. The social ramifications of becoming a victim of crime are significant and there is a major impact on the productivity and wellbeing of the community. We estimate that as much as 80 per cent of police time is involved in incidents related to drug and alcohol misuse. The presence of a significant illicit drug industry leads to associated illegal and undesirable behaviour, such as tax avoidance, illegal gambling and stolen property markets.

Substance abuse has a major impact on family breakdown, homelessness, poverty and unemployment. An area that is often not discussed is workplace safety. Our statistics indicate that between 20 per cent and 25 per cent of occupational injuries are the result of drug and alcohol use. If you look at fatal injuries, between three per cent and 15 per cent of fatal work related injuries are drug and alcohol related. The link between road trauma and alcohol is well established. In 1998, this state looked at 7,000 drink-driving offences.

I could go on for a long time giving you statistics. I just picked out the highlights. I know you have received our submission as well. One point I would make is that—and this is probably not necessary—we are dealing with highly complex issues and consequences. There is always a risk that people look for quick fixes and simple solutions. Nevertheless, the approach of this government has been to develop a comprehensive and coordinated approach in dealing with drug related issues and substance misuse.

I will now outline in very general terms the government's approach. The first point to make is that we have very much aligned our approach to the national drug strategic framework. I am sure you are familiar with that. It encompasses harm minimisation—for example, supply reduction, demand reduction, reduction in drug related harm; a coordinated integrated approach, which includes both government agencies, the community, NGOs and individuals; very much a partnership between different levels of government and with the community; and a balanced approach, in terms of supply reduction, demand reduction, harm reduction as well as a balance between treatment services, intervention and prevention. We are committed to an evidence based approach. In particular, I think it is important that we have ongoing evaluation and that we do look at a cost benefit for alternative approaches. We are committed to a social justice outcome, recognising that there are a number of groups more significantly affected and having special requirements in terms of dealing effectively with substance abuse and misuse.

In South Australia we have taken those six directions in the national framework and have developed a number of particular themes, the strongest of which is the development of a whole-

of-government approach. We are finding that in a number of areas where we are dealing with complex problems this is extremely important. We are finding that it can work at all levels of government. It happens not only at the chief executive and minister level but, as a result of that sort of interaction, at officer level where people are more enabled to find solutions across boundaries and more integrated solutions and identified gaps.

We have decided to focus on particular groups in the community that are at risk or have high needs, we have a strong agenda of building community capacity and we also believe that we need to understand the drug economy better—not only on the supply side but also on the demand side. It is a complex area that is worth understanding better.

I will give one example of cooperation across government and with the community that has worked particularly well. In 1996 we looked at strategies to reduce deaths from heroin overdoses in South Australia. We brought together the Drug and Alcohol Services Council, the South Australian Police, the Ambulance Service, the AIDS Council of South Australia, the National Drug and Alcohol Research Centre, a community group called the South Australian Voice for Intravenous Education, and hospital emergency departments. The strategy that was developed encompassed developing information material on overdose awareness and prevention—this included posters, fridge magnets, booklets, and so on—a pure education strategy and ongoing collaboration with drug users and other stakeholders.

The most important component of this was to reduce the fear in people calling for ambulances to attend to overdoses. The fear was that there would be police action and that was deterring people from calling ambulances. As a result, guidelines were developed both for police and for ambulance officers to minimise that fear and to encourage people to call ambulances. This range of protocols has been highly successful. We have it under ongoing review and discussion to make sure it continues to work and is refined as necessary, and it is now part of a national coordinated effort aimed at reducing deaths from overdose.

I talked about the importance of a whole-of-government approach. What has been particularly instrumental in achieving that has been a chief executives coordinating group on drugs. This brings the chief executives and their senior staff together on a bimonthly basis, and we discuss all issues across government in relation to drugs and substance abuse. This group reports to a cabinet subcommittee on illicit drugs. One of the major impacts has been that it has set up a number of working groups across government—across departments—where at officer level significant solutions are being developed. I am sure you heard examples of that yesterday.

The topics being covered by that group include: the coordination in gaps in drug treatment services; Aboriginal kinship programs; schools programs; early intervention strategies, such as the police diversion program; drug action teams, which are police led, working in the community; Operation Mantle, which is an information system on illicit drug law enforcement; and the clean needle program which, incidentally is particularly relevant to hepatitis C, not only HIV. It has a relevance both to the general community and to the drug using community. Clinical research projects are important, particularly in relation to opioid replacement treatments and ongoing monitoring of drug use patterns in South Australia. That gives a fairly general and high-level overview of our approach to drugs in South Australia. I thank you for this opportunity once again to present the state government's view.

**CHAIR**—Thank you very much for that and for the comprehensive submission that you have put in. It is very useful and we appreciate that. I will open the batting by talking about the Commonwealth-state relationship. We already have a national focus. I will just ask two or three general questions and then everyone can come in and we will have a general discussion about the issue.

In terms of the Commonwealth-state approach—we are the result of our federation of 100 years ago—is there anything particularly that you can think about in terms of jurisdictional issues that we might focus on? Some might say it would be ideal to have more consistent state laws—there are some weaknesses over state boundaries—in the administration of programs, where we have Commonwealth finance and cooperative programs and the new drug strategy program itself. Would you care to make some general comments around that? Is there anything specific you might offer the inquiry on Commonwealth-state issues?

**Dr van Deth**—If I may start off as generally as possible—I think it is easier to be general—I am involved in quite a few areas in Commonwealth-state negotiations on funding programs. I think the reality is that states come from very different positions and that the Commonwealth has a need for achieving certain outcomes which are uniform across the nation. What I have found a most useful approach is something like a public health funding agreement, where it is agreed that certain outcomes are to be achieved and the states have sufficient latitude to achieve those outcomes according to what is feasible within their own communities. However, I think that should be done in a broader framework which moves towards national uniformity. That as a general approach I think is most sensible and avoids getting bogged down in endless multilateral and bilateral discussions. There is always the risk of an imbalance in power, because ultimately service delivery takes place at the state level and affects communities at a state level. I think that needs bilateral sensitivity and a real will to achieve results for the community.

**CHAIR**—You touch on a very important point: the state actually has to deliver many of the programs. It is all very well for a national government to lay down guidelines and then step back, but it is the state that is left with the reality of the practical delivery. It is very important to remember that.

**Dr van Deth**—In that respect, I often find that the relationships between state governments and state representatives of the Commonwealth government are very useful and very important. It is when you are solely dealing with people in Canberra that it becomes more difficult to understand the state issues or to have them adequately debated.

**CHAIR**—Again I will just touch quickly on the issue of legal and illegal substances. We are battling all the time to get the balance right. We focus on the illegal, the illicit. It is pretty obvious that there are more spectacular headlines, or whatever spin we might like to see it in, and in some ways it is more dramatic perhaps. How do you address this balance? We know of cigarettes, alcohol and other—and the 'other' seem to get quite a degree of emphasis. How do you see that, and what is the appropriate response from your perspective?

**Dr van Deth**—Other members might like to comment as well, but my first thought is that there are two issues. One is clearly the media coverage and the sensationalism around illicit drug use, and that creates this political momentum. But I think the other issue is that illicit drug

use may be symptomatic of significant stresses in people's personal lives, and possibly more so than smoking and alcohol use, which is more socially condoned. That is just a suspicion I have. Therefore, in any discussion about how important illicit drug use we need to think about that bigger picture, like why people come to that particular situation, as well as clearly managing the politics around illicit drug use. I think other members might wish to express their views.

**Mr White**—Alcohol and tobacco are licit drugs, as we know, and they are more socially acceptable, so there is probably an element of tolerance in society for the enormous number of lives lost and casualty collisions on our roads caused through drink-driving, and that is one part of licit drug harm in society. Of course, you have a range of other areas as well, from domestic violence to serious assaults in and around licensed premises. All of those take up a substantial amount of police time.

In so far as the illicits are concerned, a lot of crime is associated with illicit drug use, whether it be robberies—in fact, I would suggest that almost all robberies are related to an illicit drug habit—property crime, of course; drug dealing to sustain a habit; and, more recently in Adelaide, we have seen a lot of violence associated with hydroponic cannabis cultivations. So, yes, the harm caused through licit drugs is far greater than illicits, but the harm caused by illicits does stretch to other crime, and often life years lost through illicits is far greater than it is for, say, tobacco and drink-driving, and I am sure my health colleagues would probably say that life years lost through heroin abuse and perhaps other illicits is far greater than it is for tobacco or for alcohol. So often the impact of illicits is far greater than it is for the licit drugs. But I will summarise my comments by saying what I did when I first started, and that is that perhaps there is an attitude of tolerance to the harm caused by tobacco and alcohol.

**CHAIR**—Could I just quickly go straight to the 80 per cent of police time estimated to deal with this issue? I do not know what the budget of the South Australian police force is, but it is some hundreds of millions. Are we suggesting 80 per cent of the total resource?

**Mr White**—I would clarify that. I would say 'up to 80 per cent', but it is always difficult to look at it across the state. There are pockets where it is no doubt as high as 80 per cent and pockets where it is not near that figure. It is very difficult to place an estimate on how much police time is related to drug and alcohol misuse, whether it is licit or illicit and the percentages vary from 40 to 80 per cent. But I would certainly suggest that, in some locations, it is as high as 80 per cent, and in some crime types it is probably even higher. So making a general statement about 80 per cent has to be treated with a little bit of caution. It is not an all-inclusive figure for the state; it differs from, say, one suburb or one geographical location to the next and from one crime type to the next, but it can reach as high as 80 per cent.

**CHAIR**—Can I conclude by saying that I would agree that in terms of the figures there is a degree of subjectivity and it is very difficult to analyse what it actually means, but of more interest to me would be: we would say that it is on the increase in that area. There would be no doubt in anyone's mind, would there, that we are on the increase over a decade in that area?

**Mr White**—There is no doubt in my mind that that is the case. For one reason or another, we have seen an escalation in violence over the last decade, a condition which is in large part attributable to alcohol.

A case in point is that very recently we realised we had an unacceptably high level of serious assaults occurring in the CBD, so we launched an operation called Operation City-Safe designed specifically to counter serious assaults in and around licensed premises. As you know, some of them might open for up to 24 hours a day, almost seven days a week.

**Ms HALL**—You were talking about 80 per cent police time being spent on alcohol and drug related matters. Do you have an idea of the split between the two?

**Mr White**—Alcohol would be far higher. For example, attending a domestic disturbance, alcohol may be a condition; attending a disturbance which may involve alcohol as a condition; attending a road accident which may have alcohol as a condition, and a whole range of other police activities that may be ancillary to those areas. So alcohol related police responses would be far higher than illicits. Indeed, illicits are more what I would call a proactive policing strategy. Because of their illegal nature, they are not as frequently reported to the police as are alcohol related incidents. So a lot of the illicit police investigations are caused by police proactively conducting those investigations.

**Mr QUICK**—Could I ask a question of John Paget and Stephanie Page in view of this whole-of-government approach? I am interested in which department takes the lead and who sets the agenda. My question to John is: perhaps there should be some prison innovation a la New Zealand, where those involved in drugs go to a separate medium-security jail. If the urine test is drug free, there is some sort of rehabilitation; if they do not pass the test, they are back into maximum security. Can you set the agenda? Can you get some additional resources from this community interagency bag of money if you see that as a priority to perhaps reducing the stress on the correctional services budget and linking in with what the police are doing?

My question to Stephanie is: if someone in the education department is really concerned—as I hope they would be—about the high incidence of young women smoking in schools, what sort of assistance do you have if you do not have the money in your education budget? With this whole-of-government approach, you can convince someone that you are an agenda pacesetter and you can get some additional money because you see that as a problem leading into what ultimately Paul is going to deal with in the police and John is going to deal with in the prisons. So there are two questions for two people which are basically related.

**Mr Paget**—I might take the first one where you asked: how is the agenda set? I think Arthur has indicated the sort of planning framework, that is, the chief executive's coordinating committee reporting to a cabinet subcommittee for a whole-of-government approach to the problem that we are all concerned with. Within the justice portfolio, there is a strategic directions plan which guides our budget bids, and within my own department we had a drug and alcohol strategic plan which was put together working across many agencies, including Graham Strathearn's agency. So that answers your question about how the agenda is set and how we indicate the way forward.

That plan was based on the best advice we could get on the sorts of things that we needed to do. In terms of the services that we provide, it is important to appreciate that, while you are focusing on substance abuse, we do tend to look a bit wider. We do not separate because of the obvious relationships between things like substance abuse, mental health problems and the sort of profile that the prison population exhibits. Something like 75 per cent of the prison

population has a drug and alcohol problem and 32 per cent committed drug related crimes. They also have very poor vocational standards. Some 44 per cent were classified as long-term unemployed at the time they committed their offence. While it is convenient to look at one aspect of the problem, our challenge is to try to pick up all those pieces—the drug problem, the mental health problem, the life skills problem and the vocational and educational skills problems as well. We do not see the substance abuse problem as something we can tackle without an integrated effort to tackle the totality of the problem an individual presents.

The sorts of interventions we have reflect the drug and alcohol strategic plan which was approved in 1997. We have a drug and alcohol therapeutic unit at Cadell. We try to maintain drug free units in all our institutions. We use differential sanctions in the way in which we treat problems, and that reflects the harm minimisation principle. By 'differential sanctions' I mean that we will react differently to a person who turns in a dirty urine sample for cannabis than one who turns in a dirty urine sample for heroin. Because of the retention of the drugs in the urine, it is very easy to go hard on cannabis and drive people into heroin use, which stays in the urine for lesser time. This notion of differential sanctions is being picked up by most directional jurisdictions.

We have methadone prerelease for people who were clinically diagnosed as being at high risk of returning to opioid use on release. We know from the South Australian Forensic Health Service that there are concerning high rates of death by overdose within a relatively short period of release. We also have prerelease methadone and methadone on entry to methadone maintenance. We now have about 120 people on methadone maintenance. That is in all jails, bar two. They will shortly come onto the program as well. That does not exclude other drugs. We have had cases where people come into the prison system on, say, naltrexone. They will either be maintained on that or weaned off it, depending on the clinical advice. So there are drug free units, the therapeutic unit and drug and alcohol programs. I think that probably answers the question you asked.

**Ms Page**—Firstly, I want to comment as to how we coordinate. A critical issue is leadership. The Premier chairs a cabinet committee and the chief executives actually attend the chief executive coordinating committee meetings, as do senior officers. I believe that that is very important in getting a truly whole-of-government approach. At the moment, Human Services is the lead agency, but our whole drug strategy is really a very collaborative initiative. One thing we are thinking about at the moment is whether the leadership resides somewhere that is not perhaps a service delivery agency. Nevertheless, irrespective of which agency takes the lead role, I believe that leadership and collaboration are a real feature of how we handle our responses to drugs.

I think your question is about how, say, Education and Corrections might lobby or argue for the limited funds available. That is an issue, because if you think about our approaches to drugs, we are going right through from supply reduction through to harm reduction if drugs are used and from prevention to early intervention to crisis intervention approaches. There is a juggling act as to where government will make the biggest impact by putting its dollars. Obviously, there are immediate demands for treatment services. From our end, that is Education's perspective, we argue about prevention and early intervention strategies and talk about how important it is to build resilience, community capacity and those kinds of things. So we have those debates out in the open in our whole-of-government approach.

**Mr QUICK**—So who is winning? All the evidence overseas says that there is a cost benefit of early intervention, as Dr van Deth said. All the evidence says that for every dollar you spend with early intervention you save $7 down the track. I am sure Mr White would love to spend an extra $6, and 80 per cent of his time is being spent on trying to sort out these things.

Returning to the issue of young girls and cigarette smoking, all the evidence is there. This situation resulted in 1,500 deaths last year—or probably even more, because the statistics are always a couple of years behind—and had a $1.5 billion impact on South Australian society. Say the principal of Port Augusta High School sees this as a real problem. However, he does not have enough social workers because the education budget does not stretch to that and there are limited resources for community services. How do you achieve this interagency, whole-of-community approach and build community capacity? What does it really mean? It is a lovely public servant phrase, but what does it mean for Mount Gambier, Port Augusta and Ceduna when it is bums on seats and the local principal and local health workers are saying, 'We've got this problem. We need some additional resources'? Who in Adelaide says, 'Okay, we'll divert some money from whatever it is because we identify that early intervention is the key. The Quit program needs an extra $100,000. Let's get the Quit program working in that area because we want to save those additional young women from getting into the mainstream'? How does it happen?

**Ms Page**—Let me just very briefly explain what our school drug education strategy is. Let me also address this issue of young women and smoking. I will do both. There are four major strands to what we are trying to do with drug education. Our overall aim is that every school should have a whole school drug strategy, and I will tell you what that involves. That then gets you onto this notion of community capacity building, because you can deal with it in terms of the individual and the individual's knowledge and strengths, you can deal with it in terms of the school community, or you can deal with it in terms of the wider community in which the school sits. Of course, schools do not operate in a vacuum. In effect, students bring issues from the community into the school. The school needs to recognise that and work within its community.

In relation to the four main strands to our school drug education strategy, firstly there is the actual teaching of drug education—so curriculum is really important. For us it is about getting appropriate teacher support materials to teach about drugs at every stage of the education process. So with the littlies when they first come into school, we might be talking about what medicines are, what they do, how you keep them, what effect they have and so on. We do not draw a distinction in school drug education between this notion of legal or illicits or whatever. Children with asthma and so on use pharmaceutical drugs very widely in schools and there are more and more medically frail children in schools. So kids need to understand about using pharmaceuticals. However, most other drugs are illicit, depending on your age. So curriculum is very important—actually teaching drug education.

The second part of our strategy is the professional development of our staff. They really need to know. We have an ageing staff—the average age of teachers is about 45. They may not know about a lot of the new drugs that are being used in the community, so professional development of teachers and how you teach about drugs are very important. The third part of our strategy is how you deal with drug related incidents. Generally you do not get a lot of actual drug taking on school premises, but you see the results of drug taking on school premises and occasionally you do get incidents. So it is about how we deal properly with those incidents and seeing school as a

protective factor in itself. We are saying, 'Don't expel children immediately. You have to deal with that. You are just passing on the problem if you are going to be doing that.'

**Mr QUICK**—Am I right in assuming that there is zero tolerance for illicit drugs in schools and there is an automatic suspension?

**Ms Page**—It is not an automatic suspension, no. It depends on the incident.

**Mrs IRWIN**—Can you give us an example. If someone is going to be expelled what would they have to have done to get expelled outright with no warning?

**Ms Page**—It is very hard to say. We give guidelines to principals. In fact, you would probably be aware that there is a national framework that has been agreed to by all the government schools, the non-government schools, Catholic parents and so on. We got together, we had a task force and we developed a national framework for developing protocols to deal with incidents. That in itself is quite an achievement I think, given the range of education providers in Australia. But the notion of that national framework is that each school develops its own way of dealing with incidents.

We do not have in South Australia—and I do not think we will have under the present arrangements—guidelines which say, 'If this happens, then you will do such and such,' but we do have guidelines on how you deal with drug related incidents, which I think are fairly clear. I am sure we could make those available if you would like to see them.

**Mr QUICK**—The reason I mention that is that I would like to know what lengths we go to. For example, if a kid is expelled from a school and is wandering the streets Paul's people have to pick him or her up. What do community services do to ensure that there is some sort of follow-up so that the kid can get back into school? If a kid is antisocial, are we having that person case managed by half a dozen people, and how do they relate to each other?

**Ms Page**—The fourth strand of our strategy which I was about to get on to is the partnership strand. It is how we work, how education people—your principal in Port Augusta or whatever—work with the local police, work with DASC and so on. The fourth plank is how the school, government and non-government organisations or whatever in that local community develop a strategy together.

The simple answer to your question is that we do not actually expel students just like that. If students are being suspended from school, it is the school that they are being suspended from which is responsible for ensuring that there is a plan for how they are going to be reintroduced back into that school. We are government school providers. We have a legal responsibility to ensure that children, particularly in the legal age group, attend school. If it is decided that a child will not continue in a particular school, then it is the principal's responsibility to arrange an alternative placement at another school. The kind of scenario you are painting really does not happen in South Australian government schools.

**Mr QUICK**—I am surprised to hear that, because I have wandered around Australia and seen most things. As a former teacher, I keep my fingers on the pulse. I would be interested to

see the plan. I would really like to see the plan put in place in South Australian schools. If you have done something as innovative as that, I think you ought to be congratulated.

**Ms Page**—If I could just address the last little bit of your question in relation to smoking: obviously the smoking issue has been dealt with in terms of the curriculum. One of the issues I think that is quite successful as an adjunct to the strategy that I am talking about is using people like elite sportspeople to come in and be part of the school's approach to drug education. For example, here in South Australia our women's netball team and basketball team—the Thunderbirds and Lightning—are used as key examples to young women in teaching about healthy lifestyles. Similarly, we use Port Power, an AFL club, extensively throughout our schools talking about healthy—

**CHAIR**—This is especially so for young women where the increase in smoking is of concern. I am going to need to move on. It is the old story that time just runs away from us, and I have seven or eight people who want to ask questions. I am going to ask that the questions be short and to the point and that the answers be just a little quicker or we will run short on time.

**Mrs IRWIN**—I just want to go on to something completely different, that is, blood borne viruses. On page 10 of your submission—and this is regarding blood borne viruses and injecting drug users—you state:

... in 1998 no new cases of HIV were attributable to injecting drug use—

Then you go on to state, which is a complete contrast:
... in 1999, 91%—

that is 71 of the 78—
of new cases of Hepatitis C could be attributed to recent or current injecting drug use.

Does this mean that needle and syringe programs are not working in South Australia to contain hep C?

**Dr van Deth**—No, and I will answer it as briefly as I can. If that is not adequate, you have to let me know. HIV and hepatitis C are two very different diseases. HIV has a low prevalence and is not as infectious as hepatitis C. So your chance of catching HIV is much lower. In addition to that, you had the very successful education campaign early on in the appearance of HIV, and people are therefore very aware as well.

Hepatitis C is extremely prevalent already amongst injecting drug users and it is also much more infectious. It is much easier to catch. Therefore, before you can make any impact, you need to have a very widespread use of clean needles and very good, clean injecting techniques to make any impact on hepatitis C. My understanding is that that is beginning to happen. We are seeing a reduction in the infection rate for hepatitis C as well, but you need a much higher uptake of the clean needle program before that is effective.

**Mrs IRWIN**—How is the program working here in South Australia?

**Dr van Deth**—Graham knows more about it, but people present to get clean needles in packs. That is done with as little intervention as necessary so people feel free to come. At the same time we encourage appropriate disposal of needles.

**Mrs IRWIN**—They actually get their clean needle at a chemist shop or a needle exchange?

**Dr van Deth**—Either at a chemist or at needle exchanges, yes.

**Mrs IRWIN**—Then where would they go from there to inject?

**Dr van Deth**—Wherever they would normally inject, whether that is in public toilets or at home. Of course, as a secondary issue, we look at the disposal issue of those needles. But that is probably not what we are talking about at the moment.

**Mrs IRWIN**—What is the South Australian government's view on safe injection rooms?

**Dr van Deth**—If I remember correctly, I think the wording is that we will watch developments.

**Mrs IRWIN**—To see if it works in other states?

**Dr van Deth**—To see whether it works. I think that is not an unreasonable attitude.

**Mrs IRWIN**—Just one quick question. At the beginning of your opening statement you stated that you were targeting various groups in the community who have high needs. What community groups are they? Are they from, say, the Vietnamese community?

**Dr van Deth**—That is a good example. It is often a high needs group plus a need for a different approach. The Vietnamese community is a good example. There are very different cultural backgrounds and family attitudes to drug use and getting treatment. Similarly, we know that Aboriginal communities, which already suffer from a lot of grief and loss in relation to other conditions, very much want Aboriginal-specific treatment approaches. They are two examples of targeting.

I think, as a more general statement, communities which are more generally socially disadvantaged, for a whole range of reasons, often have greater difficulty getting access to treatment services, support services, et cetera. We like to make sure that that is not the case.

**Mrs IRWIN**—Just one very brief question to Mr Paul White. I want to talk about policing and I am going to use the example of the Vietnamese community. This is coming out of my state of New South Wales and various other states that I have visited. I have been speaking to various police on the beat—this is all off the record; you are privately talking to a policeman as you are walking the streets, especially in Cabramatta in my electorate—and they state that they feel the police are not getting the proper training in order to understand that particular ethnic group. What sort of training are your police given in South Australia to understand the cultural aspects of that group?

**Mr White**—Very broadly, we have conducted some cross-cultural awareness training within the organisation. But I think the question is far wider than that. Often we hear that police espouse harm minimisation but police on the street do not understand that. I think there is an element of truth to that. We need to do more in terms of training our police in terms of harm

minimisation. There are many mixed messages about what harm minimisation means. Some police feel as though it contradicts what they are sworn to uphold. But that is not the case, because I would argue that harm minimisation contains a range of complementary strategies, not opposite strategies. I think that you can have enforcement plus harm minimisation. I think that there is some confusion at the street level among police as to what that means.

In terms of cross cultural-awareness locally, I would probably argue that here in South Australia you can locate your culturally diverse societies within pockets of Adelaide, particularly in the north-western suburbs and the northern suburbs. I do know that the police who were heavily involved in the investigation of South-East Asians involved in illicit drugs in the north-western suburbs received specific Vietnamese training, including some language training at one of our tertiary institutions. So there are efforts to understand those cultures.

We have community program units within each of what we call local service areas that deal with culturally diverse groups. It is probably a bit difficult to answer your question specifically other than to say that harm minimisation is an issue and, in those areas where I know that there are culturally diverse groups involved in illicit drugs, the local police have made endeavours to meet with community leaders to better understand their culture and their ways.

**CHAIR**—Assistant commissioner, thank very much. Over to Annette Ellis, who is the member for Canberra and who also has had experience in the ACT assembly.

**Ms ELLIS**—I have got two lines of questioning. The first is to Dr van Deth. You said earlier on in your opening statement that there were, I think it was, 45 heroin OD deaths in 1998—a 25 per cent increase. We are obviously not inquiring just into heroin, we have a very broad issue in front of us. You were able to give me that statistic this morning, but what about death due to alcohol, death due to amphetamines and speed and death due to other substances? Do you have those statistics and, if so, can you share them with us; if not, can you explain to us why you do not? Heroin is the headline grabber and, as important as it is, I am particularly concerned to know and understand the depths of the other issues.

**Dr van Deth**—I would have thought that the information is available from death certificates where a contributing cause is identified. Certainly, alcohol is commonly identified as a contributing cause. Then the statistics I quoted earlier are differentiated—smoking, alcohol and others—again in an attempt to get the right sort of perspective, if you like. So I think the information is available.

**Ms ELLIS**—Is it collated?

**Dr van Deth**—I think it is. I think Graham is probably more familiar with it.

**Mr Strathearn**—We can pull that information out. For the purposes of this paper, we just pulled out a number of data we thought that you would be interested to hear. The only other comment that I would make is in relation to deaths from heroin and other substances. I think it needs to be made clear that most substance abusers are polydrug users. They do not use just one drug; they use a whole cocktail.

**Ms ELLIS**—I understand that. The question running on from that is: is there any use made of the coroner's process? We have a network of coroners around the countryside, and I know that they are doing a lot of work—a national overview approach—towards the understanding of suicide, for argument's sake. Has there been any consideration of involving that sort of level of information into better understanding what we are talking about here?

**Mr Strathearn**—At the national level, coroners are starting to collect information and it is going across the whole of Australia. It is still early days. I think that they have been collecting it for only six months. That information is being made available and there will be costs associated with that to the state coroner's offices or justice departments.

**Ms ELLIS**—But you could see a justification in using that sort of network and building that up more?

**Mr Strathearn**—Yes. The other comment I would make is that, to get the data in relation to heroin overdoses, we actually had one of our workers go to the coroner's office and look through the case records to get that information. There was obviously a judgment made during that process as to whether the major cause, the major drug, was heroin.

**Ms ELLIS**—My second question is to Stephanie. It goes on from what you were saying before, Stephanie, about the education process per se. Do you have within that strategy a particular approach that is geared towards the indigenous student? In other words, is there any consideration given to the special requirements in a cultural or other way for the indigenous school population in the state?

**Ms Page**—We do expect schools to operate within their local community in ways that are appropriate to their local community. Obviously, the prevalence of certain substances and the way that they are used differs all over the state. We recognise that we need to do more in relation to particular groups within the community. We are doing some action research in our schools and the Aboriginal community is an area that we want to look at.

Our drug strategy really only got started at the beginning of this year and that is something I think we will be looking at in the next year or two. But to suggest, of course, that there is one thing that you can do about Aboriginal communities is obviously oversimplistic.

**Ms ELLIS**—No, I am not saying that.

**Ms Page**—I understand that. Our issues range from Aboriginal communities in central Australia where all kinds of drugs—alcohol or whatever—are banned; the Anango communities which are dry areas, through to country areas where alcohol is not banned but where petrol and glue and other things are issues.

**Ms ELLIS**—The main reason for me asking that question is that it is obviously an important aspect of education in a state like South Australia because there is a relatively large indigenous community. The second reason is really because yesterday we heard about a community where—I am hoping I am not misrepresenting this—there appears to be a social thing going on within the local indigenous community at a more adult level with a lot of suicide and other forms of abuse going on at far too high a level. I would like to suggest that when an area, a

community or a region like that is identified, we do not sit around and wait for the kids to come through the primary and secondary school system with nothing being done. That would be a perfect example of where, if there needs to be some innovation, quick thought and collaboration, that would be the ideal region to begin to consider doing something quickly within. Do you have a view on that?

**Ms Page**—I do, and I do not know if Arthur wants to talk about the priority target groups for our strategy in general. The way to deal with those issues is not just through education. I think education is really important, but we need a collaborative approach. Aboriginal communities are one of our priority areas, aren't they?

**Dr van Deth**—If I could just expand on one aspect of that. We have identified that smoking and alcohol use in pregnancy occurs at a very high level and is a major issue for Aboriginal communities. We have initiated, in partnership with our Aboriginal services department, a public health campaign around that. It is an area that I think people might not be fully aware of, and it is a very major public health issue which affects newborn babies as a result.

**Ms JULIE BISHOP**—I am just seeking your comments on the role that the media can and does play in this whole issue of substance abuse. Obviously it can be useful and have an educational aspect to it—raising awareness and the like—but it can also have a harmful aspect to it if you look at perhaps the dissemination of misinformation or the sensationalism that so often accompanies an isolated drug related incident. Could you comment on how the media—the fourth estate, a very powerful medium—can impact on your different areas, positive and negative; how can we work with the media?

**Dr van Deth**—To maybe start off the response—I think people might have very different views—I agree with the things you have said. I would add to that that developing a relationship with the media is important so that, when you do get a negative and sensationalist view, you can follow through with an information stream that then counters that view, and sometimes you can engage journalists to take a different view. Certainly in health we have seen that, where something highly sensational has grabbed the headlines, over the ensuing weeks a theme has developed which has been a lot more constructive and we have been able to influence that. That is the only comment I would add. I would agree with your views otherwise. We might have other comments.

**Mr White**—In very general terms, research shows very clearly that the media misrepresents certain forms of crime, and so the public are left with an impression of violent crime which is overrepresentative of what actually happens. Of course, despite that, there is also, I suspect, a cumulative effect. So the public tends to have to rely on the media for its store of information about crime, and by and large that crime is misrepresented because it overrepresents serious and violent crime. But I do not know whether I can be more specific.

**Ms JULIE BISHOP**—Isn't there an element missing in the whole-of-government approach? Given that most people get their information from the media, you need them to get your message out. It might be that you did not need to spend weeks trying to turn the story around if the story had been dealt with responsibly in the first place. It just seems to me that there is an element here that we are not yet addressing.

**Mr White**—I would agree. In fact, I think there is a lot more that we can do in terms of marketing and educating all of the community, including the media, about illicit drugs or drugs in general. I am sure there is a lot more we can do. We have seen some very successful campaigns with smoking, for instance, and even drink-driving, and I think there is a lot more that we can do with other drugs.

**Ms Page**—The role the media can play obviously is a very positive one in terms of educating. There are sections of the media that tend to exaggerate the incidence and prevalence of drugs. We get callers who have been encouraged to ring up and talk about what schools should be doing about handling drug related incidents, which seems to result in a lot of pressure around parents thinking, 'Well, if this school is expelling children immediately, then that is the place I want my kids.' What we have discovered is that parents think that until it is their child who is involved, and then they want the circumstances taken into account and other kinds of things. I agree with you: we really need to work hand in hand with the media around educating them about what are sensible, responsible responses to drug use and what are the facts.

**Mr Strathearn**—A number of years ago, we did actually try to give journalists information to report responsibly, and we tried to target the editors, but in actual fact the people who came along were the junior reporters. The stories that we would give were quite reasonable, but then the editors would come in, as you can imagine, with a headline which basically was sensational.

**Ms JULIE BISHOP**—What does that do? We appreciate what the media can do in a positive sense in educating, raising awareness, being part of campaigns, but when there is a sensational headline, an overstatement or an exaggeration, what harm does it actually do? What impact does it have? Does it make people more curious? Does it glamorise the use of drugs? What is the issue?

**Mr White**—I guess in very general terms there is a correlation between media stories of crime and increased fear of crime.

**Dr van Deth**—We have seen the same in suicide reporting. Youth suicide reporting has in fact been associated with copycat suicides. I think it is a complex issue.

**CHAIR**—You raise an interesting issue, because clearly there has been an effort in the suicide area at a national level to try to work with the media and offer awards for more responsible reporting and that type of thing. Can I just report back to you that it is a great concern in the inquiry so far about the role of the media and what sorts of recommendations we might want to make to government to see how we might advance that issue.

