COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Substance abuse in Australian communities

WEDNESDAY, 21 FEBRUARY 2001

SYDNEY

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

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STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Wednesday, 21 February 2001

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: Mr Edwards, Ms Ellis, Ms Hall, Mrs Irwin, Mr Quick, Mr Wakelin and Dr Washer

Terms of reference for the inquiry:

To report and recommend on:

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

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

WITNESSES

Committee met at 8.17 a.m.

BARNDEN, Mr Geoff, Director, Office of Drug Policy, Cabinet Office of Drug Policy, New South Wales Government

CALVERT, Ms Gillian, Commissioner for Children and Young People, Commission for Children and Young People, New South Wales Government

DAVIDSON, Ms Eleanor, Executive Director Student Services and Equity Programs, Department of Education and Training, New South Wales Government

GRANT, Mr Bill, Deputy Director-General, Attorney-General's Department, New South Wales Government

HOGAN, Mr Michael, Director, Strategic Projects, Premier's Department, New South Wales Government

SMALL, Commander Clive, Assistant Commissioner, New South Wales Police Service, New South Wales Government

WEBSTER, Professor Ian, Chair, New South Wales Expert Advisory Group on Drugs, New South Wales Government

WILSON, Dr Andrew, Chief Health Officer and Deputy Director-General (Public Health), Department of Health, New South Wales Government

CHAIR—Good morning all. Welcome, everybody, and a particular thank you to the Mayor and the City of Fairfield for their facilities and their hospitality, which are very much appreciated. This is the fifth public hearing in the substance abuse inquiry. The Minister for Health and Aged Care, the Hon. Michael Wooldridge MP, referred the inquiry to the committee in March last year. The terms of reference for the inquiry are to report and recommend on the social economic costs of substance abuse, with particular regard to family relationships, crime, violence, including domestic violence and law enforcement, road trauma, workplace safety, productivity and health-care costs. The committee advertised the inquiry in April last year and has received over 200 letters and submissions from individuals, government and non-government agencies. Most of these submissions are authorised for publication. If you would like to see a list of these, one is available from the secretariat.

Yesterday, the committee was briefed by some local agencies and had a pretty good look around various aspects of this particular community—that is, around Fairfield, Cabramatta—and also the City of Sydney itself in the CBD. After hearing from witness groups there will be time at the end of the day for a number of invited individuals and groups to make short statements. This committee works in a bipartisan way and is keen to gather evidence about the scope of the drug problem, priorities for action, what strategies appear to be working to reduce the cost associated—that is social costs and of course the economic costs associated with substance abuse. I remind witnesses that the proceedings today are legal proceedings of the parliament and as such they warrant the same regard as the proceedings of the House of Representatives. I welcome the representatives from the New South Wales Government. We

suggest that you might like to make three- or four-minute individual statements and then we can have a general discussion about the issue.

Prof. Webster—Mr Wakelin, thanks for the welcome. I would like to make just a brief opening statement. The drug problem has been evident in New South Wales since the 1970s, and back in those times a Drug and Alcohol Authority was established by the government. That Drug and Alcohol Authority back then brought together police, health and non-government groups and essentially lead to funding of many agencies in the community, way back in the 1970s. The cooperation that was established then, continues today and now we have drug and alcohol units in all public hospitals, we have drug and alcohol based community health services and we have many non-government agencies operating in the field. An important asset in New South Wales has been the Bureau of Crime Statistics in the Attorney-General's Department that will probably be mentioned later, but over the whole period of time I've mentioned it has published reports on drug-related crime and documented the efforts of law enforcement. And you'll know that that bureau is currently evaluating the drug court program in New South Wales. Each of the universities—and we have got a number of universities involved in research and teaching about drug and alcohol problems in the community—and the three medical schools teach specifically about it, and medical students undertake research. The group that follows us, the National Drug and Alcohol Research Centre, is a very important asset in the state because it works on the problems that we face and it is based at the University of New South Wales.

It is generally the case that drug problems that have become manifest become evident first in this state and I'm sure the representative of the police force will tell us about that matter shortly. But this is the place where illicit drugs commonly enter Australia, and it is a large population with many vulnerable groups in it—some of those groups you would have encountered in your visits in the last day or so. It's true that illicit drug use is high in New South Wales; the overdose deaths are more numerous. We have a need for an expanded treatment program and the chief health officer will report on that. We have quite an extensive drug treatment program, including a methadone program. So one of the characteristics of New South Wales is that it has had to innovate because of the growing and first exposure, really, in Australia to these issues. We established a long time ago counselling centres and residential and treatment detoxification centres; we were one of the first states to introduce methadone treatment and also the more recent pharmacotherapies. There are very significant treatment programs operating in our prison services, and we make a great effort to involve general practitioners in the delivery of drug and alcohol services. And as I've mentioned before, all our public hospitals have dedicated units addressing these problems.

I have also indicated that we have a strong network of non-government agencies which link with the government agencies. It is for these reasons that New South Wales has always been a strong partner in the National Campaign Against Drugs in the first instance and more recently in the National Drugs Strategy. As I have mentioned earlier, the development of the HIV-AIDS epidemic was first evident in inner Sydney in the mid-1980s and so this state has had to provide leadership in the national response to that problem. The most recent innovation was the drugs summit in 1999 in the New South Wales parliament and that has been a watershed in the approach in this state of recent times. That was a remarkable democratic event, which achieved consensus about future directions.

Its principal outcome was the idea that there was not one way of approaching this problem but the state had to explore many different options and evaluate them. And so we now have a government plan of action—with agreed objectives; we've got a committee of cabinet, which oversights it, and my expert committee. We have got well-established cooperation between relevant government departments as represented here. There is a strong focus on communities and young people. There is an emphasis on diversion from the criminal justice and juvenile justice system. And we have a drug policy unit which provides coordination through a dedicated budget. So that is the end of my overview and introduction. I will invite my colleagues to make a brief presentation.

Mr Barnden—I am very pleased to make a short statement to the committee today. I understand that you would like to hear a bit about coordination and management of the drug programs in New South Wales and I would just address this in three parts outlining the context in which the current arrangements have been developed, our cross-government point of action, and the mechanisms that we have put into place.

With respect to the context of the present program polices and the arrangements that we have had in place since the last state election in 1999, at that time the Premier, recognising the growing problem of drugs in the community and the diversity of views in the community about the problem, decided that the first priority of the government following the election would be to convene a special drug summit in the parliament. The summit was held in May 1999. It included all parliamentarians, experts, law enforcement representatives, health representatives, professional groups, families and local community representatives. More than 300 people attended and, as Ian said, it was a unique experience in democracy and in public policy making. It met over five full days of intense democratic debate, it broke into working groups, it met to debate the resolutions of those groups and to resolve approaches in a bipartisan way. Special experts were also brought from overseas to ensure that everyone was best informed of international best practice.

The drug summit reinvigorated government and community action. It resulted in an agreed communique of recommended action, which included a set of 20 principles and 172 recommendations. Two months after that summit was held, in July 1999, the government responded comprehensively to each of the summit recommendations with a four-year funded plan of action across all sectors of government and the community. The plan of action incorporates more than 400 specific drug projects. It directly involves more than 10 government agencies and it targets 11 key areas for action. This especially includes drug prevention programs to strengthen and protect families; preventive measures to keep young people from taking up drugs or placing them at risk; early intervention to prevent young people from entering an addiction cycle and to divert from the criminal justice system into treatment; law enforcement programs; better health and treatment programs; community action programs to strengthen and involve communities; better community and school drug education programs; better programs in prisons, and programs for rural and regional New South Wales.

In approaching the drug problem in this way the government wants to encourage solutions which prevent drug problems rather than engaging in crisis management after people have already entered the addiction cycle. The plan of action is fully funded and it is backed by extra funding of $176 million, allocated over a four-year period. The total New South Wales drug program budget allocation now amounts to over $500 million over the four-year period between

1999-2000 and 2002-03. This represents an approximate increase of 50 per cent in the budget over previous years and my colleagues from other agencies will explain some of the key features of their programs.

I have also brought today for each member of the committee some of the key government documents on drug policy and drug programs, which illustrate the depth and breadth of the New South Wales program. I think you probably all have those in front of you. We are steadily and comprehensively rolling out the program across the state. It is essentially a careful balance of demand-side and supply-side policies. The government has balanced demand-side initiatives such as Families First, youth programs, treatment, rehabilitation, detoxification, counselling, and diversion programs with supply-side initiatives including tougher laws against drug trafficking, smarter policing strategies, targeted law enforcement initiatives and drug crime research. And underpinning all these initiatives is a strong government commitment to evaluation and evidence-based policy. This means that each project and each program must include an evaluation component to justify continuation of funding.

I would now like to briefly outline the management and coordination mechanisms we have in place which reflect the principles and recommendations of the drug summit and are outlined in the plan of action. First, the government has appointed the special minister of state as minister responsible for drug policy coordination and the plan of action. The ministerial appointment facilitates a cross-government approach and ensures the focus on drug policy commitments, programs and the roll out is constant, continuing and integrated. Secondly, the government has established a special cabinet committee on drugs, which is chaired by the special minister and ensures an avenue for ministerial discussion of important cross-government initiatives. All key ministers responsible for drug programs are members of this committee.

Thirdly, the government has established the Office of Drug Policy, of which I am a director. This is a small office of approximately six staff; we are located in the cabinet office and we are fully funded by contributions from the relevant government agencies and the confiscated proceeds account, which is primarily confiscated proceeds of drug traffickers. Our primary role is to advise the Premier and the special minister on drug programs and policies, to provide leadership, to coordinate drug policy cross-government, facilitate integration of programs, implement and monitor progress on the plan of action, and monitor and report on drug program expenditure.

Fourthly, the government has appointed an expert advisory group on drugs. This is a very high level expert group chaired by Professor Ian Webster, and it also includes Professor Wayne Hall, Dr Don Weatherburn, Ms Linda Burney, Commander Clive Small, Miss Anne Deveson, Mr John Menadue, Ms Elizabeth Mackay and Mr Scott Nestorovic, who is our youth representative. They meet regularly; they are regularly consulted as a group or individually.

Fifthly, the government has established a senior officers' coordinating committee on drugs, which I chair. It includes representatives from about 10 agencies. We meet regularly, we receive updates on progress and we address key issues.

Sixth, the government has established, as I mentioned, a specific drugs summit budget. The additional four-year funding is protected. It can only be allocated for the purposes for which the

government has set it aside. We have put into place accountability arrangements and we are monitoring the roll-out of the expenditure, and this is an integral part of our program.

I should mention that the government is extensively involved in work with other Australian governments and the community in its policy and program coordination. The government is committed to tackling drugs in an integrated way and the government is particularly working through a range of ministerial councils and through COAG.

Finally, I would like to make brief references to the linkages between the plan of action, which is primarily focused on illicit drugs, and the coordination and management mechanisms for alcohol and tobacco. The plan of action fully recognises the gateway issues associated with tobacco and alcohol, and the government has instructed the Office of Drug Policy and the expert advisory group to consider these gateway issues in the context of drug policy and drug program developments. However the primary cross-government coordinations for tobacco and health remain with New South Wales Health; tobacco policy coordination rests with the New South Wales Tobacco Policy Unit in New South Wales Health, and they are currently finalising a new four-year strategy. Alcohol policy coordination rests with the New South Wales Health Drug Programs Bureau, and the bureau is responsible for monitoring the adults' alcohol action plan for 1998 to 2002. They are currently finalising a youth alcohol action plan. Thank you for the opportunity to make this short presentation.

Dr Wilson—Thank you for the time to address you this morning. The Drug Programs Bureau is one of the groups within the area that I am responsible for, as is the tobacco unit. It would be remiss of me to start without a reminder to the committee that while a lot of the focus of what we are going to be talking about, not just in our presentation but in most of the other presentations you are going to hear today, will focus on the use of illicit drugs. The largest overall impact on death and disability in this country comes from use of tobacco and, in terms of its social impact, particularly in relation to violence, alcohol probably has a far greater impact than any of the other drugs that you are talking about. I would also just flag that the issues in relation to the misuse of licit drugs are a problem which also compounds the use of illicit drugs. By that I mean agents such as benzodiazepines and other therapeutic drugs which are misused.

The comments that I am going to make will mainly focus on the generalities of what we have been trying to achieve in terms of treatment and rehabilitation programs in New South Wales. I would be more than happy to take any questions about specifics of the program but we have provided you with details of the ways in which we are trying to expand services at the moment. The framework in which we do that has three key components that I would just like to highlight.

The first is that, in relation to drug dependency, we believe that it is best considered as a chronic relapsing condition; that the majority of people who develop a drug dependency will have periods of time when they are drug free and periods of time when they are not; and that over many years our aim is to try and get people off drugs but we also recognise that they are likely to relapse and we have got to try and protect them from that during that process. Like management of other forms of chronic relapsing illness, we have to recognise that there is no 'one size fits all' when it comes to treatment and rehabilitation and that we have try and provide a range of options for people; that the things which are right at one time in their illness will not necessarily be the form of treatment or approach which is appropriate at another time in their

illness. The aim of our treatment and rehabilitation plan is to try and provide that spectrum of care for people to try and best match the needs at a particular time in the course of that illness with their needs at that time.

The second sort of underlying principle that we have adopted is that, given the size of the problem, even if we just focus on opiate addiction alone, estimates for opiate-dependent people in New South Wales would suggest that there at least 30,000 and potentially as many as 50,000 people who are opiate dependent at any particular point in time. When you are trying to deal with a problem of that size you have to accept that the only approach which is going to provide effective services for that size of a problem requires a focus which is mainstreamed; that the mainstream services have to take the treatment and care of people with drug dependency seriously; they have to be skilled to do that; and the specialist services which are provided have to be there to back up that primary health care level of service. Now, that is not a new revelation in terms of the provision of health care; that is the normal way in which we provide health care: that primary health care services, general practice, are the mainstream providers; they provide the bulk of care for common conditions; and they are provided with adequate backup when problems are difficult, when they need expert advice, when people need admission to hospital for particular care. That is not a process which has been well developed in terms of the management of people with drug dependency and a key focus on what we are trying to do is to move to a model which is more consistent with mainstream care.

The third component that I would highlight in terms of what we are doing is that we are focusing very much on the quality of the services that we provide. New South Wales Health has adopted a framework for looking at all its health services, which has a focus on six particular components. Those are the safety of the services, the effectiveness of the services, the appropriateness of the services for the particular community or population that we are serving, issues of access in trying to ensure that there is equitable access to services, looking at the efficiency of those services to ensure that the community is getting the best return on the investment that has been made, and the sixth one is the acceptability of those services that they match the types of services that people need within the framework of the others. We are trying to systematically apply that framework to the area of drug dependency treatment and rehabilitation services in terms of the framework that we have used.

The last point that I would like to make at this point in time is that a large concern over the last 15 years has been around the spread of HIV-AIDS in the community. We have been very fortunate in Australia that the epidemic—which has been experienced in most countries of even similar economy to us overseas in relation to HIV-AIDS in the intravenous drug using community—has not so far been seen in Australia. Intravenous drug use is still the smallest component contributor, or a small component contributor, to the cases of HIV-AIDS that we see in this country. However I strongly believe that that is a situation which could change overnight. If we lose our focus on protecting the community and in terms of minimising harm in relation to our drug use, that could change overnight. We are already seeing a very large-scale epidemic of hepatitis C in this country. We have recently launched both a national and a state program in relation to try and control hepatitis C. If there is a very small increase in the prevalence of HIV in the intravenous drug using community then we could very rapidly see a picture develop in Australia which is consistent with what is observed in many European countries and North America. So those are the sorts of general comments I would like to make. I am more than

happy later to take any specifics on the growth of treatment and rehabilitation services that we are developing in New South Wales.

CHAIR—By the way, I welcome the local member, Mrs Irwin, as we proceed to Ms Calvert.

Ms Calvert—The Commission for Children and Young People has been established to promote the interests of children and young people. The impact of substance abuse on infants, children and young people is something we are very concerned with; they after all bear the risks of adults' drug taking. For your information, in a report I will table from the Child Death Review Team, we have looked at the impact of substance dependent parents on children. But what I would like to do today though is to focus on how we are investing in the early years, which can be preventative, I think, of later difficulties for people.

One of our priorities is to effect change to policy and practice by highlighting the importance of brain development in a child's first three years of life. Brain development in the early years determines the level of competence and coping skills that affects a child's capacity for learning, their behaviour patterns and their long-term health. There is disturbing evidence that children who do not receive good nutrition, positive nurturing and appropriate stimulation in this critical window may have great difficulties overcoming these deficits later on. They remain with us, or they appear to remain with us, for the rest of our lives.

Another key factor that sets the course of a child's future path includes the strength of the relationships in that child's life. The American sociologist Michael Resnick has found that the two relationships that strengthen a child's well being are their connectedness to their parents and their connectedness to their school. Young people who have strong relationships with their families and with institutions like schools do not start to use tobacco, alcohol and cannabis until later in life, and they are also less likely to use them at all.

You can begin to see what the implications are when you hear Dr Wilson talk about the relationship between tobacco, alcohol and illicit drug use. In America, research by the Rand Corporation, which I will also table a copy of today, has demonstrated that early intervention programs directed at disadvantaged children and families have delivered positive results such as reduced maternal substance abuse and reduced participation in crime. Also in the US, the Highscope or Perry pre-school project followed a group of 123 African Americans over a period of 24 years. Half the families in that study received a combination of part-time child-centred pre-school programs and weekly home visits for one to two years and the other half received no such support. The results were quite remarkable for the very low level of investment that was made. At age 27, the children whose families had received support were less than one-third as likely to have been arrested for drug dealing. They were twice as likely to have completed high school and four times as likely to be earning a high income. The cost of the Highscope program was compared to the savings to the community and the government, and it was found that the benefits outweighed the cost by 150 per cent over the 24 years. I think this research demonstrates that everybody in the community benefits when children have a good start in life, so it makes sense for governments to join up and combine their efforts.

Put simply, if we do not invest in our children for their critical first three years we pay the price for decades to come. Not only will we be paying in terms of lost opportunities on an individual level; we will also pay on a broader scale in terms of the quality of our community.