**Mr ANDREWS**—I have four brief questions. Firstly, do you have data available—and, if so, can you provide it to the committee—on the number of needles which have been distributed in South Australia, for example, in the last five years?

**Mr Strathearn**—Yes, we can. Last financial year it was nearly three million.

**Mr ANDREWS**—Has that been increasing over the years?

**Mr Strathearn**—Over the last couple of years it has, but this year, for some reason, it seems to be levelling off.

**Mr ANDREWS**—Secondly, I note the figures in the submission in relation to teenage drinking. It would be my observation that over the past decade or so the incidence of teenage drinking would seem to have increased. Maybe it is simply that I have teenagers now, but that does seem to be the case. I am not sure whether it is the case in South Australia this week, but I think it is what is known as schoolies week, at least in some parts of the country, one feature of which seems to be to go to some beachside resort or somewhere and the incidence of drinking involved in that is a feature. I suppose my question is: if my observation is borne out by the evidence in terms of teenage drinking, then are educational campaigns at the secondary school level having any effect at all?

**Ms Page**—A lot of the research in this area is American research, and often the objectives of the campaigns are slightly different from that in Australia. If you look at the research, I do not think there is a lot of comparability across research findings about what was being looked at and so on. Graham probably wants to say something more about that.

**Mr Strathearn**—The data that we collect comes from a schoolchildren survey and, yes, teenagers drink alcohol. What we have done in this state is really linked into the national alcohol campaigns. Once we know that they are on we actually bring out all of our community workers, train them and give them small amounts of money for community grants. So a lot of activity occurs within local communities. For example, with the schoolies week that is at Victor Harbour, we have put money in there for information purposes and we subsidise transport. We know people are going to drink. We also do that on new year's eve here. Several government departments put money in that enables us to provide free transport in and out of the city between certain times of the night. So that sort of activity does occur.

**Mr ANDREWS**—I take it from your comments that there is a need for more research in the area which is Australian based. Is there a need for more studies which actually look at whether or not the various programs, whether they are educational in schools or other programs that you have been describing, are actually having some effect?

**Dr van Deth**—I was going to make the comment that generally it is quite hard to assess what health promotion programs actually really work. We do need that sort of evidence. Equally, we cannot conclude that the various campaigns do not have an impact because teenagers still drink. The other observation I would make is that, again anecdotally, teenagers are very careful about drink-driving because of the risk of losing their licence. That seems to be a pretty universal attitude and that seems to have a major impact on teenage drinking behaviour.

**Mr ANDREWS**—Presumably you would agree that if we are going to spend more money on educational campaigns we ought to know what is effective and what is not.

**Dr van Deth**—Absolutely.

**Mr ANDREWS**—My third brief question is that there is reference in the submission to drug and substance abuse problems causing family dysfunction and family breakdown. Is there

evidence, any research, findings or studies of the contrary, that is, that family dysfunction itself is a factor in substance abuse?

**Mr Strathearn**—I think that there are studies that would indicate that dysfunctional families often lead to children entering into abuse of substances. So they are about.

**Mr ANDREWS**—Given that one of our terms of reference is the impact of substance abuse in terms of family relationships, I am wondering—I do not know the answer, I am simply wondering—whether or not, given a higher prevalence of substance abuse is causing family dysfunction, we are creating a generational effect as well, that where you have family dysfunction that that in turn is leading to more substance abuse?

**Mr Strathearn**—I think if you go back to the beginning, why are people abusing substances in the first place? We need to look at the social and economic issues—high rates of unemployment, areas that are pocketed with high rates of unemployment and areas where mums and dads, and grandmas and grandpas of three generations have not actually had employment and what effect does that have on the kids. Yes, there needs to be more information gathered about that, but anecdotally we think that is what occurs.

**Mr ANDREWS**—Just finally, you make reference to new initiatives including the Drug Court Trial which commenced in May of this year. Can you briefly provide some information on how that trial is working?

**CHAIR**—The evidence will have to be brief—

**Mr ANDREWS**—I am happy, Mr Chairman, if it assists the committee for the witnesses to take it on notice.

**Mr Paget**—I have the details here. As at 9 October, 169 referrals were made, 52 per cent were assessed—that is 88 of them; 75 of the 88 who were assessed were accepted into the program and since its inception 71 people have been placed on that program; 61 per cent are still on the program, which I think is pretty high. In terms of participation, 84 per cent are male and 15 per cent are female. The age distribution was: under 30, 52 per cent; over 30, 48. As to ethnicity, 81 per cent were European; Aboriginal, 11 per cent; Asian, six per cent; African, one per cent. The primary drug of addiction was heroin, 75 per cent, and amphetamines 16 per cent. I will not go into the others.

**Mr ANDREWS**—Just briefly, is there an assessment of the trial? What is the length of the trial? When will the community know whether it has been judged to be successful or otherwise?

**Mr Paget**—I think I will take that question on notice.

**Dr van Deth**—It is initially meant to be a two-year trial.

**Mr Paget**—Was that answer adequate? Did you want the exact date of the trial?

**Mr ANDREWS**—If it is a two-year trial that is fine.

**Mr EDWARDS**—I have two questions, the first of which is to John. Every state jurisdiction that we have dealt with tells us of the relationship between drugs, crime and incarceration. Can you tell us what initiatives you are taking within the prison system in South Australia to, in a sense, try to break that relationship? Do you have naltrexone and/or methadone programs in your prison system? It might be quite a bit of detail, but I would be happy if you took that on notice if you would not mind, providing us with some details at some stage.

**Mr Paget**—We do have methadone. There are very few who come in on naltrexone. I think I can recall one female prisoner who came in on naltrexone. Naltrexone has got its own disadvantages because if they are polydrug users and use methadone it makes using Narcan very difficult and dangerous. As to the relationship between drugs, crime and incarceration, while 32 per cent of the people are in prison for drug related offences, 75 per cent have got alcohol and other drug problems. One of the issues raised by Mr Andrews was the nexus. Seventy-five per cent of women have been physically or sexually abused and 81 per cent are suffering from PTSD and it would not be surprising if the bottle or a needle would be a refuge for many bruised people. It is pretty clear to me that there is a clear nexus.

**Mr EDWARDS**—I will be interested in any follow-up information that you could perhaps provide, given your vast experience in a couple of areas that you mentioned. Arthur, in your submission you point out that the South Australian government's contribution to the standing committee inquiry focuses on state-specific statistics, issues arising and outcomes and you also say that a number of your structures were formed to ensure the state's strategic direction on drug programs. Are you satisfied with the level of cooperation between the state, the Commonwealth and other states within Australia?

**Dr van Deth**—Commonwealth-states, yes; within the state, yes; with other states it is largely information sharing as opportunities arise. It is a bit hard for me to comment on it. I suspect that Graham might have more experience in dealing with other states and might wish to comment.

**Mr Strathearn**—The only comment I would make is that through the intergovernmental committee on drugs which supports the ministerial council on drugs there are a number of subcommittees that look at a variety of issues and states contribute to those. It sort of tends to lead to much more uniformity across Australia. The answer is, yes, there is sharing of information but, yes, there is room for improvement.

**Ms HALL**—I have four brief questions. Firstly I notice that in your report you have not mentioned anything about people suffering with the dual diagnosis of mental illness and drug dependency. What arrangements are in place in South Australia for people who fit into this category?

**Dr van Deth**—You have touched on a hobbyhorse of mine, and therefore it will be hard to be brief.

**Ms HALL**—You may like to submit something in writing then, because I notice that it was missing from the report.

**Dr van Deth**—We recognise the concurrence of mental health problems and drug use and we are aware that there is probably a causative association for a number of conditions as well. The

real issue to me is that people tend to get labelled with a mental health condition and therefore, straightaway, there is a boundary and there are eligibility issues. I am trying to get around that by talking about people with complex needs, whatever those needs are, whether they are mental illness, drug related or other. Accommodation issues are a common one. To say, 'These are the functional requirements,' a department of human services, in conjunction with other government agencies, needs to come up with a solution. I find that approach useful, because it does not allow people to pigeonhole and ignore a whole range of problems. It allows you to identify the linkages that you need and the support. What I find also is that accommodation, particularly stable accommodation, is a major component in looking after people with drug and/or mental health problems.

**Ms HALL**—Would you be happy to submit something to us on that issue in writing?

**Dr van Deth**—Yes, that would be fine. Can we just clarify what exactly I am submitting on? On complex needs or—

**Ms HALL**—On the ability for those people to be treated within the system here and on the complex needs—the fact that they often slip through the system.

**Dr van Deth**—Yes.

**Ms HALL**—My next question relates to the South Australian Legislative Assembly Select Committee on Heroin Trials. I notice that there was nothing in the report on that. I understand that there were some recommendations made. I refer to the need for more resources and programs to be provided within prison. I understand that the Aboriginal Drug and Alcohol Council did provide programs in prison, but I understand also that that has been defunded. Maybe you might like to comment on that and other recommendations from that committee.

**Mr Strathearn**—I think the select committee report was tabled and there was a government response to that. If we took that on notice we could give you that response. However, at the same time, the government did fund additional programs substantially. For example, the Drug Court Trial was $1.5 million per annum for two years; drug treatment services received nearly $1 million; law enforcement received money for drug action teams. It enabled us to establish things like that for the Vietnamese worker you saw yesterday and some indigenous workers and enabled us to regionalise some of our services.

**Ms HALL**—What about the prison program?

**Mr Strathearn**—The prison program, I think as part of that, received—

**Mr Paget**—The ADAC program was originally funded by the Commonwealth. If I recall, a request had come from us to pick up the liability—the $300,000—when the Commonwealth withdrew the funding. I am not sure how the flow went—whether it went through ATSIC or what was the agency—but the funding stopped. We put in our budget bids in the normal cycle in around November the previous year. So to expect me to pick up $300,000 on such short notice was just out of the question. What we did was reallocate within the department the Muirhead money to our Aboriginal manager, who has arranged for Aboriginal people to deliver within the department Aboriginal specific programs. They are programs directly related to AOD problems

but also relating to the basis of why people have fallen into drug and alcohol use—grief and loss programs and anger management programs, for example. So they are being delivered by Aboriginal people within the department, rather than external providers.

**Ms HALL**—My third question goes to workplace safety. Is there any testing of workers in the workplace in South Australia for drug and alcohol? Do they do it in the police force? I come from New South Wales, so I am linking into that.

**Mr White**—There is no drug testing within the South Australian police; however a draft policy document has been under consideration for some time. We may well move to that position in due course. I am aware of the drug testing regime in New South Wales, of course. It is interesting to note that different organisations have different needs associated with drug testing. It is of dual importance to police in terms of integrity and accountability, but also in terms of public safety, when you may have engaged in urgent duty driving or use of a firearm. In other organisations it might solely be related to productivity, perhaps. I am not too sure but, no, we do not have it at the moment but we are considering it.

**Ms HALL**—And generally?

**Dr van Deth**—We do not drug test.

**Ms HALL**—My final question relates to something Stephanie was talking about earlier, that is, suspensions. My understanding is that each school has its own policy and it comes to the decision of the headmaster to suspend. Correct me if I am wrong. How many suspensions are there a year in South Australia? For those students that are suspended, what programs are available for them whilst they are out of the school system? I have heard of some students that were out for five weeks, and five weeks of doing nothing can be a problem. Finally, you might like to comment on how the administration of Ritalin and drugs for ADD is handled in South Australia. Is that a problem with the teachers?

**Ms Page**—It is true that each school develops its own approaches within the whole school drug strategy, but that is within systemic guidelines. So we do have guidelines that go right across the state. I am only speaking for government schools in that respect. However, the Catholic schools also have systemic guidelines and each school develops an approach. In the independent sector it is the same. So we work very closely with the independents and Catholics.

The data about suspensions has not been as good as we would like around identifying the particular reason, just because of the way the data has been collected on our computer systems. We are just changing those fields to allow us to get better information about that, because there can be a number of reasons in a particular incident for a student being suspended. We are not satisfied that a drug related episode or something may necessarily show up in that, so we are actually changing the way we collect data and we will be able to answer that question a little better in the future.

In relation to your last question about medication for ADHD, and medication in general I take you to mean that we have guidelines for schools about how they should deal with medications for children. We are in the process right now of negotiating with the unions around introducing new guidelines. It is hard to be brief about that question, but I think it gets back to our staff and

our principals understanding about how you can safely deal with medications and feeling less anxious about whether they are doing things that they believe maybe should not be being done by teaching staff, if you know what I mean. So we have guidelines about how you handle medications. In relation to other issues about medically fragile children, we have a program that involves credentialled assistants who come in and do various medical interventions and very strict guidelines around what staff in schools can do and what other people can do.

**Ms HALL**—Maybe it might be good if you could give us the details of that, because I am going to be asking this when we visit a number of states. Also, when you get some more information on suspensions, I would be really interested in that, and I am sure other committee members would. Thank you very much.

**CHAIR**—On the schools and in terms of the statewide policy, how reassured are you about the consistency of the suspension policy across the state? I will talk just about the government system, because it is difficult to talk across—

**Ms Page**—In relation to drugs?

**CHAIR**—Yes. What sort of measurement—

**Ms Page**—I cannot say that I know the answer to that at the moment, given that, as I said earlier, our drug strategy commenced at the beginning of this year, when the state allocated funds for that purpose. The process we are using is that we aim to get every school to adopt this whole school drug strategy, but we have only about 60 schools that have worked through that to date. It has been an experimental year, a very developmental year. Within three years I could feel pretty confident about giving you the answer to that, because that is when we estimate that we will have worked through every school in the state.

**CHAIR**—The issue clearly is that perhaps some reassurance about the consistency across the variation that sometimes may be apparent is able to be measured or able to be seen to be consistent.

**Ms ELLIS**—There is something I forgot to ask earlier on and I wanted to ask Mr White. There is comment going around the community here at the moment that we are quite obviously aware of in relation to the possession of numbers of marijuana plants. We have not discussed cannabis this morning. I was just wondering if you could give us a very brief view or comment on where you are currently. I am from the ACT, and we adopted a different set of rules a few years ago that were a little bit ahead of other people. I am saying that as an illustration South Australia has Western Australia, the Northern Territory—you are surrounded by other people. How do the other jurisdictional rules in terms of the possession of cannabis impact, if at all, on the South Australian situation? You have the debate going on here and then you have, obviously, different rules laying around you, all places which are accessible by car and train and bus and truck and heaven knows what. Is there any impact from those different jurisdictional situations as well?

**Mr White**—Yes, there is. Firstly, to the best of my knowledge, the current stipulation is that you are entitled to have up to three plants for personal use or possession, and if that is the case, you receive an expiation notice. The debate is whether that should go back to 10 plants, where it

was about 12 to 18 months ago. Certainly, it causes a problem for us in terms of the interstate demand for and transportation of cannabis, particularly to the eastern seaboard, and we have identified a number of syndicates that are involved in transacting and transporting drugs—namely, cannabis—from South Australia to the eastern states in particular. It is a particularly contentious issue at the moment. What we are seeing emerge are high levels of violence now associated with hydroponic cultivations. It would seem that people are either looking for drugs or attempting to rip people off or make money, and we have had a number of very, very serious assaults, including murder recently, related in some way or another to cannabis cultivations. It is a particular concern to us.

I might also add that since the cannabis expiation scheme commenced in South Australia, the COAG initiative, as you know, has introduced diversion, and so we are looking at other ways of dealing with first and second-time offenders. I know the commissioner is on record as saying that he would prefer to see no cannabis plants should be legal, and I think it is in that context that he made that comment, that is to say, that there are now diversionary schemes where we might be able to offer education, advice, a self-assessment talk or even some early assessment of first/second offenders for small possession of cannabis. So it is a particularly complex area at the moment undergoing debate. I have tried to answer it as quickly as I can.

**Ms ELLIS**—Very quickly, when you mentioned 'syndicate' and 'hydroponic', can you elaborate on the situation from your perspective?

**Mr White**—Yes. What we are finding is a couple of important case points here. One is that people realise that by growing what used to be up to 10 plants but now three plants, you can syndicate or pool people who will grow it and, if apprehended or detected by the police, receive an expiation notice for that. But the collective amount is quite substantial and is then transported interstate.

**Ms ELLIS**—So the cost value is different here from elsewhere.

**Mr White**—Yes, I understand the prices for cannabis are higher in other states.

**Ms ELLIS**—So they make money.

**Mr White**—Oh, yes.

**Ms ELLIS**—They grow it here, take it over the border, sell it for a higher fee.

**Mr White**—Yes.

**Ms ELLIS**—Then what do they do?

**Mr White**—They come back here and they are cashed up.

**Ms ELLIS**—It has been suggested to us that some of those people actually take it over, sell it, convert their dollars into other more lucrative drugs and even consider bringing them back. Is that the case?

**Mr White**—Yes, that probably occurs as well.

**CHAIR**—And there are different values in those drugs from one state to another.

**Mr White**——Yes.

**Ms ELLIS**—So there is a real sort of value adding going on here, isn't there?

**Mr White**—There is no doubt about that.

**CHAIR**—Thank you; we appreciate that.

**Mr ANDREWS**—Does that mean that the policy that is in operation in South Australia, whether it has been three plants or 10 plants, has led to an increase in the organised criminal activities surrounding cannabis production and commerce compared with prior to that policy being in operation?

**Mr White**—Yes, I believe it has, and it has not discouraged the large-scale outdoor cannabis cultivations either. We are still discovering those.

**Mr LAWLER**—In talking about blood borne diseases, I understand that there has been developed or almost developed a syringe with a completely retractable needle; it is unable to be used twice. Has there been a cost-benefit analysis with a view to putting those sorts of things into the needle exchange program?

**Dr van Deth**—We have done a lot of work on that. I think Graham will answer that question.

**Mr Strathearn**—This issue was raised at the ministerial council on drug strategy, and there has been a subgroup formed from the intergovernmental committee on drugs which is due to report to ministers out of session by the end of February about retractable needles. So it is an issue that is being currently addressed and standards are being set as to what a requirement of such a needle would be.

**Mr LAWLER**—But we haven't got a cost.

**Mr Strathearn**—The early estimates of cost are—we have seen many examples of retractable needles which retract but can be reused—three or four times the cost of a normal needle.

**Mr LAWLER**—That is what I mean. I suppose it is early days, but sure there is a higher cost; there must be a benefit at the other end.

**Mr Strathearn**—As part of the process in going back to ministers with the issue surrounding retractable needles, they are looking at a cost-benefit analysis as well.

**CHAIR**—Lady and gentlemen, thank you very much. That has been greatly appreciated and very useful to us. Thank you for your efforts and contribution and, of course, the pre-efforts which go to presenting something like this. We are in your debt.

**Proceedings suspended from 10.30 a.m. to 10.38 a.m.**

**NOLAN, Mr Dominic, Executive Officer, Australian Regional Winemakers Forum**

**STRACHAN, Mr Stephen, Policy Director, Winemakers Federation of Australia**

**SUTTON, Mr Ian, Chief Executive, Winemakers Federation of Australia**

**CHAIR**—We will get under way and other members will join us shortly after they have done their various tasks out there. I welcome to this public inquiry today representatives from the Winemakers Federation of Australia. I just remind us all that we do not swear in witnesses, but the proceedings are legal proceedings of the parliament and they are worthy of the same respect as the parliament.

Gentlemen, thank you for being with us today. Thank you very much, too, for a very comprehensive submission. A lot of work has gone into that. We would invite you to introduce yourselves and give an opening statement. Then we will have a bit of a chat about it.

**Mr Sutton**—We would like to just open by addressing some issues that may have arisen previously. We start with the fact that the Winemakers Federation is made up of two electoral colleges: one represents small regional producers; the other typically represents the large producers. Our total membership represents over 90 per cent of all wine production in Australia. Our levies are paid on a voluntary basis and around 2.5 per cent of our members produce cask wine and less than 15 per cent of our levies are derived from cask sales. Also, of the four major companies, their revenue from cask production as a percentage of total sales is 25 per cent, 13 per cent, six per cent and zero per cent. The largest wine producing company in Australia derives six per cent of total sales revenue from cask wine sales.

I would like to also add that the whole focus of the Australian wine industry has been driven towards quality. The industry's 30-year plan—2025—enunciates the policy of pursuing quality. We have seen over the last decade a very strong compositional shift in terms of the production of wine in Australia to meet the ever increasing demand for better quality wine. I think it is fair to say that that compositional shift is the direction for the industry's future. Of course, the wine that we are sending overseas into export is also premium wine.

The whole structuring of the industry throughout the nineties has been aimed at producing a quality wine. Most of the takeovers relate to the acquisition of premium fruit as the industry strives for scale to be internationally competitive. That investment would be in excess of $2 billion in the nineties, including some 40,000 hectares of premium fruit planted between 1996 and 2000. That in itself is about $1.4 billion in regional investment.

I think it is fair to say that the wine industry is probably the saviour for many rural communities. It is noticeable that where wine is being produced there is full employment, there is a dynamic community. In one regional town, for example, we know last year that the Toyota dealer sold 42 four-wheel drives and 39 of them went to the wine industry and associated industries. So the flow-on effect, obviously, of the industry's contribution to regional communities is quite considerable.

Just briefly, in terms of our exports they are running at 20 per cent growth by value and volume. We are now sending over 900,000 bottles of wine into exports every day of the year. That is 900,000 highly branded products, each proudly carrying 'Product of Australia', which means that there is probably somewhere between two to two and a quarter million people somewhere in the world enjoying quality Australian wine, and we think for Brand Australia we are making a fairly significant contribution.

In terms of the restructuring, as I mentioned in 1990, the percentage of our vintage of premium wine was 35 per cent. The percentage of premium wine in the last vintage, 1999, was in excess of 75 per cent. So there has been a very dramatic restructuring towards the premium end of town.

I just also like to make the following points. We believe that wine is different—and I think that is well established—from tobacco in terms of its moderate consumption and benefits that it confers. We think that it is inappropriate to apply tobacco-style policies. We agree that more government funding is required and it should be drawn from the already $4 billion currently taxed from the alcohol industry overall. The volumetric style affects 70 per cent of all wine consumed, not just cask wine. If I could just draw your attention to the charts that are being passed around. We had a little difficulty with an overhead so we have had to do this. I hope you do not mind.

**CHAIR**—No worries.

**Mr Sutton**—When people talk about a volumetric tax and they relate it to casks, they are not just talking about cask wine. We are talking about 70 per cent of all the wine sold in Australia. So there is a severe impact by any volumetric tax that would be introduced. There are other reasons why the industry opposes it, not the least of which is that it can be lifted by gazetting only. It is linked to the CPI, and I guess some of the recent political campaigns that have been run in Canberra remind people of how easy it is for tax to be lifted on the basis of excise.

The other chart I draw your attention to is that, contrary to a view that is promoted, cask wine is not a product of abuse across total consumption. We acknowledge that there are certain areas in Australia where cask wine is misused and is something of a symbol of the problem that exists in those communities, and I would like in a little while to talk to you about how we propose to address that. We do not, however, believe in punishing the vast majority of Australian wine consumers, and there are around 500,000 litres of cask wine consumed in Australia every day. I think that if you look at those ABS statistics, they are fairly compelling in showing that, contrary to a view that is pushed, cask wine is not a product of abuse. In fact, one of the great benefits of cask wine is that people can pour one glass and leave the cask in the fridge, contrary to a bottle, of course, where if they open a bottle they have to drink the whole bottle. We contend that those ABS figures are accurate and that the blunt instrument of taxation in penalising the whole community—probably somewhere, once again, around one and a half to two million consumers every day—is both unfair and regressive.

Also in terms of tax, we agree with Professor Stockwell when he said, 'I would like people to add that we are not proposing that this tax is going to remove the alcohol problem and, of course, it will shift drinking patterns and people selectively drink more beer, as they will drink

more of something else.' I think that our objective as a nation should be to reduce alcohol abuse, not shift consumption from one product to another. That would be the effect of tax on wine.

We also agree with this statement, 'The externalities cost needs to be reviewed.' We have had preliminary discussions with David Collins and Helen Lapsley, and I might ask my colleague Stephen Strachan if he wishes to briefly enlarge on that.

**Mr Strachan**—Thank you, Ian. You will see in our submission that we spent quite a deal of time addressing the report done by Collins and Lapsley. I will not go through all of the detail. I might add also that it is work in progress. So there is more to that when we have the final report written. Just a few comments in terms of the Collins and Lapsley research, which I am sure you are all aware has been fairly widely used in a number of discussions, including policy related discussions. In our view, the Collins and Lapsley report is a very good report. It brings forward the debate and I guess the knowledge of the issue quite a long way. I think it is a fairly highly regarded report in that regard. It is also quite a genuine attempt to quantify the cost of alcohol misuse, but I would add that we do have some reservations in terms of some of the assumptions in the report and certainly in relation to some of the policy implications that have been drawn on by others—not by Collins and Lapsley—in the report.

Just to run through some of the assumptions—and we will be happy to pick up on it during question time, if you would like—the first one is that all costs associated with alcohol misuse are social costs. We would contest that a proportion of those costs are actually internal costs—internal to the consumer of the product—and, therefore, are not social costs. In our discussions with Collins and Lapsley, they can see the logic that we apply, but their argument is that in a world where the information is imperfect, then the argument that it is an internal cost is flawed and that it becomes a social cost. We would argue that most consumers of alcohol are aware of what they are doing and that they are reasonably aware of the consequences of their actions.

Collins and Lapsley have also argued that all addictive consumption is a social cost. This is somewhat in contrast to the Productivity Commission report which looked into gambling, where some of that cost was seen as an internal cost and not a social cost. They have also assumed that 20 per cent of alcohol consumption is addictive consumption. There has been no evidence provided with regard to that figure. We think it is probably on the high side, but we do not know the answer either. For example, if the figure was 10 per cent then the costs associated with alcohol consumption would decline by 13 per cent in total. Those issues are to some extent issues which are quite academic in that you are trying to determine whether a cost is an internal cost or a cost to the community or a social cost. However, once you start interpreting that for policy reasons it becomes more than academic; it becomes quite a real issue.

The point I would make in relation to policy is that Collins and Lapsley make no comment on policy in their report. Having spoken to them, it appears that that was quite deliberate. We think that in some of the areas where the report has been used in policy it is flawed. For example, the reference to $4.5 billion in external costs and the implication that that should be the level of taxation on alcohol is limited and is flawed. I return once again to this issue of whether the costs are social costs, external costs or costs borne by the individual. There are a few other issues covered in the report, but I will not go on. I hand over to Mr Sutton.

**Mr Sutton**—Mr Chairman, I should describe how the Winemakers Federation of Australia is structured further than just the two colleges, because the issue of the influence of large companies is one that has arisen from time to time. We have two colleges. As I mentioned previously, one is the Australian Regional Winemakers Forum and the other is the Australian Wine and Brandy Producers Association.

The forum which Mr Nolan represents was formed in 1986 when it was felt that small producers were not being given the necessary attention. It is a very dynamic and aggressive organisation representing the interests of regional and small winemakers. The forum sends forward to the Winemakers Federation of Australia executive council five nominees to the board, as does the Australian Wine and Brandy Producers Association. Each company, regardless of whether they are the largest company or the smallest, has one vote. All decisions have to be taken on an 80 per cent majority. Quite clearly, any decisions made at the federation executive council table have to have very broad support from all sections of the industry before they are approved.

The policies we are putting to you today are substantially supported by the Australian wine industry, including the other peak body, the Winegrape Growers Association of Australia, and the state associations of New South Wales, Queensland, South Australia and Victoria. We have an agreement with Western Australia in terms of its policy on tax, and Tasmania has a policy on volumetric tax. I thought it was important to say that we are very much for the industry and driven by the industry in terms of how we address issues.

Another issue I mention is that the Winemakers Federation of Australia has endeavoured over a period of years to take a responsible position in terms of alcohol consumption. The 'enjoy wine in moderation' voluntary labelling was introduced in 1986. Contrary to what you have previously heard, we actually developed the standard drinks labelling policy in 1993. So there is a snowball's chance in hell that this can be promoted, to quote a previous witness. We are now working with the department of health in Canberra to develop a way in which we can promote the new drinking guidelines which are currently under review. In 1993 the Winemakers Federation of Australia and the Commonwealth signed off on the standard drinks labelling and we then spent 12 months lobbying quite strongly to have that policy introduced. We think we also played a fairly significant role in advertising self-regulation.

When it comes to alcohol abuse in Australia, we are not a very clever country. Each and every time this issue arises one sector calls for taxation to increase prices to provide disincentive for abuse via a pricing mechanism. The other sector, mainly us, rejects that and we get into dispute, which is then lobbied on and it goes to government. I would suggest that since 1993 we have had more taxation reviews than probably any other industry. We had that budget dispute at the time which led to an Industry Commission inquiry. Of course, since then we have had the ANTS process. Since that process on 1 July, we are now the highest taxed wine exporting country of any of our major competitors. That tax policy delivered us a 12 per cent tax increase from 1 July.

I ask you to imagine how we could operate if we put those resources together. I would suggest that the alcohol industry—I do not know this, but I do not think I would be too far wrong—has probably spent somewhere around $10 million in the 1990s defending itself against

tax. I dare say that the researchers funded by government that is proposing the tax have probably spent quite a considerable amount of funds as well.

There are some strategies other than tax; there is no question about that. We believe that in terms of specific areas of problems we need specific strategies to address those problems. I guess what we are saying is that if there was a collective effort to pool resources and wisdom we could develop social improvement policies in areas such as remote communities to deliver programs that address social problems to give people, particularly young people, some feeling of hope, some feeling of career opportunities and some feeling of belonging, to gradually change cultural views and to develop in Australia for the first time a solid, long-term approach to reducing alcohol abuse.

At the moment, policy is very much determined by the longevity of parliament. It is very difficult to take any longer than a three-year position on this issue because of that fact. There is no question in my mind that if we are to seriously address this issue we have to address it at its source and we have to address it where it is caused, and that is largely with social problems. We could develop a long-term strategy and develop some sort of structure whereby all parties pull together, because there are a lot of people with a stake in this issue. Collectively developing strategies on a year-by-year and then a long-term basis would be a great initiative. We have to attack the problem on the ground.

I would like to announce a project that we are undertaking—and I am pre-empting an announcement to be made by the Prime Minister in January next year, so I hope he forgives me for that. I do think this is an important opportunity for this group to consider what we have to put forward. It is not tax, but it is very much getting to the kernel of the problem in terms of alcohol abuse. I am currently addressing remote communities. I dare not say 'indigenous communities', because I think that is demeaning. But certainly in the development of this project we will be having discussions with indigenous leaders to see if it is appropriate.

The Australian wine industry is currently in the process of sending hundreds of barrels of wine into Penfolds Nuriootpa—all red wine—which will be blended into a premium magnum wine to be known as the Centenary Red, which will be the Australian wine industry's gift to the nation for the Centenary of Federation. The industry feels very proud and privileged to be operating in a country that offers such tremendous comparative advantages, such as clean air and clean soil. It is the industry's way of responding to those natural gifts that it has enjoyed. There will be some 30,000 magnums produced from what we are estimating to be around 260 regions, although we continue to be surprised at how generous the industry is on this issue. However, it is from all regions. So it will truly be a national product. It is unique in that it has never been done anywhere in the world.

For the privilege, we are going to allow producers to buy it back as a magnum. Also, with the support of the government and, we hope, all political parties—it is a little pre-emptive, because we have not had an opportunity to speak to other political parties yet—we will distribute it through the diplomatic service overseas, through the Austrade offices, through the embassies and through the Australian government offices scheme, which is already set up for doing this. We will make it available to state governments and we will also sell it through retail outlets. We anticipate a return of around $2 million. That $2 million will be invested in a foundation called the National Wine Foundation.

The proceeds from those investments will be used to fund projects from government, semi-government and private agencies which can clearly demonstrate that they have the capacity, in remote communities in particular, to develop programs that achieve the ends we were discussing earlier. The whole project has been donated by the industry and the total contribution—that is, bottles, corks, wine, et cetera—is very close to $2 million. We think this is a great way for us to get involved in this issue, because it does concern us that people misuse the product.

In closing, I say that I well remember a speech of a famous gentleman who once said, 'I have spent my life developing the safest product I can and it devastates me that people continue to kill themselves in that product.' That was the vice-chairman of Volvo in Sweden. Quite clearly what he was saying, which we agree with, is do not attack the product; it sends all the wrong signals. You have to get to the consumer. You have to change consumer attitudes and change consumer perceptions and peer group pressure. It is a whole lot of things. If we attack the product, we are saying that people who have a problem can blame the product and then pay scant attention to social problems.

We think this is a good initiative, but in the bigger picture we are not just looking at those communities which are very small in number, very important in terms of the social impact. But right across Australia in developing some long-term strategy it has to be specific because specific problems require specific strategies. I guess we are inviting this committee to consider that and also inviting those people who we have met previously on other sides of the table who do not hold the same point of view to put aside our differences and put our resources into something that is really going to matter on the ground.

**CHAIR**—Thank you very much for that. We were going to ask you a question about the foundation. So we are enlightened and appreciative of that. Good luck with that. We will celebrate appropriately and get those trust funds as high as we can. It is a great initiative. I have just got a couple of opening questions and then we will throw it open and go around the table basically. On page 1 of your introduction you say that the social costs of alcohol consumption, which were estimated to be $4,495 million in 1992, do not appear to be growing. I am just interested to know the basis of the case.

**Mr Strachan**—I guess the first point is that this study was done a few years earlier. The social costs—I think that was from 1988—were estimated at about $6 billion. Since then there have been a few methodological changes, so that is probably contributing to some extent to that. Likewise, there has been activity in terms of fewer road fatalities and so forth. So that has also made a contribution.

In terms of saying that we do not think it would be any higher, we are basically saying that, firstly, we disagree with some of the presumptions that are made in this report and therefore we think it overstates the case. Also, since 1992 there has been overwhelming evidence that demonstrates that there is a benefit associated with moderate alcohol consumption. To some extent we think that is understated in the report. To recollect on that issue, in relation to the consumption of alcohol and in terms of the harms that are caused by consuming alcohol below two or four standard drinks per person per day, there is evidence that there are some benefits associated with alcohol consumption, but once you get over that level then you start looking at harms associated with alcohol consumption. It is the J-curve description.

Just to finalise on that, we have commissioned the Centre for International Economics to look at Collins and Lapsley, to look at the research that they have done, to comment on those assumptions and essentially to replicate the work that Collins and Lapsley has done. That is in progress at the moment and will be concluded in the next two months.

**CHAIR**—Remind me of the average state tax.

**Mr Strachan**—There is none now.

**CHAIR**—That is right, but historically what was it?

**Mr Strachan**—Prior to the High Court decision in 1997 it was about 11 per cent at the retail level, which was equivalent to about 15 per cent at the wholesale level. At that time the tax on wine was 26 per cent at the wholesale level. That was then made into a 41 per cent tax, which is 26 per cent plus 15 per cent, to account for that state tax.

**CHAIR**—Can you just remind me of what the improved labelling entails? I have not followed the whole issue around labelling. You or Ian mentioned the improvements in labelling and how that is going. Can you just enlighten us on the—

**Mr Sutton**—On the standard drinks issue?

**CHAIR**—Yes. I probably should know it, and it has been a debate that has gone on for some time. Could you just remind us where it is at?

**Mr Sutton**—The original policy was that the number of standard drinks would be put on the label so that people who wanted to keep an eye on their intake could make a reasonable judgment about whether or not they were exceeding as it was then the four and two—four for men, two for women—levels of consumption. I have to say that when we signed that policy with the Commonwealth there was an agreement that there would be an education campaign run to explain to people what that means. That has happened in, I think, South Australia and maybe one other state. It is a little bit like giving people the speed limit and not giving them the speedometer, or the other way around.

The reason for that largely is that there has been work done by the Commonwealth and some of the agencies to reassess the drinking guidelines in Australia. That document is currently at large for public comment. We are hoping that that will be accepted because it is sensible. Once that document is accepted by the Commonwealth, then they will be in a position to be able to tell people what the standard drinks mean on the label. I think we have a very simple and sensible way of giving an indication of what consumption is. It is not a prescriptive process because labels do not work that way, but it is descriptive for people who seek the information. We need people to know those numbers as well as they know other numbers so that it becomes a part of their judgment when they are consuming wine.

**CHAIR**—Did I hear correctly that you are working with the Commonwealth department of health on that?

**Mr Sutton**—Yes, we are.

**CHAIR**—That has been a satisfactory arrangement? Are there any flaws in that process?

**Mr Sutton**—No. We have worked with the department of health on a number of issues. We have probably worked more closely on this one. The minister and I signed the policy document that then went forward, which was very pleasing for us. In fact, it won a gong from one of the alcohol foundations for that process. We have a relationship with the Commonwealth which I think is valuable. I think the Commonwealth's recent advertising about alcohol, particularly regarding youth, was valuable as we are concerned about youth, even though those statistics show we are not in the binge drinking area to any great extent.

The emphasis is on addressing the issue of individual responsibility. You may have seen the ad where a young fellow has the choice of taking a bottle of scotch or not taking it and then there are two scenarios: one where he does not take the bottle of scotch and he is rewarded because he gets on well with his friends, and the other one where he does and he drinks it and gets into a fight, etc. I think those sorts of campaigns are very good at just reinforcing, firstly, what is appropriate behaviour—which we should reinforce for people who are consuming moderately—and, secondly, just giving people some sort of insight into the problems they can experience should they abuse the product. We meet regularly with the Department of Health and I think, whilst they do not always agree with us, we have access to them in terms of policy advice, et cetera, and that is a good, solid relationship.

**CHAIR**—I will throw one last question in that just occurred to me. You would probably be aware that the SANFL or the people who run Football Park—one or the other—are looking for family friendly areas. You may or may not be aware of it. That basically implies less grog, less bad language and a more family friendly approach to football. It seems to me quite a sensible idea, but it could make South Australia the 'wowser state' or whatever. It is this issue around alcohol. I am sure the image is improving when we have this dynamic wine industry. Would you care to make a comment about the social norms, I suppose, around alcohol with that issue of the footy game in mind? We have actually either improved our situation where we are asking for a friendlier area and not so much bad language and grog at the same time as we are promoting it as a healthy and reasonable product to consume.

**Mr Sutton**—I think this is a question that has not floated across the Winemakers Federation board table, but I think the response would be that we do not think anyone has the right to disturb the enjoyment of anyone else.

I have just spent two days in Melbourne, where people are still allowed to smoke in restaurants. I find that thoroughly offensive, personally. In some other places, once again, its gets down to consumer responsibility and consumer behaviour. If consumers are in a situation with other people, at somewhere like the football, where alcohol has an effect on the people around them, I think there is a case for regulation.

As far as wine is concerned, we would like to think that wine is a lifestyle beverage. There is a very strong relationship to food. That is why there is such a strong drawing of demand for premium wine. We are now seeing younger people becoming more interested in the science of wine and its relationship to food. There is a major event on in Melbourne this week that will probably attract 30,000 consumers. It is great to see people showing a genuine interest in the quality aspects of the product. A lot of them are not necessarily even wine drinkers. I think the

role of the product has to be conducive with acceptable community standards. I think that is across the board, including labelling in other areas. If any product, be it alcohol or non-alcohol, interferes with the welfare and the comfort of people, particularly in a family situation, either the industry has to address it or the regulators responsible for that environment should address it.

**CHAIR**—Thank you for those words.

**Ms JULIE BISHOP**—I might have been out of the room, but could you just describe slide 1 for me? Who carried out this survey and when was it done? It is in the documents that you handed out.

**Mr Strachan**—You are looking at the alcohol drinking occasions table?

**Ms JULIE BISHOP**—Yes.

**Mr Strachan**—This was funded by the Australian Wine and Brandy Corporation, which is the wine industry statutory body. It was undertaken, I think off the top of my head, in February and May 1998 as part of the ABS population survey monitor. That is a survey of 6,000 households. It is an omnibus-type survey, which essentially means that they undertake a number of standard questions each quarter and then you can add questions to that survey to get additional information. We added a number of questions in relation to the consumption of alcohol. There is more information in there on alcohol other than bottled and cask wine, but that is what we reflected here in terms of the consumption levels per day per person responding to the survey.

As I said, there were 6,000 surveys. What these results show is that, looking at bottled and cask wine in particular, for males, a significant proportion of those people are consuming below four standard drinks and smaller proportions are consuming between four and six and greater than six, as you can see. For females the proportion is not quite as high at the low levels of consumption.

**Ms JULIE BISHOP**—This was 6,000 households, so it is a household survey?

**Mr Strachan**—Yes.

**Ms JULIE BISHOP**—I guess they are only as good as those who respond to them. It has been suggested that heavier drinkers are less likely to respond to household surveys on alcohol drinking occasions. Do you have any comment?

**Mr Strachan**—The comment I would make is that it is often said about this sort of work that the results are understated. I suspect that you could make a case that that is the case. The point I would make is that, whilst there may be some understating—I do not know—the issue for us is whether there is a difference between cask and bottled wine. I do not see that there would be any reason for there to be a difference between those two in terms of the level of understating. What it shows here is that the consumption habits of the two products are pretty much the same.

**Ms JULIE BISHOP**—It has been indicated previously that such survey estimates usually account for about half of all alcohol sold, that is, between 40 per cent and 60 per cent?

**Mr Strachan**—How do you mean? Sorry, I do not understand.

**Ms JULIE BISHOP**—The sorts of surveys that we are looking at here really can only indicate about half of the actual usage?

**Mr Strachan**—So you are saying that the people who respond indicate only to the extent of half of their consumption, or are you saying—

**Ms JULIE BISHOP**—No, I am saying that this can only indicate about half the level of alcohol sold in Australia.

**Mr Strachan**—I suppose in that regard the alternative is to do a proper census of the community, which is certainly beyond our means.

**Ms JULIE BISHOP**—Has anyone done it?

**Mr Strachan**—Not that I am aware of. There is information on per capita consumption—that sort of detail—from the ABS, but that really does not give you any indication of the level of consumption at two, four or six standard drinks and so forth. I am not aware of any information.

**Ms JULIE BISHOP**—In relation to that final column—cask wine—was the survey specifically directed to cask wine or did it include flagons and carafes?

**Mr Strachan**—That is a good point. In previous submissions probably to this inquiry there have been accusations that this does not reflect cask wine, that we did not ask a question on cask wine consumption. That is in fact true. The question was about casks, carafes and flagons. The reason we included flagons is that they are very small. It is a very small proportion of consumption. The reason that we included carafes is that most carafes actually come out of a cask. That was quite deliberate.

**Ms JULIE BISHOP**—It does not give the breakdown of restaurants or people that decant bottled wine into carafes, though, does it?

**Mr Strachan**—No, it does not.

**Ms JULIE BISHOP**—I have two other questions, but I will leave one until later, if you like.

**CHAIR**—Go ahead. We have plenty of time.

**Ms JULIE BISHOP**—If we can assume that there are concerns about the concessional tax treatment of the alcohol content of cask wine because there are public health concerns about cask wine, could we just focus on the instance that you acknowledged; that is, the use or abuse of cask wine in remote and indigenous communities? Do you accept that a relationship exists between a reduction in the sales of cask wine and a reduction in abusive, antisocial behaviour

and all of the other impacts of alcohol abuse? There are specific evaluations that have been done in Halls Creek and Tennant Creek.

**Mr Strachan**—We might talk a little about those separately. My response to that is that it is much harder to change the abusive level of consumption with a tax impost than it is to change the consumption of those who are not abusing the product.

**Ms JULIE BISHOP**—Isn't price a factor, though, in assisting the reduction of sales?

**Mr Strachan**—I do not think it is a significant factor. All of the evidence shows that if you put the price on the product up then consumption declines—and we certainly agree with that—but there is not a lot of evidence that demonstrates that price increases in isolation without any other activities can reduce harmful consumption.

**Ms JULIE BISHOP**—So price increases combined with other programs and other initiatives—

**Mr Strachan**—May work. What I would say is that it is the other initiatives that are having the biggest impact.

**Ms JULIE BISHOP**—Have any initiatives been contemplated by the Winemakers Federation to make low-alcohol wine and low-alcohol wine styles?

**Mr Strachan**—Some time ago there was a lot of activity to make low-alcohol wine styles. I am not an expert in the area but, from what I can understand, those companies that invested—and they did invest quite a lot of money into it—had a lot of difficulty in producing a product that tasted similar to the existing wine product. Those that did then venture into the commercial world with those products found that they flopped significantly. There are still one or two around, but from my understanding they are not highly regarded by consumers, probably because they are somewhat different from the existing composition.

**Ms JULIE BISHOP**—Is there anything for us to learn from the analogy with low-alcohol beer and that whole scenario, which I would say as a distant observer has been a success in terms of changing people's drinking habits and changing their attitudes? Beer would have been one of the most macho Australian drinks that you can think of, yet we have managed to change people's attitudes towards low-alcohol beer?

**Mr Sutton**—I think the process of natural fermentation and natural maturation makes it very difficult in terms of wine production to produce a low-alcohol wine without substantially interfering with the flavour characteristics of the wine. Beer, of course, is a product that is produced every six weeks. It can be adjusted. It is largely made in a big chemist's factory, if you like. Winemakers are very much at the whim of the fermentation process and the quality of the grapes, the sugar, et cetera. The blunt answer really is that it has been tried and the market just has not accepted it. The industry has invested quite a lot and it has had a very poor return on that investment.

**Ms JULIE BISHOP**—So there are no initiatives on foot?

**Mr Strachan**—Not that we know about.

**Mr QUICK**—I refer to the issue of industry responsibility in alcohol versus tobacco. I would like your ideas on the issue of marketing of social drinks to teenagers, many under the legal drinking age, and the whole issue of end-of-year rituals. While I compliment what you are doing compared with the tobacco industry—you are light-years ahead of those guys—where do you see your social responsibility? As the decline of the local pub tends to merge into drive-in bottle shops and alcohol is advertised probably better than most other products, my strong anecdotal evidence is that this is creating a huge problem in our lower high school aged kids, building horrible foundations for real trauma. I think we are building a foundation to explode that figure of $4.4 billion—way out of anyone's belief. I compliment your industry responsibility, but where do you see things going?

**Mr Sutton**—I agree with you that tobacco and alcohol are different, and hopefully so are the industries. I actually worked on the first Quit Smoking campaign in Perth in the early 1980s and I guess have some sensitivities about responsibility. I was working for the department of health in an indirect way in Perth.

I think industries have a responsibility to present their product in a responsible way. I think people who deliberately go out of their way to address underage drinkers or binge drinkers—I think you mentioned end-of-year parties—are irresponsible. We have on various occasions made those views known. We have not always been totally well received by some of the people who are involved in those sorts of policies. I have to say that they are at the fringe. I think it is regrettable and I think those people need to be called into line.

I think what concerns us is that not everyone understands the difference between alcohol and alcohol. If somebody misbehaves at the lower end, the lowest common denominator quite often prevails in a policy sense and we all get punished. We have a graph here—I would like to table it and leave it with you—that shows that wine, we believe, is not contributing to the binge drinking. It is a product that is generally consumed by people who are older than that. Our view is that—I said this before—any product that is presented in any way that causes any discomfort, threat or damage to any other citizens has to be curtailed.

I believe that there is, unfortunately, a trait in Australia whereby people seem to want to get knock-on advertising through public relations and sometimes on news bulletins. That seems to have been curtailed. We have set up a voluntary advertising code. It is actually under the chairmanship of former Attorney-General Michael Lavarch and has other prominent citizens on it. The point of that is to ensure that those people who relate to that advertising standard are in fact toeing the line and that there is an appropriate process of handling any complaints in terms of promotion. But in line, we are dead against it and we do not support it.

The last thing we as a wine industry need is people getting sick on our product. It is not good business. If people drink wine in moderation, we know that if they are normal healthy people—they are not necessarily on drugs or they do not have other health problems—they will benefit from it and they will come back. They are good customers. If people get sick on a product, there is absolutely no point to it as far as we are concerned. We have a very strong ethos of moderate consumption and consumption with food as a part of that.

**Mr QUICK**—Would I be right in suggesting that, with the corporatisation of the wine industry into some really big players, their corporate structure is such that they have responsibility for a lot of these flash cans that are easily placed in school bags and marketed and targeted to these young people? In relation to the issues that are raised on a monthly or six-monthly basis by your board, do you actually talk about any of these issues and say, 'Look, let's take some responsibility before government, state or federal, intervenes and does something to put some heat on the industry as such'? Is it a knee-jerk thing of saying, 'Let's wait and hopefully we can get rid of 800,000 cans of whatever the latest whizzbang drink is on the shelf that underage drinkers are attacking at the moment, and if no-one raises a hue and cry, well and good'?

**Mr Sutton**—Firstly, I would say that I do not think the corporatisation of the wine industry has in any way reduced its social responsibility. I have no evidence of that—in fact, to the contrary. I should be telling you that the large companies are contributing a very large percentage of the wine that we are delivering for this product because they are socially responsible people. Secondly, I do not know which shiny cans you are referring to.

**Mr QUICK**—There is a whole range of them. I can get you a list.

**Mr Sutton**—Wine products?

**Mr QUICK**—Mixes. Those sorts of things that are available to young teenage kids, especially in the high school age.

**Mr Strachan**—You are talking about some of the new-age beverages and so on?

**Mr QUICK**—Yes.

**Mr Strachan**—Correct me if I am wrong, but I do not think any of those are wine based products.

**Mr QUICK**—It is not Orlando or Wolf Blass or Woodley's Queen Adelaide or whatever that is marketing this but whoever owns those. The big corporate structures that control probably 80 per cent of the Australian wine industry, through their corporate structure, are marketing and targeting those. It is fine to say on the one hand, 'The wine industry is nice and clean and we are going to market this wonderful $2 million product and put something back into society.' But on the other hand, the other arm is saying, 'We are contributing to social dislocation by doing this.' It is the left hand and the right hand.

**Mr Sutton**—The way I would respond to that is that I am not aware of any company—particularly a corporate company but any company—in the wine industry that is producing the sorts of products that you are suggesting, but I would be very keen to respond if you could perhaps be a bit more specific. The products you are talking about perhaps are mixes of other products, not wine.

**Ms ELLIS**—Brandy and wine you can get in a can. Is that not an industry under wine? So where would they get the brandy from to manufacture the brandy and dry, I guess?

**Mr Strachan**—They may get that from one of our members. It may come from one of our members. I can see where you are coming from.

**Ms ELLIS**—I think that is what Harry is getting at.

**Mr Strachan**—Take vodka and orange or something like that. We have no jurisdiction, I suppose, over the producers of those products.

**Ms ELLIS**—No, obviously not, but you would over brandy and dry.

**Mr Sutton**—We would not, actually, over the brandy and dry, if somebody is buying brandy and doing something with it at another place. Each of our members are cosignatories of the advertising beverage alcohol code, which is quite specific about what they can and cannot do. If there are any breaches, we would very much like to hear about it, because we do not tolerate it and we are not hypocritical. We are sincere about trying to address the problem.

**Mr Strachan**—There was a situation under the former tax system where some wine based products were being used and converted into some of these new-age beverages. From what I understand, that has changed with tax reform.

**Mr ANDREWS**—Forgive my ignorance, but do I take it from what you are saying that these new-age drinks, which are commonly available in bottles as well as cans, are invariably spirit based rather than wine based?

**Mr Strachan**—As far as I am aware, yes. Take canned vodka and orange, for example. As I was saying, before tax reform there was a situation where some manufacturers were able to purchase wine and convert that into alcohol and call it vodka and orange. We do not advocate that; it was something that happened. From what I understand, tax reform has changed that so that it cannot happen any more.

**Mr ANDREWS**—What proportion of total consumption is made up by these new-age beverages these days?

**Mr Strachan**—I honestly cannot tell you. It is not an area that we focus on because, as far as it is not something that involves the purchase of wine, it is not something that we see as a competitor product. As Ian said, our demographic is really 30 years and above. There is some consumption below that, of course, but it is not a focus for us as an industry.

**Mr Sutton**—In relation to the previous question, the only complaint the wine industry has received on its promotion and advertising which was of any substantial nature was the wine cooler issue in the late 1980s, and that was addressed. The company concerned acknowledged that there had been a problem and addressed that problem. To my knowledge there has not been any major breach of the code over the past 10 years.

**Ms JULIE BISHOP**—Was that West Coast Cooler?

**Mr Sutton**—Yes.

**Mr EDWARDS**—Thank you very much for this additional information you have provided today. I must say that I am very interested to find out where you can buy Yalumba Galway Heritage or Tyrrells Long Flat Red for the prices that you quote here, because I can tell you that they are about $3 cheaper on your list than they are in any of the wine cellars where I shop. You say that the WFOA is for the industry, driven by the industry, and much of your submission reflects that. You say, for instance, in talking about a volumetric tax system that such a system would shift the relative tax incidence from high-priced premium products to lower-priced bottled and cask products and threaten 80 per cent of wine sales in Australia. You then go on to say that such a taxation regime would harm the wine industry generally but impact especially adversely on the non-premium sector, which would see a 38 per cent reduction in profits.

I understand those arguments clearly and I am very sympathetic to your industry's position. I try to relate that to our terms of reference, which are to report and recommend on the social and economic cost 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. In that context, if we were to argue your position, which would be for a reduction in the tax on the wines that you have been talking about—say, for instance, we were able to reduce it from a 46 per cent equivalent down to say, 30 per cent—what positively could the industry do to impact on those matters which I mentioned which relate to our terms of reference? How positively would Australia benefit from such a reduction—not in terms of the benefits to the industry but in terms of the benefits and the positives in relation to our terms of reference?

**Mr Sutton**—I think that there is an awful lot of information that is not known in this whole issue and that is why we tend to get generic policies being wheeled out. I think in order to address a problem you have to first understand it and I think that is where the problem lies. What is the relationship between a reduction in price and its impact in those areas that you mentioned? I am not sure that anyone can answer that question.

As to the relationship between price and abuse—I will start from the outside and work in—there is no question that if you increase the price, you will reduce consumption. But that is a cost to an industry that has to be justified by a corresponding reduction in abuse. That is the argument where a lot of this swings, obviously. My view is that the Australian wine industry is probably making a very significant contribution to the Australian economy at the moment, particularly in regional Australia, and I do not have to tell this group how important that is in so many different ways. We are measuring the contribution of the industry, particularly in regional Australia where quite often these hardships are felt—rural pressures, et cetera.

Any reduction in tax would see an increase in investment in such facilities as wine tourism. There is no doubt that a lot of small winemakers are under serious competitive pressures at the moment. I am sure those of you who have constituents who are winemakers would understand this. There has been a doubling of winemakers in Australia since the nineties from 500 to over 1,100 and those people are competing for around five or six or seven per cent of the market. Their margins are being squeezed and there is no question that those competitive pressures are seeing those people do it tough. Whilst you see the froth and bubble of the great success and the billion dollar targets, et cetera—South Australia in its own right will have $1 billion in exports probably by January—the fact is that small winemakers are going to rely more and more on

getting people out to the regions and in through cellar doors, and that is where a reduction in tax would have the greatest impact.

The tax compliance system, honestly, is a nightmare. There are rebate schemes, and it is very complicated. I think a lot of small winemakers are facing very serious problems over the next couple of years unless they can develop better facilities, decentralise their operations into wine tourism and bring the consumer out to them.

That would be my immediate reaction. But I would think that our contribution to the economy is the best piece of medicine that we could give people under hardship. Our employment is substantially increasing, as I said before. Over 50,000 hectares of vineyards have been planted. That all requires tractors, fuels, banks and schools—you know the system. I would think that is the best way, in just the same way the best thing the government—whomever they happen to be—can do for us is to give us a positive environment in which we can operate and sometimes move a little bit out of our way.

The best thing that we can do for the country is to continue to promote Australia as a quality producer of quality wine and add to the community and add value to what we are doing in regions. I think the more we can do that, the less social pressure there is on people, and I do think that it is a social issue. We would love to get together with a group of people and talk about how those social issues could be addressed through the foundation.

**Mr EDWARDS**—The point I am making, I suppose, is that I do not disagree with any of those arguments and I am sympathetic to your view. What I am saying is that, for us to more strongly argue your position, we would perhaps want some more positive indication from the industry as to how a tax reduction would benefit those issues that we are dealing with under our terms of reference.

**Mr Sutton**—Sorry, I understand now. We are in the process of conducting some major pieces of research. We are looking at the Collins and Lapsley, and the other thing, as I said, is that we are looking at the contribution that the industry is making to regional Australia. When we have that research, our approach is to show the counterproductive nature of tax and the benefits that would flow to the broader community if there was a reduction in tax. We will be putting that position to all parties around February/March next year.

We have a very simple philosophy. We like to get our research right and then we think that we can give people arguments that they can defend. But I would suggest that we are going to put up a pretty strong argument that the tax is counterproductive, and maybe that Toyota dealer could sell 50 Toyotas instead of 42 if the tax was not as high.

**Mr Strachan**—I think just to add to that, looking at other issues other than a tax reduction would be an important part of the process as well. We mentioned education before. If we are talking about a tax reduction, I think that we would also be talking about some sort of partnership or something in relation to educating consumers of the issues that are of concern to you.

**Ms HALL**—I was really interested when I heard your opening remark that areas that are involved in wine production have low unemployment. I was actually privileged to be part of

another inquiry last Friday when I was in the Cessnock area. The point that was made there was the high level of unemployment and the fact that services are being ripped out of that area. That is a wine producing area—the gateway to the Hunter. So I find that that is a little bit of an anomaly which is a lead into the question that I am about to ask, and that is in relation to the scientific rigour of the data that you have presented to us today.

There have been lots of references to social cost. What measurement of social costs are you using and what are the details of those measurements? The fact that there is a lot of reference to decreased health costs was one comment in your submission that I found quite interesting and relating that to the fact that wine has led to a decrease in alcohol consumption, a decrease in health costs. What figures are you using there? What evaluation are you using to come up with that? Are you taking into account all facts? There does seem to be some conflict between what you are coming up with compared with not only Collins and Lapsley, but statistics for all state and Commonwealth health departments. That is my one and only question.

**Mr Strachan**—Just to pick up on the Cessnock observation, I agree with you that that is an example of a wine industry that is in the middle of a very large mining industry. Our contribution to that economy is somewhat limited in that regard. If you were to go down to the south-east in South Australia, for example the area around Penola, Coonawarra, Padthaway and so forth, the impact of the wine industry in that region has been quite significant, as it has in a number of other regions like the Margaret River and so forth. It really depends on the extent to which other industries exist in those areas. There is no doubt that has been very positive.

**Ms HALL**—Mining is expanding up there, too.

**Mr Strachan**—Sorry?

**Ms HALL**—The mining industry actually is moving more towards the Cessnock area and away from the area of the electorate that I represent. They are not closing mines in Cessnock; they have been closing them in the Shortland electorate.

**Mr Strachan**—I guess my point is that the wine industry's contribution to that region has been positive and I would say significant, but it is difficult to argue that it would outweigh any other effects for other issues that are running in that region.

In terms of the measurement of our external costs, which go to the heart of a lot of the issues that we have discussed here and the issues with the Collins and Lapsley research, as I said earlier—I will just reiterate it—this is work in progress, so it is very difficult for me to give you answers to everything because it is still being done. We are working off the Collins and Lapsley report. We are essentially adopting the same methodology as Collins and Lapsley, with some changes obviously. So looking at the costs, we are going through all of those costs.

Where we had a disagreement is a lot of the costs that they have included are external costs, or social costs. We think they are overstated as social costs, although we acknowledge that there are certainly social costs involved with alcohol consumption. Perhaps to use an example—and it is probably a poor example, but it is one that comes to mind—if I am a worker and I am employed by you, for example, and I have lower productivity because of my alcohol consumption habits because I abuse the product and so forth, Collins and Lapsley would say

that that is a social cost to the community. We would say that there is probably some social cost to the community there but, because of my tendency to abuse the product, I am less employable in that operation; therefore I do not get the level of income that I would otherwise get. It is a bit of a semantic argument in its economics, but it goes to the heart of what Collins and Lapsley are using in this report. We are saying, 'Okay, there are some social costs, but some of those are internal costs; they are borne by the person who chooses to consume the product.'

Collins and Lapsley are then saying—and I hope I do not do them an injustice by trying to interpret what they are saying—that it is not an internal cost because the consumer does not go into that activity with perfect information. We are saying that they do go into that activity with a good deal of information. Whilst it will probably never be perfect—not everyone can know every possible thing about the consumption risks of alcohol and the consumption benefits of alcohol—in most cases they do go into it with some degree of information. We would, therefore, argue in that regard that counting all of those costs as social costs is certainly on the high side.

**Ms HALL**—I was not asking you to comment on Collins and Lapsley. I can refer to the report that was given to us this morning by the South Australian government. It details social costs and associated issues and workplace safety. That was one of the costs that they brought out as well as the cost to the community and the workplace.

**Mr Strachan**—They are all issues. We do not disagree with them.

**Ms HALL**—I am saying that I would like some details of the measurements that you are using in your study. Maybe you can submit it to the committee afterwards. I believe there are a lot of statements that you have made, but you have not backed them up with scientific fact, even to the extent that you say that the costs associated generally with alcoholism are different to alcohol abuse. I would like to see that broken up, too. That is a very general statement.

**Mr Strachan**—We will have this report written early next year and we will be able to provide it to the committee.

**Ms HALL**—And some scientific rigour in it would be—

**Mr Strachan**—It certainly will have. This is quite comprehensive research. We are trying to replicate the work that Collins and Lapsley have done. It is a major project. We are getting to the end of it, but we do not have the numbers and the scientific rigour, I guess, to put in front of you today.

**Ms HALL**—Just as a matter of interest, what is the difference between alcohol abuse and alcoholism as far as the social costs are concerned?

**Mr Strachan**—Can I take that on notice?

**Ms HALL**—Okay.

**Mr Sutton**—It is a part of the brief to the researchers. If I can just add to that, I think anyone who knows the Centre for International Economics and Andy Stoeckel's operations would know that it will only be supported by very rigorous research and scientific backing.

**Mrs IRWIN**—I actually want to talk about something completely different, that is industry initiatives on page 35 of your submission. I know that in your opening comments you mentioned a campaign to celebrate the Centenary of Federation. I think it was the production of a red wine. I think you stated that the proceeds of this sale were to be $2 million. In your submission you actually stated:

The proceeds of the sales of an estimated $3 million will be managed by the National Wine Foundation to provide a lasting endowment to the nation. The funds will be used to provide targeted action in the fight against alcohol abuse ...

Could you tell us a little bit more about this? What sort of action does it involve? Is it education through television, schools or what?

**Mr Sutton**—No, it will not be that. The foundation is not pretending and will not pretend to have any expertise in this area. So we will be calling on expertise from those people who have the experience in the field of addressing social problems and finding remedies to overcome social problems in remote communities. The sorts of people from whom we will call for submissions and take advice—and we have a number of health professionals whom we are in the process of approaching to be a part of this process—will be people who can clearly demonstrate that they have experience in the field. The sorts of projects could well be the building of a gymnasium in a centre that gives people a meeting place that is not the local bottle shop or under the local boab tree, for example. It could be a scholarship for somebody who has a promising football or sporting career. David Wirrapunda from the West Coast Eagles is currently very involved in going around to Aboriginal places in Western Australia and other places encouraging the youth to take up sport, to take a more active interest in sport and what it has to offer.

I want to stress that this is not all based on indigenous issues, because it is not. I want to stress that one of the groups that we will be consulting with will be the Aboriginal leaders. There is no doubt that they and only they can instruct us on this. So we do not want to pre-empt anything. Our brief is not to run education programs in the media, et cetera. We are going to have very strong performance objectives over who is granted funds—they have to be fully accountable for them—and in their submission to us they have to be able to show that they can take the situation from there to there and in the process improve it. To a large extent I am only speculating about the specific programs at this stage, because we need to go through that process. We know the Prime Minister is very enthusiastic. I have briefed the minister for health and, as I say, we will be in the process of briefing others. It is early days.

The difference between the $3 million and the $2 million is largely that we made a bad guess to start with, because when we set out on this program there was no way of being able to ascertain just how much wine we would receive. The biggest problem with the 1999 vintage was that most of it had been sold. But we will still come in at about $2 million.

**Mrs IRWIN**—You stated that you have briefed the minister for health. I notice also that on page 35 of your submission you said you would seek matching government funding. I gather that if you are talking about $2 million that would be dollar for dollar and you would be hoping

that the federal government would put up another $2 million. Have you discussed that with the minister?

**Mr Sutton**—No, I met with the minister's chief of staff. What we are saying there is that there will be some specific projects that will attract matching funds just by the nature of the projects. We are not looking for the $2 million to become $4 million. I do not think that would be possible. However, there will be some projects through different schemes that exist under the state and federal governments where, if the projects are appropriate, they will be funded. We are obviously trying to get maximum value out of this investment. If we can add value to it through state and federal government funding and our dollar can become $3, all the better. But I would think that would be a project by project sort of determination.

**Mrs IRWIN**—I gather that you have not approached the Prime Minister yet to become patron?

**Mr Sutton**—Yes, we have, and he has accepted.

**Mrs IRWIN**—He has accepted?

**Mr Sutton**—And he wants to launch it in January.

**Mrs IRWIN**—That is right. I think that is what you said earlier.

**CHAIR**—Gentlemen, thank you very much. In terms of marketing alcohol, you make the observation that the cost-benefit analysis, if I can put it as crudely as that, with women is about in balance but in men it is significantly out of balance. Is there anything else that we should tease out on the issue of gender balance in terms of alcohol consumption?

**Mr Strachan**—Are you referring to the table?

**CHAIR**—I am not sure. I am referring to pages 21 and 22 of your submission.

**Mr Strachan**—It is such a long submission.

**CHAIR**—Don't worry too much about it. I was just interested in that. I was thinking about alcoholism, domestic violence and those sorts of alcohol and, I suppose by association, wine industry issues.

**Mr Strachan**—I do not have that in front of me right at the moment. If you look at slide 1, what we have raised is the fact that moderate alcohol consumption of wine for males is quite high whereas for females it is not as high. In that regard, it looks to be that females are consuming at approximately the same levels as males. When you look at the fact that for males four standard drinks is considered moderate alcohol consumption whereas for females it is two, that does present a problem in that regard. So it is really an observation. I could not say that we have got any strategies to deal with it.

**Ms JULIE BISHOP**—You mentioned earlier that this was an ABS survey or that the Australian Bureau of Statistics had something to do with it. Has it been published?

**Mr Strachan**—Part of it was published as part of their population survey monitor, but it has not been published in this level of detail. We did a report for a conference about 12 months ago and we would be quite happy to forward that to you.

**Ms JULIE BISHOP**—I would be interested. I just find some of the statistics interesting.

**Mr Strachan**—We are actually doing more work with it at the moment. So once we finish this final report with the Centre for International Economics it will come out in that as well.

**CHAIR**—Thank you very much.

**Mr Sutton**—May we just leave you with a document that addresses one other submission that was previously presented to you. I think it was from the—

**Mr Strachan**—From my understanding, Dr Gladstone has put in a submission—it may have been a late submission to this inquiry—addressing our submission and tackling a few of the issues that were raised by the submission. What we have done is responded to his comments. We will not go through it today. It is probably not necessary. But it is there for the record.