The New South Wales government has considered the weight of evidence around the benefits of early intervention and put into practice these things by establishing the Families First program. And what we predict is that the Families First program will lead to communities and families that function in ways that make substance abuse less likely. Families First is a government sponsored strategy that aims to support families and work with communities to care and to assist their development in these critical early years of life. It links early intervention and prevention activities, and community development programs form a comprehensive network that provides wide ranging support to families raising children. Importantly, it is also breaking down the silo mentality that traditionally plagues government. It is equally important that the Commonwealth government, as a key player in the family support landscape, acknowledges this critical paradigm shift that has occurred in New South Wales and works cooperatively with Families First to achieve the best outcomes for children and their families.

As we know, families do not live their lives in neat boxes labelled Commonwealth government, state government, local government, community sector and private sector, and we have to move our responses beyond these terms. Let me give you an example of how Families First is doing that. I want to talk about the schools as community centres, which is one part of Families First. This is a combined effort by the Department of Education and Training, the Department of Community Services, the Department of Health and the Department of Housing, and they are working together to help disadvantaged families establish relationships with their local school even before their children start school. In effect the school becomes a one-stop shop for family support. The kind of practical support the schools as community centres offer families include their children having breakfast at school; transporting children to pre-school and school so they can attend regularly; having the children immunised against infectious diseases at the school; having parent support groups at the school so parents can interact, develop friendships and learn more about parenting; and locating an early childhood nurse at the school so that families with newborns can attend after they drop their school age children at school. And we estimate that about 800 families per week will be supported through these centres by the end of this year.

Families First is a genuinely whole of government activity that includes seven government departments. We are also bringing local councils in; there are a range of non government providers, private practitioners and, most importantly, the families themselves. Families First is now being implemented across New South Wales over a period of four years with a budget of $54.2 million. These prevention methods are, I think, positive strategies that in the long term can help drug proof our children, our families and our communities. And when we go back to think about the impact of the early years on children now and in later life, then I think we have no option but to continue to invest in these early years if we want a community that is going to be able to continue to raise future generations.

Ms Davidson—Thank you very much. I have given you a handout which has the five, I think, key points about school based drug education and I would like to talk to just a couple of them. But if you look at the side there, the key elements are clearly those factors that I have listed: safe and supportive school environments and the ethos and culture of a school are particularly important when we seek to establish effective preventive drug education. And, as you would know, the Commonwealth and the state governments have all strongly supported this as one of the government's ways of providing effective, preventive drug education for all students.

I will concentrate a little more on a couple of points in the middle, but Gillian noted a moment ago just how important connectedness to school is. That is part of what I am talking about when we talk about ethos and culture. In schools drug education is part of the health curriculum throughout Australia. It is there because research indicates that that is the most effective place to put it. Primary schools in New South Wales do not have a long tradition of teaching drug education. In fact only towards the end of the 1980s did primary school teachers start focusing on this as a subject. Prior to that, people came in from outside, and they did not always quite understand how the school organised itself.

So in New South Wales we are putting a very strong focus at the moment on building the groundwork and in your papers, or the booklets that you received from us today, you have one entitled *Drug Education in New South Wales Primary Schools.* It seeks to put clearly the position about why it is important that primary age students have a clear foundation. One of them is this: we know now from the current research that you really need to start talking about particular drugs about two years before the young person really comes regularly in contact with it. So if children are getting to tobacco at a particular level in the community—it might be year 5, it might be year 4—then the school will need to be focusing on preventive tobacco education about two years before then.

At the secondary level, we have had quite strong support from the Commonwealth government in developing resources and the states have also done some resource development. This is a terribly expensive undertaking; the materials need to be up to date and modern and to appeal to young people. You understand that, I am sure, because you have listened to young people talking about things that may be old fashioned, or not up with what is really happening. If they are seeing on television the very latest in media presentation, it is important that schools are able to do that. And so *Rethinking Drinking* and *Candidly Cannabis* have been two resources that have been distributed very widely to assist schools to have up-to-date materials. These of course are being revised at the moment.

The other key issue is that facts alone are not enough. Information alone will not do the trick. What the schools are seeking to do is to build skills, to help young people to be able to problem solve, to be assertive, to have a effective social skills so that if they refuse in a social situation they do it in an acceptable way and a protective way for them. Those sorts of skills are not learned overnight; they are gradually developed as young people go through school. So they might begin learning those in year 4 and they might not be successfully able to independently use them until they are into high school. Unless a drug education program has a strong component of skills development it will not be effective.

In the list of resources on the second page I have referred to Healing Time, which is a special project for Aboriginal students. It is effective when the community is involved. These are materials developed with the Aboriginal community and they rely on community support to be effective.

My third point here is the need for skilled and informed school staff. You will be very conscience of how the facts are changing, the information is different, it's hard to keep up. And so numbers of resources need to be provided for staff so that they have up-to-date information. You have an example of this today in the materials: a report, that was commissioned by the Department of Education and Training from the National Drug and Alcohol Research Centre,

on something very important to parents, Educational outcomes and adolescent cannabis use. That's in your papers. There is a lot of misinformation given to young people about cannabis. It is particularly important that teachers know what the facts are, and so this kind of document is produced for schools and then it has inside it a little handout—in other words the facts clearly and in summary so that people if they find this a little difficult to get on top of will be able to get the clear facts and understandings from this summary.

One other important one there is *Managing Drug Related Incidents*. If a young person does, in fact, begin to use drugs, the way in which that's managed is important. Some of you will be conscious from the COAG initiatives that all states received funding. These projects were developed through the MCEETYA processes, and in New South Wales this is the outcome of that consultation, a document which spells out clearly for schools how these matters should be managed.

Finally, I have two points. Schools cannot be effective without parents. It is essential that we build the links. In the next three years we are going to see very, very strong program development and support around linking parents with the school developments. We want parents to know what is happening at schools. We want parents to be comfortable. We want to assist them in knowing how to deal with these issues. Again, there are significant Commonwealth and state funds going into that project.

Finally, if students do misuse drugs, they need expert help. It's important not to overreact to what might be a trivial incident, but there will be other students who really will have a major difficulty. It is important that that's dealt with appropriately and early for the sake of the young person being able to contact with the local services and also work out at school and at home how to manage this.

Cmdr Small—Thank you. As well as being Assistant Commissioner in the New South Wales Police, I am responsible for the Greater Hume police region. That region extends from Mount Druitt, Blacktown, Fairfield, Cabramatta, Liverpool, Green Valley, Campbelltown and down to about Camden and Bowral. I have prepared a paper which has not yet been handed out, but I will make available when you wish, and what I would like to do is draw from some aspects of that paper. My comments are limited to illicit drugs.

It seems to us that it is unlikely that the problems of demand can be dealt with adequately as long as the flow of illicit drugs continues unimpeded. Reducing the demand for drugs through education, treatment, rehabilitation is absolutely crucial. Unless more effective curbs can be placed on drug supply, and those who traffic in drugs, demand reduction is unlikely to achieve its full potential. Wholesalers and retailers of illicit drugs are proven marketers and have an insidious product whose supply helps to create its own demand. The New South Wales Police Service operates within the framework of the National Drugs Strategy and its forerunner the National Campaign Against Drug Abuse.

While there has been, and continues to be, some debate in some quarters as to precisely what is meant by harm minimisation, the police service takes the view that the goal is the minimisation of the aggregate damage to the community or society, and in the case of New South Wales, quite clearly the people of New South Wales, in particular, and more generally the people of Australia. In applying the standard of aggregate damage, this prompts the police

service to concentrate its efforts on frequent, high-dose users, especially those whose addiction is accompanied by criminal activity, rather than on an occasional users. Aggregate damage also requires us to concentrate on drug trafficking and on the side effects of that drug trafficking, especially violence, the laundering of illicit profits, which are used to compete unfairly with legitimate businesses. We hold the view that drug laws need enforcement attack both supply and demand for illicit drugs.

The service view is that, from a law enforcement perspective, the aggregate damage to the community is minimised through five key strategies: (1) reducing the influence of drugs and organised crime, including corruption; (2) targeting those dealers who impact most on the community—that is, those who are most active, have established networks, resort to violence, and profit from and target our young; (3) reducing the impact of visible drug markets; (4) reducing the use of drugs by the small group of hard-core users who create problems out of any proportion to their numbers; and, (5) reducing crime by supporting prevention, diversion, treatment, education programs that reduce illicit drug use. Crime Agencies, the service's centralised investigative capability, has responsibility for drugs and organised crime and primary responsibility for the first two strategies that I mentioned. Local area command police have primary responsibility for the last three strategies.

While reports on the drug problem in this state provide widely differing views on details and its trends, a recent survey of the 80 local area commands in the state provide a picture which found, among other things, the existence of multiple drug markets in different types of drugs with different trends and different price patterns existing at the same time across the state. Drug prices are closely related to the proximity of locations to major distribution locations. The closer a location is to a major distribution centre, the cheaper the price of the drug. Significant stability in terms of availability of price and drugs existed across locations. Domination of drug scenes by identifiable groups in a number of locations stretch from Western Sydney through south-western Sydney to Kings Cross, and drug-related violence is limited to a relatively small number of areas within the state.

It is generally accepted that relatively small group of hard core illicit drug users account for probably 70 to 80 per cent of consumption and create problems out of proportion to their numbers. And among the problems this group creates is crime. Many studies have shown that dependent drug users are responsible for figures that range from 30 to 80 per cent of property crime and violent crimes of violence. In one sense, it matters little which extreme we take—whether we take the view of the 30 or the 80 per cent. The simple fact is that the contribution to crime is a major one and one that law enforcement bodies, governments and the community want to see reduced.

There is significant intelligence which suggest that from time to time during the past two years, high-level heroin traffickers have been experiencing supply shortages. And for around two months, in both Sydney and Melbourne, and in New South Wales generally, there has been a drying up of heroin. As a consequence, the cost of drugs on the street and through the supply chains has almost doubled in the past two months. It's not known how long this shortage will continue and it's not known whether the shortage will dry up even further on the markets. However, the present shortfalls in supply suggest that increasing disruptions in the supply chain at the highest levels are having a positive impact on the trade.

In closing, while I see some grounds for some cautious optimism, I see no grounds for complacency. A major challenge for law enforcement is to better articulate its achievements without becoming involved in emotional debates about 'The war against drugs is lost'. The fact is, there has never been a war on drugs, at least in Australia. Our contribution to minimising the aggregate damage to the community will continue, and I see the service playing an increasing role following on from the state government's drugs summit and the federal government's Tough on Drugs. Thank you.

Mr Grant—I would like to address some comments today on the criminal justice system diversion schemes that are in operation, with the theme of linking treatments and the criminal justice system. For years the traditional position of magistrates and judges has been to refer offenders for drug and alcohol treatment. The problems with this have included the haphazard nature of these informal arrangements, the lack of treatment places, the revolving door principle leading to co-offending, and no evaluation of the results. As a result of the drugs summit in May 1999, a commitment was made for a range of innovative diversionary schemes to be introduced and trialed. The basis of these diversion schemes is to link offenders to treatment regimes commensurate with their drug problem and the nature of their offence.

In addition, there has been a legislative response, including section 36A of the Bail Act 1978, which allows magistrates and judges to impose the following conditions on the grant of bail. The offender is to enter into an agreement to be assessed for drug and alcohol treatment and rehabilitation. The offender is to enter into an agreement to participate in a drug and alcohol treatment and rehabilitation program. Further, section 11 of the Crime Sentencing Procedure Act allows the court that convicts an offender to adjourn proceedings and grant bail so as to assess the offender's prospects for rehabilitation and allow the offender to undertake and complete rehabilitation.

A range of criminal justice system initiatives are being introduced and have been introduced which aim to link treatment programs to justice system outcomes. These are the cannabis cautioning scheme, which operates state-wide; the drug offenders compulsory treatment pilot cautioning scheme operating in the North Coast and Illawarra districts; the Young Offenders Act amendments, which operate state-wide; the Lismore early court intervention scheme, sometimes known at MERIT, which operates on the North Coast and which, on 5 February, commenced operation in the Illawarra; the youth drug court in Western Sydney; and the adult drug court in Western Sydney, which commenced operation in February 1999, a few months before the New South Wales drug summit.

The cannabis cautionary scheme trial commenced on 3 April 2000. The target group for this scheme includes first- and second-time adult offenders who admit the offence. The offence is possession or use of less than 15 grams of dry cannabis leaf and/or possession of implements for cannabis use. They are summary offences only. Excluded from this scheme are those persons who have prior convictions for drug, sexual or violent offences. The outcomes of the scheme are a police caution with a cannabis cautioning notice. The notice contains warning of health costs and legal consequences of cannabis use. Information is provided about treatment and support services, and, of course, the police always retain their discretion to charge in individual cases.

The target group for the drugs compulsory treatment pilot cautionary scheme in Lismore and Illawarra is first- and second-time adult drug offenders who commit minor—that is, summary—drug offences and admit the offence. The offence involves possession of less than half the small quantity of the prohibited drug; you are excluded if you have a conviction for drug, sexual or violent offences. The outcomes of this scheme are a police caution and attendance for assessment by a case management team, and referral for appropriate treatment, which could include detoxification, residential rehabilitation, et cetera. Non-compliance with the treatment means the caution can be withdrawn and proceedings can be commenced by the police.

The Young Offenders Act was introduced to provide a hierarchy of invention for young offenders, beginning with warnings, police cautions, youth justice conferences and, of course, court. Under the act, young offenders are entitled to the appropriate level of intervention, depending upon their convictions and their criminal conduct. Amendments to the act, which were introduced after the drug summit, will now permit young offenders who commit summary drug offences to be dealt with under the act by means of caution or conference. It will also be possible for police or courts to divert young offenders from the courts to treatment and rehabilitation programs.

The Lismore early court intervention scheme—MERIT—commenced in Northern New South Wales in July 2000. The target group for this scheme includes adult offenders living in the trial area who commit an offence not involving violence or sexual assault, who have a demonstrable drug problem and are willing to comply with the program. If you are admitted into the program, after assessment you will be bailed for up to three months to attend appropriate treatment programs. If you enter the program, your progress is monitored by a drug treatment team who will report progress to the court. There is a wide range of treatments available to suit the individual needs, and after completion of the program you return to the magistrate for sentencing. Unlike the adult drug court, you are not sentenced first and you do not have to enter a plea. You attend for drug treatment; if you comply with the programs, you then return to the magistrate, who takes that into account as part of the normal sentencing process.

A youth drug court trial commenced operation in Western Sydney on 31 July 2000 as part of the normal children's court. The target group includes young offenders committing crimes who have a demonstrable drug problem and who admit guilt. The offenders are assessed by a drug assessment team and a treatment plan is developed. If they are admitted into the program, offenders are heavily case-managed and attend a variety of drug and other treatment programs. While attending these programs, offenders attend court regularly to meet with the children's magistrate to discuss progress. If the offender finishes the program, their participation is again taken into account in the matter of sentence.

Finally, the adult drug court trial commenced on 2 February 1999 in Western Sydney. The target group for this purpose-built trial was 300 adult offenders charged with non-violent crimes who are dependent upon illicit drugs and who face imprisonment as a likely sentence. They must enter a plea of guilty and agree to participate. The program is a minimum of 12 months duration and people must be completely drug free to finish the program. Entry to the program included treatment for drug dependency; intensive case management; provision of a range of support services; regular appearances before the court, which in the first three months of the program is on a weekly basis; and random drug tests.

These criminal justice initiatives are being trialled or introduced to provide a more effective response to drug-related criminal activity. The schemes provide an effective and proportional response to drug-related criminal behaviour and aims to deal with the offender by treating their drug problem. The schemes also ensure that offenders' participation in these programs is thoroughly evaluated. All those schemes will be evaluated.

Mr Chairman, I will make available copies of the paper I have just prepared, plus results of the drug diversionary schemes to date, a copy of the Bureau of Crime statistics, and a research paper on monitoring of the adult drug court which was issued in December of last year. I also provide a report which was released yesterday as part of the adult drug court evaluation, the interim report on health and wellbeing of participants. Thank you. I will hand over to Mr Michael Hogan from the Premier's Department.

Mr Hogan—Thank you very much for the opportunity to provide some information to you about the government's initiatives in relation to drugs and community action. I am a director of the Strategic Projects Division of the Premier's Department. The Premier's Department has been given responsibility in the government's plan of action for implementation of two key strategies in this arena. I also have a copy of a presentation, which I will make available to the committee when I am finished.

The background to the drugs and community action strategy derives from a pilot national program to establish cross-sectorial drug action teams, one of which was in Fairfield. In the Premier's presentation to the national leaders meeting on illicit drugs in early 1999, the Premier put a proposal for a national approach to supporting community action as part of a package of dealing with illicit drugs. A commitment to supporting additional drug action teams was included in the government's policy platform in '1999—Fighting Drugs', and became one of the key issues on the agenda of the drugs summit. Working group 8 at the drugs summit was chaired by the Special Minister of State, and was devoted to the issue of drugs and community action.

The summit gave a very strong and clear endorsement—not only from that working party but from a number of working parties—that communities need to be involved and engaged in an active way if we are going to sustain effective responses to the incidents, the causes and the impacts of illicit drugs and also that we need to improve the relationships across stakeholders—across not just government agencies but across levels of government and across other sectors of the community—and to involve them in partnerships that can link their efforts, their ideas and their resources to deal with illicit drugs. The drugs summit made a clear recommendation that the government should support community drug action teams where local communities are keen to actively participate in the fight against drugs and where there is leadership and a willingness to build partnerships between the council, community groups and business and the state government.

As a result of that, in the government's plan of action, the government committed to a four-year drugs and community action strategy, and we have responsibility for its implementation. It is a state-wide strategy. The government has committed approximately $4 million over four years. It is operating at local, regional and state levels. The primary vehicle in the strategy is locally based community drug action teams, and the strategy is closely supported by the

Premier's Department regional coordination program, which also brings the area managers of all relevant state government agencies together at a regional level.

The objectives of the strategy are essentially to create greater stakeholder and community awareness; to achieve a constructive and coordinated action at local, regional and state levels; to customise the responses by government and others to those characteristics of illicit drugs, in particular communities; to facilitate innovative and integrated service delivery initiatives; to build better links across funding programs and initiatives—not just specifically drug related ones; and to help achieve a better alignment of efforts at local, regional, state and national levels.