**CHAIR**—Is it the wish of the committee that the document on volumetric tax and the response to Dr Gladstone's comments provided by the Winemakers Federation be incorporated into the transcript of evidence? There being no objection, it is so ordered. Thank you very much.

*The documents read as follows—*

[11.55 a.m.]

**BAUM, Prof. Frances Elaine, National President, Public Health Association of Australia**

**CHAIR**—Thank you very much for being with us and for your submission. I understand you would like to make a brief opening statement of a few minutes and then we will get into some questions.

**Prof. Baum**—That would be great. I thank you all for the opportunity to appear before your inquiry. The Public Health Association of Australia is the peak public health body in Australia. We are linked to the World Federation of Public Health Associations. We represent 2,000 public health professionals who are multidisciplinary, including doctors, nurses, educators and a range of other professions. I guess our concern is with evidence based public health and with acting as advocates for the public interest in public health.

When we thought about the terms of your inquiry, we recognised that they are very broad. You have been asked to look at the social and economic costs of substance abuse and then you have been asked to look at that in relation to family relationships, crime, violence, road trauma, workplace safety, productivity and health care costs. I think the broad nature of your terms of reference really demonstrates the key point that I would like to make. If we are going to reduce the massive harm from substance abuse in Australia we really have to tackle the underlying problems that are manifest in many aspects of our society, because the substance abuse problems affect all aspects of our society.

We also think that there is a series of other problems with common causes. We see these as including rising suicide rates, particularly amongst young men, eating disorders, rising rates of depression and other mental health problems. In fact, the World Health Organisation has predicted that mental health problems will be the biggest world health issue in about 20 years time. I think substance abuse is part of that pattern.

What we say at PHA is that we think this really calls for what we call upstream thinking. So often what we do with public health problems is focus on downstream curative action. So we are pulling bodies out of the river all the time rather than going upstream and finding out why they are falling in in the first place. We think a key question that a committee such as yours could be asking is: how do we move towards creating a society in which people are happy, productive and satisfied and why is it in an era when material wealth has been steadily increasing we are beset by so many of these problems, including substance abuse? I guess those are the questions that are really at the heart of the new public health.

There are some key problems that we have identified that we think are common underlying problems. I will say these very quickly. They are massive issues so please excuse me for going over them in a broad sweep, but time is obviously limited. We think one of the difficulties is that all political parties have been focusing on economic factors to a far greater degree than social factors in public policy in the last few decades, and we identify that as a major problem. There are growing inequities and there is an increasing body of public health and epidemiological evidence that indicates that where there are greater inequities health outcomes

are worse and problems such as crime are also worse. As the sociologist Raymond Arons says, when inequities grow too large the idea of community becomes impossible. We believe that it is strong communities that stops substance abuse.

We also believe there are particular problems for young men in a society in which women have made significant advances and where the role of young men is less clear. Here I would like to quote from the British psychiatrist and broadcaster Anthony Clare, who put the problem for men thus:

> Throughout the world, developing and developed, antisocial behaviour is essentially male. Violence, sexual abuse of children, illicit drug use, alcohol misuse, gambling—all are overwhelmingly male activities. The courts and prisons bulge with men. When it comes to aggression, delinquent behaviour, risk taking and social mayhem, men win gold.

So it really means that if we want to prevent the range of problems he has identified, including substance abuse, then we face a vital question in regard to young men: how do we create a society in which young men have a valued role, are imbued with hope for the future and believe that life is worth living in a drug-free, responsible way? We feel that if we are going to solve these problems as a society, we really need one in which we do away with the blame culture and have much more tolerance and acceptance of a variety of views and have a social debate about how we think we can create these healthy communities. I think that is healthy schools, workplaces, healthy employment policies. One example I will give you from South Australia is the healthy cities project in Noarlunga. They have had that project there for 12 years and at the moment they have a very strong Noarlunga community action against drugs that is taking place within that broader framework of Healthy Cities.

So that is the broad sweep. Many of the more downstream solutions that help us deal with the substance abuse issues that we have—because, obviously, PHA believes we have to deal with those as well as take this broader sweep—we have detailed in our submission. We have noted that the greatest social and economic harm results from tobacco and alcohol use. Many of these harms are detailed in our written submission and you will see from that that we believe that policy is the most important tool. To take tobacco as an example, we note that in April 1996, Martin Bryant killed 38 people at Port Arthur and within 10 days, John Howard, the Prime Minister, had instituted new gun control laws and secured agreement for a temporary surcharge on the Medicare levy to fund a buyback of semiautomatic rifles and pump action shotguns. Yet tobacco kills more Australians every day than Martin Bryant did on that one day. So we think we should have a three-month national quit blitz that is well planned, well advertised and at which people can obtain nicotine replacements at heavily subsidised cost.

We have detailed in our submission that we think more dollars should be spent on anti-tobacco, and we outline 11 areas of action against tobacco, headed by passive smoking. We note that the federal government over the coming two years is likely to derive at least 1,000 times more from tobacco excise than it committed to tobacco harm minimisation in the 1998-99 budget. That information comes from the work of Simon Chapman.

It is a similar picture with alcohol. We note that alcohol does have a massive impact on the community in both cost and health terms, and many of those costs are in terms of the lower end of the continuum, not just in terms of problem drinkers. We note in our submission that all drugs should be assessed on the basis of their actual harm and benefits. This would include illicit drugs, medicinal drugs and legal non-medicinal drugs. The current laws and policies tend

to demonise some drugs—for instance, marijuana and narcotic analgesics—while neglecting the harms associated with others. For instance, with benzodiazepines there has been concern about their dependence potential but not enough concern about other harms—for instance, broken hips caused by falls through dizziness. I am just pointing to the wide impact that drugs have.

Finally, we think that in relation to illicit drugs, harm minimisation and demand reduction is the policy that evidence suggests is most effective. There is little evidence to support an overemphasis on law enforcement. So our main justification for harm minimisation is its proven effectiveness. Therefore, we would argue for decriminalisation, allowing facilities such as safe injecting rooms and methadone maintenance programs to support people in reducing their dependence on drugs. We note here particularly the strong link between crime and drugs. The estimates in the literature of the number of prisoners in jails because of a drug-related crime seems to be from 75 to 85 per cent. Jails are expensive and not effective. They take away breadwinners from families, they break up families and they chain people to engage in further criminal behaviour, and young men are further brutalised. They are very unhealthy places and they pose a considerable public health risk to the inmates and the community. So if you think that over three-quarters of the people are there because of some drug implication and the reason that they are there, you can see the huge potential to both save money and do something about that problem.

In summary, I think the causes of substance abuse are deep rooted and reflect many other issues in our society. We really should treat these problems as if they are related and not have mental health problems here, drug problems here, and crime problems here. The relationship and the complexity should be acknowledged. More than anything, we need local campaigns to create healthy communities that are based on working across different sectors involving community people and injecting cash to support communities in dealing with their own problems.

**CHAIR**—Thank you very much, Professor. I have just a couple quick questions and then we will go around the table. You suggested that under section 112 of the Constitution state governments have the power to levy licence fees on tobacco retailers, and you appear to support the introduction of a requirement of retailers of tobacco to be licensed. Why do you think that the state governments have not done so already?

**Prof. Baum**—Sorry, can you say the points again, please?

**CHAIR**—I understand you are suggesting that under the Constitution state governments have the power to levy licence fees on tobacco retailers. Why do you think they have not done it, as you suggest, at this time? What is the main blocking of the states? There are a couple of obvious ones that come to mind.

**Prof. Baum**—I presume they would rather see the Commonwealth to be taxing people. I imagine that is the main reason.

**CHAIR**—There is a degree of—

**Prof. Baum**—I do not really know, but I think they see it as a Commonwealth government responsibility.

**CHAIR**—You are suggesting clearly that you believe that the states have a capacity to do it.

**Prof. Baum**—Yes.

**CHAIR**—Yet they are not doing it for whatever reason.

**Prof. Baum**—No, they are certainly not doing it and it is certainly one of the issues that our state branches lobby their state governments on, but I guess we have not been effective yet in persuading—

**CHAIR**—What has been their response? Do you remember their response?

**Prof. Baum**—I think that it is generally one of the issues of Australian politics—a buck-passing to the Commonwealth government and seeing it as their responsibility to tax these products.

**CHAIR**—Some would say the odium of the collection of tax and the pleasure of spending it might rest somewhere else.

**Prof. Baum**—Yes.

**CHAIR**—The last question from me is to do with the statement that 84 per cent of alcohol-related costs are avoidable. I am just wondering what sort of alcohol-related costs you believe are not preventable?

**Prof. Baum**—That is a good question. I think what we are saying is that there are some costs associated with alcohol use that we are never going to prevent. We are not supposing there is a world in which you will get 100 per cent prevention, in which everything is perfect. I think that sum is an acknowledgment of that—that even low levels of alcohol use can result in some harm, but we are certainly not arguing for prohibition of alcohol.

**CHAIR**—It has been tried before, hasn't it.

**Prof. Baum**—It has been tried before, yes. As the previous people who gave evidence suggested, there are, of course, benefits associated with moderate use of some forms of alcohol.

**CHAIR**—Thank you.

**Mr LAWLER**—I am a little unclear. It gets into a very grey area when you are talking about the problems of mental health and drug abuse. I think that it is accepted that the use of drugs—say, marijuana in youth—leads down the track to some mental health problems. Without asking you to give a flippant answer, is there some work done, or can you give us any sort of breakdown, on whether the drugs come first and the mental health problems come second, or how much of the end result is mental health problems leading to drug use?

**Prof. Baum**—I think, as you point out, the literature really is not clear on the direction of that relationship and different points of views are argued on that. I do not think that there is a

definitive answer on that question. But as you will see from our submission, there is increasing documentation. In some ways, it is almost commonsense. People who have problems in terms of depression, in terms of psychosis also are the people who tend to abuse drugs. I am afraid that, in terms of whether it is the chicken or the egg, the jury is really out on that one.

**Mr LAWLER**—I do not—

**Prof. Baum**—And that is why it is important, I think, to deal with the problems together. I think that it is very hard to design a study where you can absolutely tease out those factors and be quite definitive about the pattern of causality.

**Mr LAWLER**—But does the organisation accept that the use of drugs—again, say marijuana—does bring out a mental health problem down the track in those who are predisposed to do that?

**Prof. Baum**—Again, the evidence is not that clear. There is not a strong body of evidence to support that view.

**Mr LAWLER**—So you are not worried about decriminalisation increasing the problem that we have down that track?

**Prof. Baum**—There does not seem to be evidence that decriminalisation increases use. It leads to more responsible use, and I guess that is what PHA is interested in—in minimising the harm from substance abuse.

**Mr LAWLER**—That evidence comes from South Australia?

**Prof. Baum**—From South Australia. The best way we can get that evidence is by comparing usage in different settings and looking at the different legal frameworks. When you do that, if you compare the USA with some European countries, the difference in use is not such that you would suggest that having a strong prohibition approach actually results in a reduction in drug use.

**Mr EDWARDS**—I just want to address the issue of tobacco. I have two questions, but the first one relates to tobacco use. We have taken evidence today to say basically that smoking is once again on the increase, particularly amongst various age groups.

**Prof. Baum**—The young.

**Mr EDWARDS**—You argue basically for a number of things to try to turn this around again, including an increase in the price—an increase in the tax. It seems to me that that has worked to some degree; it is not now working. What other specific strategies do you have in mind? Secondly, can you just tell me a bit more about chop chop tobacco?

**Prof. Baum**—About?

**Mr EDWARDS**—Chop chop tobacco. How much more prevalent is that in society, and where do we reach the stage where tobacco purchased through a shop becomes so expensive that people start to turn to other alternatives such as chop chop tobacco?

**Prof. Baum**—I think the main strategy that PHA would promote is the No. 1 in our list, which is dealing with the problem of passive smoking and, in effect, having the situation where people can only really smoke in their own home, so making it very clear that it is an antisocial behaviour. So I think that is No. 1 on our list. The other issues are indeed to do with the promotion of tobacco projects—the pricing, the education, supporting people to stop smoking, and, in terms of the education, particularly school-based education.

The price sensitivity of tobacco is an interesting one, because we know that the people who are most likely to smoke are people on low incomes, and some of the public health research suggests that when you talk to, say, single mothers who smoke, it happens to be one of the few pleasures they have in their life, so that is why they smoke. So the sort of blaming approach perhaps is not very helpful. I think you have to look at: why are young women smoking? I am not aware of evidence to suggest that rates are actually increasing. Our latest evidence suggests that the uptake has not changed for 10 years. In the last 10 years the uptake amongst young smokers seemed to remain fairly stable. So I think again it is asking those questions about: what role is smoking playing? Looking at this in a social context: what is it that young women get from smoking? What is the image? All those sorts of issues, and how can we change that? They are the approaches that seem to have worked most successfully in the past.

**Mr EDWARDS**—You mentioned in a couple of parts of your submission the vicious cycle between poor mental health and problematic alcohol use. You also state that two-thirds of opiate-dependent users had a mental health problem and a risk rate seven times that of the general population. In another of our submissions—and we will be taking further evidence from that group today—the suggestion is made 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 the use of illicit drugs. I would like your comment on that.

**Prof. Baum**—We would be very concerned about any policy that would perhaps make people reluctant to seek treatment. My great fear there is that it would be a counterproductive policy, because people would be fearful of being tested if they were going to be found to be using what is an illegal substance.

**Ms ELLIS**—I thank you for your excellent presentation this morning. It has been very helpful from my point of view.

**Prof. Baum**—Thank you.

**Ms ELLIS**—In your submission, you point out that there are longitudinal studies examining alcohol consumption among pregnant women that are showing that the number of women who are drinking during pregnancy is increasing with time. That is an obvious concern. Why do you think that is happening and what can be done? Of course, education is one option, but can you explain why you think that is actually occurring and what we can actually do about it in a realistic way?

**Prof. Baum**—Again, I think it is a bit like asking that question: why are people smoking? What are the stresses they are under? Why do they decide to do that? I suspect that we need more good-quality research to try to understand the social patterns that are behind that. Talking to colleagues, nurses, midwives and others who work with young mothers, of course they do not want to harm their baby. No mother would want to do that.

**Ms ELLIS**—Exactly.

**Prof. Baum**—So the problem is more complex than simply giving people information, because I think by and large now, particularly if people do go for pre-natal care, they get that counselling information. Obviously the group that we need to work for are women before they get pregnant and, in fact, young girls before they even take up smoking. So I think it goes back to that issue of: how do we make smoking an undesirable thing to do rather than a socially desirable thing, as it seems to be becoming in the culture of some groups of young women? I do not have the answers to that, but I think it is the sort of question that good, qualitative public health research can answer by trying to understand the culture that underpins those behaviours.

**Ms ELLIS**—If we do not have it, could we get from you the source of those studies so that we can actually see them and source them for our own purposes?

**Prof. Baum**—Yes, absolutely.

**Ms ELLIS**—The other question I have is in relation to alcohol. In your submission, you say that about 84 per cent of alcohol-related costs are avoidable and amenable to public policy initiatives and to behavioural change. Could you elaborate on that for us? Give us some examples of what that 84 per cent is but, also, what are the bits that are not? What is the other 16 per cent representing that we cannot attend to?

**Prof. Baum**—That is the question we had before. Obviously, the alcohol problems are on a continuum—I am sure you have had this—from very heavy problem drinkers, who represent a small proportion of the population, through to much more widespread social behaviours. I think the one we quote in our submission is binge drinking, and that can have a high impact at a population health level because it is a much more prevalent behaviour. So we would therefore see intervention amongst the group that partakes in binge drinking—i.e., generally people in their teens through to early 20s—to be the most effective means of doing that. There we would see a whole range. With any public health strategy, no single approach will work. We do need direct behaviour change strategies through schools, through workplaces, and even through pubs and bars. We also need policy to support that in terms of the sale of low-alcohol beers, of law enforcement in terms of underage drinking and in terms of creating environments, within pubs even, that do not see people getting their highs out of binge drinking. There are other ways of doing that.

**Ms ELLIS**—Do you have a view on the role of the alcohol industry generally in this? I do not mean this in a blaming way; I am just wondering if you have a view as to what their role is or could be or should be.

**Prof. Baum**—I think they have a very important role. Clearly, in any effective public health strategy, the ones that we can point to, perhaps with the exception of tobacco, are generally

based on partnerships, on people working together. I think in a country like Australia where alcohol is clearly part of our culture—drinking wine, drinking beer—the only way that we can do something about that is to engage with an industry that, as the previous people who gave evidence suggest, is also a major employer in this country. So I guess the challenge for us as public health professionals is to find a way to work with an industry, to literally minimise the harm associated with that drug. There are clearly tensions for the industry, because their bottom line is profit. As public health professionals, our bottom line is health and harm minimisation. But any public health strategy involves negotiating and working around those different perspectives and trying to come to a position that promotes both the health and, I guess, the enjoyment that people do get from the responsible use of alcohol.

**Ms JULIE BISHOP**—Just on that, do you draw a distinction between the alcohol industry and the tobacco industry in the sense that some might say having a cigarette is as much an Australian way of life as having a beer? Do you draw a distinction between the possibility of working in partnership with the tobacco industry as you said that we could with the alcohol industry?

**Prof. Baum**—I think the difference is the evidence base. The evidence base is that moderate drinking—some of the evidence suggests—can even have mildly beneficial effects to your health. There is no evidence that even a few cigarettes a day have a beneficial effect on your health. So I think there is a big difference there between the two industries. From our point of view, tobacco is a product that really has no positive benefits.

**Ms JULIE BISHOP**—But you are not calling to make tobacco products illegal.

**Prof. Baum**—No, because we do not think that it is effective. Always our concern is what does the evidence suggest is effective, and we do not think making it illegal would be an effective strategy.

**Ms JULIE BISHOP**—Just one other question on the studies and it is page 250 in our book. In your submission you say, and I think you have referred to it, that you believe:

... that vastly greater costs to society are incurred from the lower ends of the continuum of alcohol use (e.g. binge drinkers) than from the few ... (problem drinkers) at the severe end of the continuum, and this is supported by epidemiological evidence.

Do I assume, therefore, that binge drinking is more prevalent than problem drinking?

**Prof. Baum**—Yes. If you look at the surveys of alcohol use across the population, there is a group of people who abuse alcohol in a quite vicious way, whom we label as problem drinkers, but they are a small number. So in terms of their impact on the whole population and the costs, it is not as great as harm caused at the lower end of the continuum where many more people are doing that, leading to problems such as drink-driving. A lot of the studies on drink-driving suggest that the problems are not caused by those problem drivers—

**Ms JULIE BISHOP**—Problem drinkers.

**Prof. Baum**—Sorry, yes, the problem drivers, too.

**Ms JULIE BISHOP**—They become problem drivers.

**Prof. Baum**—They become problem drivers because of their problem drinking. Most of the people who are drink-driving are not problem drinkers. I suppose that is the issue. So it is a matter of the population statistics and just a few people do not add up to the same cost as the abuse across the rest of the population.

**Ms JULIE BISHOP**—The problem alcohol use, you go on to say, is the second leading cause of death and disability in Australia.

**Prof. Baum**—Of—

**Ms JULIE BISHOP**—In Australia, problem alcohol users.

**Prof. Baum**—I think that is the problem of alcohol rather than problem drinkers.

**Ms JULIE BISHOP**—Problematic.

**Prof. Baum**—'Problematic' would be a better use, yes.

**Ms JULIE BISHOP**—You referred to epidemiological evidence; is that readily available? Is that something that you could refer us to?

**Prof. Baum**—I could certainly get the secretariat to get hold of that from one of our members.

**Ms JULIE BISHOP**—If you could just give us the reference that would be good.

**Prof. Baum**—Sure.

**Mr QUICK**—Following on from that, there are several pages in your submission about promotion and price, and point of sale and public education on tobacco, but nowhere in your submission is that relating to alcohol. One of my concerns that I have raised today is the marketing, the pricing and point of sale and the lack of public education for teenage children in the whole issue of alcohol. I would like your thoughts. We no longer have cigarette advertising on television. We still have alcohol advertising on TV. Should we? If it is such a detrimental social cost to society, should we be thinking about banning it?

**Prof. Baum**—Banning the advertising?

**Mr QUICK**—Yes.

**Prof. Baum**—Again, what I have called for, given that we have evidence that moderate use of alcohol and responsible use of alcohol has few health effects and there may even be some beneficial effects—although again I think the jury is out on that—this would be one of the issues where I think the best approach would be to work in partnership with the alcohol industry

and call on them to go for responsible advertising only. I think, obviously, the example of the cooler drinks a few years ago was a good example of irresponsible advertising.

**Mr QUICK**—I have heard anecdotal evidence today that it is starting to re-emerge. The evidence I have from this time of the year is this carte blanche—turn a blind eye—'Let us see what the economic benefit is of having an influx in either Victor Harbour, northern New South Wales or southern Queensland of tens of thousands of under-age drinkers'. It is, 'It's a tradition. Let's bear it'.

**Prof. Baum**—It is not inconceivable that this might be an area where change might be amenable to education, working with the settings in which young people drink and talking about the need for people selling the alcohol, advertising the alcohol and using the alcohol in those settings to be called upon to be responsible in the way that they do that. I do not know if anyone has done a study of the kind of impact of those weeks. I seem to recall that I have seen one—particularly on the Gold Coast—but I am a bit hazy on that. But it would be interesting to look at the evidence of what is the impact of those weeks in terms of the immediate harms of drink-driving and injury through the misuse of alcohol. But I think your basic point about the need for responsible advertising would be absolutely supported by the PHA.

**Mr QUICK**—What sort of message is it sending to the 12- and 13-year-olds—the siblings of those people—'Okay, it is a rite of passage; your turn will come. You can get your big brother or sister to go to the liquor store or the drive-in shop and get some of those fancy cans that you can put in your pack and take to scout camp or whatever.' What sort of message is it sending to our kids?

**Prof. Baum**—Obviously, if that is the message they are getting, that is not a good message. But I think that there are examples—again, I have a lot of experience with the Noarlunga community action against drugs project. One of the things that they are doing is using youth theatre where young people actually write the script themselves and literally act out through theatre issues to do with the responsible use of alcohol. They look at the issues and that, at the end of the day, if you use alcohol irresponsibly, you actually end up looking pretty stupid and you are not a hero—that it is actually not a good thing to do. I think that it is important that schools, youth groups and community groups reinforce that message over and over again—that it is not a smart, cool thing to do. I think there are good examples of where that message is being put across. We need to put more resources into enabling communities to be able to push those sorts of campaigns and initiatives such as youth theatre, campaigns through schools, and working with the point of sale to encourage them that, in the long term, it is in their interests to be responsible in the way that they run their establishments and serve alcohol.

**Mr QUICK**—I have one other question. Another hobbyhorse of mine is early intervention. We heard from the South Australian government today about a whole-of-government approach and I asked who is taking the initiative. My reading of the evidence from overseas is that the cost benefit of early intervention is a proven. We are talking about $4.5 billion lost to the community. Someone has to bear the cost. What are your thoughts on early intervention? Why aren't we having this interagency early intervention up and running? Is it because we have got states and everyone wants to do their own thing? Is it this rail gauge mentality again?

**Prof. Baum**—I think that the states would be very well placed to obviously be responsible for the early intervention. I fully agree with you that we need both absolute health promotion and early intervention in terms of a range of public health problems. The difficulty is that very often the sector of government that takes the lead in those approaches is the health sector or human services sector. So often the focus of the attention of those departments is on dealing with the hospitals and dealing with the demand for hospitals, particularly at a time when resources are being cut. It is a continual problem in public health around the world that the resources for health promotion and disease prevention are not as great as I consider they should be in relation to how much money we spend on kind of pulling the bodies out of the river. We only have to look at the front pages of the newspapers to see stories on emergency department queues and babies who need treatment to see how the public agenda focuses very heavily on the need for the kind of end result, if you like, of a lot of the abuse of substances rather than on the prevention and early intervention. But I could not agree with you more that we should be ensuring that we are resourcing that prevention and health promotion as much as we possibly can and putting a high national priority on that.

**Mr QUICK**—So do we start from specific communities at risk? We have heaps of evidence to say that certain pockets in Australia contribute in a greater way to the problem we are talking about here statistically. They are not necessarily defined by state boundaries; they are regions. How do we get regional and community focus onto this when, say, it covers 10 agencies? Quite often the manifestation is in the education system.

**Prof. Baum**—Exactly. One of the approaches that I have seen to be fairly effective internationally and within Australia is this World Health Organisation healthy cities and healthy communities project that was originally piloted in Australia in Illawarra, Canberra and Noarlunga here in South Australia. If you visit Noarlunga now you will see that that approach has been running for 12 years. They have remarkably successful interagency approaches. Their community action against drugs involves the police, education, human services, welfare services, community groups, community agencies and non-government agencies all sitting around the same table saying, 'What can we do in this community to tackle drug problems?' They work together at a range of levels and at a range of strategies in what I think is a very effective way.

What we need are more modelled projects like that that are properly evaluated so that we can assess the results to work out the characteristics of these projects that work across sectors, what they call in the UK joined-up working, which make them work. What are the facilitating factors that make bureaucrats happy to step out of their safe role within their department and take risks to work with other departments? I think that is the only way we are going to solve many of these problems.

**Mr QUICK**—So perhaps support from the Commonwealth directly to some of those areas rather than Commonwealth-state.

**Prof. Baum**—Hopefully support from both levels of government.

**Ms HALL**—My question relates to people suffering mental illness as well as having a drug or alcohol problem. What sorts of education programs are being implemented within the public health system to assist staff to deal with this problem? What sort of approach is being taken

generally within the public health system to deal with these people rather than them being people who just do not fit in a box—that is, they are not people who have mental illness or they are not people who are suffering some sort of drug or alcohol problem? Are there any policies or guidelines being developed within this area?

**Prof. Baum**—You have identified one of the major points in our submission—that is, this issue that is increasingly being referred to as co-morbidity where people, if you like, have the double whammy of a substance abuse problem plus a mental health problem. I am sure most committee members are aware of the struggle that most states and territories are having providing good, effective services for people with mental illness. I do not know of any places in the world that have really got it right. Australia has now experimented with deinstitutionalisation. There are still many problems when you read various reports in the states of the way in which services are provided for people with mental illness.

When I talk to my colleagues who are service deliverers rather than public health people, very little focus in the past has been put on seeing people more holistically. People are either dealt with in terms of their substance abuse problem or in terms of their mental health problem. The Commonwealth already has some initiatives to look at this issue of co-morbidity. PHA would certainly support that, because the epidemiological evidence is that there is so often that overlap. Again, it comes back to the issue of looking at people holistically, looking at the range of problems that they face and encouraging and supporting service providers to be able to do that. At the moment there is very little training for community based mental health professionals because when most people were trained these issues of co-morbidity were not raised. It is an area in which we have to get a lot smarter than we currently are in terms of our service delivery.

**Mrs IRWIN**—I want to congratulate you on your excellent submission. It is really good. Regarding links between domestic violence and alcohol, your submission states:

There is a general lack of inquiry by health professionals in antenatal clinics, accident and emergency departments about domestic violence and its relation to harmful alcohol use.

Why is this so? How should it be addressed? I find this quite horrifying.

**Prof. Baum**—I suppose it is part of the campaigns we have had in the past that have come under the title of Break the Silence. There has been a silence around issues of domestic violence. People have preferred not to dig behind the obvious evidence. However, it is one area in the last decade in public health terms in which there have been some breakthroughs, mainly as a result of the women's health movement demanding that that silence be broken and working with groups such as the police and doctors in accident and emergency by encouraging them to both report and talk to people about that potential. But I still think we have a long way to go. It is still a major issue that women and children in particular are subjected to violence. It often remains undetected. There is almost a conspiracy of silence, which would include the victims themselves.

Again, it is this multi-pronged approach of working with women and children who are victims and saying to them, 'It's not your fault. We can do something about this. We can support you.' We should also support the men who are perpetrators of violence to say, 'You can change your behaviour. That is possible.' Again, it is also working at the broad societal level to look at the stresses and strains that result in domestic violence. Very often there is this connection

between particularly the use of alcohol and violence. A feminist perspective would suggest that men should not be excused for violent behaviour because they were drunk at the time and that violence is still a problem. That is an important thing to remember.

**Mrs IRWIN**—I thoroughly agree with you. I think you are right. Women have come a long way, but we still have a long way to go.

**Prof. Baum**—I think that is basically the message. I would not like to say that these issues are now clearly recognised by our police force and by our hospitals. We still have to take it further than we have already, but at least they are all on the agenda, which is an important step forward.

**CHAIR**—And I might add that men have a long way to go, too.

**Prof. Baum**—I let the Chairman say that.

**CHAIR**—Some men. Thank you, Professor. That has been very enlightening. We really appreciate your great effort.

**Proceedings suspended from 12.39 p.m. to 1.31 p.m.**

**ROBERTS, Mr Geoffrey, Project Officer, Aboriginal Drug and Alcohol Council (SA) Inc**

**WILSON, Mr Scott, State Director, Aboriginal Drug and Alcohol Council (SA) Inc**

**CHAIR**—I welcome the Aboriginal Drug and Alcohol Council (SA) Inc to these public hearings. I should point out that, while the committee does not swear witnesses, the proceedings today are legal proceedings of parliament and warrant that respect. Good to see you again after a very good day yesterday.

**Mr Wilson**—Thank you, Mr Chairman. The Aboriginal Drug and Alcohol Council was started in 1993 as a result of the royal commission into black deaths in custody. As you probably know, around the country a lot of the communities got together to look at the recommendations, considering that 44 of the 99 deaths had something to do with substance abuse as a result of people being arrested in the first place, and I think about 80 of the 320 recommendations related to substance issues.

In South Australia the community came together and decided that one approach was to establish a state community controlled organisation that could provide a whole range of coordination strategies and try to come up with programs. So in 1993 the Aboriginal Drug and Alcohol Council—which I might add is the only organisation of its kind in Australia—was created. We are the largest community organisation in this state. We are currently representing about 28 Aboriginal communities across the state. Most of our membership is mainly geared toward rural and remote South Australia. As you can probably guess, there are a number of Aboriginal organisations in metropolitan Adelaide and, so that those organisations did not outvote or outsway our folk in the country and remote areas, they made it so that the council is more skewed, I suppose, to those sort of concerns.

We basically are employed. We receive 100 per cent of our recurrent funding from the Commonwealth. We do not receive any state government recurrent funding at all. As a result of that, our council basically is recurrently funded for three positions, which obviously is not enough when you are a state body. We have been a bit successful over a number of years in being able to manage to employ between 10 and 12 people since about 1995. Those people we employ unfortunately are employed on short-term contracts. I heard one of the questions that was directed this morning to the state government and, as you probably heard, that project once again was Commonwealth funded. But at the end of the day we had to terminate the four staff we employed in that project. One of our other staff members that we used to employ we have terminated five times because each time his project came to an end we had to terminate him and hope that we had another project that that person could slot into.

So it is not an easy road being an Aboriginal drug and alcohol organisation in South Australia to continually seek state government funding—more than likely what happens is that the Commonwealth funds our programs—and to continue down that track obviously is having an impact. We believe that we have been successful in a whole range of areas. One of our major concerns is the nature of funding. At the end of the day, we seem to be successful in getting funding for a range of projects only to have those projects not continue.

For example, I have here a copy of a package that was launched at the Age of Celebration conference by the Minister for Aged Care, the Hon. Bronwyn Bishop. Last year at the Age of Celebration conference, which is the major initiative for the International Year of the Aged, that training package, which is a national training package for dementia for indigenous communities, was launched by the minister and commended for being an excellent package, but what she forgot to tell the 1,500 delegates at that conference was that that was the end of the project because the funding had actually run out. So we have hundreds of these training packages sitting in our office, us and the Alzheimer's Association of South Australia, but actually do not receive any funding to continue that package. That seems to be part and parcel of the direction or the way things are happening for Aboriginal organisations across this country.

Just in winding up, I would like to apologise. Obviously our chairperson, whom some of you might have met yesterday, Mrs Isabell Norvill, was going to attend today, but unfortunately due to another death in the community that some of you heard about yesterday and other pressing needs she could not attend today. So on her behalf we apologise.

**CHAIR**—Scott, thank you very much for that. You have made some significant recommendations in your proposal. I do not propose to go through all of them. One did jump out because it is an area that I know and I thought I might follow that one up and ask others to be ready with their questions. In terms of policing, basically you are talking about the Yalata community and asking the police to come in and, after a suitable time, really enforce the rule. I find that quite a valuable concept. Could you make a comment about that in terms of safe motoring? It is very important, very basic and, as it simply says, a blitz—roadworthiness, licence checks, stopping overloaded vehicles. So you really are suggesting some significant attack on the serious issues. That is very welcome and I just welcome your further response.

**Mr Wilson**—Those recommendations were contained in a report. We were commissioned by the Federal Office of Road Safety to look at some of the road safety issues in the west of the state because at the time it had the highest road fatalities per capita in Australia. The Office of Road Safety monitor and try and find out why. So we sat down with the community, looked at some of the issues. Those were their recommendations, not ours. As you probably know, considering your electorate covers a huge area of South Australia, there is a long distance that people have to travel, and part of the problem is a lot of those vehicles are unroadworthy. Part of those vehicles obviously are unregistered and a lot of people do not have licences, and there does not seem to be a lot of programs put in place for people for whom English might be a second language to understand some of the complexities of getting a licence or even looking after their vehicles. So the community was looking at those issues. Those are some of their recommendations. They thought, if there was that sort of seriousness, that the police would come in in partnership with the community and perhaps be involved in those road safety programs, actually look at the vehicles and, if they were not up to scratch, enforce the law that currently exists.

**CHAIR**— That is quite welcome and I congratulate you—

**Ms ELLIS**—Scott, I do not know whether you were in the room earlier today when we were listening to part of the South Australian government discussion and particularly Stephanie from the Department of Education in South Australia. When we were out and about yesterday we heard some reference to the level in some regions of death by suicide or by other means—I am

being general. My question to the Department of Education was really: when you are formulating policy for schoolchildren, particularly considering our indigenous schoolchildren, is there any concentration on them for a start; and, secondly, when you hear of a region having problems of a particular nature, is there a view that we should pay attention to that when it happens and move, in conjunction with the community, and work with them to try to see whether we could build a future in the longer term that may eventually lead to eliminating or assisting in dealing with those sorts of problems of multiple deaths in communities? I am sorry my question is so general—

**Mr Wilson**—No, that is okay.

**Ms ELLIS**—I think it is a really important one because it seems to me that if ever there was a flag-flying exercise it is that sort of instance that is the flag-flying exercise and I am just wondering if you would like to give us your views on how you see it. I might be barking right up the wrong tree, but it seems to me—there should be a policy, anyway—that there are times when you see signs of a community in crisis. It does not happen overnight and it does not last for one day. At the other end of the scale is your long-term approach to it. Do you have a view?

**Mr Wilson**—There does not seem to be, on behalf of the Education Department, those sorts of programs, as you are correct in assessing, in the Aboriginal community, anyway. There seems to be what they call cluster deaths. For example, if we are involved in a bus accident or anything like that, there would probably be a whole range of grief trauma counselling brought into play for the police officers, ambulance drivers and people like that. The Aboriginal community seems to be experiencing a horrific rate of death, whether it is through suicide or other means. I was talking to some people last night at the public meeting. In one family alone there were five brothers who had basically lost their lives to drug and alcohol in the last couple of years. There is no counselling or intervention by the school system for those people. When young folk are killed in car accidents or other things like that, basically, the school does not really seem to get involved.

In terms of something we think the Department of Education could look at, considering they are a significant part of communities right across this state, they know when there are significant family problems, family death or other traumas. Perhaps the school could play a significant role in helping that community and family come to terms with that. But, unfortunately, I suppose schoolteachers, like everyone else, are fairly busy and do not really see that, at the end of the day, as their role. What we would argue is that, because there is no intervention at that level, unfortunately it does not take that long—I know of one person where there was a death in the family and a year later the son died—for that to be repeated time and time again in Aboriginal families. One will either suicide or die of a drug overdose or some other traumatic death and within a short period or within a year so will another family member. Yesterday, when we were out visiting there was an overdose death. That person was related to somebody who actually hanged themselves about six weeks ago. From our point of view, a lot of people in the Aboriginal community are suffering what they call post-traumatic stress disorder, because they do not really have the time to get over and grieve the loss of a loved one before there is another death.

**Ms ELLIS**—Can we take that just a step further then and broaden it to the general use and abuse of substance—tobacco, alcohol and other substances? What are the advantages in having

programs that are culturally significant to your community, to your people? In relation to children, in a number of cases—not all of them—they are living within the usage of those substances by older people in their family groups. What advantage would there be in a proper concentrated consultative approach with the community on early intervention right across the school age system in those indigenous communities? Can you see any benefit in that? Can you discuss that with us?

**Mr Wilson**—We would like to see school drug education programs start in primary school rather than waiting until kids get involved in high school. This morning you asked questions of the state education department. We cannot understand, with respect to the national police diversion strategy, for example, why there is no linkage between the police diversion strategy and the school drug education strategy. If a kid gets picked up at school for drug use or whatever, why suspend them? Why not divert them, just as if they had been picked up on the streets in Adelaide, when they would have that opportunity? Obviously, early intervention is a must. There do not seem to be a lot of programs around. For example, community organisations like ours and others do not receive funding for things like health promotional programs. We do not receive funding for basically a lot of those sorts of early intervention-type initiatives. We think that those are the ways to go.

I have handed out to members documents containing a snapshot of indigenous families that we had a look at when there was a range of deaths in the community. The last one is of a family from the Northern Territory. All of those boxes in green represent kids 13 and under. If there is no intervention for those sorts of children, eventually they will join the people up the top, if they make it that far. They will join in the circle and eventually, unfortunately, join in the substance misuse or problems as well. As you can see, these families are devastated by alcohol, heroin and other drug abuse. These programs are quite important. Unfortunately, in the past mainstream organisations have failed when the federal government and state government come out with their big major campaigns. For example, the last one was Making Choices, an alcohol campaign targeted at youth. From my point of view, that was a great campaign. But it really showed middle-class kids having a wow of a time. It did not show average kids who might live in lower socioeconomic opportunities. They missed the opportunity; they could have put Aboriginal kids, Vietnamese kids or other ethnic groups in there that would have affected those sorts of people to say they were part of it. At some stage down the track, if we are lucky, they will put in some funding to run an indigenous specific campaign. We believe that they missed the boat on that one. It is the same, from what I understand, with the illicit drug campaign that probably will be launched next year. Once again, that will be targeted at that sort of group of people.

**Ms ELLIS**—I do not want to give the impression that I am blaming all of this on schools and that therefore all of the solutions are within schools. In some of these communities the only out-of-family experience for a lot of the kids is in fact school. Can you tell us to what degree you are aware of what cultural training is involved in the teacher training processes that begin to address some of the issues that we have been talking about?

**Mr Wilson**—My understanding is that there is not a lot. I know that the education department here does have a cultural awareness program for its staff. But, for example, with respect to the medical students, we are asked once a year in a six-year course to go up to the Flinders Medical School and give a half-hour lecture on drug and alcohol to medical students who are doing a six-year course. It begs the question as to what the problem is.

**Mr Roberts**—I might put another spin on that or add an additional component. Quite clearly, I support what Scott has just said. In terms of the longer term problem, we are continually being asked to come up and have a yarn with the guardianship board or appear there and advise people from the office of the Public Advocate. We are dealing with people who have gone through a heap of trauma in life—a lot of loss of life—and who become involved in the drug scene, which leads to co-morbidity. So we have people aged 16, 17 and 18 in forensic psychiatric units, with relatives not knowing what to do about them and how to deal with it. The guardianship board is exactly the same in that it is unsure as to how to handle these people. We hear about the revolving door of prisons. There is also a revolving door for these people in terms of psychiatric units. There has been a fair bit written up by the coroner about the gaps that were there, certainly in this state, when it has come to the ultimate end for some of these people. If a 17-year-old lad came into our office and said, 'I've got this problem. How can I deal with it? Where are the programs? Where can I go?', The short answer is that there are not any. The first opportunity basically that people get to deal with these issues is when they become incarcerated for the first time. As to whether those programs are effective or not—that is certainly not reflected in incarceration and recidivism rates. So again it is just a never-ending saga. I think that is where you start to see the long-term effects of people who have been exposed to significant trauma and grief and loss at a younger age.

**Mr QUICK**—Would you like to see a protocol when an indigenous person is incarcerated that there are certain steps that need to automatically flow on? A person, for example, might end up in Port Augusta jail but he comes from Mount Gambier, and the family are not sure where the hell he is. He is on his own; they are unsure; there are no linkages; he is just put in for three months for GBH or whatever it is; and if he survives, it is more good luck than good management. I guess that links in to something—and I have interrupted you. As to this holistic thing that you slam—and I am glad, in a way, because it is a big cop-out, I think—I am interested in what priorities you see. Rather than looking at the whole, let us get back to the body parts, I guess; that is what you are saying. Have you developed a protocol for incarceration? Could you go to the John Pagets of the world and say, 'Look, you are in charge of correctional institutions in South Australia today'—and we heard they have this wonderful interagency approach and the government is doing these wonderful things. Do you actually do it or do you wait for John to do it?

**Mr Wilson**—Basically, as you probably heard, we did have a program that was funded by the federal government. Part of that was trying to look at some of the issues that you raised in terms of programs for prisoners as they came in. We also had a peer outreach program attached to that, so that when people came out we would have picked them up, because about 30 per cent or 40 per cent of prisoners do die within a relatively short period upon release due to heroin overdoses and a whole range of other things. We developed specific health diaries for prisoners, we developed help cards for prisoners, and we even had an exit kit that we would have given people as they were coming out.

Unfortunately, as you heard this morning, the state government—upon evaluation three times by the National Centre for Education and Training in the Addictions at Flinders uni, who said that that program was best practice—when we went to them in November, considering the budget does not come out until May, they told us that they did not have the money, and the $300,000 that they did mention this morning was the top end of the scale. That was for us to actually run our program for every prisoner, including Aboriginal and non-Aboriginal prisoners.

The budget that we actually put to them for Aboriginal prisoners only was roughly $200,000. That was three years ago.

Unfortunately, these sorts of things that we produced for prisoners, we could not then get into the jail because our program had finished there and we were not able to go back and actually deliver them. So we now have quite a few thousand of these that we actually give out to people in the community as part of promoting our organisation, and we still think that they are quite useful for people on the street. Our outreach program came to an end as well. Geoffrey at the time was our project leader for that prison program, and unfortunately we had to terminate him and other people. So there were programs—and they were good programs that would have looked at the whole continuum of care for prisoners—that were run by a community organisation from outside the system, but unfortunately that has finished.

**Ms HALL**—It seems to me that there is a problem with the way we are funding the program we were just talking about, the prison program, and many other programs that you have run that you have designed specifically to help your people when they have drug and alcohol problems. What would your suggestion be to overcome the problem whereby it is funded for two years, you find out it is successful, and then, once you have established the fact that it is successful, the program stops? How do you think we should deal with this issue?

**Mr Wilson**—Our own organisation, the main body, is funded annually by the Commonwealth, but we actually have some programs that are funded for four years through the National Illicit Drug Strategy. We build in to all of our programs some sort of evaluation process where we use outside bodies—for example, the National Drug Research Institute at Curtin uni or the National Centre for Education and Training up at Flinders—to evaluate our programs. If, at the end of the day, after a year, those programs go through some sort of evaluation process and they are deemed to be successful or on track, you would think that we could then submit that evaluation/interim report to the funding body—most of the time the Commonwealth—and, based on that, the Commonwealth would then re-enter into a negotiation with us where they might continue that funding for a triennium period. Instead, what happens now is we hand in the evaluation report and everybody sort of says, 'Oh, this is really good, but unfortunately that is the end of that funding cycle. Come and see us next budget', but it never really happens.

**Ms HALL**—I was pleased to see that Geoff identified the issue of mental health. That is one of the areas that I am particularly interested in, mental health and substance abuse. It seemed to me that it is an area of particular concern for Aboriginal people, as you mentioned. Do you have any ideas on how that should be addressed within your community?

**Mr Roberts**—I am currently involved in a project looking at the quality use of medicines. It is a collaborative project between us and the Flinders University School of Nursing. We are looking particularly at where Aboriginal people's social and emotional well-being is impacted on with a mental health problem, but more particularly where substance misuse or abuse has been one of the catalysts for that and causes psychosis and those sorts of things. I have interviewed quite a number of people—and it is only early stages in this—but it is poignantly clear that education is just imperative, and it has to come from a lot of sources. It has to come from the community. We have to have educated health workers in the field working with the community and explaining these issues, stepping through it, and additionally, advocating on

behalf of these people. As I said earlier, two weeks ago I was asked to provide advocacy in the guardianship board on this very specific issue. If you give people education, if you give them knowledge and it is culturally appropriate, then people can have some ownership and some self-determination in relation to this.

But a lot of the literature is very difficult to understand when you get these medications. People might have an anticholinergic effect in relation to antidepressants, so they start to get dry in the mouth, they cannot empty their bladder, the libido drops a bit, so they say, 'I am not taking these', or, conversely, 'Once I finish them, do I need to get any more? Is it okay to use these in conjunction with substances such as cannabis, alcohol and maybe other drugs?' There is not that knowledge amongst the community. It is very poorly explained by the medical profession to these people. Usually it comes from the mainstream, and I do not say that of everybody. Chemists as well. People do not understand the relationship between sharing their medicines and substance misuse.

Whilst it is only early days, there are some clear trends emerging, and not unexpectedly for those of us who have worked in this field, who work at the coalface every day. When we talk about programs, I think there needs to be these programs of educating people, but again, like Scott said, they have to be evaluated. A lot of times people talk about programs, and when you pull back the layers, the emperor is not wearing any clothes.

**Ms HALL**—This morning we heard a little from the wine industry. I notice that in your submission you talk about replacing the ad valorem tax with the volumetrics form of tax.

**Mr Wilson**—Basically, I suppose, we are part of an alliance with the Archbishop of Australia, the Reverend Carnley, and the Australian Medical Association and the Alcohol and Drug Council of Australia. I actually do have a letter from the archbishop that I would like to tender as evidence.

We were not going to bring this up unless the Winemakers Federation themselves actually introduced the issue. You heard the Winemakers Federation talk about how they produce something like 500,000 casks of wine a day and people only have a little sip of that and put it back in the fridge. Well, 500,000 casks of wine every day means that they are drinking a little bit more than a sip. If you look at the Living with Alcohol Program that ran in the Northern Territory, in a small town like Alice Springs, for example, when the cask wine levy was introduced the consumption of alcohol through cask wine was 4,000 casks a week in that community of 20,000 people. Once the cask wine levy disappeared, that consumption shot up to 7,000 casks a week. When you consider that there are only 20,000-odd people there and they do drink other beverages, it has had quite a major impact.

We were interested when they mentioned the centenary red. One of the questions I heard one of the members ask was were they asking the federal government to put in an extra dollar for every dollar that they were putting it. I put it to you that you are actually putting the whole amount in, because they are going to give you the red and you are going to buy it back and stock the embassies with all of that. So you are actually paying the $2 million yourself. But at the end of the day, $2 million is a lot of money, I suppose, for some people. The reason we would argue that the Winemakers Federation introduced that is that in about August this year we had a press conference with the archbishop and others in Perth. Shortly after that we

received a letter from the Winemakers Federation outlining that they would like to meet with us to discuss this program, which had the patronage of the Prime Minister and things like that. I and, obviously, the archbishop and other members did ring the Winemakers Federation for a meeting to discuss the issue; that was the last time we heard about it until this morning.

Volumetric tax is a fair way of taxing alcohol content. In actual fact, if members want to go back and have a look at the wine industry's own inquiry a couple years ago, they will find that one of the major recommendations from their own inquiry was the introduction of volumetric tax. They seem to have changed their tack with the help, I suppose, of the big producers—the big three—who produce the majority of their wine, which is cask wine, not premium wine.

At the end of the day, if you look at some of the issues around the place, the major cause of alcohol-related harm among Aboriginal people and other people—the major cause of social disruption through police and things like that—is the consumption of cask wine. The major cause of dementia among Aboriginal people is alcohol-related brain damage. Because at the end of the day, if you have got four or five litres of cask wine sitting here on the table, I bet you 10 bucks that you would sit there and drink the lot; whereas if you had a bottle of wine there, you might have a couple, or drink that bottle but you are not necessarily going to nip down to the bottlo to buy another one because you might already have had too much. We really believe that volumetric tax gives certainty to the wine industry and to the winegrowers themselves, because they actually then know, for example, year by year, how much money they have to pay to the federal government in tax.

I suppose you have all heard about salinity of the Murray River, and South Australia obviously is affected quite greatly by that. We would suggest that part of that salinity problem is created by the wine industry. For example, there is something like 18,000 hectares of land in South Australia that has been ripped up for planting of vineyards and things like that. That is 18,000 hectares of vineyards that is an oversupply in this state and, obviously, uses up a hell of a lot of water that contributes to salinity as well. On my understanding, even the federal Treasurer himself, the Hon. Peter Costello, has suggested that when they looked at the tax mix when the GST was being introduced perhaps they did get it wrong and that perhaps the way to go in the future is to look at volumetric tax. We think that is the fairest way.

**Ms HALL**—Finally, would you like to make a comment on the relationship between employment and drug abuse and abuse within your communities?

**Mr Wilson**—Yes, unemployment, obviously, is quite extensive and quite high in a lot of mainly rural and remote areas. You have been here in Adelaide for a couple of days. I guarantee that if you walked up Rundle Mall or looked at any of the shops you would not see an Aboriginal person employed in any of those sorts of places. Obviously, if you are sitting around at home, you have no hope and you are looking into a whole life of despair. At the end of the day, it is very easy to turn to either the bottle or other drugs to make your life look a little bit different.

From our point of view, if people were given meaningful jobs, perhaps at the end of the day that could be a way of building pride and things like that in Aboriginal people so that they would not have to go down that track of drug addiction. CDEP is a major initiative—and Aboriginal people have been working for the dole in this country for over 20 years—but, at the

end of the day, if you have got to walk around to some of these remote communities and just pick up rubbish as part of your CDEP program, it is not really meaningful. Yes, unemployment is part of the key.

**Mrs IRWIN**—You were stating that the prison peer education program is just scrapped—no more Commonwealth funding whatsoever. What other programs are no longer receiving funding?

**Mr Wilson**—From what? The prisons?

**Mrs IRWIN**—Prisons—say all over.

**Mr Wilson**—Obviously, this program here, which is dementia training for indigenous communities, the prison peer education program, and the outreach program that we used to run. We used to get moneys for education and training but unfortunately we do not receive any of that, so we have to do that ourselves. I could sit here probably all day just listing the programs that started. For example, petrol sniffing—we were funded when there was a coroner's inquest into a young person who died in Amata. We put a submission to the state government two years before. They quickly funded that, I suppose, to take a bit of political heat—

**Mrs IRWIN**—Is this Making Trax, this mobile service?

**Mr Wilson**—No, this came before that. This is one that we had before that. After 12 months, that program ceased because there was no more funding. No, the Making Trax has only just been funded by the national illicit drug strategy last year and it is only into its first year.

**Mrs IRWIN**—On page 3 of your submission you state that in South Australia there is a complete lack of facilities for Aboriginal people and that if an Aboriginal person fails within these systems, it is the fault of the Aboriginal person. Why is this? Can you describe why drug and alcohol services fail to meet the needs of Aboriginal people?

**Mr Wilson**—I suppose to be fair and to be honest, both Aboriginal and non-Aboriginal services have failed Aboriginal people in this state for a number of years. There are a number of programs that are funded by the state or the Commonwealth to provide services to Aboriginal and non-Aboriginal people but for whatever reason do not seem to be able to deliver.

We would suggest that perhaps it is time that some of these funding bodies—whether they are state or federal government—actually did their job. At the end of the day, your project officers in these departments know whether you are actually delivering. Part of the problem, I think, is that some of them are a bit worried that, if they looked at the issue, the rest of the Aboriginal community might turn around and sort of call them racist for actually suggesting that a program is not working. So in actual fact, they do nothing. Those programs limp along year after year after year, not really providing any service directly to the people that they are there to provide a service to in the first place, which is basically a tragedy from our point of view. It just sort of continues. But there are not a lot. For example, there is no indigenous illicit drug rehabilitation centre in this state, in Western Australia or the Northern Territory. You visited yesterday an alcohol rehabilitation centre. That is basically the only one for the whole state.

For example, if you live at Coober Pedy, you know you are going to have to come all the way to Kalprin—if you can get in there. As you heard those people saying yesterday, they take people from basically right across the country, but if you are an Aboriginal person who wants to voluntarily give up heroin or other illicit drugs in this state today, there is not a lot for you.

**Mr Roberts**—In addition to that, as people get more mobile, we are seeing a lot more people from up north and the Northern Territory coming to Adelaide. Those issues in terms of substance misuse and culture are certainly different to those who reside in the city. That is another issue which compounds the problem that we have—that is, how do you deal with these traditional people in relation to the problems that they have in relation to substance misuse and co-morbidity? The structure needs to be looked at in wider terms, not just in South Australia. People of various cultures are coming from other areas of this country, and we cannot look after any of them.

**Mrs IRWIN**—What facilities are there for Aboriginal people who want to detox?

**Mr Wilson**—If you are a youth and you want to go through detox, you could go to the Hindmarsh Youth Centre in South Australia. The problem there is that a lot of young Aboriginal folk do not actually stay there to go through the detoxification process. If you are an adult, you can go to the major public facility, which is Warranilla, which the Drug and Alcohol Services Council funds. That does not seem to have too much of a success rate for Aboriginal people there either. If you are lucky enough to have a job, private health insurance and things like that, perhaps you could go into some of the private facilities. If you are lucky enough to have a couple of thousand dollars, you could join one of the naltrexone clinics that operate here, but unfortunately most Aboriginal people would not seek that avenue.

**Mr Roberts**—Detox is just one component of it as well. If you want to progress from there to rehab and learn cognitive skills, then there is nothing for our people. One of the reasons we do not have success at Warranilla is that, because of safety reasons, they lock the doors at 9 o'clock at night, although it is voluntary detox. That has a different connotation in terms of Aboriginal people.

**Mrs IRWIN**—So your answer is that there is nothing out there.

**Mr Roberts**—That is correct, yes.

**Mrs IRWIN**—I congratulate you on your submission, and never, ever give up the good fight. Congratulations on what you are doing.

**Mr ANDREWS**—I want to read to you some remarks that Noel Pearson made in his Chifley lecture. He said:

The solution to substance abuse lies in restriction and the treatment of addiction as a problem in itself. When I talk to people from Cape York Peninsula about what is to be done about our ridiculous levels of grog consumption and the violence, stress, poor diet, heart disease, diabetes and mental disturbance that results, no-one actually believes that the progressive prescriptions about harm reduction and normalising drinking will ever work. The rule of thumb in relation to most of the programs and policies that pose as progressive thinking in indigenous affairs is that if we did the opposite we would have a chance of making of progress.

He went on to say:

> This country needs to develop a new consensus around our commitment to welfare. This consensus needs to be built on the principles of personal and family empowerment and investment and utilisation of resources to achieve lasting change. In other words, our motivation to reform welfare must be based on the principle that dependency and passivity are a scourge and must be avoided at all costs.

I am interested in your comments about his remarks.

**Mr Wilson**—To a certain extent, we obviously support some of his remarks quite wholeheartedly. For example, the approach of the federal and the state governments for a number of years in terms of Aboriginal programs has been this concept of holistic health—that is, that you need to look at all the underlying issues before you actually deal with the problem. The problem here is obviously substance abuse. We believe that it is all well and fine for people who want to do that, but at the end of the day it is really not helping anybody who has an addiction problem. We believe that you need to have programs that will look at the addiction first. Other problems like unemployment, low self-esteem and all of those will obviously then sort themselves out.

In terms of welfare dependence and things like that, some Aboriginal people live in a remote community where there are not a lot of prospects for jobs. Let us face it, Aboriginal people like nice things just like non-Aboriginal people. They like to buy clothes, cars and things like that, but there is not much opportunity if they have no prospects of getting a job, bar getting a social security payment or whatever. From Noel Pearson's point of view, he is talking about his own communities. Many communities in Far North Queensland have what they call wet canteens. South Australia does not have that concept where people rush in and have couple of hours to drink and can get as drunk as they possibly want. A lot of South Australian communities have taken this approach such as Yalata and Pitjatjanjarra lands, which are dry communities. To give you an example, there is one community at Oodnadatta where the community owns the pub. I suggest that they have no fewer or no more problems. In actual fact, to a certain extent they are a model community in terms of drug and alcohol problems. I do not know whether that answered your whole question.

**Mr ANDREWS**—Whilst you made some remarks about a holistic approach, what I am trying to tease out in my own mind is whether or not attacking the addiction itself but not putting it in the greater context of what else is happening within the communities is ultimately going to do very much. Perhaps it is, but that is the real question. We could tackle addictions and substance abuse, but if the broader context within which that occurs is pulling in the opposite direction, it may be that we are not getting very far at all. That is what I am interested in trying to pursue.

**Mr Wilson**—To answer that part of your question, one of our programs which we believe goes a bit towards that is the Making Trax program, and Louis who is appearing next with the foetal alcohol people works with us on that. That program involves going into a community which invites us in and sitting down with that community and coming up with a whole community approach where we draw up a contract as to what we expect from the community to participate in this program and vice versa. They tell us what they expect us to do. We then sign a community agreement with them to try to help that community develop their own local strategies.

If we came in and said, 'Here's a strategy to deal with substance misuse', it would not matter which town it is, there would be no commitment to that because they did not have any part to play in it. Through the Making Trax program we are there to help that community. We sit down with them and develop their strategy. Because they were involved in it and they own the strategy, they will have more commitment to working with it and making sure that some of those problems you have brought up will obviously be addressed.

**Mr ANDREWS**—Finally, has there been an evaluation or assessment of Making Trax that indicates that it is doing what you hope?

**Mr Wilson**—Prof. Dennis Grey from the National Drug Research Institute is the evaluator for that. We have had an interim report, because it has only been going since October last year, which indicates that we have met all of the objectives that we negotiated with the Commonwealth. It seems to be on track to produce outcomes. Our team has signed six community agreements in this state. By the way, that program is not just here; it goes all the way up to Alice Springs and over to Kalgoorlie. So it covers probably about a quarter of Australia's land mass with two staff.

**Ms JULIE BISHOP**—On the ad valorem volumetric debate and the concessional tax treatment of the alcohol content of cask wine, you mentioned an example in Alice Springs where there was a levy put on cask wine. Something like 4,000 casks were sold when the levy was on and when the levy was removed 7,000 were sold. That would indicate that price is very much a factor in assisting the reduction of sales of cask wine.

**Mr Wilson**—Yes.

**Ms JULIE BISHOP**—Was there a correlation in the incidents of alcohol related harms and abuses that went with that change from the 4,000 cask scenario to the 7,000 casks. Was that study done as well?

**Mr Wilson**—Yes. We can probably provide copies of the evaluation of the Living with Alcohol Program. From memory, this basically saved the Territory health service something like $129 million in hospital related admissions and it actually saved a number of people's lives. It had a huge benefit. I was not sure whether or not it was you, but one of the members was actually asking about the whole concept of low alcohol beverages.

**Ms JULIE BISHOP**—Yes, I asked about that.

**Mr Wilson**—As someone who grew up in the Northern Territory, the Territorians had the image of being the biggest drinkers in the world and that was sort of promoted quite well. When they actually brought in the Living with Alcohol Program, the whole shift did go from the macho image of getting as drunk as possible to getting people to accept low alcohol beers when they first came in. There is no way in the world that any of us would have drunk any of that, whereas in Darwin and places like that, there is a huge acceptance. One of the things that I was interested in is why the wine industry in Australia cannot produce low alcohol wine. I wonder why wine producers can do this in places such as America, in California in particular. It gives people a choice. If you have got low alcohol wine on the shelf, which obviously is one of the results of volumetric tax, then surely over a period people will take that opportunity. It needs a

lot of promotion and a lot of advertising, which is what happened with low alcohol beer. It is possible to do that.

**Ms JULIE BISHOP**—It is an interesting argument that because they cannot make a low alcohol wine that tastes acceptable, they cannot have a low alcohol cask wine. I find that rather interesting given the taste of cask wine.

**Mr Wilson**—Yes, it is pretty awful. Another issue concerning the alcohol industry is that we must not forget that alcohol kills 18,000 Australians every year. It is the biggest drug killer in Australia. I was sitting here this morning listening to the Winemakers Federation and it made me think back to the days when we had the tobacco industry saying that their products did not cause lung cancer.

They produce 900,000 bottles of wine for export every day. In regard to labelling, for example, if you live in certain states of America and you buy a bottle of Australian wine, it has a health warning label on the bottle about consumption whilst pregnant. We cannot understand why that same health warning label is not on that same bottle of wine that is produced and labelled here in Australia for Australian consumers to consume, considering that the National Health and Medical Research drinking guidelines until recently were zero consumption for pregnant women.

I will not go onto foetal alcohol because the people that are speaking afterwards will obviously talk more about that. It is a major problem and that is one of the reasons why we looked at originally going down the track of developing our own sort of health messages. Originally that was going to be foetal alcohol, but then we looked at the fact that there are a number of young Aboriginal girls out there who are pregnant and who are injecting drugs and things like that. That is why we have included in our submission a recommendation for labelling and health messages to be put on alcoholic beverages that are consumed in this country.

**Ms JULIE BISHOP**—I have one question on another topic. You cite statistics that talk about the incidence of hep C infection in South Australia and state that the rate in 1998 is the second highest in the country. Why do you think the hepatitis C infection rate is so high in South Australia? Secondly, you referred to the research that was done on injecting drug use in some Aboriginal communities in appendix 1. I had difficulty following what you were saying. Under 'Risk behaviour' on page 13, appendix 1, it states that there is the Aboriginal cultural concept of 'sharing', which goes against the idea of safe needle use. Is that an insurmountable issue? You state, on page 17:

While most survey participants believed they were most unlikely to be at risk of contracting BBV because they did not share needles or injecting implements ...

Is there some inconsistency there? What is the actual situation?

**Mr Wilson**—No, there is no inconsistency. We will leave a copy of the full report here for you to have a look. That is the only research of its kind in Australia where it looked at not only injecting drug use, but also alcohol consumption amongst Aboriginal people. Basically, we conducted this research with NCETA at Flinders. The issue was when it came to sharing amongst that group of participants. For example, if Geoffrey and I were related, we would use

the same needle, but there would be no concept that we were actually sharing, because he was my brother or my cousin. Some people in the community connect sharing injecting equipment to sharing with a complete stranger. Sharing does not have the same connotation if it is with a family member, or even with a close friend for that matter. They said, 'If he had some sort of disease or anything like that, I would know about it and he would not put me under that risk.'

If you go into the prison population and places like that, you might have one syringe, or if you are lucky, a light bulb filament or other sort of instrument. You will share that with many people because you are not going to say no. It comes about with that sort of issue. There is no concept of who you share with. If they are strangers, that is fine. If you share with a family member or close friend, then you would do that.

**Ms JULIE BISHOP**—There was the question on the incidence of hep C in South Australia.

**Mr Wilson**—Basically, I have no real idea why hepatitis C rates are so high here—whether or not it indicates that there is a lot of injecting drug use and other issues out there. Our council has just received funding to do a prevalence study in metropolitan Adelaide. We are going to look at the prevalence of injecting drug use because we believe that it is 10 per cent or higher, which means that there is over 1,000 Aboriginal people in this community here that are into that sort of behaviour.

Part of our program is also to look at the incidence of hepatitis C amongst the Aboriginal community. This was done in Melbourne with the Vietnamese community, where they looked at those Vietnamese who were injecting and found that 87 per cent of them tested positive for hep C and did not know they had it. We believe that a lot of Aboriginal injectors do not necessarily know that they have hepatitis C, therefore there are all the other problems that come with that—for example, diet, don't drink, don't take paracetamol. So you need to find out what the problem is and then try and come up with the programs that can at least give people education about what they can or cannot do.

**Ms JULIE BISHOP**—Education is the key, isn't it?

**Mr Roberts**—Yes. It is a blood borne virus, it is pretty resilient in comparison to HIV and the modes of transmission are many and varied. As Scott was saying, given that the sharing component is rellos or friends, it could be just using the same haircutter: you cut your head as you are shaving your hair and two days later somebody else does the same, and there is a high risk they are now hep C positive. It can be just through simple things like that.

**Mr EDWARDS**—I just want to remind you of your submission where you say:

ADAC is recurrently funded by the Office for Aboriginal & Torres Strait Islander Health (OATSIH), for 3 positions. The Council does not receive any recurrent funding from the State government.

Despite being only funded for three positions, you have managed to employ 11 people since 1995, based on a number of initiatives, including mostly Commonwealth funded initiatives, by tender. You also say that in South Australia there is a complete lack of facilities for Aboriginal people.

We took evidence this morning from representatives from various state government bodies who argue, as most jurisdictions do, that the delivery of services is something that the states have to take responsibility for. One of the things that we need to do is get a national perspective about that. In the context of those comments, it seems to me that South Australia has dropped the ball in terms of giving you the sort of support that is required. It is also of concern that we seem to have already lost the lessons that were learnt from the royal commission into Aboriginal deaths. I know that is a fairly broad statement, but I wonder whether you would like to comment on what I have just said.

**Mr Wilson**—I will comment in terms of the state and Geoff can comment in terms of the royal commission. We have no real understanding as to why that has been the case basically since we started. I suppose the state government thought at the time that there was no need for an organisation like us because they had the Drug and Alcohol Services Council, even though they will tell you themselves that less than five per cent of their clients are indigenous people. We have tried constantly and have spent a lot of time putting in submissions to state government funding agencies. At the end of the day, some of those have been successful. Basically, these sorts of diaries were funded by the state government. But if you need major infrastructure—for example, for Making Trax, the prison program, for dementia training and things like that—the Commonwealth government seems to be more willing to explore those sorts of ideas than the state. Most of the money that comes into the state for substance abuse, which is about $15 million or $16 million, goes to the Drug and Alcohol Services Council, which is the statutory body here. Each state seems to have some body like that.

But when it comes to Aboriginal programs, it is almost like back in the old days, when we originally were funded by ATSIC, and if you went to a state government department they would say, 'ATSIC can fund that.' It is almost an assumption that there is this Aboriginal bucket of money out there. It is the same with the prison program. When we went and saw Mr John Paget, who spoke here this morning, his first comment to us was, 'If you can get money from OATSIH to fund most of this, then we might put in some top-up money.' So we keep getting pushed into this Aboriginal-only bucket.

This is why an organisation like ours tries to do a whole range of programs with mainstream organisations like the Alzheimer's Association. We try to compete competitively, I suppose, for NHMRC grants and a whole range of other avenues rather than just rely solely on OATSIH. Their national funding budget is $18 million this year and I do not think, to be honest and realistic, that in the five years that we have been funded by them they have actually had an increase in real dollar terms. I think it has just kept up with inflation. In 1995, it was about $14 million or $15 million and over the last five years it has crept up to about $18 million. It is a national program. You divided that by about 70 programs that they fund and it works out to be about $300,000 per program on a national basis to deal with such a huge problem.