In terms of implementation, the strategy is supported by nine project managers across New South Wales, three in metropolitan Sydney, and six in regional areas. There is also a project manager responsible for statewide issues, and they operate in a team in conjunction with another team of three positions responsible for the community drug information strategy. That strategy is governed by the whole of government working group involving 12 government agencies. This strategy reports through the Premier's Department to the Premier and to the Special Minister of State and the Cabinet Committee on Drugs. The strategy is supported, in addition, by a small funding grants program to provide the regional project managers and the drug action teams with seed money to commence initiatives at a local level. They will also be supported by a series of materials, a framework for action, newsletters, information sheets, a website, tool-kit and some training for local government, which are soon to be launched or under development. And again, copies when they are available, can be made available to the inquiry.

The membership of the drug action teams at a local level—and I understand you heard a little yesterday about the Fairfield Drug Action Team, perhaps in some of the comments from the NGO members' representative that you spoke to—typically involves councils, state government agencies at a local level, including the police, schools, area health services and the Department of Community Services, non-government organisations and local service providers in particular. Community organisations like Youth and Community Services, PCYCs, voluntary groups, service clubs, churches and representatives of local business including chambers of commerce.

To date, there are some 46 community drug action teams established or in the process of establishment across New South Wales, and in the presentation I'll give you the names of the locations of those drug action teams. In terms of some examples of the sorts of things they doing, they are creating information that brings together information from various service providers and agencies about contact points in relation to drug and alcohol services. In one location, they are working with local retailers on a voluntary code of conduct covering the sale of solvents to minors. They are involved in organising safe events for young people, community events to make local treatment services known to the community. In Kings Cross, for example, there was some months ago a tour of local services that was made available to the community to create better understanding of what services are being provided. They are organising forums in local areas, they are organising training programs for agencies and for community organisations. It is early days and we have yet to see I think the full potential of the drug action teams realised, but we are very hopeful that they will play an important part in sustaining effective responses by state government at a local level to illicit drugs.

CHAIR—Thanks very much. We'll go straight to questions and if we each keep our questions short and our answers short as well, we'll get through as much as we possibly can in the 25 minutes available to us. Andrew Wilson, the methadone program and the amount used suggest that it may have started high and has been coming back a bit in recent years. What have we learned about the methadone program in recent years?

Dr Wilson—Sorry, Mr Chair, can I just clarify: you are talking about the dose or the number of people on treatment—

CHAIR—The dose, yes.

Dr Wilson—Look—

CHAIR—Sixty-five or 80, maybe up to a 100.

Dr Wilson—Professor Webster could probably comment on that better than I can, I'm not a—

CHAIR—Okay, Ian might like to have a go at that. It's just something that came up in the last few days, and I am interested.

Prof. Webster—This is a question about the level of dose that's used on the methadone program?

CHAIR—Yes.

Prof. Webster—I mean, that's been examined over a period of time and in the early days there was this idea of massive blockade by methadone. And then people changed their views about this. I'm talking about 20 years ago now.

CHAIR—Yes.

Prof. Webster—But over a period of time it's been found that to retain people in methadone programs you've got to deal with the level of dependence and their physiological dependence on the drug, and so increasing doses have been found to be necessary to maintain people in the treatment program—otherwise they leave it and go back on illicit drugs. There are some doctors who are quite thoughtful and scientific about this who use much higher doses than the average used in the public system, but the average level in the public system would be about 60 to 70 milligrams a day, I should think.

CHAIR—Okay.

Prof. Webster—But there is an increasing acceptance that in some people you have to go to higher levels of dosage.

CHAIR—Thank you. Geoff Barnden, in the move to solutions versus crisis management, it would appear that the crisis is very much an individual thing and community thing, depending

on your individual perception. How well based do you think it is on research? What's your degree of satisfaction with the research working on solution based management? We are about to speak to the National Drug and Alcohol Research Centre, and they offer some pretty good, soundly based advice: how much do you think the solution base we want to work towards is based on sound research?

Mr Barnden—I'm actually wondering if perhaps Professor Webster—

Prof. Webster—I would like to intrude with a comment, which would be of interest to all of the members present. Mr Della Bosca, who's the minister of state who is responsible for this, has said on two occasions—in fact he said at the drug summit—that he was interested in evidence based politics. And I think one of the big outcomes of the drugs summit was that people learnt that there was good research such as the early intervention that Ms Calvert has spoken to us about. There is a lot of research—and I think New South Wales stands high in the level of research that is conducted. The National Drug and Alcohol Research Centre is extraordinarily valuable and the state Department of Health under Andrew Wilson conducted a great deal of research. And Andrew, you might like to comment?

Dr Wilson—Mr Chair, if I could, I think there is an issue here that the field is clouded by rhetoric which tends to confuse and hide a lot of work which is being done. However, certainly in relation to the treatment and rehabilitation area, I referred to the quality framework that we are putting in place, and one of the key elements of that quality framework is trying to get a better understanding of the outcomes of the treatment and rehabilitation services that we offer or that we fund. And a large project being jointly run by the Commonwealth and New South Wales will be focusing on looking at the outcomes of different types of treatment programs and trying to get a better handle on how the system deals with people and manages people and the outcomes of that for people who have contact with treatment services over a long period of time.

CHAIR—Assistant Commissioner Small, you mentioned that there has 'never been a war on drugs' Can you just develop that a little bit for us, please?

Cmdr Small—I think if the governments, state and federal, were to say, 'We want to declare a war on drugs', I think we can solve the drug problem in Australia relatively quickly. I think, however, society would be much suffering as a result of that. The fact of the matter is that in war you kill people, they don't face trial, they are arbitrarily interned, there are a whole range of human rights that are given up in the face of war. We have never declared that situation to be the case here with drugs. What we are doing is trying to have a law enforcement role in a civil and democratic society.

CHAIR—Gillian, can you give us a clarification on the US study and the African-American study: what was the name of that study?

Ms Calvert—The Highscope study. It is listed in the Rand report that I tabled, Mr Chair, so you will be able to have it.

CHAIR—Another quick one—alcohol and pregnancy in terms of effects on foetal brain development: could you make a comment for us, please?

Ms Calvert—I am not a doctor. I would probably defer to someone else but, in terms of the substance dependence on children, I convened the child death review team which, on an annual basis, looks at all deaths of children in New South Wales. We conducted a study looking at about 70 children who had died where we felt substance abuse had played a role. As a result of that, New South Wales is implementing a number of recommendations to become much more aware of the impact of treatment, not only on the person but also any children that they may have responsibility for, and again I have tabled that report for the committee's information.

CHAIR—Thank you. Just one quick last one to Bill Grant: you mentioned the report on the progress of the drug court program, but could you just say how you think it is going? You have probably given us a bit of an insight, but what are some of those reports going to tell us on how it is going?

Mr Grant—I think we have to be very careful looking at the adult drug court we have established at Parramatta, because it is so different from where these models came from, which is the United States. The fundamental point of difference is that they basically deal with people who are charged with using or possess offences and they jail people for six months, 12 months for use—which is most unlike the harm minimisation approach that we have adopted in this country, let alone this state.

In terms of the adult drug court, the retention rate I think at the moment is about 55 per cent, somewhere around that mark, but when you are looking at the people we are dealing with, the very hard nosed end of the market, if you like—the people deeply involved particularly in opiate use and usually with a correspondingly heavy criminal involvement—it is a very difficult client group to deal with. Perhaps Professor Webster and Andrew Wilson could comment on the retention rate, but 55 per cent seems to me to be a very good rate—if we can hang on to something around that, having regard to the client group that we are dealing with. The signs are good so far, but again, the evaluation will keep happening over the next 18 months.

CHAIR—Ian, do you want to add something?

Prof. Webster—I think there is a high retention rate and a lot of effort is put into these people, so we are going to have to look at the economic costs of doing this program. My subjective experience with it is that it is a valuable and worthwhile effort. I have looked after quite a lot of people on this program and they seem to do quite well. I think Andrew is a bit more sanguine than I am.

Dr Wilson—Well, we set it up to evaluate impact; I think we should wait and see what the outcome of it is. I mean, we are looking at the health outcomes but clearly its intention is to try and also reduce recidivism rates, and we need to look at those outcomes. If I have got any concerns about it at all, it is that we will learn things from it. The question of whether that particular model is a model that we can proliferate, if you like, around New South Wales is a different question. But I think whatever happens we will learn things from that model.

Ms ELLIS—I think my question is to Bill Grant and/or Clive Small. I do not know which one of you would prefer to answer it, but it is to do with the prison system. We had the delight of visiting Goulburn jail a couple of days ago. One of the points that came through to me very clearly—and it follows up from what was just said—is the access to education and the access to

retraining, given that the enormously high proportion of prisoners—we are told—are there for a crime which is in some way drug related—and I use that term loosely. Given that the literacy and numeracy levels with these people are incredibly low and we were told informally that out of the population in that prison of around 500 people, there were 40 education places, 25 currently filled, and I think anecdotally I recall them saying approximately 80 applications a month are received from prisoners to access education and given that some of those, in human terms, are probably flirting with maybe an easier way of spending a day, do either of you have a view as to how we are actually handling the recidivism in terms of drug related property crimes, assault crimes and so on in connection with the drug question, when we are looking at those people in the prison system?

Cmdr Small—I suppose there are a number of aspects to it and I would not want to directly comment on the issue of corrections. What I would want to comment on is that I think there are increased opportunities available to us to actually coerce people into treatment. A recent change in policy in terms of drug law enforcement in this area will see, I believe, arrests being used increasingly, bail provisions being used increasingly to control dependent drug users and to in fact, in a sense, create a crisis in their life where they have a choice of saying, 'I can go to jail or I can essentially receive treatment.' And we would certainly support every treatment option that was available, whether it be in the community or in the prisons. Our purpose is certainly not to clog the prisons with low level users and dealers; that is not our purpose. But certainly we see that we have to somehow break the cycle of the revolving door, and it also seems somewhat unconscionable to suggest that treatment is a major option if the facilities for treatment, whether that treatment be physical or education training or whatever, are not available to people.

Ms ELLIS—It is in your bailiwick, isn't it: correction?

Mr Grant—No.

Ms Ellis—It is not. Is there anybody here in whose bailiwick it falls?

Dr Wilson—If I could swap hats for a minute, I am also a member of the Board of Corrections Health Service, which provides health services in to prisons in New South Wales. I cannot speak for Corrective Services and we apologise; it is remiss of us not to have representation from them because that has been a very major strand of the government's response to the drug problem in New South Wales—recognising that—to perhaps use a bad phrase—it is a captive population and that there are very special opportunities for intervention. The corrections health service is working with Corrective Services to expand treatment options in prisons across the state and, in particular, expand the detoxification facilities. The particular element that we are focusing on is the post-release period: that there is a very high risk of people post release who may have had quite successful treatment commenced while they are in prison but on release, find themselves in a situation, one, where they are back in an environment where drugs may be more freely available, but also in a situation where they may find themselves at a loose end. And a specific project is to be initiated over the next six months, which will look at how we better link people, post release, into treatment services. The other element that you alluded to I think was, I think, the general education rather than specifically drug education in prisons.

Ms ELLIS—Absolutely—literacy and numeracy and further education.

Dr Wilson—And certainly the work which is being done in prisons in New South Wales confirms exactly what you say, and Corrective Services are trying to expand the way they provide those services, but I cannot be more explicit than that.

Ms ELLIS—Can I just say that it was alarming for us to hear that an inmate can walk out that door after a period of time in that prison and actually get their first shot of whatever in the car park from the friend picking them up. There appears to be very little, if any, flow on outside that door in support services and reintegration back into the community, and you are all nodding in agreement.

Dr Wilson—That is something identified very specifically as a high-risk period; it is a high-risk period for overdose deaths as well in that post-discharge period. These trials will look at different ways of providing support during that period of time: one, through the better skilling of people who are involved in that service already—people in the probation and parole services; but also in terms of ensuring that the link for people into treatment services continues—that it is seamless between inside prisons and when they come out of prisons.

Prof. Webster—Can I just make one comment: that is about the prison service. There are methadone programs in the prison service—

Ms ELLIS—Yes, we understand that.

Prof. Webster—And we have got more people, I think, in that treatment than other states. And the methadone program has to be followed up. Of the people who get discharged from prison in New South Wales, the highest proportion that get discharged from methadone programs are out in this area of Sydney, and so one of the important things we are trying to do is provide co-ordinated care outcome along the lines that Andrew was speaking about.

Ms ELLIS—I have one more question to Eleanor Davidson in relation to the package of information for schools here. Can you just very quickly explain: is all of this approach part of core curriculum in every school, public and private? You mentioned COAG funding in relation to this; can you just explain what that was and where that money came from and what teacher training is involved in the handling of this? The parent pamphlet says, 'further details including a full discussion and copies of this report are available at every school'. How many does a school get? Is it just something that lands somewhere in a cupboard or is it something that actually becomes part of the school teaching process?

Ms Davidson—Getting information into schools is quite critical; you clearly know this. It is important, for example, with something like this that there is not just one copy, that there are multiple copies for the teachers. However, this one we provided at the level of one per teacher on the staff and made it clear that additional ones are available. Increasingly we now get around the difficulty of distribution by putting them up on the website. That way is probably the most effective way to ensure that everyone has ready access, and that way we can also keep things up to date when we want to make minor changes. This one, *Guidelines for managing drug related incidents in schools*, I would need to provide the full details about later in terms of the COAG initiative, but COAG talked about this about two years or three years ago. Commonwealth put extensive funds into it, but agreed that because it was going through the schools in every state, it would be important that the MCEETYA format was used. So it was that a task force was

established, which had a representative from every state. The non-government systems were also represented, and the parents. They drafted the framework—which has been released by the Commonwealth and you've probably seen it—'Caring for kids: yellow and blue' has been distributed.

States clearly have different legislation. If you are going to talk about alcohol it is not going to necessarily be the same in New South Wales as it is in Victoria. Hence, if you look at the back of this book with all of the appendices, you find that it talks about what is the law in New South Wales for New South Wales staff and what is the department's position if you are in a government school with respect to alcohol or tobacco on site. So those are explained in their appendices.

This book acknowledges the COAG and the MCEETYA process, and if you look at it on page 25, appendix 1 says, 'Guiding principles for responding to illicit and other unsanctioned drug use' and then refers back to the documentation through MCEETYA. So I can provide that formally. Now in terms of the curriculum for government and non-government schools: in New South Wales the curriculum is established or the syllabuses are agreed by the board of studies, which represents both the government and the non- government system, and you can be certain that at the secondary level the PDHPE syllabus—personal development, health and physical education, which is where drug education is located—is a mandatory syllabus from 7 to 10; then in 11 and 12 there are electives. And in the New South Wales system we have a 25-hour course which has two areas that focuses on relationships and drugs—we think probably the most critical issue for young people as they are leaving school.

The non-government system has been very extensively involved in the development of the materials that are funded through the national system, but they will also use New South Wales government school resources quite extensively, so something like that, which is a list of resources for teachers, they will buy and we sell them readily for use to anyone who would like them.

Ms ELLIS—Is there training for all this?

Ms Davidson—Teacher training, as you know, is being reviewed at the moment overall by both the Commonwealth and state to make sure that teachers coming out are ready to teach drug education effectively. We have had a major focus at the moment on primary teachers. These are generalist teachers, and so drug education is a harder area for them because it is a very small part of their overall responsibilities.

There is extensive funding gone in now to make sure that not only do they have help with the syllabus, which is new in primary, and with the use of documents like this, but also that they can meet and talk about matters that are relevant in their school. For example, if you are out in Wilcannia, you might want to talk about: how do schools co-operate with health and docs in addressing something like inhalant use. That is not relevant at Forest High, where they might want to be talking to the Department of Health and the police about: what is the availability, for example, of ecstasy in the area and what is the most appropriate way for schools to make sure that young people have adequate information? So we try to target it.

Ms HALL—The first question I would like to ask is: what percentage of the funding—of the money available for drugs in New South Wales—is being spent on law enforcement and what percentage is being spent on harm minimisation?

CHAIR—Do you have the answer for that, Geoff?

Mr Barnden—It is a very difficult question actually. I mean, harm minimisation is actually harm reduction—supply reduction and demand reduction. So harm minimisation actually takes into account law enforcement issues. We have actually done some research into the drug budget and the cost of drugs in the community, and it is a question of how you allocate the funding in terms of direct drug costs or indirect drug costs. So in fact you could actually say that we have got a very small direct allocation to the police service in terms of drug law enforcement, but the actual cost to the police service in terms of their mainstream budget is very significant. So the drug law enforcement costs are very significant but they are not specifically identified. So every time a police officer goes out on the beat, 50 per cent of his work might actually be involved in law enforcement action, so it is a very difficult question.

If you were to actually look at our overall drug budget though, you could probably say that a very significant proportion is focused on—especially with our new programs—the areas of New South Wales health. Of the additional funding that we provided, I think at least 60 per cent has gone into the New South Wales treatment and support services, detoxification services, those sorts of issues, those sorts of programs. Andrew, I think you might recall that we had a $90 million budget, which was given to you—I think you had a $90 million allocation given to you -

Dr Wilson—I cannot comment on the amounts spent on the law enforcement area, but we can get those figures for the committee. In terms of the harm minimisation work in the health sector versus the drug treatment sectors, we spend about $150 million a year in direct services—there is a hell of a lot of other expenditure which is indirect in terms of care of people with drug and alcohol problems—that goes to the treatment of people with drug dependencies, and we spend about $20 million to about $25 million in services which you would say were primarily harm minimisation in intent. So, that is the sort of order of magnitude within the health sector.

Ms HALL—So you will get some more detailed figures and send them to the secretariat. Good, thank you.

Mr Barnden—If I could just be a little bit more specific, I do have some figures here. As I mentioned, of the overall four-year drug program, specific drug program budget of $500 million, over $400 million is going to New South Wales Health. That is a fairly significant proportion of the total budget.

Ms HALL—That's good. Thank you. My next question is just a very simple one, and it is to do with provision of health services for prisoners in New South Wales jails. That is picked up by state health?

Dr Wilson—Yes, we have a separate health authority, the Corrections Health Service, which provides services as a statewide service across the state into all prisons. The specific drug and alcohol services are provided partly by the Corrective Health Service and partly by Corrective Services. It is a sort of historical factor which we are currently actually looking at.

Ms HALL—There is no Medicare money going in?

Dr Wilson—In terms of the money that comes to the states under the health care agreements, some of those funds would go to provide health services to people in prisons. Prisoners, on the other hand, are not able to access Medicare in terms of getting a Medicare number—and anyway it is a bit difficult to get out and go and visit the GP or a specialist to take advantage of that.