**Mr Roberts**—Just briefly, if I may, I would like to comment on the royal commission into Aboriginal deaths in custody. Those five volumes from start to finish, cover to cover, are set in concrete. They remain unchallenged since the day they were written. What ought to be challenged is: where did the money go? Organisations that were funded to be set up to do certain things simply did not do them and are still purporting to do stuff. I heard this morning reference to the Muirhead moneys. I find that offensive, quite frankly. It is not Muirhead money,

it is moneys that came about to deal with the issue of Aboriginal deaths in custody and the historical as well as contemporary issues that caused that to be.

Our people for 170 years were not allowed to drink, so there was never the opportunity to learn to drink socially—not at all. Elliott addresses those issues in length, not only in the recommendations but in the lead-up to the recommendations. I would like to see Johnson recalled to revisit it. Then we might cause a few people to be accountable or to explain why they did not do what they said they would do with the moneys that they received.

**Mr LAWLER**—In South Australia there is a complete lack of facilities for Aboriginal people. In regional New South Wales, when you are talking about detox and rehab facilities, there is a complete lack of facilities for Aboriginal health. I think most people accept the importance of a culturally sensitive environment for many programs where you have a large number of Aboriginal people. Given the fact that there simply is not an endless bucket of money to deliver a program for every group in a community, have you got any suggestions about how a detox and rehab centre could be modelled, if you like, in regional areas for both indigenous and non-indigenous people?

**Mr Wilson**—One of our recommendation is that each state and territory be given a minimal level of service, so if there is no detox or rehab, for example, in a certain area then at least fund those to start off with. We obviously do not believe in discrimination and we kept this in mind with our own prison programs. We did not discriminate. We allowed whoever wanted to come and do our programs to enter those programs. In a lot of the cases the Aboriginal inmates actually brought their own non-Aboriginal, Vietnamese or other friends with them and we thought that was fine, too. That is why we tried to put in two submissions to the state government to do all of the prison population or just the non-prison population.

For a lot of the Aboriginal rehabs currently funded in some of the states and territories, from my understanding, part of the problem was that that prior to this year they did not have letters of offer to Aboriginal organisations that set out that the funding was for Aboriginal clients. OATSIH have actually changed their letter of offers to Aboriginal organisations to say that this funding is for Aboriginal clients. Prior to this year they found that in rehab type places there were a lot of non-Aboriginal clients, not just Aboriginal clients, who seemed to fit in quite well and obviously went through the same sorts of programs. At the end of the day, that was a choice for them. They could have gone to a mainstream one but they obviously felt more comfortable coming to the indigenous programs at the time.

In some of the remote rural areas there is obviously a huge cost factor. For example, if you were going to set up a rehabilitation centre in the far north of this state and turn around and say, 'This is just for Aboriginal people', then you are obviously going to have a huge problem with the non-Aboriginal residents. They have alcohol problems and things like that in towns like Coober Pedy—with Aboriginal and non-Aboriginal. So you would have to have programs in those regional areas that are accessible by either group of people that choose that sort of facility. At the end of the day, you still need to have that choice, and at the moment there is no choice.

**Mr Roberts**—You would fund it by cutting the duplication. If in Adelaide you have got 10 or 12 organisations purporting to have culturally specific substance misuse programs, that would

seem weird to me because I do not think there is a need for that. It seems that there is a heap of duplication in relation to substance misuse, a lot of it unnecessary.

**Mr LAWLER**—I just missed that. Could you say it again?

**Mr Roberts**—I know there is a lot of duplication in programs for Aboriginal people, and I think that is unnecessary. If you shake the nearest tree and somebody purports to have a program, it will fall out of that tree. If you honed in on what is practical and what the community wants, then you can cut a lot of this duplication and channel some of those funds into places like rehab and culturally specific detoxification centres. I do not think you need any more money.

**Mr QUICK**—The last question sort of jumped out of the ground. Having done a two-and-a-half-year study into indigenous health, I would say that one group that has not been mentioned in the couple of days that we have been here is the Aboriginal Medical Service. Who should be the peak body to oversee all this if the state governments are doing a hopeless job? Do we do it through the AMSs because they train medical workers? We have got a plethora of them. They are like mushrooms: they are all over the place. Which one is the biggest? Do we fund the biggest or the one that jumped out of the ground the last? We talk about non-indigenous silo rail gauge territorial behaviour. Have we got the same sort of problem in the indigenous community that we cannot identify who the movers and shakers are? Is it family versus family, region versus region, land council versus land council?

**Mr Wilson**—To answer your question: yes, there is that sort of problem, the same as in any other community where the medical people are battling groups like us. For example, we are not members of the Aboriginal Health Council here in South Australia, even though we are the largest Aboriginal community organisation. We are not one of the members of the national Aboriginal community controlled health organisations because, at the end of the day, they argue that substance misuse is a social issue, not a health issue. We believe that, if you are looking at issues in terms of funding, then you fund the people that have the expertise in the problem. We believe that substance misuse needs a substance misuse approach. A lot of the health services themselves—who are members of our council, by the way; it is a bit schizophrenic when you think about it—

**Ms ELLIS**—They belong to you, but you do not belong to them.

**Mr Wilson**—Yes. We do not exclude anybody. We allow anybody who has an interest in the issue of substance misuse, as long as they are a community organisation, to become members of ADAC. In May this year we set up the National Indigenous Substance Misuse Council. The federal government and others fund a whole range of programs that deal specifically with substance misuse, but there are those who do not actually have a voice in terms of sitting at the table and fighting over the crumbs that might be thrown out in funding. Until now we have had to rely on the goodwill of the AMSs to do something. But they are so busy—not to trivialise their point of view—trying to deal with a whole range of other medical related issues that substance misuse problems—they used to have responsibility quite some years ago—always became the poor cousin.

There was not the funding—it was redirected into diabetes or heart problems or whatever—and that is why you had organisations like us and a range of other specific organisations. I might add that we do not get into any other area bar substance misuse, and that is why to this date we were voted the Community Organisation of the Year in 1997 and a couple of our staff has been given Australia Day ADCA awards. That is because we are fairly focused. We do represent 20,000-odd Aboriginal people in this state on the issues of substance misuse. The AMSs tend to look after the local clientele and not a whole state based response. We are the only state, and we have included a copy of the plan, that has taken the direction, as a community organisation, to try and develop a state strategic plan in substance misuse. AMSs have been around for 20-odd years. Up until date, unfortunately other issues, medical problems are there, and substance misuse is not a priority.

**Mr QUICK**—Back to Bronwyn Bishop and the non-funding of the jail thing: I think it is a lovely cop-out for governments of all persuasions to say, 'We will scatter it out like seeds and hopefully it will fall in the right places.' There is not enough, and other people would say, 'Look at all the money that is going into the indigenous community. They are divided. Some are in and some are out. We obviously cannot fund them all, so we will give them a little bit of everything.' But you do not get enough of anything. What recommendations do we put in our final report to say that this is a huge problem? We are about to get another part of the jigsaw from the next group of people with more horrific news. Why do we have to have another little subgroup, important though they are, and yet another little subgroup and another one, when you can put a blanket over the whole issue? Our indigenous health report cited what is happening in other countries with indigenous people: the gap is decreasing. Here, it is continuing to widen. How do we resolve it? What recommendations would you make?

**Mr Wilson**—There is no coordinated strategy, whether state of federal government. There is no coordinated strategy, whether it is local community organisations such as us. We are out there battling on, to a certain extent on our own and with the goodwill of the communities that we represent. We have a national body. I would argue that, based on the success of our own organisation, there has been a cry from those states and territories since 1994, when I have been trucking off to national Aboriginal health worker conferences where they have all been screaming out for the same sort of issues: a national voice so that these issues which Noel Pearson and others have been screaming out about are addressed. The reason they are screaming out is that they cannot see anything positive or concrete happening with this hodge-podge approach.

Personally, if it was up to me—and this is with my own organisation that I work for included—this is perhaps radical, but I would re-look at the whole issue of substance misuse and the way things are funded. I would maybe start from scratch and refund the organisations that are based on sound evaluation polices and principles and the fact that they have delivered accountable and evaluated programs in the past. To the rest I would perhaps say, 'You have not measured up, and it is time to move on.' But let's face it: up until now nobody has had the courage or the guts to go that far. That is why you are continually funding a whole range of ineffectual programs that bumble on.

You go and talk to people in the community. They will tell you what you should do or what should be funded and what should not. They will tell you the programs that are out there that are not working because they are the ones who, when their kids are dying or need help for drug or

alcohol problems, ring those programs that are getting funded and get told to get on their bike and go to the next program down the road.

Thank you a lot for inviting us here today. This is part of getting out there and listening to the community and putting your ear to the ground. It is not that often that organisations like us get an opportunity to come along and perhaps tell you what is really happening out there. If you listen closely enough, you will hear what the community is saying. They are saying that they need effectively evaluated programs that, at the end of the day, do deliver and, if they do not deliver, do not fund them. Unfortunately, when you seem to be on the funding train, whether it is state or federal government, and you have just poured in a million dollars into some sort of centre over the road there, you are not going to pull the rug out from under them next year. You are going to put the same million dollars back in there year after year after year. That is what has happened. Maybe you might have a better outcome if you had a look at what they were doing in the first place, worked out what they were not doing and put in the programs that maybe can help them achieve their goals rather than just defund them. I hope that answers your question.

**CHAIR**—You made the point about being focused. Whilst agreeing with the holistic nature of it being all-encompassing, you say this inquiry runs the risk of being too broad and missing the point. I take that as a fair comment. What would your advice be to us in that sense? Are we going too broad and might miss the point? You obviously have been successful in being very focused. Maybe we need to take something away from that. Can you just make a comment about the terms of reference?

**Mr Wilson**—Basically, like I said, we are focused. You do fund programs that have that focus to deal with what the community problem is. At this particular point in time the community problem is substance abuse and related issues. There need to be programs like ours. We are the only one in the country. Perhaps establishing them in some of the other states can coordinate the response and move ahead. At the moment most of those other community organisations that are out there do come into contact with ADAC because they see us and come to us for resources. We are not funded to help people all over the country but, at the end of the day, we will send them our own materials and try and respond to them. It would be good if I could go to New South Wales, for example, or any other state and be able to go to one body that has a handle on everything and can provide people such as yourself with a clearer picture, rather than having to run around and just get little snippets of it.

**CHAIR**—Scott, thank you very much and thank you for yesterday as well. Geoff, thank you very much. It is proposed that Bringing it all Together—ADAC's Policy and Strategic Framework, the letter to Mr Sutton from Dr Peter Carnley, and the summary of drug and alcohol patterns be received, taken as read and incorporated in the transcript of evidence. There being no objections, it is so ordered.

*The document read as follows—*

[2.56 p.m.]

**DUNN, Mr Dallas, Secretary, National Organisation for Foetal Alcohol Syndrome and Related Disorders**

**FLYNK, Mrs Lyn, Committee Member, National Organisation for Foetal Alcohol Syndrome and Related Disorders**

**HARRADINE, Mr Graham John, National Organisation for Foetal Alcohol Syndrome and Related Disorders**

**MIERS, Mrs Sue, Spokesperson, National Organisation for Foetal Alcohol Syndrome and Related Disorders**

**MIERS, Mr Tony, Chairperson, National Organisation for Foetal Alcohol Syndrome and Related Disorders**

**ZAGNI, Mrs Kerry, Member, National Organisation for Foetal Alcohol Syndrome and Related Disorders**

**CHAIR**—Thank you very much for being with us. No doubt someone would like to make an opening statement. I am required to point out that the committee does not swear in witnesses but the proceedings today are proceedings of parliament and warrant the same respect.

**Mrs Miers**—We are pleased to have the opportunity to address the committee today and we thank you for your invitation to do so. We believe that any inquiry into the social and economic costs of substance abuse cannot ignore the impact of foetal alcohol spectrum disorders, especially with regard to family relationships, crime, violence, law enforcement and health care costs.

Today we would like to highlight some of the major concerns that we identified in our submission and also share some personal stories with you that illustrate these concerns. NOFASARD believe that foetal alcohol spectrum disorders are far more common than most people in Australia are aware. Unfortunately, there is limited Australian data on the frequency of foetal alcohol syndrome. However, overseas studies that have been accepted by the World Health Organisation place the incidence rate for foetal alcohol syndrome at 1.9 for every 1,000 live births. These studies estimate that an additional seven to eight children may have significant long-term disabilities related to partial foetal alcohol syndrome.

Australia's population is just over 19 million, so for Australia I would like you to consider that these incident rate estimates could mean that approximately 174,000 individuals may be suffering significant long-term disabilities related to exposure to alcohol before birth, but this has not been recognised. Overseas studies demonstrate that in both human and economic terms the lack of recognition, diagnosis and appropriate intervention for foetal alcohol spectrum disorders has the potential for wide-ranging ramifications. Secondary disabilities associated with foetal alcohol syndrome include drug and alcohol abuse, early school dropout,

employment problems, offending issues and mental health problems. In fact, longitudinal studies show that 95 per cent of people with foetal alcohol spectrum disorders have mental health problems. This could be particularly significant with respect to dual diagnosis issues. I would like to read to you an article in the Foetal Alcohol New Zealand Trust newsletter that was written by a mental health therapist, Kenneth Dunning. He had this to say:

When we fail to recognise a child or adult with foetal alcohol spectrum disorders, then we set the client and ourselves up for weeks, months or years of one frustrating treatment failure after another. Standard treatment modalities for coexisting mental health diagnoses typically do not work with an individual with a foetal alcohol spectrum disorder.

Here the analogy of a personal computer is useful. It is like trying one software after another in an attempt to address a problem which is inextricably tied to an underlying hardware malfunction. Canada and the USA have developed diagnostic clinics, early intervention programs and specific resources and support groups to help parents and care givers raise affected children and adolescents. I would like to table some documents that highlight some of the Canadian government's recent initiatives for dealing with the impact of this disability. In the experience of those of us who are carers raising young people with foetal alcohol syndrome there are no such initiatives in place in Australia.

Where does that leave the 174,000 possibly affected but undiagnosed or misdiagnosed and therefore inappropriately managed individuals? It means these affected individuals are currently being denied access to the appropriate management and care that is provided to those with other more visible and familiar disabilities. This places tremendous pressure on their parents and care givers who are trying to raise them without appropriate interventions and support. There is an urgent need in Australia for improved diagnosis and access to health professionals who have had specific training and experience in managing the core disabilities associated with foetal alcohol spectrum disorders.

Our association is currently providing resources to teachers, care givers, health workers, social workers, psychologists, psychiatrists and students from all over Australia. We have also provided information about foetal alcohol syndrome to the Ministry of Justice in Western Australia and the Attorney-General's department in Adelaide. We are not funded so this has been at our own expense. This should not be our responsibility. Prevention is clearly the first line of defence against the effects of alcohol in pregnancy. Yet Australian educative literature about the effects of alcohol on the unborn child is nowhere near as informative as that available to women in other developed countries. Nor does it reflect current concern and debate relating to the effects of alcohol on the foetus.

This debate centres not on whether alcohol can harm the foetus but rather on what is the threshold dose at which harm begins to become increasingly likely. Researchers have been unable to establish a safe level or a safe time for alcohol intake during pregnancy. There is now an increasing number of studies emerging that demonstrate that even small amounts of alcohol may have a detrimental effect on the foetus. There are absolutely no health benefits of alcohol for the unborn child, only the potential for harm. With this uncertainty in mind, pregnant women in Canada, USA, New Zealand, Sweden, Ireland, Austria and Denmark are advised that it is safer not to drink alcohol if they could become pregnant, are pregnant or are breastfeeding.

In view of emerging research in this area it would seem prudent that, while scientific debate is continuing, guidelines that relate to alcohol use during pregnancy should err on the side of

prudence. Unfortunately, the newly released National Health and Medical Research Council draft Australian drinking guidelines and the draft national alcohol action plan fail to reflect this caution. We would also like to table our response to these documents. When I tabled that first lot there is a brochure there that should not have gone with it, but you will hear about that now.

We would also like to table an alcohol and pregnancy brochure, which you have already got, designed by our organisation to give pregnant women what we consider to be accurate, realistic information about the effects of alcohol on the unborn child. Pamphlets such as this are commonplace in Canada, USA and New Zealand. Yet we are unaware of any similar documents currently being disseminated in Australia. This is just a black and white photocopy of the master and we are currently seeking funding for printing and postage so that we can disseminate this brochure, initially to health clinics in South Australia and eventually nationally. Pregnant women have the right to information that will enable them to make informed choice about alcohol use in pregnancy.

In our submission we also highlighted the vulnerability of some Aboriginal communities to the impact of foetal alcohol spectrum disorders. Although in absolute terms the number of people with these disorders would be far higher in non-Aboriginal communities, in relative terms there could be a far higher incidence rate in some indigenous communities. NOFASARD has received anecdotal evidence that supports this possibility, and this has also been the experience in indigenous communities in North America and New Zealand. We are particularly concerned that the impact of foetal alcohol spectrum disorders may be a root cause of the poor literacy and numeracy skills and high incarceration rates recorded in some Aboriginal communities.

I have permission to share the following emails with you. These extracts represent the views of health workers from two remote Aboriginal communities in Australia. The first email is from a health worker from a remote community in Queensland. The sender has asked not to be identified. They write:

Dear Sue

Good news that you have the opportunity to address the House of Reps. I am convinced that the issue needs attention. I am still searching for good resources in Australia re the effects of alcohol. It is such a difficult situation. Until people have the facts about the effects of alcohol, they cannot make sound, informed decisions. Some leaders in the community still believe alcohol is okay. You have to remember that the councils in remote communities receive a lot of funding from canteen pub sales. For instance, in our community a carton of beer sells for over $50, double the retail price of liquor outlets in the city. The money raised goes to support various council run programs like the women's shelter, the youth centre, et cetera. The council gets very protective about beer sales. It is a money making exercise. So the problem lies in how to turn things around.

I am afraid that revealing the community where I work would make things very difficult. It takes a lot time to develop trust. Without trust, there is no chance of getting the message across that alcohol is destroying lives. At this stage, people are still very protective about their right to drink alcohol when they like. We need to remember that until the 60s Aboriginal people were denied the rights we enjoyed.

I am also concerned about how to address the problem of pregnant ladies drinking. Education is the key. My concern is that women need support and encouragement to stop drinking. That is why so far I have just been teaching the pregnant ladies about the effects of alcohol. If they do not stop, I notify an elder who can talk with her. A full community education program would be great, but my fear is the end result for the alcoholic pregnant lady. Violence is such a problem. The last thing I want is ladies being beaten because of the alcohol problem. There is a huge need for more resources to address the problem. Alcohol is the biggest problem here. I am telling all the young pregnant mums that alcohol has permanent effects on the baby's brain. But I am afraid that I believe a lot of this generation of young mothers are suffering the effects of foetal alcohol syndrome themselves. They are also self-declared alcoholics, so it is extremely

frustrating. This year I hope to gain more community support to address the issue. I have already talked to the women's group and some of the women elders about my concern. There is no way I can stop the women drinking. I can just inform them and support them. I will start writing letters to the government and to the beer organisations to try and prod them to start investing in our future. Wouldn't it be great to see a warning on all beer cans and in liquor outlets.

The second email is from Lisa Balmer—she is happy for me to use her name—a health worker employed by the Pitjantjatjara Women's Council in Central Australia.

Dear Sue

I am just writing to let you know that we have finally managed to get our first three children officially diagnosed with foetal alcohol syndrome. Whilst it is sad, it is also a great tool for us to now have official confirmation that will help lobby for more resources. These three children take up most of our time these days and as they get older the problems get worse. I am sure you know all about this. I would be happy for you to use this example of the importance of diagnosis wherever you like. In fact, I will highlight the importance even further for you. These three children are siblings of the same mother, different fathers. They live at a remote community on the Pitjantjatjara lands of South Australia. Their mother was known to drink heavily throughout her pregnancies and is still a chronic alcoholic. The children are 13, 11 and 9. The oldest is a boy, who is the most severely affected. The other two are girls.

In May this year I received a referral about their health and wellbeing. Their primary carer is their maternal grandmother, who is now hospitalised with end stage renal disease. They were not going to school at their local community school as the school did not have the skills, nor resources to deal with their behaviour problems and learning needs, which inevitably would cause them to be disruptive and then removed from the classroom. The two girls were coping a little better at school and the youngest is quite bright. I made a referral to Family and Youth Services which resulted in very little. On further investigation, I found out that the boy was first referred to them 10 years earlier without any intervention. All three came to Alice Springs, residing at St Mary's—the girls at the education accommodation and the boy at the behaviour management centre. The girls lasted a term and a half until the situation fell apart and they were asked to leave. The two girls are back at their community without any proper guardianship, food or shelter. The older girl was reportedly sexually assaulted last week, which was something I had feared for awhile. I could see the signs, but nobody would listen. Family and Youth Services will not intervene as they say there is not enough evidence.

The boy was doing well at Forrest House, the behaviour management house. He was going to school half days with the assistance of a support worker, and Forrest House was working on a strategy to manage his behaviour problems. He was also learning some life skills that would enable him to return to his community as a young man with appropriate skills. However, after an initial eight weeks at Forrest House, St Mary's said that his needs were too high and that they would require an extra $1,200 a week to employ an additional worker for him. Here is the problem: who pays this kind of money for a boy who is, as far as the department is concerned, simply neglected? However, having received the diagnosis this week, we now have an argument for a whole range of interventions; that is, disability services, education department, family and youth services. Had we been able to get a diagnosis earlier, he may still be at Forrest House receiving the education, shelter, food and life skills that he will need to cope as a young man in his community.

In terms of offering generic services to children with foetal alcohol syndrome, I think this young lad's case highlights why this is not sufficient. Firstly, there are very few services at all in the remote communities, let alone special services. The only generic services available to these three children were generic services in Alice Springs that could not deal with them either, as they were not sufficiently resourced to deal with the special needs of these children. Generic services may be appropriate at times for people in major towns or cities where there are services and you have choices in these services. However, this argument is weak when talking about services to remote communities. Of course, the best case scenario would be that these children could be cared for in their own communities, but can you imagine how much that would cost per child, per community? A diagnosis is the only means to access any services at all for these children. I think it is important to tell this story.

I would like to add the following comments in relation to these two emails. I believe that the examples in these two emails are just the very tip of a huge iceberg. The responsibility for the failure to provide an early diagnosis for the three alcohol affected children and provide them with appropriate services does not lie solely with the Aboriginal community. It lies with the broader community and mainstream agencies. The drinking history of the mother of the children in Alice Springs would have been evident and should have alerted the professionals involved to the extremely high possibility that her children may be affected by exposure to alcohol before birth. The unique and very special needs of these children should have been recognised at birth, and support and services should have been provided to the community concerned to manage

these children appropriately. This would have been the case had they been born with a disability such as Down syndrome or spina bifida.

There should have been an understanding that special services would be required for these children for the rest of their lives. With diagnosis should have come the understanding that the children would be extremely vulnerable to sexual exploitation and a management plan implemented to try and prevent this from occurring. If specialist interventions had been in place for these children from the time they were born, I have no doubt that their outcomes would have been very different—and they are just the first three children to be diagnosed in this community. That particular community has been asking for help and diagnosis for a long, long time.

It is unfortunate that our health policy has failed in the past, and still now fails, to acknowledge the extent of foetal alcohol spectrum disorders and fails to address, at any level, issues pertaining to this disability. Aboriginal communities cannot deal with the impact of these disorders without adequate understanding and system support in the broader community. To expect them to do so is analogous to expecting them to deal with diabetes without an understanding of, or system support for, diabetes in the broader community. Brendan McCreight, a therapist in the USA who has worked with alcohol affected children for many years has this to say:

> The characteristics of foetal alcohol syndrome lasts throughout life and create complications in the lives of people who have the condition and in the lives of those who live or work with an affected person. People who have foetal alcohol syndrome can only manage the condition. Any changing to be done must be carried out by those who do not have the condition. The changing must be done by the parents, by the educators, by the health professionals, by those who make policy, by those who are friends and neighbours of alcohol affected persons.

Most children with foetal alcohol syndrome and foetal alcohol effects face more stress, more obstacles, more loneliness, more failure and less success in a single day than most non-affected people face in a far longer time. These children are not exceptional because they have the condition. They become exceptional through trying to survive despite all odds.

The tragedy lies in the reality that they are denied their basic human rights to have an appropriate education, to be raised in a supportive environment and to grow up to be adults who participate in life in a productive and satisfying manner. We urge your committee to consider and act upon the recommendations that are contained in our submission. The provision of high quality information to health professionals is fundamental if accurate diagnosis is to occur and appropriate and effective help provided at all levels. There is an urgent need for health professionals, community organisations and government to work together to try to prevent foetal alcohol syndrome and to provide appropriate services for diagnosis and management of those individuals already affected so that their life outcomes can be improved. Thank you.

**CHAIR**—You mentioned that any national guidelines that do not advocate complete abstinence from alcohol by women who may become pregnant or during pregnancy and breast feeding are totally irresponsible. Therefore, I understand that you would regard the NHMRC guidelines as irresponsible in what they say?

**Mrs Miers**—Yes.

**CHAIR**—And in the submission you recommend that the federal government legislate for the labelling of alcoholic beverages to warn about the dangers of alcohol to unborn children?

**Mrs Miers**—Yes.

**CHAIR**—You may have heard the Wine Federation this morning—did you?

**Mrs Miers**—Yes.

**CHAIR**—What would you suggest about the labelling? You would have a clear-cut direction, would you? Not just as a health hazard?

**Mrs Miers**—It would be very simple: drinking alcohol may affect the health and wellbeing of the unborn child.

**Ms ELLIS**—Are you aware of the medical profession, the AMA or anybody else for that matter supporting that notion?

**Mrs Miers**—I have not heard. I have written to the AMA but I have not had any answer from them.

**Ms ELLIS**—I am not saying it is not a good idea—

**Mrs Miers**—No.

**Ms ELLIS**—I just ask to what degree the medical profession would stand behind that with you. It took a long time, after similar approaches, for the smoking warnings to finally be, thank heavens, adopted, so I just wonder what the medical profession's viewpoint would be on that.

**Mrs Miers**—I have not heard from them. I have written but I have not had a reply.

**Ms ELLIS**—Could I suggest that we, as a committee, seek the views of the College of Paediatrics or the AMA on the position?

**CHAIR**—Yes. Are there any further questions?

**Mr ANDREWS**—Why do you believe that the NHMRC are possibly going to water down their guidelines?

**Mrs Miers**—Could you repeat that, please?

**Mr ANDREWS**—You expressed concern about the NHMRC; the submission says:

They have also been alerted to rumours that the current guidelines of abstinence during pregnancy may in fact be altered in the new guidelines that are currently due for release.'

**Mrs Miers**—Yes. The new guidelines are now out.

**Mr ANDREWS**—They are out?

**Mrs Miers**—Yes. The old guidelines said very directly that there was no safe known level so women should abstain from alcohol during pregnancy. The revised guidelines—I have not got them in front of me—do not say women should abstain. They say women may choose not to drink alcohol. But I went into their guidelines and they do not clarify, I do not believe, a lot of the statements they make in their guidelines.

**Mr ANDREWS**—Did you make submissions to them?

**Mrs Miers**—I have made a submission and you should have a copy of it there. It goes clause by clause into why I am unhappy with what they have said.

**Mr ANDREWS**—Has the council responded?

**Mrs Miers**—Just with a general letter that they send to everybody saying that they will take them into consideration.

**Mr ANDREWS**—Thank you.

**Mr Miers**—The guidelines infer that drinking one glass of wine a day is an acceptable level of consumption.

**Mrs Miers**—Yes, if they are going to drink no more than one glass on any one day.

**Mr Miers**—And I guess the overseas research is showing that the blood alcohol content of a foetus is exactly the same as that of the mother, so by inference you are saying that the developing foetus can consume that amount of alcohol, and yet you would not dare give that amount of alcohol to a child that had just been born.

**Mrs Miers**—Alcohol is a teratogen and studies of teratogens have established that alcohol is a neuro-behavioural teratogen. They are a special group of teratogens that cause brain damage and modify behaviour. Because it takes larger doses of neuro-behavioural teratogens to produce physical malformations than it does to cause central nervous system damage, the neuro-behavioural effects of teratogenic agents, such as alcohol, can be observed at levels of exposure that produce no physical abnormalities. I think this is where the problem is. We are talking about a hidden disability. At the moment, I think our doctors may recognise foetal alcohol syndrome because you can see that. It is evident in the face like it is evident that you can diagnose someone with Down syndrome. But the damage to the brain is not evident. It is hidden.

Just briefly, this is how alcohol causes damage. It disrupts and impedes foetal development in several ways. It has a direct toxic effect on the cells and can produce cell death, thereby causing certain areas of the brain to contain fewer cells than normal. Alcohol can also impede the transport of amino acids, which are the important building blocks of protein and glucose, the main energy source of cells. Alcohol can also impair the placental foetal blood flow causing oxygen depravation or derange the hormonal and chemical regulatory systems that control the maturation and migration of nerve cells in the brain.

Moderate alcohol and episodic exposure also produced deleterious effects on the offspring, as do exposure both early and late in pregnancy. Brain damage can occur without accompanying physical manifestation and from lower doses and frequency of exposure. That is another reason why we are concerned.

**Ms JULIE BISHOP**—I note that in your submission you state that researchers still have not determined a safe level of alcohol consumption.

**Mrs Miers**—No.

**Ms JULIE BISHOP**—I appreciate your position that no level of alcohol consumption should be considered, but the difficulty with the research seems to be that we are not able to get a definitive statement that there is no safe level of alcohol consumption during pregnancy.

**Mrs Miers**—All the research they are doing has not been able to find a level that is safe. They are saying that, while they cannot find a level that is safe, the only prudent advice should be to suggest no alcohol at all. I suppose you could liken it to X-rays in pregnancy. They think that only very small radiation doses in pregnancy might be okay but, because they are not sure, doctors have no qualms in saying to pregnant women, 'We don't know, so we suggest you do not have X-rays during pregnancy.'

**Ms JULIE BISHOP**—There is a conflicting message coming out then, isn't there, that a small amount of alcohol can be good for you? There are benefits from consuming a modest amount.

**Mrs Miers**—And I would like that clarified every time with the words 'except for pregnant women'. That is where I think the problem is. I do not mind them saying that alcohol may have beneficial effects, but not for pregnant women and the unborn child. I am upset with the NHMRC guidelines because they do not clarify that each time they make that statement.

**Mr LAWLER**—You spoke about the concentration of alcohol in the mother's circulation being the same that goes to the foetus finally. There would also be concentration in breast milk immediately after birth. Do you have any recommendations one way or the other about consuming alcohol if you are breastfeeding?

**Mrs Miers**—I have not done a lot of research on alcohol and breastfeeding. I have read that they know that, if mothers drink while breastfeeding, alcohol goes into the breast milk. I do not know much more than that.

**Mr LAWLER**—Given your argument for banning it in pregnancy, wouldn't exactly the same argument follow?

**Mrs Miers**—It is for breastfeeding, too.

**Mr LAWLER**—But you do not pursue that?

**Mrs Miers**—Yes, I say breastfeeding as well. If women may become pregnant, are pregnant or are breastfeeding, they should understand that there could be an effect on their baby.

**Mr LAWLER**—I was astounded by the groups you list that are the highest risk. I know these are US figures, but it appears that the lowest likely group in the US are uneducated, young, non professional women who do not smoke.

**Mrs Miers**—If you are looking at the overall numbers, there are fewer numbers there.

**Mr LAWLER**—It is completely the opposite of the group that you are telling me.

**Mrs Miers**—But, if you also look at the American research, they say there are some very high risk groups in the indigenous communities. That is when you look at relative and absolute terms.

**Mr LAWLER**—I was not criticising you, it was just quite interesting. When I read it I though I must have misunderstood.

**Mrs Miers**—It is the difference between relative and absolute. It is the difference in the overall numbers of people who are likely in a population. You are far more likely to have people in the higher socioeconomic groups drinking alcohol during pregnancy if you are looking at overall figures. But, if you are looking at individual communities, the rates in Aboriginal communities are higher; they are considered at much higher risk.

**Mr Harradine**—I am an Aboriginal person and I work with ADAC for the Making Trax program that the lady referred to earlier, so I get out to the coalface. Some of the symptoms or revealing signs are prenatal and postnatal growth deficiencies, mental retardation, developmental delays, hyperactivity, attention deficit disorder and neurological dysfunctions, which include seizures. If you go to any hospital in the country, you can find that Aboriginal children suffer from all those things at some stage in their life. If you go to other communities there are other signs, such as some of the facial features. I first became aware of foetal alcohol syndrome through a program in the prison that I did with ADAC.

I was a 20-year criminal and a 12-year drug addict. I have reformed myself and I want to try and do something to stop children from going through the same or similar situations that I did. A lot of Aboriginal people that I met in jail are suffering from foetal alcohol syndrome because it has not been addressed in this country. Some of them have got the facial features of foetal alcohol sufferers. They are going to be continually on the wagon wheel that takes then back to prison until they die. A lot of people who should have grown up to be my age are gone. Sixteen of the 17 kids that I grew up with are dead. A lot of their parents are drunk. I am not saying it is related to foetal alcohol syndrome or effects because I do not know that, and no-one will know that until we have some sort of study in this country to address this issue. We have got a big rage on now about the stolen generation and people are talking about the stolen generation. What are we going to call the generation that goes this time—the FAS generation?

**Mr QUICK**—What are the paediatricians saying?

**Mr Harradine**—Yes, what are the paediatricians saying?

**Mr QUICK**—You have 24 years of research here, pages and pages and pages, but it is all coming from America. Do the paediatricians agree with you? Why does this suddenly jump out of the ground from South Australia? Why are you putting out brochures like this with no contact? If I was a father with a pregnant wife it would scare the bejesus out of me. Apart from scaring people, what other constructive things do you envisage by putting this out, rather than just saying, 'This brochure is produced by a national organisation emanating from South Australia'?

**Mrs Miers**—That is because we are the only organisation in the whole of Australia. There are no other support groups for foetal alcohol syndrome.

**Mr QUICK**—Why?

**Mrs Miers**—I would like everybody here to answer that question. I think that is a really good question. Why have we not got in Australia anything to support or help people bringing up these children? Why has it been ignored? Why are we in denial that we do not have these rates?

**Mr QUICK**—Why did it take the Canadians so long—they have just announced it now—if the Americans discovered it in 1976?

**Mrs Miers**—The Canadians are a long way down the track. If you read through the stuff I sent you about what they are doing, they are a long way down the track.

**Mr QUICK**—Yes, I know they are a long way down the track compared to us, but basically most of this research here on pages 10, 11 and 12 emanates from 1976, 1977, 1978 and so on. Yet, 20 years later, the Canadians suddenly discover what the Americans have known for years and then suddenly you jump out of the ground and reproduce a brochure.

**Mrs Miers**—The reason is I have a child with foetal alcohol syndrome, and I had to go to Canada to get help because nobody here was able to give me the resources and help I needed as a parent. I think that is a pretty appalling state of affairs.

**Mr QUICK**—I can understand that, but to say on the first page of your submission that there may be 174,000 affected individuals—

**Mrs Miers**—Yes.

**Mr QUICK**—That is scary stuff.

**Mrs Miers**—It is.

**Mr QUICK**—It may be that there is, there will be, there could be.

**Mrs Miers**—I think that is very scary stuff.

**Mr QUICK**—How do you base that on someone conservatively estimating that it is 9.1 of every 1,000 live births?

**Mrs Miers**—That is based on studies in countries where they have done studies on foetal alcohol syndrome.

**Mr QUICK**—Which countries are they?

**Mrs Miers**—The studies that went into those particular figures were done in France and America and they have been accepted by the World Health Organisation. The incident rate that I have based that on is accepted by the World Health Organisation as the incident rate in developed countries for foetal alcohol syndrome.

**Mr QUICK**—Back to my original question: what are paediatricians and obstetricians saying? Do they agree with you?

**Mrs Miers**—In South Australia the paediatricians, because I have been lobbying extensively, are doing something there. I do not know about the other states. I started lobbying extensively when I came back from Canada because I realised it was an area that is just not being addressed.

**Ms ELLIS**—I have already suggested to the committee secretariat that we as a committee should approach the College of Paediatricians and the AMA and maybe do a bit of research ourselves as well. Very quickly, I want to divert the discussion just a bit. Mrs Lyn Flynk is sitting here. I think you introduced Lyn as a carer of children.

**Mrs Miers**—Yes, and she has something she would like to say.

**Ms ELLIS**—We are sitting here academically and politically discussing these people. I would like someone—and I am asking you, Lyn—to tell us about the kids you care for. I think I can imagine what we are talking about, but can you briefly share with us some experience? Just tell us who these children are and what they are suffering from. What is their day-to-day life like? I am sorry: if this is a difficult question, do not answer it, but I do not know what you mean when you say 'cranio-facial features of an FAS child'. I have no idea what that means. I would like to bring the kids into the picture here.

**Mrs Flynk**—I have written a couple of pages.

**Ms ELLIS**—Would you like to submit those to us?

**Mrs Flynk**—It has a few alterations.

**Ms ELLIS**—That does not matter.

**Mrs Flynk**—Basically, I have been a foster parent for a very long time. About 10 years ago, I started helping children outside the system on a voluntary basis. I have now become an auntie or grandmother to quite a few children. Two of them have been diagnosed with foetal alcohol effect and two with foetal alcohol syndrome. The ones with the syndrome actually have facial features. They have got a tiny head, slightly different eyes, very thin upper lip, there is something to do with their toes and fingernails, a very small stature and they have intellectual disabilities and hyperactivity. The main problems are that they do not have much sense, they do

not have much reasoning, they are very hyper, they have no sense of consequences, they have no sense of danger—which is really fantastic when you have got a toddler that is escaping all the time and going out on the road. They go out on the road and they do not stop and look for cars.

**Ms ELLIS**—Without wishing to flippantly try and categorise it, they sound very similar to symptoms you would see in a range of other children with an intellectual disability of one sort or another.

**Mrs Flynk**—Yes. We struggled and struggled with a lot of the problems—Dallas has actually worked with my children—through intellectual disabled services because nobody knew much about foetal alcohol. It was not until I read a book by Michael Dorris, *The Broken Cord*, that I suddenly read a story about my children. That is a story about an American Indian child, and the story is just so familiar. It is just like, 'Hey, that's the story about my kids.' The frustration of living with these kids is just terrific, trying to cope with the schools, trying to cope with all the different services, because my kids appear to be relatively normal to look at them and it is not until you are actually living with them that you see where the deficiencies are. One boy has returned home, he has been home 10 months, and he is now into drugs. He is roaming the streets and nobody can control him.

**Ms ELLIS**—How old is he?

**Mrs Flynk**—He is 13 years of age. His 11-year-old sister is going to be sexually active very soon and I am trying to help get services in now for some form of birth control, but because she is only 11 years old I am going to have trouble. She cannot understand the consequences of sexuality. You can tell her, but she just does not understand it. My best illustration is that you can stand at the backdoor and say, 'Don't do that when you go out in the backyard.' They will go out and do it. You bring them back and say, 'What did I say?' They repeat it, but they will go back out and do it because they just do not understand the connection between what they have just said and what they are doing.

**Ms ELLIS**—Would you be prepared to leave those two sheets with us? Don't worry about the alterations. We do that ourselves. We can make sure that we have a copy of it to read at our leisure.

**Mrs Flynk**—Yes.

**Ms ELLIS**—Thank you.

**Mrs Flynk**—I am in trouble because I am outside the system. My children are not foster children, even though it is a similar situation. The parents asked me to look after their children. So I am outside of the system, but I use a lot of systems. It is really hard because, even though people say, 'Other kids are like this, ADD kids are like this,' there is a difference. I have had lots and lots of foster kids with lots and lots of problems, and nothing prepared me for these kids when I got them. It is just so totally different.

**CHAIR**—We really are out of time. Harry and Julia want to ask a question, so just two quick questions and quite quick responses, then I will just make a statement and we will wind it up.

**Mrs IRWIN**—I notice that Mrs Flynk referred to Dallas. Dallas, are you a counsellor—do you counsel these children?

**Mr Dunn**—I am a development educator with Minda. I work with people with intellectual disabilities. I worked with Bart, Lyn's 13-year-old who was sent back home. I worked with him for about a year on appropriate social behaviour and protective behaviours, but in the end that was the reason he went back home, he was a danger to the younger girls at home.

**Mrs IRWIN**—I know that we have not got much time. I am just wondering if Dallas Dunn has got anything that he might want to table for the record, and Graham Harradine as well.

**CHAIR**—That was what I was going to say at the end.

**Mr QUICK**—You raised the link between ADHD and FAS. Is there any research to say they are one and the same?

**Mrs Flynk**—A lot of people are diagnosed with hyperactivity, but there is a difference. My own daughter is a hyperactive child and I did not take drugs or alcohol or anything when I was pregnant. But it is quite different with these kids. A lot of their hyperactivity is actually being social hyperactive. If I brought them in here, they would be totally off the planet because it is outside their normal range of activity. When they have got into a set routine of getting up, going to school, going home, doing their activities and going to bed, they are fairly calm. You take them down to the shopping centre and they have stimulus overload and all of a sudden they are off the planet.

**Mr QUICK**—I used to be a teacher and I know all about ADHD. Sue, what is your version, do you think there is a link?

**Mrs Miers**—People with FAS have ADHD but a lot of people with ADHD do not have FAS. There are differences. I do think that, because in Australia we do not have very many children identified as having foetal alcohol syndrome, a lot of them could be diagnosed with ADHD that are not ADHD but foetal alcohol syndrome. You will never ever deal with the ADHD if you are not recognising the underlying root cause of their problems because there are very different interventions needed. There is an understanding there that means you are setting them up for failure.

**CHAIR**—Thank you very much for bringing this to us today. As was indicated earlier I invite anyone at the table to bring forward any other papers before we conclude. As the Deputy Chair has indicated, we will take it up with paediatricians and the AMA and get their considered opinion as well.

Is it the wish of the committee that Alcohol and pregnancy; Children with foetal alcohol syndrome, the NOFASARD submission on the National Health and Medical Research Council Australian drinking guidelines, a letter to Leanne Wells of the Department of Health and Aged Care and papers from Mr Graham Harradine be incorporated in the transcript of evidence? There being no objection, it is so ordered.

*The documents read as follows—*

[3.49 p.m.]

**KEMP, Mrs Robyn, Representative, Toughlove South Australia Inc.**

**STEPHENS, Mrs Mary Kathleen, Secretary, Toughlove South Australia Inc.**

**VANALOPULOS, Mrs Janine Dawn, Deputy Chairperson, Toughlove South Australia Inc.**

**CHAIR**—I welcome representatives from Toughlove SA. I need to point out that, while the committee does not swear in witnesses, the proceedings today are legal proceedings of the parliament and warrant the same respect as the parliament.

**Mrs Stephens**—Thank you for inviting Toughlove South Australia to speak today on drugs and how we are handling them. Janine Vanalopulos, Robyn Kemp and I are Toughlove representatives and members of our South Australian management committee. Toughlove has been in South Australia for seven years and was introduced by Relationships Australia. When they ran out of funding, a parent steering committee was formed. We are parents, incorporated with a management committee. We are all volunteers and we get our funding from the sale of resources and grants. We fund an office worker for one day per week. We are not funded from government or private enterprise as it is not a popular cause.

Toughlove is a support group for parents of out of control adolescents with behavioural problems. These parents often come to us as a last resort. They are in crisis and there does not seem to be any help for them to deal with their child who is continually getting into trouble with the law, school et cetera. These kids are playing all the shots. They think they have the power and all the rights in their own homes and the parents have lost control. Society supports the child by blaming the parents. Parents feel helpless and useless and when they go to the support agencies they find there is no support for them or their teenager. At the Drug and Alcohol Services they are told they have normal teenagers and that it is normal for them to experiment with drugs, and there are other agencies who are saying similar things.

Our database has produced statistics that show that a good number of the families we meet are experiencing drug problems, ranging from marijuana to heroin. Our latest annual general meeting report is submitted for your information. As you will see from this report, heroin use has increased in males by almost 150 per cent over the last 12 months of our records. Cannabis use represented 44 per cent of children's drug abuse reported by parents. Ten per cent reported alcohol and cannabis, an increase of seven per cent on last year. Seven per cent reported cannabis and amphetamine use. The majority of these children using drugs fall between the ages of 14 and 22 in males and from 12 to 18 in females.

A lot of children, including my own child, began experimenting with drugs at a very early age. It is usually marijuana first. We parents are usually the last to know. It is not until our child's behaviour changes and these troubles at home are escalating that we find that there is a problem with drugs. Families often deny that their child is experimenting with drugs at all, finding other things to blame. They hear stories from other parents in our groups with similar

situations and similar behaviours, and they then realise that there really is a problem. Part of the Toughlove solution is to educate parents about drug abuse. As shown in our statistics last year, nine per cent of parents could not state whether their child was using drugs. This was a decrease on the previous year of 17 per cent which could indicate that the population is educating itself about drugs out of necessity. The drugs issue is now talked about more openly.

**Mrs Kemp**—Most of the adolescents that we deal with are still developing. In fact, their brains are not fully developed or mature until they are 26 years of age. The effects of cannabis on their brains brings out very distressing behaviours that families and the community have to deal with. There is a wide range of behaviours—such as aggression, violent outbursts, domestic violence, stealing, visits from the police to the home, payment of fines, appearances in court, failing school grades, suspension, expulsion, dropping out, changes in friends and changes in appearance—that threaten the previous normal life.

The parents who ring our 1300 number—we have a parents self-help line that these statistics are taken from—report the following domestic violence incidents. Twenty-six per cent are being verbally harassed at home by their child; 12 per cent report verbal and physical harassment by their child; 13 per cent report verbal, physical and emotional harassment; 10 per cent report property damage to the family home and stealing from the home. Twenty per cent of parents prefer not to state what is happening in their home, which indicates to us that they are in grief. They are in denial and they are feeling guilty and ashamed, and therefore stressed, because of the violence they are experiencing.

While statistics show that 29 per cent of our children are having problems with school and home, there is a further 16 per cent that have problems with home, school and the police. This is at a cost to the community with police resources and education resources. It is also a cost to the child and to the parents. Those kids have lost life chances, lost career prospects and lost motivation through their abuse of cannabis. They can drop out of the school system by age 15. They then become a burden on the community through their dependence on social security or worse—committing crimes of breaking and entering, stealing and shoplifting to support their habit. This is also a big health cost. One report from overseas that we recently looked at showed that people who have been using cannabis for a long time suffer horrific throat and lung cancers. They cannot hold down jobs because of their addiction and cannot be a valuable member of the community. Further reports show that paranoid schizophrenia tendencies jump from one in 10 in a normal population to one in three of those using cannabis on a regular basis.

We photocopied an article, and I submit that now for you, from the *Advertiser*, dated 25 October 2000. In that article, our police commissioner actually noted the number of aggravated serious criminal trespassers in the Adelaide metropolitan area, from 1 April to 16 October this year. During this six-month period, there have been 14 reported home invasions for dope, for marijuana—with two people being killed and one person being left with brain damage. I would say that this is the tip of the iceberg. These are only reported aggravated violence incidents. How many of these go unreported because people do not want to be in trouble with the police for having more than three plants in the state?

Our children believe that it is okay to smoke cannabis as their friends and a lot of adults do. The so-called drug pushers target our kids to pass on or to sell marijuana throughout the schools and the streets, making juvenile criminals out of them. In return, they get compensated with

their own supply of the drug. The kids believe it is okay to use, as cannabis is decriminalised in South Australia and therefore it must be okay. It is very accessible to them. Until parents come to Toughlove, they do not understand the difference between legalised and decriminalised. Unfortunately, driving under the influence of marijuana, as far as I know, cannot be detected by any easy test at this stage. With the rising road toll, it is time that more research was done into this area also.

Research is important but it is a costly process, and therefore government assistance is sought by our organisation to keep the communication lines open so that more investigations can be carried out in regard to marijuana and other drugs. Toughlove has a petition at the moment that asks the government to fund proper research into cannabis—to test for hydroponically grown and the more potent hybrids, such as skunk, to determine the THC, Tetrahydrocannabinoloids. This main active ingredient in marijuana is contained in the bud which is most often smoked by kids, and by parents too—the most commonly smoked part of the plant. Within this petition, we ask that research be done within the psychiatric hospital wards of Australia where a young person is admitted with psychosis, that every attempt be made to assess the extent of their marijuana use and that the link between marijuana, depression and suicide be examined. We believe this link is there. We just need to have the research to find it.

The other thing that we would like researched is the link between marijuana and subsequent heroin use. The results of the research should be made widely known and policies regarding early intervention and prevention should be re-examined in light of these findings. We believe that cannabis is a gateway drug. We believe the only way to solve the problem is through zero tolerance, through drug education at an early age—and we are talking about primary school—of our community and our children, and by providing adequate resources to rehabilitate those who are addicted because people are addicted to dope.

**Mrs Vanalopulos**—Thanks to Toughlove a lot of parents throughout Australia and the world have been able to help change themselves and learn to cope by putting new strategies into place, thereby not tolerating the outlandish behaviours of their children as they come down from their highs. This is not easy and it is not a quick-fix situation but, with the support of other members of our group, we find they can learn new ways to deal with their problems, which ultimately teaches our children to become more responsible members of our society. Through the Toughlove philosophy parents realise that they can control only what is happening within their own homes by empowering their children to make choices and take the consequences of their actions. Unfortunately, some of our children do not follow our house rules and end up on the streets through their own choice, and this is also a cost to the community and to the family.

We have a Child Protection Act which is supposed to keep our kids safe until age 18, but this is not being enforced when we have children as young as 14 and 15 being used as prostitutes to procure drugs for themselves and for the people controlling them—often older men. We also have a Young Offenders Act in this state which allows children to have up to 70 to 80 charges against their name and to break two to three good behaviour bonds without meaningful consequences to deter their actions when they begin. Why do we have these acts in place when they are not enforced? We need to save the next generation from drugs and at least give them the correct information about the effects of drugs on their bodies and lives so they will at least make an informed choice one way or the other. We trust you will listen to the Toughlove parents

of Australia, on behalf of whom we speak, and we appreciate having this opportunity to put forward our case. Thank you.

**CHAIR**—Thank you very much. You focused a lot of attention, obviously, on marijuana, and you clearly believe there is practical and other medical evidence that supports that. You talked about zero tolerance—there are a number of things, because a lot of this, as you would understand, is state, not federal, law.

**Mrs Kemp**—But it is the World Health Organisation that states that cannabis should not be available to children or to adults, isn't it? As far as I understand it, our state actually contravenes the United Nations stand.

**CHAIR**—Thank you. I can remember that 30 years ago it was seen to be fashionable to encourage the use of marijuana; it was quite acceptable and there were no obvious side effects. Over what period of time have you observed this effect on people? What age are the people you are observing the effect of cannabis on?

**Mrs Kemp**—The children in Toughlove that we are dealing with are from six to 36. As to the period of time you are talking about, I have been involved in it in Toughlove over the last five years. The THC content of marijuana in the sixties and the seventies was only about three per cent. We are now looking at a THC content in some of the varieties that are hydroponically grown in South Australia—for example, skunk—of up to 38 to 40 per cent THC. I do not know whether you know about THC but it is fat soluble, and that sits around the brain, in the fat and in the reproductive system. On Sunday we heard about research by Dr Anderson which shows that it can actually be passed on to the unborn child. You have been talking about foetal alcohol syndrome today; in 10 years we are going to be talking about cannabis syndrome, because he is saying that THC can affect the unborn child and bring out the receptor that brings out ADHD. I am not saying that I can support his research, because I have never seen any papers of his or anything else, but I am just reporting to you what was told to us at a meeting on Sunday.

**CHAIR**—What do you believe the community perception is now of marijuana and the use of marijuana?

**Mrs Kemp**—That it is a soft drug, that it is not dangerous and that, as you said, 30 years ago it was quite acceptable. Thirty years ago a lot of people were not smoking the hybrids that we have today. They were not hydroponically grown; they were not as intense.

**CHAIR**—I would have thought that your organisation would have a number of people who would have a different view. I would have thought that the community might be changing its view and that those people would be challenging that view now.

**Mrs Kemp**—There are now, but we have been educating the parents in South Australia for the last three years. We hold meetings regularly every two or three months and bring down experts to speak about marijuana to our parents and the general community.

**CHAIR**—Do you believe there is greater wariness or are you saying there is a greater acceptance of marijuana in the community?

**Mrs Kemp**—There is an acceptance in South Australia because people think it is decriminalised, it is okay.

**Mrs Vanalopulos**—And it is a soft drug.

**CHAIR**—But you people do not think so.

**Mrs Kemp**—No, we do not, because we have seen the effects of it in our own home.

**Mrs Vanalopulos**—In our children.

**Mrs Kemp**—We have seen the effects of it in our community.

**Mrs IRWIN**—You mission statement stated that Toughlove actually started in America. How did it start in Australia? How did you find out about it?

**Mrs Kemp**—It was started 20 years ago in the States by David and Phyllis York. They were family counsellors who had a drug problem with their own family. They found that all the stuff that they had learned in university was not helping in their own family situation. Their friends stepped in and formed a support group for them and would not let them talk to their daughter or rescue her anymore. From that Toughlove started. It came to South Australia seven years ago with Relationships Australia. They received a bucket of money from the federal or state government; I am not sure where. They sent someone to America to be trained. They came back and started the first few Toughlove groups in South Australia. After that money ran out, it was handed back over to the parents in a steering committee. The steering committee got the constitution and the mission statement up. We then formed a management committee and we have been going ever since with volunteers. All of us are volunteers. We work full time. We come along here as a volunteer status as a rep.

**Mrs IRWIN**—You also stated in your submission that you have got a good working relationship with the police and schools. Can you give me an example of what would happen if the police got in contact with you to help a family out? What would you do? What are the steps that you would take?

**Mrs Kemp**—The family has to come to a group. This is a support group situation. We educate the police that we are out there and can support families who are dealing with this problem. They give them our pamphlet. The parent contacts us and we say, 'We have got a group in your local area. It meets on Tuesday nights at 7.30. Come along and go through an orientation process. See if it is for you. If it is, then join up and stay with it.' It is actually a support group. A parent goes every week to a meeting, there is a structure that they follow in that meeting that is set out in the philosophy of Toughlove, and the structure works if you follow it. One thing that we teach a parent is that you cannot change anyone else. You cannot change other people, you can only change yourself. The parent has to change the way they react with their child. By doing that it is a pendulum: the child will change too.

**Mrs IRWIN**—Say if a young boy or girl has broken the law and the police gave the family your brochure and the family got in contact with you and go to a meeting. Then you would virtually educate them into how to handle their child within the family home?

**Mrs Kemp**—We focus on behaviours. We talk about emotions but we focus on behaviours. We support the parent in various ways. We might go with that parent to the court, although we would not be allowed in. We could sit outside and be there for them when they come out. We could go with them to a school counsellor, for instance. We could go with them to the drug and alcohol services. We could support them in that way. We can also support them within the group situation by not agreeing with them. For instance, we might have someone who wants to have their 13-year-old aborted because they are pregnant. If the group feels strongly or someone in the group feels strongly that they cannot agree with that, then they would have to say that. It is part of the supportive confrontation network that we have set up. There are other ways that we support too in confrontation. We support people by pointing out to them that you are rescuing your kid. By going along and paying his fines, he is not learning anything. He needs to face a consequence. He needs to go to court and be given some community service, and you need to make sure that he goes and does it.

**Mrs IRWIN**—How many families have you come in contact with?

**Mrs Kemp**—There are about 300 a year that contact us.

**Mrs IRWIN**—And success rate?

**Mrs Kemp**—We do not really have figures on that. We are obviously successful.

**Mrs Vanalopulos**—We are successful.

**Mrs Kemp**—People who stick with the program do get success.

**Mrs Vanalopulos**—It is long term.

**Mrs Kemp**—It is long term. I went to Toughlove for four or five years before my kid turned around. It is a long-term process is all I can say. People who are not prepared to change themselves and want to continually rescue their kid are not going to get any success out of Toughlove because the kid is just going to be calling the shots and continuing down that way. One of the things Toughlove would like to start working on if we had the resources—it takes money, of course—is to get the community out there supporting us. We talked a little about the family community, the FAYS Child Protection Act and the Young Offender's Act. In my son's case, he had 80 or 90 charges before he spent any time doing any sort of consequence. He broke three good behaviour bonds and he still did not spend a day in the Magill Training Centre which is for youth down here.

**Mrs IRWIN**—You would not recommend to a parent to try to talk their child out of the methadone program if that was helping that child?

**Mrs Vanalopulos**—No, if it was helping the child.

**Mrs Kemp**—We want to help the child too. We want the child to be making choices and facing consequences for those choices to become a responsible member of our community. If methadone is helping them that is up to them.

**Mrs Vanalopulos**—You mentioned about the police. We were talking about the police. We also invite the police to come and speak to our groups too so that we are aware of what they are doing and they are aware of what we are doing too. That is what we do with our groups; we invite community groups to come and speak too so that we can understand how they can help our families and also that they can recommend the people they meet to come to our groups.

**Mrs Kemp**—It is also to break down the community perception of, 'This kid is a lout, he must come from a bad home.' There are a lot of people in Toughlove who are well-educated people. Both my husband and myself are both tertiary trained. We are on over $100,000 a year. Our kid still acted out. He still got into marijuana, he still started abusing us at home, breaking up the family home and stealing from us. He stole my car. It was his choice to do that and it is his choice to face the consequences.

**Mrs IRWIN**—And he is not using now?

**Mrs Kemp**—Not now.

**Mrs IRWIN**—How did he stop using?

**Mrs Kemp**—Tough love. I was tough on him. I did not rescue him.

**Mrs IRWIN**—No treatment, nothing whatsoever, cold-turkey?

**Mrs Kemp**—He has gone cold-turkey. I do not know how he is doing, but last time I saw him he was doing okay. He was pretty angry about it all, but he was getting there. I know of one rehabilitation centre in Adelaide. That is Archway down at Port Adelaide, but it mainly deals with alcohol and cannabis addiction, and not just cannabis addiction. It does not deal with young people with cannabis addiction. I believe cannabis is addictive. I believe it is a very dangerous drug and even worse for us than heroin.

**Mr ANDREWS**—I am trying to tease out the same thing. I was trying to understand in my mind the pedagogy that Toughlove employs. As I understand it, you are saying that you face people with taking responsibilities for the consequences of their own behaviour. Is that it in a nutshell?

**Mrs Kemp**—Yes.

**Mr ANDREWS**—And that parents do that initially by taking responsibility for your own behaviour and your actions and saying to your children that they likewise have to be responsible for the consequences of their behaviour? Have I got it right?

**Mrs Vanalopulos**—That is exactly right.

**Mrs Kemp**—We empower our children to make those choices because we talk to them about, 'This is your choice, if you choose to do this, this is the consequence.'

**Mr ANDREWS**—Yes.

**Mrs Kemp**—And you walk away and it is up to them.

**Mr ANDREWS**—You would equally say that, if they make what you might regard as a wrong or bad choice, then the consequences ought to apply. They should not be saved necessarily from the consequences of an inappropriate choice. Is that right?

**Mrs Vanalopulos**—It is very hard as a parent to do that, because our heart is to rescue them and help them, but we know that it has not helped our children.

**Mr ANDREWS**—You do that and the groups are essentially support groups to enable you to do that. Is that correct?

**Mrs Vanalopulos**—Yes.

**Mr ANDREWS**—Why do Relationships Australia, having introduced this, pull out of it? Looking at your financial statement, I think this year's turnover was about $20,000. It is hardly a huge amount of money.

**Mrs Kemp**—As far as I know, their budget money ran out and they could no longer fund it.

**Mr ANDREWS**—Thank you.

**Ms ELLIS**—You are all volunteers?

**Mrs Kemp**—Yes.

**Ms ELLIS**—I just commend you for what you are doing. I do not mean that flippantly or gratuitously because you have your own lives to lead and yet you have decided to take this path into helping other people lead theirs as well. You have to be commended for that.

Can I just be a little bit provocative for a second and play the devil's advocate? There are, as we would all know, times when children play up because of factors that they are presented with and sometimes abuse or alcohol abuse or family breakdown almost dictates to them how they behave. If you have a family present to you like that, how do you react to that family? In a lot of cases you have got the situation you have described, Robyn, which is the relatively normal family—which means a bit of everything—with a child that decides, for some almost inexplicable reason, to go a bit haywire. But then you have also got families where children react to the environment which they are in and they can become the victim, and by becoming the victim they create a few victims around them. So how do you, as a group, deal with those families because in that family there is no right or wrong as clearly as could be perceived in some of the other cases you deal with?

**Mrs Vanalopulos**—We have got an adopted son and he is now 19. We adopted him at eight and a half years old and he came with a lot of problems. He had learning disorders and cranial facial problems and all that sort of thing. My husband and I went everywhere to get help for him for 10 years. Nobody could help us so we went to Toughlove. We came to the point that it is time for him to take responsibility for his actions. And now, because we did that lovingly, and it

was hard work for lots of reasons—he was sexually abused and all sorts of other horrific stuff—he has a job. He has now left home because we cannot live with him because of his problems but he has a job and is doing really well and our relationship with him is the best it has ever been.

**Ms ELLIS**—I think I am being a bit subtle. I will be a little bit more to the point.

**Mrs Kemp**—We are talking about dysfunctional families.

**Ms ELLIS**—I am. I see cases in my office—and I am sure my colleagues do as well—where a parent drags a child in, or comes in, and says, 'That so-and-so daughter of mine has run away again.' The parents are the archangels in this when in fact that is not the case. The child is reacting because mum has had one boyfriend too many, or dad has hit her around the ears, or mum and dad have had too much drink and have argued, and this goes on for a few years and the kid in the end thinks that he or she does not have much option but to join them or rebel in some way. You have to get to the bottom of that because sometimes the family can misrepresent the situation—let us be blunt about it. So what do you do with those? Your example is a good one, but I am talking about when the family is the unit that comes to you and says, 'Help me straighten this kid out,' and in the process you find out that there are problems on the other side and, in fact, the kid is the victim—

**Mrs Kemp**—Yes, we can do that, too.

**Ms ELLIS**—and their behaviour is the result of that. What do you do with the parents in that case?

**Mrs Kemp**—There is one thing that we say to parents when they first come to Toughlove: 'We do not tolerate violence and we do not tolerate abuse of our children.'

**Ms ELLIS**—So do you find yourself sitting down and saying to the parents occasionally, 'You have got to sharpen your act up and then maybe we can help little John?'

**Mrs Vanalopulos**—Definitely.

**Mrs Kemp**—Exactly, and that is part of the confrontation I was talking about. Quite often we will have parents come who have totally different views of this kid—

**Ms ELLIS**—It is not always the kid's fault.

**Mrs Kemp**—It is not always, no. But, in other words, there are other things you have got to think about. We are not a blaming organisation either so we do not blame the parents for this. We say to them in a supportive and loving way, 'You have to change. What you are doing now is not working. Your kid is never going to change unless you change.'

**Ms ELLIS**—I get the impression that one of your major concentrations is cannabis, but what about alcohol? What is Toughlove's view on the effect of alcohol on our families?

**Mrs Kemp**—Most kids will start off having a few drinks here and there and then get into the cannabis as well, but we find that cannabis is the main problem with our teenagers. In our statistics we quoted that 49 per cent of our kids are using cannabis on a regular basis, and I am talking about every day of their lives.

**Ms ELLIS**—Okay. So you are saying that cannabis is a bigger problem for teenagers than alcohol?

**Mrs Kemp**—Yes, I believe so.

**Mrs Vanalopulos**—Because they have been told it is a soft drug and because they believe it is okay.

**Ms ELLIS**—Can I ask that differently? Are the statistics showing that cannabis is used more often with teenagers in your view than alcohol? Forget about the degrees of your view of one against the other because alcohol is a legal thing. Are you saying that cannabis is used more often and is therefore more of a problem, in that sense of measure, than alcohol with teenagers?

**Mrs Kemp**—In South Australia it is definitely, because it is more available. They say, 'We have three plants, we have 10 plants in our backyard and so does the guy next door.' The statistics in South Australia are that every second house in South Australia has marijuana growing.

**Ms ELLIS**—Good grief! Where does that statistic come from?

**Mrs Kemp**—I am not sure, but I read it ages ago.

**Mrs IRWIN**—Don't believe everything you read.

**Ms ELLIS**—Can I just say, if there is a stat around saying that, we would like to know where it is so that we can source it.

**Mrs Kemp**—I think I read it in some paper somewhere along the line over the years. If you talk to our police commissioner, I am sure he will have some statistics on it.

**Ms ELLIS**—We have, thank you.

**Ms HALL**—Once again, thank you very much for coming along today and sharing your time with us. I just want to get it very clear in my own mind: do you believe that if a child smokes cannabis they should be treated as a criminal and dealt with through the criminal system, or are you happy for it to remain decriminalised as it is at the moment?

**Mrs Kemp**—We have got to have a system of rules for our teenagers. Every kid is going to experiment at some stage, but the way it is at the moment, as my son did, he had up to 80 or 90 charges. He was not looked at as a holistic problem. He was looked at and people said, 'Oh, he has had a pipe 10 times, he has done graffiti six times, he has done break and enters three times, he has done this so many times,' and each thing was looked at as a separate issue. It was not

looked at as a holistic issue, and I am going to the court saying, 'Please put my child into the training centre for a day, for a week, for a month, give him a consequence because he is laughing at you, he is laughing at the court, and I don't have to do anything.'

**Ms HALL**—I understand the whole problem of your son and all the behaviours he was engaged in, but I am just interested in Toughlove's opinion as to whether or not the use of cannabis should be treated as a criminal act and the consequences of that.

**Mrs Kemp**—It is a hard question.

**Ms ELLIS**—It is a very hard question, isn't it?

**Mrs Kemp**—I believe for people over 18 it should be. This is my belief—it is probably not Toughlove's, I don't know. But I would believe that for people over 18 it should be a criminal act. It is a very dangerous drug, and the thing is we talked about it being passed on to the unborn child, we have talked about the fact that it affects the brain and people become paranoid schizophrenics on it. It is a cost to our community. Why are we tolerating it?

**Ms HALL**—The other question is: in your approach to drugs, both licit and illicit—so that is taking into account alcohol, tobacco and the illegal drugs; but I suppose it really goes more to the illegal drugs—do you accept an approach of harm minimisation as opposed to one of enforcement? Which would you favour? Do you think there is a role for harm minimisation, or do you think it should be straight down the line of enforcement?

**Mrs Kemp**—It is very interesting that you should ask that. I was talking to Raelene Allen on the weekend, and she was telling me that in the Melbourne papers Dr Penington had actually just come out and said that he was concerned about cannabis use by youths.

**Ms HALL**—Not only cannabis, I mean all drugs.

**Mrs Kemp**—I don't know. I don't know the answers to the questions. I just know what it is doing to families and what it is doing to communities in South Australia.