Ms HALL—Just a tidge. We experienced just how difficult it would be the other day. Gillian, I am very aware of all the good work you have done in New South Wales over a long period of time. Could you share with the committee a little bit of information on government investment in children that you talked about. How could the three levels of government work together to improve that situation?

Ms Calvert—I think children's well-being is impacted by a number of things. Some of the policy levers are helped by the Commonwealth government, for example income support, and the levels of income support are controlled by the Commonwealth government. A lot of the service delivery is at a state level, if you think about health, community services, housing and so on. And I think local government is a critical player because they are close to people and communities, and often the tone of the community has a very strong impact on families and therefore on children's well-being. What I would like to see is cooperation in planning, so that not only do we jointly plan between the government agencies at the state level, but that the Commonwealth joins us at the table and certainly—and we are seeing this—the local government people get very much involved in planning for services and activities, and planning with each other about how each of us can pull our particular levers in order to achieve the common objective which is children's well-being and support for families.

So certainly joint planning is one thing. I also think that there is much more scope for joint research and for bringing our efforts together in relation to researching ways in which we can improve children's well-being. They are some of the ways in which I would want us to move if we were to more effectively make use of the efforts all of us are individually putting in.

Ms HALL—Thanks very much. And did you give us some information on the Families First—is there some documentation that has been handed in?

Ms Calvert—Yes, I have given you the four newsletters that we have produced with Families First which I think are probably the easiest way. We also have a web site, which you should be able to access as well.

Ms HALL—Yes, thank you. Eleanor, students caught using illicit drugs in New South Wales schools, what is the suspension?

Ms Davidson—If there are illicit drugs, there is an immediate suspension and then there is an evaluation by the school counsellor about what actually was the issue, and then we try to make an appropriate program available to the student. Sometimes that will be done in consultation with the Department of Health and sometimes it will be done with other services that exist in the community. However, all school and TAFE counsellors now have undertaken additional training, so that they are more able to work with young people who are involved with drugs.

Ms HALL—My understanding is that students that are suspended often just spend that time at home without any program.

Ms Davidson—It is extremely important that the way that the school deals with the suspension does not cause more harm, and that is specifically stated in this document. We draw attention to the fact that the best thing that can happen is that the student gets back quickly to school and that the program be undertaken. Sometimes the cause of delay is the difficulty in being able to contact the family and unfortunately that occurs from time to time, but in general I think people increasingly understand the best thing to do is to get back to school. After all, if young people develop literacy and numeracy skills it is a much better way to go through life.

Ms HALL—The community drug action teams, partnerships—I noticed you talked about partnerships between various people. Once again, I noticed that there were not any federal partnerships. With the cautionary programs, how easy is it to get people actually into detox and rehab, given the fact that we have been told on a number of occasions that you can't get them in?

Mr Hogan—In relation to the community action strategy I think there is scope to improve the linkage between Commonwealth programs like Community Partnerships with what is happening with the community drug action teams. I think they are a very important vehicle and we would get a lot better return at a local level if all levels of government were coming on board and would be happy to pursue that avenue with the Commonwealth.

Mr Barnden—In terms of partnership between the state and the Commonwealth, the Commonwealth-state drug diversion agreement is an excellent example of a partnership agreement between the two spheres of government. It is extensively funded by the Commonwealth and all diversion programs, including the Cannabis Cautioning Scheme, are embodied in that agreement. The funding provided under that agreement is providing an enormous number of services to support young people and young adults and divert them from the criminal justice system.

Dr WASHER—Dr Wilson, I want to compliment you on the focus of attention now on people released from the prison system—there seems to be a major problem there in terms of follow-up and also death from overdose of opiates. Relating to the prison system, is there a problem with transmission of blood-borne diseases within the prison system from illicit drug usage?

Dr Wilson—There is no doubt that rates of hepatitis C are much higher among prison populations, particularly if you look at women prisoners. The complicating factor here is that, particularly for women, drug use is a major reason for incarceration of women. So they are starting with a group of people who have a high rate of infectivity. There is certainly also evidence to indicate that there is spread within prisons, and that is an issue that is obviously of some concern.

Dr WASHER—Is that going to be addressed?

Dr Wilson—New South Wales has pushed the limit, if you like, in relation to trying to develop harm minimisation within prisons through the promotion of use of bleach and other

strategies in terms of education of people about trying to reduce their risks, about trying to identify people and assist them into treatment programs and through having effective treatment programs in place. We are currently revisiting that whole area to look at whether we are doing as much as we can.

Dr WASHER—That is terrific, thank you. Dr Saunders, has this whole elicit drug issue now detracted from the tobacco/alcohol problem that we have, knowing that tobacco kills more people than all the rest of this combined? Has the focus come out of our management?

Dr Wilson—Sorry, Mr Washer, if I could just reply to that on John's behalf; he was unable to get here this morning. One of the decisions that I made administratively was to separate out from the drug programs the tobacco group for two reasons. One is that in terms of natural alignment in terms of interventions, they fit more closely with a range of other health promotion activities. So the synergy that we gained there to my mind it was better to have them sit with the health promotion people. But the other component of that is that the national and state focus has been very much on illicit drug uses, and I was concerned that we did not want to lose the agenda in relation to tobacco and it was a deliberate move on our part to separate those two. We think they are important linked issues, but in terms of just trying to maintain the profile in relation to tobacco.

Dr WASHER—Now just a quick question to you, Assistant Commissioner about heroin drought. That must be a compliment to you and congratulations to the police force, but I guess the issue is now: is cocaine going to be a cheaper item, which is perhaps a more dangerous and dreadful management problem from the medical profession side of things? Do you think this way of focusing is going to shift the whole spectrum to different drugs? Also, do you think that when and if it becomes readily available again, and hopefully that will not be the case, but then we would have more problems with overdose situations?

Cmdr Small—I suppose there are a number of things, but the first comment is that, whilst there is a deal of talk, much of it unsourced, about the prevalence of cocaine in the communities at the moment, the fact is that on the two drug reporting situations we have in New South Wales, one at Bankstown and one at Parramatta–that is where people are tested after they are arrested for drugs in their body–cocaine shows up in a very small fraction of numbers only, which suggests that at least amongst those people who commit crimes and come to notice, it's not a widely used problem. That does not mean that it is not used by, if I can describe them as otherwise law-abiding citizens, who might want to indulge socially in cocaine at this stage.

The fact is however that most of our hard-core heroin users at the moment are already poly drug users, that is they use whatever drug is available at the time. So I think cocaine, at this stage, is certainly not seen to be a drug of preference; heroin is still the main one. As I indicated in the comments that I made, it seems that those who traffic in drugs are very good marketeers and they will pursue whatever avenues are available. However, there are probably some other general barriers to cocaine, more so than there is to heroin. I would think that, rather than there being any outbreak in cocaine use—and this is a personal view—it is more likely that we would see the introduction of methamphetamine from Asia. In other words, Asia would remain largely a source of our imported drugs and there has been significant changes and increases in the production of amphetamine, or methamphetamine, in that country.

I think one of the things that still provides us with a large degree of protection is that numerically we have a small population, the market opportunities here are rather limited and if you are an entrepreneur you have to say, 'Is the risk on the investment made worth the return?' I don't think we should be complacent about that or rest on our laurels, but I think that certainly influences decisions that are made in the market.

Dr Wilson—Mr Washer, you may also wish to address your questions to the representatives of NDARC, who are the National Drug and Alcohol Research Centre, who coordinate the monitoring on what drugs are currently being used across the state.

Mr QUICK—Ms Davidson, how many students were suspended due to illicit drug use in New South Wales schools?

Ms Davidson—In New South Wales government schools, about 11 per cent of all suspensions are for drug use.

Mr QUICK—What sort of numbers are we talking about—200, 500?

Ms Davidson—Far less. In term 4 last year we had 55 incidents that related to illicit drugs. Of those, five or six were simply people passing the school and using it as a place to inject or staff advising. At the end of the day we had less than 40 over term 4 of young people who were found either with a bong or with ecstasy in about four cases.

Mr QUICK—So about 160 last year roughly?

Ms Davidson—I can only give you the term 4 figure because that is the only one I have in my mind. If you would like the full figure I could look at it—

Mr QUICK—I would like the whole lot and if you could also provide us with a copy, with name and school deleted, of what you say here:

Students suspended because of drug use will undergo specialist drug counselling and education, with their progress monitored by school and health authorities using a case management approach.

Could you give us a copy of two or three of those 160, or however many there are, with the name of the school and the name of the student deleted, so that we can see what structure is being implemented by New South Wales? So when we go around the other states we can—

Ms Davidson—Well, actually it's specified in this document.

Mr QUICK—Yes, but–

Ms Davidson—The precise way in which we deal–

Mr QUICK—I know, but a lot of that is 'tick the box' and send the analysis and all that sort of stuff. I would prefer, as an ex-principal, to have an example of student A and student B and various things. My other question is: do you think that four hours training in drug related issues

in four years of pre-service training for teachers is adequate, in light of the huge amount of money that is being spent on the issue of drugs?

Ms Davidson—I think it is a major issue that is being looked at at the moment. There are comments from the review of teacher education in the report that New South Wales has just released and the Commonwealth currently has a study. So that's quite expert and I draw your attention to those documents. But to follow up the previous one, if you look at page 21, there are no ticking boxes there. That is the outline of intervention and referral in New South Wales for any student who is involved with drugs—what the process is, how the assessment is made and who does it.

Mr QUICK—I would still like an example—you know, 'a student at Green Valley High or whatever, referred to Bankstown or Liverpool' and so on—so that we at least have an idea of how the system works. My last question is to Ms Calvert about early intervention. Having worked in disadvantaged schools most of my life, I applaud the fact that governments are finally realising that money spent early on is a hell of a lot better than waiting till children are 16 or 17 years old and picking them out of the gutter. What additional resources are being allocated to the community centres—schools as community centres? I notice that you mentioned 800 families which is a drop in the bucket, and the fact that there are only two or three schools there that are part of the process and that once again we have got another pilot, another trial. So when we have breakfast at school and all the other things, as an ex-principal I know that here is another thing lumped on the school. So what additional resources are being put into these so that the thing actually does work?

Ms Calvert—Can I just say that the 800 families refers to the six areas that we have rolled out Families First in. Over the next two to three years it will be rolled out across the whole of New South Wales. It is not a pilot; the money that has been allocated remains for the length of its need and its effectiveness. We appreciate the frustration of having (a) something imposed on you from above and (b) only for a certain period of time. So the additional money that has gone into Families First is $54 million and builds on the existing investment that already existed—for example, within the child and maternal health services, within some of the family support services and the existing school as community centres. So that is additional money and it is not pilot money. As I said, it will be rolled out across the whole of New South Wales. The decisions about where these are located are made by local groups of the various agencies after there has been a needs analysis and a mapping of what already exists. That committee then decides where their allocation should go, whether it should go into a school as community centre, whether it should go into additional maternal type health services, whether it should go into volunteer home visiting, whether it should go into structured play groups or whatever. So we've tried to, I guess, take experiences like yours, when you were a school principal and had things imposed, and said, 'No, we actually want this to come from the people who are close to the community, after they've had a look at what's already there and what's needed for the future'.

Mr QUICK—Does every high school in New South Wales have a school counsellor, Ms Davidson?

Ms Davidson—They have access to a school counsellor, yes.

Mr QUICK—Do they have their own school counsellor?

Ms Davidson—No, they will have one depending on the size of the school. Some will have a counsellor five days a week, some will have them two.

Mr QUICK—So could you provide us details of how many school counsellors are in New South Wales and what their areas are? I notice you mentioned somewhere that there are only 11 drug curriculum advisers and they'd only spend two days a year in every school.

Mr EDWARDS—My first question is to Professor Webster. In your introductory remarks you spoke very strongly about the drugs summit—you said it was a watershed and that it led to consensus. Geoff Barnden, when he was talking, said that the drug summit reinvigorated government action, led to an additional $176 million worth of funding. Also, we have heard this morning the various experts we have here talk constantly about the need for partnerships, sharing resources between local, state and Commonwealth agencies. In view of all of those things, what is your view about the value of a national drug summit?

Prof. Webster—The commencement of the national campaign against drugs was heralded by Mr Hawke. What he said at that time was a drug summit. It was a summit actually between the premiers of the states and in the run-up to that–this is 1985 I'm speaking about–I had the opportunity to chair a summit where people were called from around Australia. There were some politicians, but there were judges, priests, users and so on. Those people went through the sorts of things that ought to go to the meeting of the premiers and that was where the idea of harm reduction, which people seem to use in various ways since, emerged. The first principle that was agreed then was that Australia should embark on the reduction of harm.

Yes, I think a national drug summit would be useful, so long as it is properly conducted. I think one the great things about the New South Wales one was that it was chaired by two remarkable people, Ian Sinclair and Joan Kirner, who have a lot of respect and I think the politicians at that drug summit learned an enormous amount. They all went out and visited places and they had to hear the evidence given by ordinary people. The most common word that was expressed through the drug summit was 'compassion', which was totally different from the newspaper lead-ups to it, where it was a dialectic of accusation, and I think most people went away from the drug summit feeling good about it. There were some who were disappointed about a couple of the recommendations but, for the vast majority, there was assent and the focus on young people and communities and education and increased treatment programs. So I think it was a wonderful process.

Mr EDWARDS—Professor, what is it that you and your team hope to see eventuate from the trial on the injection room?

Prof. Webster—The government agreed to that arising out of that drug summit and Andrew Wilson beside me is one of the key people in determining whether that goes ahead and whether it meets particular standards. The first thing is that we want to learn something from it and we want to evaluate it very closely. There is a very formal evaluation team which has been put in place and that evaluation will be a very comprehensive evaluation. It will be about the experience of the people who use it. It will be about the adverse events, such as overdoses, which may take place, but more especially it will be an evaluation on its impact on the community. Don Weatherburn, who is the director of the Bureau of Crime Statistics, has responsibility for oversighting this and, as Commander Clive Small mentioned, one of the tests

of that outcome will be the effect on the amenity of the local community. So I think it is important to appreciate that it is going to be comprehensively evaluated.

I think on the negative side, it is only one place and one place cannot tell you much about what would happen in other places. So I think it's going to give some marginal information, which will allow us to move forward in dealing with a relatively small but highly dependent group of drug users.

Mr EDWARDS—I would like just to say it is a process of learning for us and I just want to thank everyone personally for what they have contributed to our learning this morning.

CHAIR—And is it possible to get a copy of the evaluation?

Prof. Webster—The evaluation of the injecting room? We could probably provide you with the guidelines and the structure for the evaluation. It has not of course been started because the injecting room has not been initiated, but could you do that, Geoff?

Mr Barnden—We could certainly provide the committee with the appropriate documentation. At the moment we are just being extremely cautious because the matter is before the courts.

Mrs IRWIN—I will be brief—I know that time is of the essence. Just going back to the safe injecting room, we were actually in Kings Cross last evening, though we did not inspect the premises—it is very, very impressive and I hope it really works for the sake of the young ones whose lives will be saved.

I want to go to the government's response to the drug summit. I think it is on page 236 where you say, 'section 3, health maintenance and treatment services'. I am just going to quote a few sentences where you stated:

A five-year drug treatment service plan will be developed in consultation with the new expert advisory group on illicit drugs.

Then you go down to say:

The government **will provide** immediate additional funding for drug treatment services.

Now the reason why I am asking this question is: firstly, I suppose this is definitely happening; has all this money been released, is there going to be more money? And the reason why I'm asking this is that I am very concerned with detox. Cabramatta is the heart of my electorate. I have young ones that come to see me, I have counsellors, I had a mother that came to see me a couple of months ago who actually bought heroin on the streets of Cabramatta to keep her son alive. I would have done that as a mother to keep my child alive. The reason why she had to do that is that this young man was trying to get into detox and had something like a three- to four-week wait. It was impossible for him to detox at home, hence he was shooting up in the bedroom while mum was throwing up in the bathroom. I just want to know why there is there such a long wait for our young ones to get into detox when they are crying out for help and will there be more money thrown into detox facilities?

Dr Wilson—I will reply to that. The dollars that we received were real dollars, they were real expansion, they were on top of the additional funds that were given to Health for expansion of services generally. They are tied or accounted for in a way that we don't account for our other health dollars, that is, they are very specifically tied to projects. In relation to detox beds, there is a very specific allocation and we are in the process of rolling the expansion of those projects out. There is a problem in expansion of treatment services and as a member for this area you will be well aware of that in that there is a very strong NIMBY factor that goes with treatment services, that people are concerned about having such facilities located in their areas. We have to try and find ways to deal with that particular characteristic but it has caused some delay for us in terms of expansion of services. I have additional funds for additional services for this area and we are having great trouble in expanding services in relation to that.

Mrs IRWIN—Are you actually saying to me that you have got the money for services in our electorate and you cannot release that money? Can you explain please?

Dr Wilson—One of the limiting factors in the expansion of services at the moment is finding locations on which to base those services; that is a real issue for us. It is not confined to this area I might add—I don't want to pick on this area. There are problems around the states of trying to find appropriate places to expand facilities of a whole range of different types of services. Obviously, the most publicity that has been received is in relation to methadone treatment places or methadone clinics, but it is not methadone clinics alone that we are talking about. And this is where this key approach, this key partnership, has to be developed. Fairfield Council, I see, are appearing after us and they have got very strong views on how that should occur. Those are things we have to take into account, but it is a limiting factor at the moment and not just here.

The other major limiting factor for us in expansion of services is trained staff. It has not been an area that has been attractive for people to work in in the past. There is an Australia wide shortage of, for instance, adequately trained doctors and nurses in terms of this area and that is another part of our program for expanding it, but it is a rate limiting step in terms of expanding services.

Mrs IRWIN—Assistant Commissioner Small, what is your working relationship with the Federal Police? We have got a heroin drought at the moment. If you know that there's more heroin going to come in to, say, Liverpool, Warwick Farm, Cabramatta or even up at the Cross, are you informed by the Federal Police that there is a shipment coming?

Cmdr Small—I should say that I took up my position here at basically 1 January for practical purposes. Prior to that I was the commander of crime agencies, which was the central investigative capability for drugs and organised crime in the state. In that capacity, I had a very close relation with the Australian Federal Police. We in fact ran joint strike forces targeting major drug importations, particularly heroin, but importations and high-level traffic in general. So, in that sense, I had a good relationship not only with them but with the National Crime Authority, the state Crime Commission, Customs, AUSTRAC and so on. And that relationship, I think, worked quite well, not only on a personal level but on a professional level and an organisational level. In terms of my position here, I would expect that relationship would continue. I still stay relatively well informed on these matters, but we don't always know when an importation is about to occur. What we can say at the moment is that they are in trouble and

can't get any importations through and there is probably a whole range of reasons for that. There are clearly issues of security that if you know that there is a tightly-knit group that are prone to corrupting individuals and organisations, you cannot simply put a message out saying, 'Oh, they're at work again and they're bringing an importation'. So, there's a practical problem there that has to be held very tight. But we would detect and I would become aware very quickly if there was belief that a large importation had arrived and if there was a change in availability on the streets we would become aware through the street contacts very quickly.

Mrs IRWIN—I love Cabramatta—I'm in there quite often—and, from talking to the local policemen who might be walking around the beat, I'm rather shocked that you haven't got very many police officers that speak, say, Vietnamese or Chinese.

Cmdr Small—I can't give you the numbers. There are a number in the area that do speak various Asian languages, but we also need to be aware that there are a lot of people in Cabramatta who also speak English and a whole range of other languages as well, and we need to cater for all of them. I think it is the same with any government department; there are limited resources, we do the best we can, and I think overall we are proceeding well. There has been a significant change in the approach to policing in the region in recent times. I would not dare to suggest that we are claiming victory or anything at this stage, and I do not suggest that we would be able to resolve 10 or 15 years of problems in any few weeks. What I would hope to see is that things will get better, significantly in the first instance and then we'll chip away with things on a daily basis to ensure they get better as the weeks and months go by. That includes an improvement in relationships with the police and the community and better partnerships.

CHAIR—Thank you very much. Do you have anything to add?

Mr Barnden—In relation to an earlier question about detoxification services, I just thought you might actually like to know precisely the sorts of allocations that have been made. You have to remember it is a four-year program, so we actually set the money so it rolled out slowly because it was such a big program and there is such a lot for everyone to do.

Mrs IRWIN—I think when I asked, you virtually said the money is there, the state government has got the money for say, Cabramatta, but you're having problems.

Dr Wilson—We know what the bucket is from the beginning of the program, how much money we are getting each year. There were specific decisions about what those things would be spent on each year in terms of expanding the program and we are held accountable to those. There is some variation in that because we have to be flexible in terms of where certain acute needs arise. There is some flexibility in that, but in the main we know what we are supposed to be delivering on for those years.

Mrs IRWIN—So you can't tell me how much money there is for Cabramatta.

Mr Barnden—We are allocated funds for the—

Mrs IRWIN—I want it in my area and I want it now!

Mr Barnden—There is money for the south-west area. There's significant funds for a new drug and alcohol unit in south-western Sydney. There are significant funds for Wentworth Area Health Service detox unit, Central Coast Area Health Service detox unit, for an integrated service in New England and an integrated outpatients' service on the mid-North Coast. So we do have a lot of funds and it's a matter of just rolling these things out.

CHAIR—Thank you very much, and I am sure federal members will show a continuing interest in that matter. Ladies and gentlemen, thank you very much for your contribution. This whole issue is a fairly gruelling business and we do appreciate your going through it all to give us information.

[10.23 a.m.]

HALL, Professor Wayne Denis, Executive Director, National Drug and Alcohol Research Centre, University of New South Wales

CHAIR—Welcome, Professor Hall. Although the committee does not swear in witnesses, the proceedings today are legal proceedings of the parliament and as such they warrant the same regard as proceedings in the House of Representatives. Professor Hall, would you like to make a brief opening statement and then we will just have a general discussion, considering we had a very informal discussion yesterday at some length.

Prof. Hall—I apologise there are not more of us here, in contrast to the preceding group from New South Wales Health. It just so happened that the visit of the committee to Sydney coincided with the start of two major projects in the centre and key staff are otherwise occupied with that. You have had our submission and I will say something briefly about that. As you have said, you visited the centre yesterday and had an opportunity to learn about our work. I guess the main points I would want to make about the contribution research can make to good drug policy, because I think we have heard already the necessity for there being community consensus on what the problem is and what the best way to address it is. Certainly in the recent past in parts of Australia that has not been the case and I think that has made government action very difficult.

We need combinations of strategies—there is no quick fix for the drug problem. We need strategies that look at prevention of drug use and uptake, treatment of people who have got into difficulty with drugs, and law enforcement to reduce supply and deter use and encourage people into treatment. The drug policy needs to be seen in the setting of broader social policies, particularly around education—I think that point was made in some questions in the previous session. The prime recruiting ground for a lot of drug use is young people who perform poorly in school. And we really need to be thinking about investing more in particularly the primary school years to reduce the number of young people who find drug use and antisocial behaviour an attractive alternative to education. We also need to be looking at improving opportunities for employment for young people because good, useful employment is, I think, probably the best way of deterring drug use.

But more generally, our policies towards different drugs, both licit and illicit, ought to depend upon the prevalence of use, the harms that they cause and the effectiveness of the sorts of interventions that are available to reduce their use and the harms they cause. The role of research in this particular enterprise is to give good data on the prevalence and patterns of use of drugs—I think we have been well served by that in Australia—good descriptions of the harms that drugs cause to people who use them and to the communities more generally, and information on which of the range of alternative interventions—prevention, treatment, law enforcement—are the most effective buys from a public point of view.

And to that end, we need to be continuing to ensure that we have good funding for research, both through national centres such as the one I head, the one in Perth and South Australia. Also we need research funding for specific projects, both research which is commissioned by

government, such as surveys of drug use and studies of drug related harm, and also opportunities for investigators to initiate research and look at them in detail.

I am quite happy to answer questions that you may have about specific research projects or research undertaken by the centre and I'll finish there to allow you to do that.

CHAIR—Thank you, Wayne. On the economic data, and we did touch on it yesterday, where do you think we should be heading with the use of the economic data now we have a study of some 10 or 15 years standing which people refer back to and that has been updated. What is the focus, do you think, for the best use of this economic data in terms of the cost?

Prof. Hall—I think there is not only economic data. I think the other as interesting data is the work coming out of the Australian burden of disease and injury study, which is an alternative way of attempting to assess the adverse impact of various conditions—health conditions in this case on the Australian community, and that includes the contribution that alcohol and illicit drugs make to the overall burden of disease. I think there are a couple of things of value in exercises of this sort. One is trying to focus our attention on where the major harms are. As you well know in the course of your hearings, the newspaper and other media interest in drugs is not always in proportion to their adverse impact on the community.

CHAIR—The reality.

Prof. Hall—Yes. And I am not wanting to downplay the adverse impact that illicit drugs have for example, but I think we have underestimated the adverse impact that alcohol has, and a lot of the things that we say about heroin apply in spades with alcohol in terms of its impact on premature deaths from motor vehicle accidents, its contribution to suicide, violence and to criminal activity, and its adverse affects on families, for example. So I think that the value of cost studies of that sort, or of the burden of disease is forcing us to see where drugs as a whole fit into the bigger picture. They do make a substantial contribution to premature death and disease, but also within the drugs field we should look at the relative burdens of the illicit drugs in comparison with alcohol and tobacco as well, and to a lesser extent the pharmaceutical drugs, which also tend to be a bit neglected.

CHAIR—On that phrase, 'the burden of disease', can I just have a—

Prof. Hall—A bit of a description of that?

CHAIR—No, I'm sure it makes its impact, but maybe just variations on what we're really talking about there.

Prof. Hall—The phrase comes from a study that was done by the World Health Organisation and the World Bank about three or four years ago, and it is a way of attempting to combine the two major adverse impacts that drug use or other conditions have on health. The most obvious one we all understand is premature death. It provides a way of combining numbers of deaths that different forms of drug use cause with disability—the extent to which people's quality of life and capacity to enjoy life and contribute to the community more generally is impaired by their drug use. And it attempts to combine those two major impacts into an overall estimate of total burden that is contributed. I guess one of the major impacts that that approach has had has

been in seeing the importance of chronic diseases, with depression being the familiar one. The federal government has funded the Depression Institute largely in response to the fact that here is a condition which is very, very common in the community, which is quite disabling for those people affected by it and which causes a substantial number of premature deaths from suicide. The same could be said for alcohol. Alcohol comes up quite highly in estimates of burden of disease—not as highly as depression but it is certainly in the top 10 in developed countries as cause of disability and death.

CHAIR—In terms of setting priorities in this area, where would detox fit in the general prioritisation of substance abuse, do you think?

Prof. Hall—Of substance abuse treatment. It is certainly what everybody wants, and clearly it is desirable for people who are fairly severely affected by alcohol and opiates. They do become very ill and severely affected when they're abstinent and we ought for reasons of humanity and compassion be providing treatment to assist people to get through that withdrawal process. I think there is a misunderstanding abroad in the community that this is a treatment in and of itself, and our experience is that if that is all that you do for people, if you do not provide the support—the psychosocial support; the education training; the family support that goes with it—then 90 per cent of people are going to return to alcohol or other drug use within about a year of detoxification. So we need to be looking at ways of increasing access to detoxification. I do not think it all needs to be done on an in-patient basis. I think there is an overemphasis on people being detoxified in hospital beds, and I think there are other ways of providing the detoxification, spreading the services around so that you do not get the long delays which I think have already been mentioned in questions to New South Wales Health and difficulty of access to detox.

CHAIR—Yes, and really I suppose it highlights this whole issue of substance abuse—that it really is a very big picture and we can only hope to make progress with a very big picture approach to it and to see it as very much long-term issue.

Prof. Hall—Yes.

CHAIR—Do you believe that we can beat it in the long term? It is a leading question, but can we beat it in the long term and what would be the two or three priorities from where you sit?

Prof. Hall—Can we beat it in the long term? I don't think we can beat it in the sense of producing zero drug use any more than we can eliminate crime or premature death. I think we could certainly make a substantial improvement in rates of use among young people and we could certainly reduce a lot of the harm that alcohol and illicit drugs cause in the community. In terms of where priorities ought to go, I think there has to be some combination of seeing the bigger picture and investments in young people, particularly around education and family support—a lot of the infrastructure that was there when I was a child, you know, child health care services and support for women with young children, support in early years of school and an education system responsive to problems that young people have in learning to read and performing would be a very substantial advance, and not just for drugs, but for a whole range of antisocial and other outcomes. I think we need to see drugs in the broader mental health, public health and social policy agenda.

More specifically in the drugs area, I think there should be certainly more attention to alcohol. We forget that all the great majority of young people who use illicit drugs are also using large quantities of alcohol, and alcohol is a major contributor to opiate overdose deaths for example, and to a lot of the violence that goes around with illicit drug markets and so on. Not that we are wanting to reduce the importance and the concern about heroin and other drugs, but I think we need to be raising community awareness of the role of alcohol and reducing the amount of social tolerance that we have for heavy drinking, and drinking to intoxication. There is an attitude among parents that you hear all the time towards drunkenness, particularly among young males, that at least they are not using drugs, as though alcohol were not a drug.

CHAIR—Thank you very much. I'll pass the chairmanship to Ms Ellis for a while.

ACTING CHAIR (Ms Ellis)—You've referred in your submission to a wealth of research being done in Australia and I have two questions based on that. First of all, do you believe there are any gaps in any of that research? Just to give you an example of that, we've had foetal alcohol syndrome mentioned to us a few times in our travels, as a possible gap, or whether there should be more work on it. The second part of the question again refers to the extent of research. In a previous inquiry this committee did where there was an enormous amount of research, there was also a clearing house created at a university in WA which became the authoritative stop shop for people to go to access almost every piece of research on the subject. Is there such a thing in this area, and if so where? And if not, should there be? We assume you will agree that there is a lot of research of value being done.

Prof. Hall—Starting with the gaps, I reiterate the answer I gave to the chairman's questions. I think alcohol is a drug that we have neglected, and it has certainly been a frustration in my centre that we've found it difficult to be funded to do research on improving treatment of alcohol dependence. Although there is a lot of research being funded on drug treatment approaches to heroin dependence, I think there is as interesting and important advances in the treatment of alcohol dependence that need to be better known, and we need to be improving treatment services for alcohol. The same could be said for tobacco more generally, although I think that there are groups, such as the Cancer Council and others—the Anti-Cancer Council in Victoria in particular—that have done a lot of work on tobacco. So I'm a little less concerned about that as an issue. Certainly, some of the health consequences of foetal alcohol syndrome is an issue that has been ignored and I know that that is a concern particularly in some indigenous populations where there is not a lot of recognition or understanding of the risks of drinking. There is a large number of young women in those populations who are drinking in large quantities and certainly putting themselves at severe risk of it, and it would not hurt to be reminding women more generally in the community of the risks of alcohol consumption during pregnancy. I know that this is part of the new guidelines from NHMRC on recommended levels of drinking and it does discuss that, so there may well be an opportunity to educate women about that.

In terms of other gaps, I think we need to be doing more work on the aetiology of drug use—the reasons why young people use drugs. I think there is beginning to be a fair amount of expertise developing in Australia, not so much in the drug field as in the area of child and adolescent health and mental health, which is beginning to recognise that alcohol and other drug use among young people is an important component and a contributor to poor mental health and poor social outcomes generally. Some of that work is beginning to have an impact, and forming

linkages and partnerships between the drug and alcohol field and researchers with a larger field of mental health and child and adolescent health will be important in remedying some of those gaps in current research.

In terms of the clearing house, I think the federal government did fund the Alcohol and Drug Information Network, ADIN, which is intended to be web based—I'm not sure whether it is still planning to be a 24-hour telephone contact service, which will provide a very detailed set of information with linkages to all the major sources of information on that. The Australian federal Department of Health and Aged Care also has a lot of information on its website as well, and there are other groups such as the Alcohol and Other Drugs Council Australia, and the Alcohol and Drug Foundation Victoria, which would do that. I think it is probably less the lack of information than the fact that it tends to be disseminated a bit and there is no core source. I think the funding of ADIN was intended to ensure that there was one single authoritative source which would provide access—

ACTING CHAIR—How far has that proceeded?

Prof. Hall—It has been funded and I would have to check as I have not kept up with it lately, but I understood it was up and being trialled in the field at the moment with drug and alcohol people having access to it, to test the content and see whether people are happy with the content, and then for it to be rolled out nationally with open access to anybody who wants it.

ACTING CHAIR—So you would agree it's a good idea?

Prof. Hall—I think it is an excellent idea. The difficulty in implementation was, precisely because of the variety of sources that are out there, deciding which sorts of sources ought to be linked to a source of this sort. I think the quality control and the linkages has proved to be a bigger problem than people anticipated.

Dr WASHER—I would like to ask you a little bit about the media—you mentioned it a moment ago—and two aspects in particular. One was the educational process that we have had some experience with now over a long period of time in alcohol and tobacco campaigns and their effectiveness. I would like just a few comments on, say, why we have younger women now taking up smoking and where we are doing some research and how effective media is. That is the first part of the media question. The second thing is: do you feel that the media has been responsible in terms of community education in getting some of our new and what might be perceived as slightly controversial treatment programs out into society?

Prof. Hall—There's an interesting set of issues raised in that question. I might start with the last one first, about the role that the media has played in popularising some of the treatments that have been particularly prominent in the last several years—Naltrexone being one example as a treatment for heroin dependence. Media are in the business of selling newspapers and attracting audiences and the dramatic and sensational is typically what sells. I think particularly the stories were unfortunate that were initially published in a women's magazine, I think, of the treatment in Israel under general anaesthetic with Naltrexone. They certainly created a lot of dangerous expectations which could not be delivered with this form of treatment—or any other form of treatment for that matter—and I think that tended to distract. I think that had some untoward effects in a variety of ways. One was that we ended up with three or four state

governments spending something in the order of $4 million or $5 million setting up or trialling this form of treatment before it had actually been adequately evaluated. Given the desperation amongst members of the public, the family members of young people affected by heroin dependence, I can understand the difficulty government had in not responding to that demand and providing some sort of service.

So I think media often in those ways raise unrealistic expectations and they also distort allocations of government resources very often towards the dramatic and extravagant claims—of some medical entrepreneurs in this particular case. So they do not always pick out the important issues and as a consequence valuable treatments are often lost. I think Naltrexone has a role in the treatment of heroin dependence and we have never said anything to the contrary, but I think it is a relatively minor role in the larger scheme of things. Ironically its value is in the treatment of alcohol dependence and we think that has largely been lost. We have been trying to do research on Naltrexone for the treatment of alcohol dependence—in fact, we tried to get the drug registered in 1994 for that purpose in Australia. You cannot interest people with alcohol dependence in Naltrexone now. Because of all the bad publicity and mixed publicity they do not want to touch it; it is something that's used for treating heroin addicts and they are not heroin addicts; they do not want to go near it—that has been an unfortunate consequence.

Regarding the role of the media, I think you are right about the extent to which the targeting of young women and tobacco use happens and we have ignored that. My centre's role is more around treatment than prevention, so we have not looked at that in any detail, but I think the media do have an important role, not always for the best, in terms of creating public panics about drugs which create a crisis mentality and which is not the sort of environment in which to make sensible decisions about drug policy.

Mrs IRWIN—Professor, on page 15 of your submission you mentioned that a special challenge for the education system is developing school policies towards cannabis use that balance the interests of students who do and do not use cannabis. Could you explain for us what you mean by that statement?

Prof. Hall—Yes. The difficulty for schools is the children who get involved in cannabis who come to attention are typically often fairly heavy users. They may well be involved in selling to their peers as a part of financing their use, and you can understand the parents of other children in the school who learn that there is a child in the school who has been detected using or selling cannabis—they want them out of there; you can understand the parental demand for that. That seems to be an easy solution all round. The difficulty is, and I think it was mentioned in evidence I heard earlier from the state Department of Health, that often the consequence is making the situation worse for the child who has been detected using cannabis. They are often excluded from the school, they end up out of school, their education is at an end, and it is easy for them to drift into heavier drug use, criminal activity and more serious and harmful patterns of drug use. So the difficulty is in finding policies which address the problems of that individual child and that clearly require a response—interventions, education, maybe support for family members and others—while reassuring other parents that something is being done, and I do not envy schools this task, and that this child will not continue to sell or their use of cannabis will not continue to encourage others in the school to use it.

Mrs IRWIN—On page 16 of your submission you refer to increased heroin use among young Australians and suggest that one of the reasons for it is the increased availability of cheap, pure heroin. What are some of the other factors that, in your view, might be contributing to changing patterns of heroin use?