**Ms HALL**—Would you like to comment, Mrs Vanalopulos?

**Mrs Vanalopulos**—I think it is a very difficult question too. We just want to see more education so our children can make informed choices, and they are not making informed choices because they are not given the true picture, are they? That is with everything, isn't it?

**Ms HALL**—Does Toughlove support the needle exchange program?

**Mrs Vanalopulos**—I do not know what that is, actually.

**Mrs Kemp**—The needle exchange for heroin users; I would have to say that probably we would have to support that because of the incidence of hepatitis C.

**Ms HALL**—Thank you very much.

**Mr ANDREWS**—Have you had any experience of the new drug court and the diversion programs in South Australia since they started in, I think, May of this year? Have you had any contact with the drug court?

**Mrs Kemp**—No, we have not heard about it.

**Mr ANDREWS**—Just briefly, apparently, according to the evidence from the South Australian government this morning, there is a pilot drug court program which commenced in May of this year, and the object of that is, rather than to have the consequence of people being imprisoned, they can choose to go into a program of treatment and be assessed for that.

**Mrs Kemp**—That sounds like a wonderful idea.

**Mrs Vanalopulos**—That sounds wonderful.

**Mrs Kemp**—To get back to what Greg Wilson was saying before, we need the accountability of DASC. We need to have some sort of funding of community programs that work with kids that are on drugs. We need an accountability FAYS in this state. Our government needs to be taken to task for decriminalising having three marijuana plants, because it is a much harder drug. Education is the big key.

**Mr QUICK**—I would like to add my thanks to all the rest of the people in Toughlove. I come from Tasmania and I know the problems that Toughlove face down there and the wonderful work they do. All of us around here are a soft touch. We get drayloads of it every day. It would be good for us to adopt the Toughlove principles. After eight years as a politician, I know that we try and save a hell of a lot of people. In retrospect, after listening today, we ought to be throwing the onus back on them and saying, 'Look, I am sorry. How many times do we have to help you out of the mire?' I can think of half a dozen kids in families that society and I have tried to save. After a while, you just get sick of seeing their names in the *Hobart Mercury* every Monday for being on remand. I know the stress and strain that you go through. Thank God I have not gone through this with my kids but I can imagine how hard it would be for you to say, 'Enough is enough. The door is shut and you are on your own.' I compliment you for the guts, determination and strength that you and your partners have for doing this.

**Mrs Kemp**—It is the only thing that saved my child.

**Mr QUICK**—That is right. And every win is a win. I do not know how we, as a House of Representatives committee, could have one recommendation and a one-page report that says, 'As a federal parliament, the problem is yours.' We could fund a whole range of activities but I do not think we would ever get things in place to suit everybody. Listening to the South Australian government today, it is obvious that we have been mucking around for 20 or 30 years and arguing between departments, saying, 'It is not my responsibility. The kid was antisocial in high school.' The health department or somebody is saying it is an education problem. If the kid gets arrested in the street, the education department says it is a police problem, but you know it is your kids' problem.

Hopefully we are moving along the track. We need to get things in place so that, if you live in Mitcham, there is something within a bull's roar so, at 2 o'clock in the morning when your kid

goes off his face, you can get some redress straightaway. Hopefully, some of our recommendations will assist in doing that. When we get to that stage where the safety net is strong and hardly anybody falls through it, we as a government, at both state and federal levels, can say to parents, 'Everything is in place: early intervention is there, support and respite are there, and counsellors are there 24 hours a day; the whole range of things are there. It is yours.' When we get to that stage, it will be a wonderful society.

**Mrs Kemp**—A utopia.

**Mrs Stephens**—Drug education is important. When you look at the statistics in Sweden and the USA, their drug education programs are bringing the statistics way down. We need to be able to educate the community and the children.

**Mrs Kemp**—If you look at the money that is spent on cigarette advertising in our country and the money that is spent on drug education, there is no comparison.

**Mr QUICK**—I would not cite America as a wonderful example of doing anything, let alone dealing with drugs. They have got the worst record in the world. I might look at Scandinavia; I think they are perhaps a bit more progressive.

**CHAIR**—We are going to have to wind up because we have another group to see. Thank you for that, Harry. Just one quick one from me. On parental skills, in terms of your view of your 300 families, how are we going in the parental skills area? In terms of the commitment, the general approach of parents generally, how do you think parents are coping? You people have coped in pretty difficult situations: what can we do more there? What more should be done?

**Mrs Vanalopulos**—Education, I suppose.

**CHAIR**—But is it because it is tough love for parents too, to accept responsibility?

**Mrs Stephens**—There is Toughlove for teachers and you can use Toughlove in any situation, it does not have to be just in the family. I am sure that it could be used in a lot of different ways. Early intervention is a good one.

**Mrs Kemp**—No-one is born with the skills to be a perfect parent, they have got to go somewhere and get taught. Unfortunately, too much of our skill development is put back onto our schools and not onto families and not into the community. We expect our schools to do everything now, from sun safety to road safety to protective behaviours to keep our kids safe, Aboriginal education—everything is supposed to be crammed into what equates to, I think, one-thirteenth of the year. So somewhere along the line someone has got to take some community awareness and put some things back in there. There are some great programs around for parents when the kids are young, and Toughlove is there for when they are older. Hopefully, if we can keep going, they will be there for people in the future. But education and rehabilitation and funding of programs that actually work, rather than a frittering of money across a wide spectrum, is something that we really need to do. Thank you very much for listening to us.

**Mrs Vanalopulos**—Thank you so much for your support and encouragement too.

**CHAIR**—Thank you very much, Mrs Stephens, Mrs Vanalopulos and Mrs Kemp.

[4.34 p.m.]

**BRESSINGTON, Mrs Ann Marie, Administrator, Festival of Light/DrugBeat of South Australia**

**d'LIMA, Mr David, Field Officer, Festival of Light**

**GOSLING, Mrs Kate, Festival of Light/DrugBeat of South Australia**

**PHILLIPS, Mrs Roslyn, Research Officer, Festival of Light**

**CHAIR**—Welcome. We have, regrettably, about 33 minutes to do what we need to do. I just remind you, of course, that the committee does not swear witnesses but proceedings are the legal proceedings of the parliament and to be regarded in that context. Would you like to make a short opening statement?

**Mrs Phillips**—I apologise that my husband, Dr David Phillips, the Chairman of Festival of Light, could not be here this afternoon. I and David d'Lima will be giving a brief introduction to our submission. Ann and Kate have prepared a separate written submission as well as wanting to explain verbally their concerns in DrugBeat South Australia. I presume you have all received our written submission?

**CHAIR**—Yes, indeed we have. We have it in our briefing papers. Would you like to make a few comments to it?

**Mrs Phillips**—Yes. Having been a community organisation in South Australia since 1973 promoting Christian family values, we get contacted all the time by not only our supporters but also members of the public who really do not know who else to go to. Quite a lot of them have come to us over the years because of drug problems with their family. You heard quite a bit of that from the last set of witnesses from Toughlove. We have a similar story to tell of parents coming to us. They actually have a good home and marriage yet, because of the surrounding culture that has grown up with the acceptance of marijuana as a soft and apparently harmless drug, their children have got caught up in the drug culture and the parents say, 'Where do we go?'

Our concern is that government authorities in South Australia have been very slow to catch on to the real dangers of marijuana and are not giving very helpful advice to parents. We checked this out ourselves when so many parents had said, 'We've been to the Drug and Alcohol Services Council and they won't speak to us as parents. They tell us that, if our children have problems, it is not marijuana but it might be amphetamines or something else, or it might be the way we parents are treating them. They will not accept that marijuana is a problem.' We rang up and got the same story—except, when I rang the Drug and Alcohol Services Council yet again when I was preparing this submission, for the first time I got a positive response.

At the end of the telephone line I had this book recommended to me—produced, I believe, with Commonwealth funding—called *Quit: A guide to quitting marijuana*. I read it. It was repeating the stories that parents had told me, it was answering their questions and it was very helpful and very well written. We had been told by the lady on the phone that, if we wanted more copies of the book—which I certainly did—to just call in at Greenhill Road and pick them up. When we called in in person, we were told by the girl at the desk, 'No, we don't stock that book. You can't get it here.' They did not believe in it and, yes, it was produced by the Commonwealth government and we would have to go to them—which we did. We now stock this book, and we recommend it to parents who come to us for help.

**CHAIR**—Can I be clear on this? You then sought it from another source?

**Mrs Phillips**—Yes, we rang up Canberra, we paid our money and we bought some.

**CHAIR**—But there were none down here?

**Mrs Phillips**—No.

**CHAIR**—Would we be able to view that book?

**Mrs Phillips**—Certainly. That just demonstrates the problem. I also did some research. I knew from other sources about the link between drug use—particularly marijuana, but also amphetamines and others—and mental illness, and I knew that South Australia was in crisis over the great increase in mental illness here. I rang the health commission to find out if they had any advice to give me on the link between cannabis, for example, and mental illness, and they referred me to somebody else. I was referred to Glenside, which is our primary mental illness hospital. Everybody passed the buck to somebody else until I finally got some doctors who said that there was no link: you might get bronchitis or something from smoking marijuana, nothing more. They were not prepared to say that there was any particular link. They did not check out their patients, when they were admitted, to see if there was any drug use. They could not give me any statistics on the number of their patients who also had a drug problem. They did not really see that it would prove anything or be relevant.

It seemed to me that they were in denial. In contrast, somebody recommended that I get a booklet from Queensland. The Queensland government not only acknowledged the problem but they have produced a book. They called it a double problem: if you have mental illness and you also have a drug problem, it is not just two separate problems. They compound, which makes it much worse. The message I seemed to be getting was that our bureaucrats, at least in South Australia, are in denial. I say bureaucrats rather than the Minister for Human Services, Dean Brown, because he said on Radio 5AA just a couple of weeks ago—I think it was on 3 November, or on a Sunday night around then—that he personally would discourage any person from using marijuana. He said there is no doubt that mental illness in some patients is linked with their marijuana use. He also referred to the serious cancer problems which can come from marijuana. So the minister is in no doubt, but the bureaucrats to whom I spoke seem to have a problem and to be in denial.

Doesn't the Commonwealth government provide funding to South Australia and other states in this area? Surely, it should be a precondition of any funding that you provide that there is

some system in place which would force our bureaucrats to recognise the drug link with mental health problems and to institute programs which are likely to help. The reports we get from many parents are that there is nothing available to help their young people to quit marijuana. The programs that are available to help children with drug problems are often revolving door programs. They go in, they get detoxed and they go out, and their underlying problems are not addressed, so they go in again. It is not really helping them to become free from drugs; it is more a case of maintenance with methadone or something else. It is not treating the underlying cause.

**CHAIR**—In your submission you mention testing for drugs in the body with respect to people going into a mental institution or mental health facility. Could you expand on that and perhaps give us some of the pros and cons as to what the response has been to that suggestion.

**Mrs Phillips**—The doctor to whom I spoke in Glenside could not see what it would prove and was not interested. I believe the only way to have the government authorities recognise the link between mental illness and drug abuse is to start off by simply having a routine test of all patients so that they can at least see what percentage of their mental patients have a drug problem. They can then start to draw conclusions and consider whether they need to treat the drug problem as well as the mental illness.

**CHAIR**—What I had in mind was the wider community. David is a field officer working in the community. I just wondered what the response was in terms of the general approach to drug testing in this particular situation.

**Mr d'Lima**—On that matter of drug testing, people out in the community are at desperation point. They are very keen to hear any ideas about anything that can be done to try to find out more information about the situation and the damage that has been done through libertarian drug policies. Another matter is in relation to the testing of people who work in the drug rehabilitation field. We recently networked with some other pro family organisations to find out whether they would support mandatory drug testing of MPs and others who are involved in legislating for or working in the drug rehabilitation area.

**Mrs IRWIN**—Like the Sisters of Charity? I work very closely with the Sisters of Charity at St Vincent's Hospital and they are a wonderful group of women who are doing a lot for our loved ones. I would be absolutely horrified to ask them to take a blood test.

**Mrs Phillips**—They would probably be happy to.

**Mrs IRWIN**—I read your comments in the paper and I asked the sisters about it and they were horrified. I would write to them to get their advice.

**Mr d'Lima**—I am sure not everyone agrees but, in our networking with other concerned pro-family organisations, there was consensus that we ought to invite people to consider this on a voluntary basis initially and consider making it mandatory later. We think legislators and those who are involved in making drug policy should set an example. I mention that issue because it raises the question of the presumption of innocence. There was some discussion of this in our FOL executive meeting. Our concern is such that we are prepared to consider something that might raise questions about the propriety of the reversal of onus.

**Mr EDWARDS**—You recommend 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. I find that quite a ludicrous suggestion. I cannot believe that an organisation like yours would make such a recommendation. For instance—I will give you one example—I have a lot to do with the Vietnam veteran community, many of whom suffer mental health problems that are not in any way related to drugs but to war neurosis and post-traumatic stress disorder. They are not the only group in the community who suffer such things but they are one of many groups who would find any drug use quite alien to their way of life. If they had to run the gauntlet such as you propose, they would probably not come forward for treatment. Have you considered that side of the coin when you make a recommendation such as this?

**Mrs Phillips**—What is the difference between that scenario and having to blow into a breathalyser when I drive on the roads? I do not think it is a big deal; I see it as routine. If a patient has a problem, it can be addressed. Otherwise you will not know that there is a problem. What is difference between that and breathalysing?

**Mr EDWARDS**—If you cannot see the difference between that and what I am talking about, I must further discount your recommendations and the whole of your submission.

**Mrs Phillips**—That is a very strange response. Do you object to breathalysers?

**Mr EDWARDS**—No, I do not.

**Mrs Phillips**—What is the difference between a breathalyser that detects one drug—alcohol—and a similar test that detects other drugs?

**Mr EDWARDS**—I have already given my answer.

**Mr LAWLER**—I was going to ask a similar sort of question—although perhaps not as strongly as Graham. I would be concerned that mental patients may not come forward for help if they had to take such a test. Have you considered how you would cope with people who had that problem? I think we have probably reached an impasse.

**CHAIR**—That is fine. That is what democracy is about: people have different points of view.

**Mr LAWLER**—I think the answer is that those people will just have to get over it. I was looking for something a bit more than that—I do not know what. I do not think guaranteed confidentiality would meet the requirements of the patients that Graham is talking about. I think I will butt out.

**Ms JULIE BISHOP**—I want to go back to the South Australian cannabis laws. Could you outline your organisation's stance on the issue of diversion programs whereby drug offenders are diverted from the criminal justice system? Do you support those programs and the effort that is going into diversionary programs?

**Mrs Phillips**—I think they are marvellous, if they had enough of them. I think the problem is that there is nothing there to treat young people with a cannabis problem. They just do not have

them. I would like to see a lot more of it. Perhaps Ann Bressington and Kate might have something to say.

**CHAIR**—I wanted to come to Mrs Bressington in terms of DrugBeat. We needed to talk about that, and time will run away with us. Would you like to make an opening statement? Perhaps you would like to deal with DrugBeat as well when you do that. I am aware that Mr Andrews has to leave in a few minutes too, so it is all getting a bit tight.

**Mrs Bressington**—DrugBeat deals with heroin addicts to start with, but we also work through every other addiction that they have accumulated along the way. Heroin addicts do not just have one addiction—they have many. What we have actually found is that marijuana is the most difficult for them to get over—that is not through lack of motivation; that is due to the fact that it is so addictive. It is far more addictive than heroin. It is much more residual than heroin. The withdrawal from marijuana is similar to heroin when they really get into it.

There are no programs that address the withdrawal process from marijuana, and there are no programs that address any sort of residential care for people that really do want to get away from the environment that they are in and change their life. Marijuana is so much in your face out there. Those people said that every second household in South Australia is growing marijuana and, from where we are located out in the northern suburbs, I would be very apt to agree with them. You can actually smell it in the neighbourhood when you are walking in the streets. The smell of a night-time is there, and it is everywhere. Our clients have no problem at all in obtaining marijuana from absolute strangers at the shopping centre. It is too available, and we do not have any treatment programs that address the problems that go with marijuana use.

**CHAIR**—You may have said as much as you wish to, but in terms of DrugBeat itself—the definition of DrugBeat—

**Mrs Bressington**—In 1998, my daughter died of a heroin overdose. She was 22 years of age, and I had known for four years prior to that that she was a heroin user. I had tried to seek out assistance within the system and I got none. Methadone was not suitable for her. It made her ill—more ill than heroin itself. So I basically started to do research. That was around the time the story broke loose about naltrexone—the 'I woke up cured of heroin' story. So I started doing research on naltrexone and on the services that were available and I have continued from there. It started out as a lobby group. I had no intention of getting into treatment and rehab at all. We have now been running a facility out in the northern suburbs for 18 months—that has been supported by Dean Brown—and have just received funding for an evaluation process of the program.

We are an abstinence based program, but we do use methadone for some as an interim if that is what they need. We do not believe that naltrexone is the be-all and end-all for every heroin addict. We treat each case as an individual and, as I said, we work through the addictions that they have gathered along the way. We have treated 585 clients. We have a 78 per cent success rate at abstinence over a 12-month period. We have a 100 per cent retention rate of that 78 per cent of people over a two-year period, who continue to come in for counselling and continue to come in for groups.

We deliver family therapy for the addicts and their families. We are a little like Toughlove but not a lot like Toughlove. We do believe that behaviour is learnt and that, if our children are seeking a mind altering state at the age of 12 to 14, there is a reason for that. It is not all rebellion. Some of it is emotional distress. And we address the parents and the clients and try to treat them in a synchronised manner.

We also acknowledge that there are other areas related to the drug issue that are very rarely addressed. There is the increase in the divorce rate because most of our parents that have been involved in the family therapy have been very close to divorce due to the stress that has been put on them through an addicted child. There is an increase in unemployment among the older generation because a lot of the parents are unable to sustain employment because they are operating under such stress and trauma on a daily basis. There are increasing health care costs for parents and family members as well as for the addict. There is an increasing suicide rate by family members and addicts. There is an increase in the number of house fires that occur, in the rate of domestic violence reports and in the number of homeless. There is an increase in the number of parents and other family members suffering from nervous breakdowns and requiring assistance through the mental health system. There is an increase in the number of drug users seeking assistance from the mental health system due to drug psychosis. There is an increase in the number of children seeking the homeless allowance and in the number of younger persons unmotivated to seek employment. There is an increase in the bad behaviour that is being experienced in both primary and high schools, in the number of children not attending school, and in the number of children who drop out of high school before their education is completed. These are all side effects of drug abuse in our community.

We were asked to address the costs and I have a paragraph here that relates to the cost of drug abuse. The health care costs as a result of drug abuse within the community have been well documented but I doubt very much that those costs also include the medical attention required by family members who are functioning under constant stress and trauma. In a report of 1997, *Drug use in South Australia*, DASC calculated that the tangible cost due to the illicit drug use in South Australia and related to road accidents, loss of productivity and health care, can be estimated at $104 million per annum. The overall cost to Australia was estimated in 1992 to be around $1,900 million annually with $450 million for law enforcement. It was also stated in a report by Collins and Lapsley in 1996, that the estimated health care cost to the community for a person using drugs is 80 per cent more than for the average citizen. Ambulance, hospital and medical costs were estimated in the same report to cost around $43 million per annum.

**CHAIR**—We are aware of the Collins and Lapsley work. I would like Mr Andrews to ask his question because he may pick up something useful.

**Mr ANDREWS**—I have two things. Firstly, I was going to ask you about your program but you have covered that. But could I make a suggestion through the chair? If you are willing to table the longer document which you would have read had there been more time then we could have the advantage of reading the longer document—and the same could apply to any of the other witnesses who had a statement to make. If it can be tabled then we can, at least, get the advantage of it.

My question was to Mrs Phillips and it really went back to the matter which was being discussed before. As I understood it, the recommendation that you made about the testing was

basically with the objective of trying to ascertain the connection between cannabis use and mental health. I take it from your submission and what you said that there does not seem to be adequate research about that. I wonder whether an alternative way of trying to ascertain the actual connection that is said to exist would be some sort of research study which did not have the problems of testing people—that Mr Edwards or others alluded to—but would still make that sort of connection. Would that be a way of achieving what you were trying to get at?

**Mrs Phillips**—It certainly would, but you would need to test those in the study obviously. What you are suggesting, I assume, is—

**Mrs Phillips**—Indeed, yes.

**Mr d'Lima**—Although there could be some difficulty if they were not competent.

**Mr ANDREWS**—Yes, although there are still ways of obtaining consent in those circumstances.

**Mr d'Lima**—Yes.

**Mr ANDREWS**—That was all I wanted to raise. The other material has been covered.

**CHAIR**—Have you had the response that you wanted?

**Mr ANDREWS**—Yes, and the other material has been covered by Mrs Bressington.

**CHAIR**—I want to honour Julie's statement, too. Julie had some questions.

**Ms JULIE BISHOP**—I was just talking about the diversionary programs, and that was answered.

**CHAIR**—As you are happy with that, then I need to go to Mrs Bressington and say, 'I am sorry about the fragmentation but you have virtually presented and I think we have got the gist of what you are doing.' Did you want to add any more?

**Mrs Bressington**—No. I just have a study here that was done last year by the University of South Australia and is entitled *Users and treatment programs: how do they fit?* I think what you are looking at in this committee is very well covered in this study and I would like to submit it with a written statement.

**CHAIR**—You are happy to table that with us? Thank you.

**Ms JULIE BISHOP**—Who was that study done by?

**Mrs Bressington**—The University of SA. It was actually done for a Bachelor of Social Work degree.

**CHAIR**—Thank you very much.

**Ms ELLIS**—I want to briefly pursue what Graham Edwards and Kevin Andrews were speaking about. There are two recommendations that I would like you to elaborate on. Firstly, I want to explore the first one. Your recommendation actually says 'illicit drugs', it does not say marijuana, and your main concentration in your presentation verbally to us today has been on cannabis, marijuana. If this was in place and was testing for anything illicit, not just cannabis, what way would there possibly be, in all fairness to the patient concerned, to establish or prove that it was post or pre the mental condition? That is my biggest problem with this, and I have to declare that I am not all that terribly keen on this recommendation. I would be very concerned as to how on earth you could possibly establish that someone tested positively for an illicit drug of any kind, not just cannabis, and that you could prove—because I think that would be your whole motive—that it was pre or post the mental disturbance, problem or illness.

**Mrs Phillips**—No, our motive is more than that, because the evidence from Queensland, for example, shows that use of these drugs, once you have a mental illness, makes it very much worse—it compounds the problem. What we are saying is that doctors cannot even begin to treat something that they do not know the patient has.

**Ms ELLIS**—Okay. That actually changes my understanding or interpretation of what you said earlier. The *Hansard* can clarify it for me, but I think what you said was that, because you were concerned that cannabis leads to mental illness of some kind, you wanted to establish that. But what you are saying now, and what your recommendation is, is that you want to look for an illicit drug of any kind and you do not mind necessarily whether it is showing that it caused or was used after the development of a mental illness—in other words, it is a blanket thing you want to look at.

**Mrs Phillips**—Yes.

**Ms ELLIS**—The other recommendation I want you to elaborate on, which has already been talked about as well and which Graham spoke about, is the Commonwealth funding issue. This says the Commonwealth funding of research, of counselling, of treatment and of policy development. So research means people in pharmaceutical companies, the NHMRC, the CSIRO, everywhere—you want all of these people to be drug tested to prove that they are clean. What is your motive for doing this? I would like you to explain it to me.

**Mrs Phillips**—It has been widely rumoured that some of our drug policies have come about because in the 1970s a lot of uni students used marijuana and tended to think of it as a soft and harmless drug. That belief has influenced their policies. These people have moved up into government or bureaucratic positions and they are the ones who are now making the policies. They now have a big influence, based on their own experience and use of drugs.

**Ms ELLIS**—I am going to be provocative here: that is an assumption that everybody who is working in the research area, in this area in Australia, is over 30, 40 or 50 years of age.

**Mr d'Lima**—It is countering that possibility. People in the drug industry, say the tobacco industry, have been notorious for covering up the truth. This is the human tendency towards corruption. We are keen for anything to be put into place which will reasonably minimise the potential for corruption.

**Ms JULIE BISHOP**—But if they experimented 20 or 30 years ago, you are not suggesting that this measure would somehow elicit what they are doing now?

**Mrs Phillips**—Our point is that they may still be using.

**Ms JULIE BISHOP**—And they may well not be.

**Mrs Phillips**—Exactly, we do not know.

**Ms JULIE BISHOP**—But you are not going to be get to the nub of your concern if you believe that their personal experience has impacted upon the way they now develop policy or whatever they do. To drug test them today is not going to tell you what their personal experience was at university 30 years ago.

**Mrs Phillips**—Indeed. All we are saying is that, just as MPs have to declare interests, shares and so on that might affect their decisions in government, it would be good to know the vested interests—if they have them—of people who are using drugs and then making public policy on drugs. If they are privately using a drug, it would be good to know whether this might be affecting public policy. That is all. If they experimented years ago and stopped, that may have been as a result of their decision—

**Ms ELLIS**—Can I suggest that it might be worthwhile finding out how many of us have speeding tickets in case we are making rules in relation to speeding on the roads?

**Mr d'Lima**—That would be very useful. We cannot have people making the rules who do not believe in the rules.

**CHAIR**—Thank you very much. Can we think in terms of about six or seven minutes, with a quick question and a quick response, if that is possible.

**Mrs IRWIN**—I am still thinking about the Sisters of Charity lining up for their blood tests. This is a question to Ann Bressington. Are you associated in any way with the Festival of Light?

**Mrs Bressington**—No.

**Mrs IRWIN**—Do you agree with the comments that they have made in their submission or what you have heard today?

**Mrs Bressington**—Some of them I do.

**Mrs IRWIN**—Which ones?

**Mrs Bressington**—I agree with the request that some people who are in a position of making drug policies in this country undergo drug testing. I have been researching this for almost seven years. There have been too many references made by too many people, and there is too much evidence to show that we have a liberal drug policy in this country. That liberal drug policy was

developed by a gentleman named George Soros, and it has been propagated in this country. There are people in charge of drug and alcohol services who are known associates of Mr Soros. This has been reported through DEA in America, Capital Research Centre and *Forbes* magazine. Drug Watch International also has many reports on this. If those people in higher places are actually connected with a gentleman who wants legalisation of all drugs and availability of all drugs, then we really have to question what their ethical and moral base is and whether they are in fact qualified in the position that they are holding.

**Mrs IRWIN**—Who would you say should be blood tested? People like members of parliament?

**Mrs Bressington**—No. I know of a number of professionals in the field that have been seen taking monetary awards from George Soros. It has been videotaped. They have their name associated with him on the Internet, on his board of directors. If they are government employed to research into treatment and rehabilitation of drug addicted people and they are taking monetary awards from a gentleman who professes that legalisation is the only way to go, to me that is a conflict of interest. These people have to be identified publicly, I do believe, before we can see a change.

**Mrs IRWIN**—Because you do not agree with his views, is that right? Is that why you have this attitude—because you do not agree with his views?

**Mrs Bressington**—With whose views?

**Mrs IRWIN**—The gentleman that you are talking about over in America.

**Mrs Bressington**—George Soros?

**Mrs IRWIN**—Yes.

**Mrs Bressington**—It is not a matter of agreeing with his views; it is a matter of looking at his views and wondering what his motivation is and what outcome he is trying to seek. If he is trying to seek legalisation of all drugs across the board with no age limit on who can use it—he belongs to an open foundation society—a 10-year old child could walk into a corner store and buy a joint of marijuana because it is there or could procure cocaine over the counter because it is there. Who would agree with those opinions? He has come out and said it. He has been quoted as saying this. If we have officials in Australia who are supporting that sort of an approach, shouldn't we be questioning whether they should be in the business of making drug policy?

**Mrs IRWIN**—I can see your point with questioning that, but I just cannot get over this idea of blood testing.

**Mrs Bressington**—We have 20 people associated with our organisation who are volunteers, who work in the field and have done for five years. They have not been paid for what they do. We, none of us, take offence at the suggestion that we would be asked to do a random urine test once a month to prove that we are not drug users ourselves. I cannot honestly see the problem with this. If you are not using drugs, if you are doing this because you know there is a problem

there that needs to be fixed, what is the problem? People who are abusing illicit drugs will not want to be urine tested.

**Mrs IRWIN**—You are taking the rights of people away—the right to say no. I would like to move on to discuss DrugBeat. Congratulations. I think you were saying you have had success with 585 clients in what you are doing with your program. What is your cost factor? The reason I ask this is that I know of a detox clinic in Sydney that uses naltrexone, but they charge something like $7,000 to $8,000. What is the cost factor for the clients that are coming into your clinic?

**Mrs Bressington**—We actually charge nothing for the detox process. They live in as a resident while they detox. We charge board and lodging for that process, which takes about five to seven days using temgesic. The cost for the entire program is $2,800, now plus GST. That covers the counselling and the workshops for as long as they actually require to be in our care with their parents and family members as well. If a client requires five years of counselling and workshops, that is what they get for their money. If a client requires only 12 months of counselling and workshops, that is what they get for their money, but they are basically a lifetime member. Our services are available to them for their lifetime, if that is what they need.

**Mrs IRWIN**—That is good to hear. If we are ever back in South Australia, I would like to actually be able to come out and see what you are doing there.

**Mrs Bressington**—Please do.

**Mrs IRWIN**—Thank you very much.

**CHAIR**—I have two quick questions. In May 1999 the Department of Education, Training and Youth Affairs released the National School Drug Education Strategy and Tough on Drugs—information for parents on the National School Drug Education Strategy. Have you heard of these documents at all?

**Mrs Phillips**—Not specifically, no.

**CHAIR**—Thank you. We just needed to get feedback. We worry about whether people have heard of these at all. Therefore, the next part—what do you think of them?—is somewhat superfluous. In your submission you state with regard to harm minimisation that under this policy Australian drug education is largely taught, the so-called safe use of drugs, without seriously addressing abstinence. Julie has talked about diversion and harm minimisation. My question is related to the marijuana pamphlet: would you therefore be quite strongly advocating that there is nowhere near a strong enough effort put into abstinence?

**Mrs Phillips**—No, I believe that seems to be missing.

**CHAIR**—It is way, way insufficient from your perspective?

**Mrs Phillips**—Certainly people get the impression that, as long as you use a clean needle and do not do too much of it, then it is fine, but the practical experience of the parents who contact us is that this just does not work. On this ‘every second household in South Australia growing

marijuana', while I cannot comment about the accuracy of that, I can comment on a *Sunday Mail* survey that was taken last year. It was just a survey of parents and what their attitudes were on a whole lot of issues relating to family—drugs was only a minor part. One of the questions of the parents was: have you ever smoked marijuana? And I was astounded that, out of over a thousand replies, something like 98 per cent of those parents said they had. I think you would not get that answer in any other state. We are hearing from all sides that South Australia is the cannabis capital of the country. It does seem we are awash with the stuff. People in my own church—people from a background where the use of abusive substances is not on—still have this problem in their own families and in their own backyards. It is a real difficulty which our government has not grappled with yet.

**CHAIR**—Thank you very much. Mrs Gosling, do you want to say anything in particular?

**Mrs Gosling**—I probably do not have the time to say it now.

**CHAIR**—Fine, but just a couple of words?

**Mrs Gosling**—There are maybe two things. Julie Bishop, I saw you raise your eyebrows when Ann mentioned that due to drug addiction there would be an increase in house fires. I thought maybe you could have had a problem with that one.

**Ms JULIE BISHOP**—No, only inasmuch as it is a statistic I have not heard before.

**Mrs Gosling**—I am very lucky; I can sit here and say my own daughter is alive thanks to somebody seeing the smoke coming out of the window. She came home from interstate—and not a piece of clothing did not have burns on it. They burn everything—constantly. They light a cigarette, they fall asleep and they burn.

**Ms JULIE BISHOP**—That was probably my reaction. I was trying to get the connection. I thought you meant arson.

**Mrs Gosling**—No. It is shocking.

**CHAIR**—Which your body language was conveying very strongly.

**Mrs Gosling**—Yes, it was Julie. The second thing is that, thanks to Ann's program, we now have a child who is not dependent on the state system. She was heavily dependent on it. As a family we have had probably in the vicinity of 300 to 400 hours of counselling by Ann's organisation in the last 12 months for nothing. She has turned my daughter around into a useful member of society.

**CHAIR**—For which you are—

**Mrs Bressington**—About four years ago Lisa was actually diagnosed by a psychologist as drug dependent for life.

**Mrs Gosling**—She has just finished doing research for Dr Greg Pike and John Fleming.

**Ms JULIE BISHOP**—How is she doing?

**Mrs Gosling**—Very well. She has finished there now. She is going on to an IT course, and back to full-time study. She has been an addict for 10 years.

**CHAIR**—We are indebted to all of you, Mrs Bressington particularly, for coming today. To me it was an unexpected, lively discussion. You really got some people going here and that is what we need to have in this debate. You come from the most—words do not describe it—deep-rooted experience. I thank you very much. Mrs Phillips, again I thank you.

**Mrs Bressington**—Kate has prepared a statement, as well. Can we submit that as well?

**Ms JULIE BISHOP**—Please do.

**CHAIR**—Is it the wish of the committee that the DrugBeat of South Australia presentation by Ann Bressington, the paper entitled 'A proposal for a cost evaluation of the DrugBeat programme' and the presentation by the House of Representatives Community Conference on Drugs by Kate Gosling be incorporated into the transcript of evidence? There being no objection, it is so ordered.

*The documents read as follows—*

Resolved:

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 a public hearing this day.

**Committee adjourned at 5.18 p.m.**