Prof. Hall—This is much more speculative. There is a lot of uncertainty about the reasons why we have these apparent epidemics of heroin use. One of the hypotheses around is that you get the conjunction of two things. One is a massive increase in availability—I do not think there is any doubt we had that, probably beginning five or six years ago. It is a bit hard to be precise about when it happened, but we certainly followed over the last three or four years steep increases in purity. It was first monitored by the Bureau of Crime statistics in New South Wales about 1993, 1994 in south-west Sydney. We went from a situation where the average purity of heroin was in the 10 per cent to 20 per cent range up to around 60 per cent. The nominal price remained more or less the same, but the purity went up so the cost of the drug had dropped very substantially. The other conditions that make it possible were, firstly, that the drug is provided in substantial quantities in an environment or social setting where there are large numbers of young unemployed people; secondly, lack of other social opportunities—there may be people who disagree but I think this is a reasonable hypothesis; and I think the third factor has been that a lot of these young people do not have salient examples of older brothers and sisters who have got into difficulty with heroin. So a lot of the young people we looked at who used it have drifted into use, as people tend to with heroin, often starting by smoking rather than injecting and thinking that this is a safer route of use, and being caught up in it unawares and drifting into more regular use. I think it is the conceit of all young people, as it was in my generation, that 'we are better than our parents and we will not make the same mistakes.' For most of the heroin dependent people in treatment even five or six years ago the average age of somebody in a methadone program was 30, which was about the average age of the parents of the young people who would have been initiated in the early 1990s. I think there was that big enough age gap that young people were convinced that they knew better and they were not going to get into the difficulty that older people had done.

Mrs IRWIN—You might have been here actually when the New South Wales government representatives were before us, and they were saying that there is a heroin drought. Why do you think this is so? Is it because, as some people say, that they have their holidays in January, and then there might be an increase in February or March?

Prof. Hall—I think I have collected three or four theories for the explanation of the drought. Certainly, one has been the conspiracy theory that the suppliers have held back supply in order to raise the prices. I think that is a bit implausible, given that it has happened around the same time right across the country. There is still heroin around, but the people who are now supplying it are different from those who supplied before and it is a different form of heroin. That suggests that the source has changed and there may well be real difficulties experienced in importing it. I think law enforcement may well have played a role and we have put a lot of resources into it. It is not only the attempts to interdict or prevent the stuff coming into the country, but also particularly activities that Commander Small talked about, directed at major importers in this country and Sydney and New South Wales in particular, as being the major distribution centre for heroin on the east coast of Australia. So it is entirely possible that our law enforcement has had a substantial impact on the availability. And it is certainly a remarkable event. Dr Seidler, who has been treating heroin dependent people in the Kings Cross area for 15 years, said it is

the longest drought that he can ever remember. We have been interviewing drug users over the last two weeks and they are saying exactly the same thing, that it really is a remarkable event. There have been occasions when heroin has been difficult to get for a week or 10 days; this has been now of the order of six or seven weeks.

Mr EDWARDS—Professor, how closely do you work with state agencies around Australia?

Prof. Hall—We have good relations with state agencies. We are certainly critically dependent on the New South Wales state government for access to data on overdose deaths; on people seeking treatment; ambulance data on non-fatal overdoses attended; access to surveys on school students, and so on. We get similar cooperation from other states as well, but not as close—geographically we are a bit further apart. But I think on the whole they have been very cooperative.

Mr EDWARDS—What would your view be about the value of a national drug summit?

Prof. Hall—The New South Wales one was a very valuable experience. Not all of us who went into it were optimistic about the outcome. Certainly when an issue is as divisive as drugs had become in New South Wales around the time of the last state election, when there were tabloid newspaper headlines almost daily on the issue, there was a lot of conflict and anger and disagreement about how to proceed. I think it is critical in those circumstances, if the government is to move forward, to bring people together to try and achieve some sort of consensus on what the problem is and what the approaches and options are. And I think, on the whole, the New South Wales drug summit was very successful in doing that. I think there would have been a clearer value in a national summit a year or two ago. I would certainly not oppose it now, but I think there has been a lot of effort put into funding services. I think the issue is less of a hot issue in the media now than it has been, and on the whole the level of media discussion of drug issues now is a lot better than it was two or three years ago.

Mr QUICK—On the issue of tobacco use and its cost to society, on page 11 you mention that in 1997 there were 18,000 deaths and almost 150,000 hospitalisations. One would assume that that number would have increased, or stayed about the same—

Prof. Hall—It has probably gone down marginally because the prevalence of tobacco use has fallen and it fell long enough ago that we are starting to see reductions in deaths attributed to tobacco, but certainly it has not gone down a lot; it would be around that order.

Mr QUICK—So our terms of reference are the social and economic costs of substance abuse. Is any research quantified in dollar terms about 18,000 premature deaths and the economic loss to Australian society?

Prof. Hall—The Collins and Lapsley study that I think the chairman referred to earlier, which was published in 1995 is about to be updated, and that will certainly provide an updated estimate of the economic costs. I guess, from the point of view of the community, a lot of the deaths caused by tobacco tend to occur much later in life, so in terms of life years lost and productivity and so on, the economic impact is a bit less than it is, say, for alcohol or illicit drugs, which tend to be younger people who are affected, and a lot more years of life are lost as a consequence. That is not to say that we ought not to be paying attention to it; we should be paying more attention to tobacco.

Mr QUICK—And, associated with that, in 1997 there were 4,000 deaths and just under 100,000 hospital episodes attributed to alcohol. I just worked out roughly that that means 50 deaths a day for tobacco, and I am not too sure what the number is for alcohol-related deaths—it is probably 12 or 15 a day. And are we talking about 700 deaths from overdoses?

Prof. Hall—There were almost 1,000 in 1999.

Mr QUICK—So, are we skewed the wrong way? Why is all this money being poured into the illicits when there are hundreds of thousands of hospitalisations, tens of thousands of deaths with tobacco and alcohol? Is it because it is so visible on the street and it is easier for the media to grab it and front-page it in the *Mirror* and the *Telegraph* and we all rush around and pour money in and focus on it? And the others are sort of behind closed doors—unless you go into the emphysema ward in St Vincent's Hospital you do not really know that another 50 have died today around Australia?

Prof. Hall—I think that is part of it. There is no doubt at all, as I said earlier, that the media preoccupation with illicit drugs has meant that we focus almost exclusively on that as part of the drug problem rather than looking at alcohol and tobacco. I think that because alcohol and tobacco have been part of our society for hundreds of years, they are not seen as a form of drug use and that the deaths they cause, particularly in the case of tobacco, are seen as natural causes, although they are not—heart disease and cancer, for example—and they typically tend to occur later in life. I would not want to suggest that illicit drugs are not a problem even though numerically the number of deaths that they cause is a lot smaller. You have got to remember the average age at which those young people are dying; they are primarily people in their mid to late twenties who are dying of opiate overdose deaths for example, and it is the same with alcohol. It is reasonable for the community to be paying a bit more attention to alcohol and illicits than it does to tobacco, precisely because of when those deaths tend to occur.

The other thing about tobacco was a fairly cynical observation made in the *Yes, Minister* program by Sir Humphrey that tobacco is exactly the form of drug use that governments like to encourage because people pay taxes and work and they drop off their tree just about the time they are due to collect their pensions, whereas in the case of illicit drugs it is young adults who are the valued part of the community who are dying.

Mr QUICK—On page 16 you mention that a recent study of the number of dependent heroin users in Australia estimated there were between 67,000 and 92,000. Do we have any more specific figures and is the number increasing at a rapid rate, or compared to other countries, the trend is the same?

Prof. Hall—It is hard to be sure, and certainly the estimate we got in 1997 was remarkably similar to estimates that were derived around the same time in Western Europe or in the European Union, and they were almost exactly the same as the United Kingdom and Britain. That is not a cause for complacency but I think it helps put it in perspective that we have a serious problem with heroin, but it is not uniquely a problem that we have that other countries do not.

In terms of the rate of increase in numbers of dependent heroin users, that is a much tougher question to answer. I think we have certainly had a steep increase over probably the last five or

six years. My bet would be that we have probably levelled off and seen the worst of that, but we are going to live with the consequences of that epidemic for some considerable time to come.

Mr QUICK—So is it possible to say that a dependent heroin user uses a given amount per year in dollar terms, or is that wishful thinking?

Prof. Hall—You can make estimates; they would be fairly approximate and they would involve a fair amount of guesswork. A dependent heroin user is someone who is predominantly a daily heroin user, but people would have time out from heroin use either involuntarily, if they are in jail for example, or voluntarily if they had treatment or they take time out from use. American data—we have not got exactly the same here—would suggest that over a long period of 10 to 15 years of heroin use that dependent users there would be using heroin on a daily basis roughly half the time, so in any one year about half of the year would be spent in daily heroin use and there would be time out, probably in prison. I think the American figure might be a bit higher because there are much higher rates of imprisonment there, but that would give you some sort of order of magnitude.

Mr QUICK—There are roughly 100,000 heroin users and some people suggest that if we provided them with their daily dosage that the cost to society would be less because crime rates would plummet—they could go to wherever it was and get their daily usage and it could be monitored and their health could be monitored and a whole lot of other things rather than the system that we have at the moment. How radical is that?

Prof. Hall—It is an attractive suggestion that is often made. I do not think that anybody has succeeded in implementing on that scale. The two countries that have experimented with heroin prescription have been the United Kingdom, which nominally has that as an option but very few people receive it, and Switzerland, which has implemented the program on a larger scale. But even in that case, their estimated number of heroin dependent people was about 15,000, of which about 1,000 to 2,000 were in heroin prescription treatment and the great majority were in methadone treatment or not in treatment at all. The conditions under which a community would be prepared to allow heroin to be prescribed would be so restrictive that it would: (1) make it a very expensive option as it is in Switzerland and (2) would not be as attractive to heroin users as we might imagine.

Mr QUICK—So what is the cost per person, per year in Switzerland?

Prof. Hall—I could not give you that off the top of my head, but I could certainly dig out the information from the Swiss reports for you.

Mr QUICK—Thank you very much.

Dr WASHER—Just to take you up on that statement about tobacco, because that is a commonly held belief that the government loves to gain the revenue, the tragedy is that because these people tend to die of cancers and vascular disease and the outcome in costs and hospitals is astronomical before they do die, so we lose—so if it were a revenue based thing we would lose.

Prof. Hall—I would not disagree with you. That was a cynical view that I was quoting rather than my own.

Dr WASHER—I know. The big problem we have had, and I want some comments, is that since the taxes have been increased to act as a deterrent and to hopefully put some more money into educational processes, illegal tobacco like chop-chop has increased dramatically in Australia, and I want your comment on that. But the second thing is that the problem we have had with the tobacco industry because it is a legal and legitimate industry marketed by massively resourced companies, we cannot compete, as governments,to counteract that effect. And just to follow that, one of the things is that there is a tendency with some people to think, 'Why don't we legalise marijuana? It is so common in this country, at the end of the day why make it illegal, why don't we just legalise it?' But the argument then is that if they are going to market it as 'Joe Camel', then we will increase it dramatically and have all the nightmares of fighting the big corporates with their massive resource to try and educate against it. Can you comment on some of that confusion that we have of how to handle this?

Prof. Hall—I will start with the points about tobacco. I think taxation is certainly a common remedy advocated by those in public health, and certainly it's something I broadly support. But I think there are limits to how much tax you can impose on these goods. As you say, if you tax them too heavily you create incentives for illegal production and you end up with smuggling and black marketing of tobacco, which is happening in Australia. I know when the Canadians imposed very stiff taxes on tobacco there, there was a massive incentive for smuggling from the US into Canada. So I think there are limits on our capacity to control consumption of any substance, whether it be alcohol, tobacco or cannabis if that were ever legalised, by taxation. So I think it is a policy instrument, but it's a lot blunter and not as effective as people would allow.

I think it is certainly true that if we were to legalise cannabis in the same way as we allow the sale of alcohol and tobacco, we would very quickly end up with a very large and powerful industry which would have every interest in promoting its product, and every interest in resisting regulation and resisting efforts to reduce use. It is difficult to say what impact that would have on prevalence of cannabis use. It would be remarkable if it did not increase the number of regular users as happened when cigarettes were introduced in 1920s into most developed societies. But I think certainly legalising an industry and allowing the manufacture, production, promotion and sale of it, experience with other drugs would suggest that if we were to do the same with cannabis we could expect similar sorts of consequences in terms of use. To put the argument on the other side, we would certainly be capturing for public use income from the sale of those drugs which currently goes into the criminal fraternity.

CHAIR—You noted marked social differences, different categories of people—although I am reluctant to use that term—in rates of smoking with particular groups that may be less educated or whatever having high rates of tobacco use. Why do you reckon the health education campaign has not seemed to have picked up certain groups?

Prof. Hall—There are a couple of factors at play there. One is generally that people who are better educated are more responsive to health education campaigns, they pay more attention to information that is provided—they are more interested in that sort of information and more likely to act on it. But I think there is probably also access to support services if people are smokers and want to quit, and we probably need to be putting more effort into communities

where there is higher prevalence of use both in terms of educating people about risks and providing support for those that want to stop, to help them to stop. I think that is something that we do need to pay more attention to.

CHAIR—I suppose the supplementary question relates to a different type of campaign. A few things come to mind that we might do things differently. Maybe it is the same message making the same point, but put differently—that it will do you in eventually if you are not on the job.

Prof. Hall—The Americans by and large have put, as they do in everything, a lot more resources into research and interventions and there has been work around smoking prevention messages that are tailored for lower SES groups, particularly in some of the larger cities, and they have proved to be as successful when the effort is made as in any other group. I think that is true. We have probably taken the easy way out in advertising through the sources that are more likely to be read by people who are better educated.

CHAIR—You have jogged another supplementary question from the American system of extra expenditure. There was a comment yesterday floating around about what we do here—that it would cost in America twice as much, I think. Just a couple of things you might like to mention and I apologise if they have already come up, but on the cultural difference why is it so in the US—as Sumner Miller would have said?

Prof. Hall—I think the Americans as a rule tend to invest much more in higher education research generally, right across all sorts of areas and I think they see the value in that. I think if we had as positive an attitude towards our scientific research as we do to our sports people we might expect to see something similar. As a society we have done remarkably well, as measured by the number of Nobel Prize winners, but I think it is also telling that the great majority of those people did their work outside this country. It is certainly something I am aware of in training lots of young people that if they were wanting to go where the opportunities were they would not stay in Australia, they would go to North America. And I think that unless we start paying more attention, not just in the drugs area but to higher education research support more generally, we are going to lose a lot of good young people.

CHAIR—Thank you, Wayne, your contribution is much appreciated.

[11.19 a.m.]

WATKINS, Mayor Robert, Mayor, Fairfield City Council

CHAIR—I welcome the Mayor of Fairfield City Council, Robert Watkins. Robert, thank you very much for the support and hospitality shown to us in the last two days. It has been overwhelming, and we really do appreciate that. Would you like to make a short opening statement.

Mayor Watkins—Thank you, Mr Chairman. On behalf of the residents of Fairfield City, I welcome the inquiry to our city. It has been identified by surveys of Fairfield City residents that the drug problem is the issue of most concern to our residents, so I welcome the important work that your committee is undertaking and obviously I look forward to the results and recommendations of your inquiry.

The council's submission this morning addresses the social and economic costs of illicit drug use in the City of Fairfield, with particular reference to workplace safety and productivity, crime and law enforcement, and family relationships. The other two terms of reference of the inquiry, being road trauma and health-care costs, I do not believe are within our capacity to comment on in an expert fashion. So I have only concentrated on those first three terms of reference.

I will outline the key points with respect to workplace safety and productivity. Discarded needles and syringes have had a huge impact on the workplace safety and productivity of our employees. We have had to put risk management strategies in place to protect our employees, including specialised training, providing specialised protective clothing and equipment, modifying work practices—for example, checking fields prior to mowing for syringes as they can act as a missile if a lawn mower is left unchecked—and vaccinating staff against infectious diseases such as hepatitis A and B. Other impacts include industrial issues resulting in lost productivity, workers' compensation costs, as well as intangible psychological costs to employees who may be confronted with overdose victims, intoxicated persons in their daily work, as well as the trauma associated with needlestick injuries. We have had some needlestick injuries here at Fairfield City Council. The collection and disposal of over 100,000 needles per year is a financial burden on ratepayers. It is estimated to cost council in the vicinity of $200,000 a year. We support harm minimisation principles which the needle syringe programs are based on. However, we are concerned about the by-products of these programs, which have a huge economic and social cost upon our community.

With respect to crime and law enforcement, crime and safety was identified as the issue of most concern to Fairfield residents. This represents an intangible social cost. The council has shown its commitment to strong law enforcement by installing and operating a major CCTV street surveillance system in Cabramatta, which has proved to be an effective tool in improving public safety. This is at an annual cost to Fairfield residents of $400,000. It must be highlighted, however, that without adequate police resources to support this system, it is ineffective as a tool. The council has also employed a senior manager to oversee all council activities in the Cabramatta township, to identify gaps and to work in partnership with other organisations to address the needs of the community. We have also allocated over $1.5 million to improve the urban environment, which has a major impact on actual and perceived safety in Cabramatta.

This includes the installation of the CCTV system, improved street cleaning programs, upgraded public infrastructure—for example, seats, litter bins and footpaths—improved lighting in public spaces, the installation of needle disposal bins and enforcement of food and environmental standards.

With respect to family relationships, our young people need to be diverted away from the drug culture. Many do not possess the necessary skills to obtain work. They drop out of school because of poor literacy skills and are attracted into the drug culture as they have limited options available to them. These poor English skills prevent them from gaining basic level employment or seeking training opportunities. Migrants have a particularly hard time finding employment services and support for these people is very limited. English classes need to be accessible to all migrants and there needs to be greater access to services for temporary protection visa holders, who receive minimal assistance from the government. For those young people who are unfortunate enough to be caught up in the drug culture, there is an urgent need for a range of treatment and rehabilitation facilities to assist them to break this cycle.

The council has developed a model to encourage the establishment of comprehensive drug treatment services that provide access to a range of medical and psychological services for the treatment of Fairfield residents. These services need to be appropriately located, multipurpose and culturally specific. Drug treatment services must include comprehensive medical and psychosocial assessment, access to a range of pharmacological treatments, counselling, behavioural, intervention and therapy, self-help through Alcoholics Anonymous and Narcotics Anonymous, and further comprehensive life skills and employment services. A treatment service should also focus on assisting patients to acquire or reacquire basic social, vocational and, in some cases, parenting skills.

Youth homelessness is another social cost of substance abuse. This has been an increasing problem in Cabramatta. There is an urgent need for new crisis accommodation services that have appropriate resources to address the needs of young people with present or past drug problems. I have established a task force to look into this issue to determine which services would be most appropriate. At this stage, it is unclear what these services will be. However, it is envisaged that they will be substantial and will involve significant resources, which the federal government must address.

Building up of the social capital is also considered to be an effective way of reducing the adverse impact of drug abuse in Fairfield. We are developing a major investment and development package for Cabramatta that will involve: a major car park and commercial area incorporating quality urban open space development in the heart of Cabramatta, a major youth recreational facility, and the redevelopment of Cabra Vale Park to encourage community activities and events in the park. The $30 million funding for these initiatives has yet to be identified. We need assistance from the federal government to address issues such as the importation of drugs into the country. A significant amount of these drugs are distributed through Cabramatta. With respect to youth homelessness, it has been reported recently that 1,000 young people are now living on the streets in Fairfield City. Employment opportunities for our community need to be improved, particularly for migrants, who are often unable to access English classes to assist them in finding work. Recent surveys indicate that 31.8 per cent of Fairfield residents have poor English literacy skills. That is three times the national average.

We also have the highest refugee intake in any local government area within New South Wales and, I dare to say, Australia-wide.

We need to ensure that there is a range of treatment options available for drug affected people and that a holistic approach to their care is taken. This includes not just health treatment, but employment, social and living skills. We need to ensure that our young people have access to quality education and that our young people have access to employment and training opportunities.

Most importantly, we need to ensure that sufficient resources are allocated to our region in order to adequately address this issue, which has been at a significant social and economic cost to our community. As I informed the inquiry yesterday, of the $50 million allocated by the federal government last year, the federal seat of Fowler, which incorporates much of Fairfield, and more particularly Cabramatta, received .001 per cent of that funding—$76,000. It needs to be improved, and greatly improved.

ACTING CHAIR (Ms Ellis)—Thanks very much, Mr Watkins. I would like to ask one question at the beginning of this process. With respect to Cabramatta, like it or not, you are the mayor of an area that, nationally, probably carries the tag of the drug capital of Australia. It must be very difficult for any council to administer urban design needs and renewal in an area like that, and you have got more than Cabramatta in your area—that is the other point to make. How important do you see the need to have that urban renewal? What about the effect that this whole question has on business development and seeking further broader business investment in the area? It is all part of the same argument, isn't it? How do you see getting over those questions? How do you see getting the money to do the urban renewal, and being in a position where you can invite successful diversionary businesses and so on into the area, in order to answer a lot of those questions in relation particularly to youth and their future?

Mayor Watkins—There are many questions there and I will address them as I can.

Ms ELLIS—I know; just discuss them with us.

Mayor Watkins—We believe that it is necessary to take a holistic approach. It is not just a law and order issue. I am seeking partnerships, both with the state government, which we do have in place, but more importantly, more significant partnerships with the federal government.

Business development in Cabramatta has been severely hampered and stifled by the media attention that goes with the drug problem in Cabramatta. Significantly, the statistics tell me that arrests for narcotics, or possession of narcotics, are 10 times the New South Wales average. Possession of drugs is also 10 times the average for New South Wales. That has a huge impact, both economically and socially, within our city. Many of our residents within Fairfield City—and we have some 27 suburbs—refuse to go to Cabramatta because of the publicity that the area receives. We are about dealing with the problems, but also promoting Cabramatta as a vibrant, economic, social and cultural hub of Fairfield in which to work and visit. We are trying, through partnerships with the state government, through our tourism action plan and other business development activities, to promote Cabramatta as a vibrant area in which to work and to visit. We do have some successes in our tourism plan. However, whilst we still have a significant drug problem—as I said, it is 10 times worse than any other area; this statistic is contained in

our submission and comes from the Bureau of Crime Statistics—Cabramatta will never reach its full potential.

Cabramatta can be such a wonderful place in which to work and live, and to visit, but it is severely hampered by the drug problem. It needs to be eradicated; it needs a holistic approach. It is not just a state government policing problem; we need major assistance from the federal government. We need major assistance from Customs and the Federal Police. We also need to deal not only with the drug problem, but what do we do with people who find themselves on drugs? It is not just a law and order issue; once people are on drugs, what do we do with them? It is about appropriate and intensive rehabilitation that takes a case management approach and which deals with all of their needs, not just their medical needs. We need to look at their lifestyle skills; we need to look at employment opportunities; we need to look at family counselling. All of these things need to be culturally sensitive. We have the most multicultural society in Australia. We have 133 different cultures, and one model does not fit everyone. They need to be appropriately located. We have had significant problems dealing with methadone clinics in the CBD area of Fairfield. These centres need to be appropriately located as well.

ACTING CHAIR—Thank you. I will ask Mrs Irwin to ask questions. We might need to keep them brief, because of the time constraints.

Mrs IRWIN—I am only going to ask the mayor two short questions, on workplace safety and productivity. I am very fortunate that your door is always open to me. Sometimes we agree and at other times we disagree on things, so I thank you for that; hence the two short questions. With respect to workplace safety and productivity, referring to your page 4 of your submission, you say that, of the estimated 500,000 needles and syringes distributed in Fairfield every year, a significant percentage end up on the streets, parks, properties and laneways of our city. Could you give us a more precise estimate of the proportion of needles and syringes that end up improperly discarded?

Mayor Watkins—The half a million are distributed through our needle exchange programs, which operate from Fisher Street, but also from four mobile locations, and we also have distribution through Guild Chemists, and through other chemists as well. Of the half a million that are distributed, council currently collects in the vicinity of 100,000. I have no figures showing how many others are returned to point of sale, or point of exchange, so I can only guess that of the 100,000 that we collect, that leaves a remainder of 400,000. I suspect that the majority end up on the streets of our city, disposed of in an inappropriate way.

The other problem is that, whilst we have adequate distribution through our mobile and static needle exchange programs and Guild Chemists, there are other pharmacies which exploit drug users by raising and lowering the price of their needles based on the availability from the other authorised sources. A lot of these chemists—not all, but some of the chemists which are not participating in the program—distribute needles in an inappropriate way and do not distribute their needles in a safe disposal pack. They just wrap them up, in some cases in a page from the Sydney *White Pages.* These needles are a significant danger not only to council workers, but to the residents of this city.

Mrs IRWIN—Could you give us a brief history of the mobile needle syringe program? We have got the four locations; we have got the bus going to those four locations around the

Cabramatta town centre. Do you feel that they are delivering a service? The reason why I would like you to give us a brief history is that I know there was quite a bit of controversy about this bus—that it had to move from various sites.

Mayor Watkins—There certainly was. The original idea was to establish a static location for needle exchange in Fisher Street. But the community, together with the business community in Cabramatta, were very concerned about the adverse effect—or the honey pot effect, I suppose—of consolidation of that site as the only location. So the council, together with the community, the business community and health officials, came up with four mobile sites which have been located in areas in a way which will have the least amount of impact on the amenity of the area, both social and business. From all reports, that appears to be working well. Drug affected people know very well where those locations are; they are as discreet as we can possibly make them, and appear not to be having an overwhelming impact on business activity or the amenity of the surrounding area.

Mrs IRWIN—Could you also give us a bit of background about the 50c that you have got to pay to go into the public toilets? We went on an inspection on Tuesday afternoon. I think it was pointed out to us that those toilets are cleaned every 20 minutes—

Mayor Watkins—They are.

Mrs IRWIN—and that you have got people going in there who are injecting. The reason why these people are doing this and are paying their 50c—and I have spoken to some people who are injecting in those toilets—is that they say it is a safe place, because if anything went wrong they know that someone is going to be there within 20 minutes.

Mayor Watkins—The problem we have had is that toilets in surrounding areas have been closed because of the adverse impact of people going into any little nook and cranny—and public toilets are a favourite haunt—to inject their drugs. What you need to understand is that these people are desperate. When they purchase their drugs, they are looking for a place to go that is out of the public eye or public view in most cases, and little nooks and crannies in out-of-the-way places like toilets are a prime target. The council has significant problems with people injecting and leaving their paraphernalia; vomiting and associated antisocial behavior in our public toilets. This had a severe impact on business activity in Cabramatta and a severe impact on encouraging tourism within Cabramatta, because no-one had any safe place to go to use public toilets. So Fairfield Council developed the safe toilets in the Cabramatta car park.

I would not want the inquiry to think, from the honourable member's question, that council in some way condones drug injection in those toilets. If we have any knowledge or any suspicion that someone is about to go into those toilets to inject drugs, they will not be allowed into the toilets. The toilets are there for the public to use and to feel safe in an environment to go to the toilet. That is purely and utterly the only reason we have opened those toilets. There has been some media speculation in the past about this being council's safe injecting room. I reject that utterly. The reason that the toilets are there is to provide a safe place where, under supervision, people can go to the toilets, know that they will be cleaned every 20 minutes and know that there is an attendant on hand so that they can feel safe about going to the toilets. That is the reason the toilets are there.

Mr QUICK—I would like to compliment you, Mayor, on what we have seen during our brief stay here and on your endeavours to try and rectify a huge problem.

Mayor Watkins—Thank you.

Mr QUICK—I also note that you were rather annoyed that your fair share of Commonwealth money through Tough on Drugs has not come here. I am interested, having read the New South Wales Drug Summit plan of action, that it does not look like you got a guernsey in the Schools as Community Centres program either, having regard to the centres that are mentioned on page 3 of their report. So with respect to Families First and Schools as Community Centres, have you missed out on that as well?

Mayor Watkins—I am not aware of the money that we will or will not receive under that program. I would not like the honourable member to think that I do not ask the state government for more money. I am always pressuring the state government for more money. It is not just about bashing the federal government for more money.

Mr QUICK—No, I understand that.

Mayor Watkins—I hope the honourable member does not think that.

Mr QUICK—Coming from a disadvantaged area myself, I note that it states:

The program has resulted in increased literacy, immunisation, preparation of children for school, better nutrition, reduced absenteeism, fewer confirmed cases of child abuse and neglect.

I notice in your submission that you mention the stroller brigade, the next generation. You are facing two problems: the obvious problem out in the streets now and then the siblings of those people that are caught in this horrible, insidious net.

Mayor Watkins—Yes.

Mr QUICK—One would assume that a lot of money would have been poured into this place, because all the statistics in your report are miles in front of everybody else's, so why not target you, with a view to coming up with a national program, because you have got lots of innovative things happening. This morning, innovation was mentioned in about every second sentence, by the New South Wales government.

Mayor Watkins—I am well aware that the state government has introduced, for some time now, drug education programs in the schools of Fairfield City, and not only just for high school students. It is a sad indictment on our society but we have drug education programs in our primary schools. So children up to about 12 years old are receiving drug education, and that is a sad indictment on our area.

We have been receiving resources from the state government. Obviously, I would like to see a lot more resources from the state government, but we have, very importantly, strategic partnerships with the state government. Through the Cabramatta Cares program, which was instigated in 1998, together with the state government, Fairfield City Council has a place

manager, a very senior officer of this council, whose prime responsibility and role in life is dealing with issues in Cabramatta. The New South Wales government, through the Premier's Department, also have the same model in Cabramatta. They have a place manager who is looking at strategic issues to do with Cabramatta, and that is from an educational viewpoint; a job creation viewpoint, and relating to law and order issues and the drug problem. So those strategic links are there. We are very pleased with that strategic partnership because we have received funding for various programs. We do assist, together with the Premier's Department, various non-government agencies in the area, such as the Salvation Army and Adracare, as the honourable member saw yesterday.

Mr QUICK—With respect to the CCTV, involving $400,000 a year, some people might say, for that amount of money, if you gave that to the New South Wales police department they could put an extra 15 police on the street and you could go a hell of a long way towards solving the problem. Obviously, the council looked very hard and long at expending $400,000 per year to set up a system. How did you come to the balance going one way and not the other?

Mayor Watkins—That is a difficult question and it continues to be a difficult question for council. The history of the CCTV situation was that council, together with the state government, needed to do something about the drugs issue in Cabramatta. Part of the strategy for law enforcement in Cabramatta was crime intelligence and detection. It was felt at the time that the CCTV system, through our security consultants and partnerships with the state government, was the way to go. So council and the state government went fifty-fifty on the installation of the CCTV system. However, the ongoing expenditure on the CCTV system—as the honourable member has rightly pointed out—of $400,000 a year remains a significant drain on council's resources. Many residents who do not live in or visit Cabramatta could rightly question the validity of that continued expenditure.

When the CCTV system was put in place, the crime statistics were telling us that 60 per cent of all convictions for drugs in possession or dealing were directly attributable to intelligence gathered through the CCTV system. The other advantage of the CCTV system is in putting cops back on the street. When an offender is confronted with the video evidence, more often than not, they plead guilty as charged. So instead of police sitting around for days on end in court to give evidence, alleged offenders tend to plead guilty, which has the effect of putting the police back on the beat where they belong far quicker. Whilst the statistic of 60 per cent of all drug detection being directly attributable to the CCTV system has slipped somewhat, through new and innovative ways of drug dealing, it still remains a significant deterrent within the CBD of Cabramatta. And there is the perception that the place is a safer place to visit and work because of the cameras. I believe that, whilst it is still a significant drain, and I certainly would encourage and welcome further contributions from the police to help us to meet that cost, it is a worthwhile expenditure.

CHAIR—I say this for the benefit of all witnesses: feel quite free to take things on notice.

Ms HALL—I would like to join everyone else in thanking you, Mayor, for the time you have spent with us. I do have a few questions that I would like to ask. In particular, I would like to follow up about the CCTV. My rough calculation is that, since 1997, when it was installed, in excess of $2 million has actually been spent on that surveillance. My question is: firstly, does it move the problem from one area to another, given that people would become aware that it is

there? Secondly, do you think that that money could be better spent on providing some assistance to the people who are actually using the drugs?

Mayor Watkins—That is a very difficult question to answer. The obvious answer at this stage is that, because we are continuing to expend the money, we believe it is money well-spent. As I said, the installation of the cameras has had an effect on drug dealing and has had a positive effect on people visiting the area—making them feel safer. It was never going to solve the problem. It is one of many tools to address the drug issue in Cabramatta. It is not the be-all and end-all, and I would never come before you and say it is the be-all and end-all and the only strategy.

The honourable member has obviously highlighted that having the cameras in place do lead to either a dispersion of activity or changed methods. I have many in camera discussions with the police. Only last week, I welcomed the two new local area commanders for Fairfield and Cabramatta and the new regional commander, Clive Small, who I believe addressed this committee earlier. I was privy to certain covert operations that are continuing in Cabramatta. I am very confident in the calibre of police that we have in place at the moment.

The intelligence suggests that, whatever method we come up with—and the CCTV system is one method of drug detection and surveillance—there is always a way that smart crims will get around it. It would appear that drug deals are now being done in side alleyways, in some of the local shops and businesses. In some cases, some of those businesses are a party to those operations and at other times they feel intimidated in trying to do anything about it. There are also other methods of doing the deals. At times, all you see is a meeting going on; no money or drugs are exchanged. An arrangement is made to meet at a later place for the exchange to take place. These are constant problems that the police face in this area. But I do not believe you solve that problem by dismantling the CCTV system, packing up and going home. It is one system of surveillance; it remains an effective tool. I believe it warrants its continued expenditure.

Ms HALL—It would appear to me, having read the submission from Fairfield Council, that you have got a strong emphasis on law enforcement and a question mark over the needle exchange program. Whilst you say that you can see some benefits, having read your submission, I tend to get a feeling that most of it is directed towards removing it. Is that a fair assumption on my part? How much support in this area is there for the needle exchange program?

Mayor Watkins—I do not believe it is a fair perception from the report. It would be fair to say that there was huge community concern. During my first term on council—certainly it was a baptism of fire—I was one of the councillors who voted in favour of the instigation of the needle exchange program. I can understand that community concern. It would be fair to say that the council was fairly split down the middle on this issue. So it was a very difficult issue for councillors to take on board, bearing in mind that the councillors are reflecting the community's view.

I am very pleased to see that council did take the view that we should support the instigation of the needle exchange program because we saw it as a health issue. Australia enjoys the lowest infection rates of HIV-AIDS and other infectious diseases associated with dirty needles of any

other Western country, and it is because of our publicly funded needle exchange programs. In saying that, there were all the arguments about it creating the honey pot effect and people would be coming to Cabramatta for needles. I am sorry to disagree with that point of view: the council took the view, and I took the personal view, that people come to Cabramatta for drugs.

Before the needle exchange program, people were accessing needles from chemists, not in a fit pack, so there was no safe disposal, and because they had to purchase them from the chemist, they would leave the needle behind for the next drug user to use. You were in Freedom Plaza yesterday. We had a huge problem because drug users would place a piece of chewing gum under the seats and, after they injected themselves with heroin, they would then stick the needle under the seat for the next drug user. That is what we were confronted with in Fairfield City. That not only has a huge impact on the health and safety of the intravenous drug users within our community, but also there is a huge potential for a blowout of HIV-AIDS and other infectious diseases among intravenous drug users in Fairfield City and also among the wider community. We believed we had a social responsibility and a health responsibility to the area not to do the popular thing, but to push ahead and support New South Wales Health in the instigation of the needle exchange program.

Ms HALL—My final question relates to page 21 of your submission, which says:

> Fairfield has no rehabilitation facility within the city and is unaware of any plans to provide any such facility. This situation needs to be addressed.

Previously, we were addressed by the New South Wales government. We heard from them that there is money actually allocated for this sort of facility with this area, yet it is because of a slow take-up rate by local authorities that this facility is not in place. Would you like to expand on that a little more for us?

Mayor Watkins—Yes, and I would like to refute those claims as well. We have had a fairly chequered history in Fairfield with drug treatment centres. When I talk about drug treatment centres, we have had an experience with a for-profit methadone clinic in the CBD of Fairfield itself. The history of this matter has been that, when the licence was allocated, the licence agreement was fairly loose. It was not as tight and specific as it should have been. In saying that, the operator of that for-profit methadone clinic was constantly exceeding the patient numbers that he was allowed to see under the licence. There was a huge concern within the business community of Fairfield and also within the general public of Fairfield that this sort of establishment was causing untold damage to the very social fabric and business activity in Fairfield CBD.

I am very pleased to say that, through the constant hard work and intervention of the state member for Fairfield, Joe Tripodi, NSW Health have prosecuted that operator—with the assistance of Fairfield City Council—and his licence has been revoked. The operator appealed to the Supreme Court, then the Court of Appeal. Both appeals have been declined by those courts but I understand that, at the moment, that operator is seeking leave to appeal to the High Court. That is not the sort of operation we want in Fairfield. As our submission points out, drug treatment in Fairfield is not about the allocation of for-profit methadone.

Ms HALL—But what about money from the state government that is there?

Mayor Watkins—I am getting to that. Council has been, for the last twelve months, negotiating an appropriate location for a drug treatment centre within Fairfield city. We have an agreement with NSW Health, the police and our community about what drug treatment in Fairfield means, and that is a holistic approach; it is not just about the dispersion of methadone. I am very concerned at the moment. I have just penned a letter to the Director-General of Health, saying that that agreement now appears to have waned. The agreement we had was that we would not locate a comprehensive drug and rehabilitation centre in any of our central business districts because of the adverse impact it has on business activity and on the social amenity of the area. That agreement was drawn up through negotiation between NSW Health, council, the community and the police service. It would appear from correspondence we have received, from the bureaucrats of NSW Health, that they are no longer willing to uphold to the agreement that we have.

Ms HALL—But what about detox and rehabilitation? My understanding was that that was all included.

Mayor Watkins—There is a detox unit. The history is that there was no detox in Fairfield City. We have Corella Lodge at Fairfield hospital, but my understanding is that that is not up to 100 per cent efficiency at this time through a problem that NSW Health has in attracting appropriately trained staff. The problem we have with a drug treatment centre in Fairfield City is that it needs to be appropriately located, and the model that we have created expressly forbids those establishments in our CBDs. NSW Health are not saying it has to be in the CBD. That is an obstacle we have to overcome. We believe we have an obligation to not only the business community but also the rate payers of Fairfield City to ensure that the establishment of a comprehensive drug and alcohol rehabilitation service is appropriately located. We have agreement with New South Wales Health and I will continue to ensure that New South Wales Health are held to that agreement.

Mr EDWARDS—Can I just prefix my comments by saying to the mayor that it seems to me that you have a unique set of problems in your city, problems which are not experienced by any other local authority anywhere in Australia. I sympathise with the issues that you, as a local authority, are having to deal with. Do you feel that you are being asked, as a local authority, to take up responsibilities which are traditionally the responsibility of state and federal government?

Mayor Watkins—It would be fair to say that a significant amount of ratepayers' money is not going into what would traditionally be regarded as local government core responsibilities. But we have taken a more pragmatic view of the issues that we face. When the residents of our city talk about law and order associated with the drug problem we have, I believe we would be failing in our responsibility to the residents of our city if we did not take some positive steps in dealing with those issues. That is why we are seeking those strategic partnerships with both the state and the federal governments. As I said earlier to the committee, we do have strategic partnerships with the state government at this stage.

What I am concerned about—and what I am urging your committee to recommend—is the need for those strategic partnerships with the federal government. You have a number of areas that we have identified in our submission that clearly come under the purview of your responsibility. To date, I do not believe the federal government have lived up their total

responsibility, especially when I quote back to your committee that out of $50 million, this area, or the federal seat of Fowler, received 0.001 per cent of that funding.

Mr EDWARDS—Would it be fair to say then that your emphasis in dealing with the issues, particularly around Cabramatta, has mainly focused on the security, safety and wellbeing of your rate payers and visitors to the CBD?

Mayor Watkins—No, it would not be fair to say that. We believe that that is an overly simplistic view of the problem that we face in Fairfield. We believe that it goes far beyond both law and order and health issues; it goes to employment opportunities. Now we have double the national average of unemployed in our city. Until very recent times, we had an unemployment rate—not a youth unemployment rate, a general unemployment rate—of over 16 per cent. It is down to around 11 per cent now. I am very concerned that part of that fall in our unemployment is not due to an increase in employment opportunities for our residents but is partly to do with a change in the eligibility rate for how you gather your statistics. It is about providing assistance to migrants and refugees in our area. We have more refugees residing in Fairfield and taking up stakes in Fairfield than any other local government authority in New South Wales. I have not quoted Australia because I am just not quite sure of that fact, but I would think it would be Australia as well. We do not deal with these new residents by not providing the support structures that allow them to assimilate into our area—support services like English language skills and employment opportunities.

Going back to statistics, we have three times the national average of people who have very poor English literacy skills. You do not deal with that issue by saying to new migrants, 'Sorry, you don't get access to those programs for the first two years,' or, 'You don't get comprehensive access to job creation programs and training programs for the first two years that you are here'. We have these children land in our schools with very poor English language skills, and there are very poor support mechanisms for both them and their families. It is no wonder that some of those young, and older, people fall into the drug culture. Some of those people feel supported by that culture because they are not getting the support that they need as newly arrived migrants.

Mr EDWARDS—I have one last question that relates to the very strong attitude that you appear to have in relation to supervised injection rooms. Why does your council feel so strongly that it will not support the establishment of a medically supervised injection room in Fairfield?

Mayor Watkins—That is a very interesting question that I constantly get. People say to me, 'You are very concerned about the drug problem, why don't you have an injecting room?' The council has taken the decision that, whilst supporting the current trial that is being conducted by the New South Wales government in Kings Cross, we do not support a so-called safe injecting room in Fairfield city. Cabramatta and Fairfield are far different from Kings Cross. Kings Cross is promoted as a red-light district. People know that they can go to Kings Cross for reasons other than those for which they come to Fairfield and Cabramatta. Cabramatta is predominantly a local shopping centre and we take the view—and are firmly of the view and continue to be of the view—that it is inappropriate to have a so-called drug injecting room in a local, suburban shopping centre.

We are also very concerned that, as I pointed out from the Bureau of Crime Statistics, we have 10 times the amount of drug arrests and arrests for the distribution of drugs. You do not

deal with that by saying that it is okay to inject drugs in Cabramatta and also saying, 'We are going to be tough on drug users.' You cannot have it both ways. You cannot say to people, 'We are going to run you out of town if you come here for drugs,' and then, 30 metres up the road, say, 'Go in there and we will medically supervise the injection of drugs.' In saying that, I will also, together with the council, be very interested in the results of the current trials that are being conducted in Kings Cross. But I have yet to be convinced that the way you deal with the drug problem is to put a drug injecting room in a suburban shopping centre.

Dr WASHER—I am very impressed with the progress you have made in this area. I think you have taken up the bit and you are really running with it. It is terrific, although you have a long way to go. I want to talk to ask you about funding. Naturally the drug issue has been perceived initially as a legal issue, a law and order issue drifting down to a health issue and now, inevitably and commonsensically, to a community issue. So federal funding has naturally gone mainly to states because they handle, as you know, the law and order aspects of things and they tend to handle the health issues in their states. However, as we increasingly realise that this is a large community issue, NGOs have been funded. But what you say is that local governments have not been addressed as looking at directly funding local governments. My gut feeling is that we should rethink that. I guess that is not a question, it is a statement. I think you pointed that out and I will take that on board personally.

What have we learned from the mistakes of Cabramatta in terms of prevention in the future? I know you are fixing it up now. I guess they must be refugees, legal or otherwise, who are not getting this education. You do not get into this country these days unless you can speak English. The big problem we have with these refugees that you are having problems with locally—I make this as a comment to you—from a federal point of view is community opinion. These people are perceived as coming to this country as refugees, legally or otherwise, and then people detest the fact that the federal government gives them money and assistance to get on and create a life in this community. It is backfiring. Can you just elaborate on that? I feel despondent like you, but that is what we get out in the community: 'What are you doing? We don't get this on the dole. These people get everything.' It is that attitude.

Mayor Watkins—Politics is a pretty tough gig. If we did what was popular, nothing would ever get done. Governments at all levels need to demonstrate leadership and conviction on what is the right thing to do. We do not go around doing what is the popular thing to do. If I wanted to do the popular thing, I would not have supported the needle exchange programs. And there are probably people in this very room who are still against the needle exchange program. I am not here about doing the popular thing, I am here about doing what I think is the right thing—and I think that is what the federal government should be doing. I am also acutely aware that, whilst you have constituents who begrudge the federal government providing any assistance to people who are not in full-time paid employment, I too have constituents who constantly are knocking on my door and writing me letters, begrudging the amount of money we spend in Cabramatta. I am acutely aware of that. But you do not deal with those issues by doing the popular thing and by not funding those things.

The honourable member talked about NGOs being funded. Many of the NGOs that are operating in our area receive no government funding. They receive money from their own charitable endeavours, which is very, very hard. They are expert in their field and they are doing a wonderful job, but they are receiving no government funding. Council has supported the

couple of programs: ADRACARE, which made a submission in camera yesterday to this committee, and also the Salvation Army with their Café Horizon, which is providing young people who are endeavouring to get off drugs with life skills in the restaurant and catering trade. Significant amounts of money for them have come from charities, but council has seen a need to support some of those NGOs in the area. And there would be some of those residents who are saying, 'I want my road fixed, I never go to Cabramatta, why should I spend money there?' But it is about doing the right thing, not the popular thing.

Ms ELLIS—I wanted to you one final question. On our walk around yesterday we visited Cook Square, which has been recently refurbished for a very good reason, with a good outcome in terms of amenity—

Mayor Watkins—And more to come.

Ms ELLIS—And more to come. Do you ever feel like a little boy sticking his finger in the dyke to try to solve all of this? It must be so frustrating because on the one hand we will applaud Cook Square. I wouldn't say it was a bad thing at all, but where do the people who used to deal there and shoot up there go? And then how many times do you see yourself just chasing your tail around? I am not wishing to denigrate what you are doing. I think it must be one of the most frustrating jobs in the world, to be the mayor of the area covering Cabramatta with a genuine, obviously a genuine, wish to do something about it but with barely any funding, if any at all, from the federal level. You are battling to get money out of the state level and you get it and that is fine; but, at the end of the day, how many times do you see over the next 20 years that you are going to have to redo Cook Square or another area?

Mayor Watkins—The analogy the honourable member has used is very accurate. I have got fingers in so many dykes, I haven't enough hands.

Ms ELLIS—I sort of get that impression, and I applaud you for it. We might give you some more fingers.

Mayor Watkins—I, together with this council, have to find over $40 million worth of capital infrastructure to deal with many issues in our city. A significant amount of that capital expenditure, which has been identified in our attachment to our original submission, is for Cabramatta. We have a budget of some $100 million. We are the fifth largest or fourth largest, depending on whose figures you look at, local government area in Australia and people say, '$100 million, wow, that's a lot of money!' I've probably got discretionary funding of about $2 million a year to do something with. All the rest are fixed costs. I've got to find $40 million for the works that we have identified and that we identified with your committee yesterday.

You wouldn't want my job for quids. I have to find that money; I also have to ask the residents of Fairfield to support me in getting that money. Some people will support some of our initiatives, others will begrudge the amount of money, for instance, that we might decide to spend in Cabramatta. If you never go to Cabramatta, and some people don't because of the adverse media reputation that Cabramatta has, you would begrudge me spending that amount of money in Cabramatta. But, again, it is about doing the right thing, not the popular thing—but being acutely aware of those concerns by residents as well.

CHAIR—Thank you very much Mr Mayor. What is shaping up in my mind very much, I think in our collective mind, is that your region is bearing disproportionately the load of, for want of a better phrase, the population policy. I think it does require a much more considered approach than what we have seen in the past.

Mayor Watkins—Yes. Just one statistic, Mr Chair: New South Wales Department of Housing tell me that Fairfield city is the most popular area and has the longest waiting list for affordable housing because we have such a multicultural society. If you are from a specific ethnic origin and there is a population here it is fair to say, 'Well that's where I want to live, that's where I feel comfortable.' But that also has its own social impacts and impacts on our financial capacity.

CHAIR—Yes, I hear that loud and clear and this last day and a half has brought that home to me personally very much. So we are deeply appreciative of that and, once again, to your magnificent committee, thank you very much.

Mayor Watkins—Thank you for the opportunity of speaking before you too.

[12.24 p.m.]

GORDON, Mr Bruce Raymond, Member, Family Drug Support

HAVAS, Mr Thomas, Volunteer, Family Drug Support

HILL, Mrs Karmen Marija, Volunteer and Board Member, Family Drug Support

INTA, Ms Elli, Board Member, Family Drug Support

JENKINS, Mrs Lorrimer Anne, Volunteer, Family Drug Support

MATTHEWS, Dr Donald George William, Volunteer, Family Drug Support

MORRITT, Mrs Faye, Board Member, Family Drug Support

STRATTON, Ms Penelope Gay, Volunteer, Family Drug Support

TRIMINGHAM, Mr Tony, Chief Executive Officer, Family Drug Support

Mr Trimingham—Thanks, Mr Chairman and members of this committee, we very much appreciate the time that you have given us to give evidence today.

CHAIR—I need to point out that we are witnessing a legal proceeding for parliament and as such it warrants the same regard as the proceedings of the House of Representatives. Please continue.

Mr Trimingham—We represent 1,800 members in our organisation across Australia. We take telephone calls from 12,000 affected families on a single 1300 number. You have our written submission. We support a wide range of activities from early intervention and prevention and education through treatment and harm reduction. I guess our focus today is on the human face of the problem. That is what we want to bring home to this committee and we are going to do that in two ways: by a slide presentation, which will introduce you to my son and a number of other people who died from heroin overdose; and having some of our members tell brief personal stories. And then, of course, we welcome your questions.

I'll just mention a couple of things that I want to emphasise before I start the presentation. We strongly believe that in looking at drug problems there is an important need for family support. For years and years and years we've had a history in Australia of family support being neglected. Where family support is not present families do become disengaged from the drug user and there is despair and of course there are a lot of negative consequences for the user as a result of that. On the other hand I think some of the people here today will demonstrate to you that, where we do have family support in place and people do have access to other people who are affected and get awareness education and information, that leads to resilience, to coping, to management of the problem and to an altogether a better outcome.

I want to commend the New South Wales presentation this morning. I think that all round team effort that we saw there is highlighting the changes that are happening in this state. I also

want to mention what other people have mentioned earlier today, and that is the current drought of heroin. I guess idealistically as a parent organisation we would like to think that we could eliminate heroin from our country and never have this problem to deal with again. However, realistically, as Wayne Hall mentioned, we had up to 92,000 dependant heroin users in 1997. He assures me that that figure is probably a minimum of 95,000 now and upwards from that. We also know that over 400,000 people would have tried heroin in the last 12 months. When there is a reduction in supply there are some very negative consequences. Our support line is receiving lots of phone calls about more violence, more poly drug use, an increase in use of benzodiazepines, amphetamines particularly and cocaine, crime is increasing because of the increase in price and we of course are having people demanding treatment now. There are no detox places available, yet people are hammering at the doors because they are forced into withdrawal because of a reduction in supplies. I was very distressed to hear that—if it's correct I'd be very disappointed—that $15 million from the methadone program has been diverted by Dr Wooldridge into medical research. Whilst we support medical research, there is currently an urgent need for methadone and the last thing you ought to be taking away from it is $15 million. Having mentioned those things I will go into my presentation and then we'll talk to some of our members.

An audio visual presentation was then shown—

Mr Trimingham—I am just going to quickly show you another set of slides. These are people who have died in the last two years. we have an annual memorial service and these were photographs that were submitted to that service.

An audio visual presentation was then shown—

Mr Trimingham—Thank you for that. I don't apologise for showing those pictures. Of the 95,000 dependant heroin users and the 400,000 casual users, it would be true to say that very few of those would be the stereotypical street user that we generally imagine. The vast majority of people look normal and are connected to their families, and I think it is very important to make that distinction. Unfortunately those who do become disconnected usually end up as the stereotype. And I would now just like to pass over to my colleagues from Family Drug Support, starting with Karmen Hill.

Mrs Hill—My name is Karmen. I lost my son Aaron when he was 23 years of age. That was nearly seven years ago. He started using drugs at age 16, cannabis and alcohol, which he thought were quite harmless and everyone else was doing it. A few years later he was on speed. He was not what I would class a constant user but tended to binge at weekends while holding down a good job through the week. The night before he died he attended a party and he and his girlfriend bought heroin on their way home the day after. They had bought it at Cabramatta and then went on to Baulkham Hills. The heroin was pure, he had alcohol in his system and he died immediately.

I could go on and tell you what he was like but what I really want to communicate to you on my behalf and other families is a wish list. And what I wish most is that someone would have given me alternative advice other than, 'They have to hit rock bottom,' or, 'Kick them out.' I wish that I had understood what addiction is and that the process is not black and white—that I had understood that it was not a matter of simple willpower and saying no. I wish I had known

that recovery does not happen at the first attempt at detox but can take years. I wish I had had the support of someone who had been down that road, and that I had had more knowledge of the drugs than I did have. I wish I had been able to communicate in a more effective manner with my son, a manner that may have been more conducive to him seeking treatment. I wish that I had had the knowledge of how to access information not only on drugs but on the treatments available. I wish that there was someone I could have talked to at my most desperate moments, not an answering machine. I wish I could have spared the pain that his grandparents carry and his sibling. I wish that there had been family drug support available then so that I could communicate with people, where the stigma of losing a child to drug abuse solicited an open and loving response instead of judgment, abhorrence and silence. But what I wish most is that I had died before my child and that he was still alive.

I have now moved out of the Sydney area and I live in the Southern Highlands where I have endeavoured to start Family Drug Support meetings. The community down there still denies that there is a problem. I am confronted with people phoning me with their problems but who are frightened to come to a meeting in case someone finds out. I am a newcomer down there and I am still getting people ringing me all the time, asking whether I know where they could access help for their child and for themselves. I find a community where resources are stretched to a limit; where, to get counselling at the moment for drug addiction, there is anything like a waiting list of a month; where access to detox or rehabilitation is non-existent. In fact there has not been a drug and alcohol worker down there for about 18 months and the response from family GPs is simply, 'They must stop using drugs and everything will be okay.' As an individual I do not know how I have survived but I do know that my aim through Family Drug Support is to help ease the burden for other families even for a moment, as they are still easing mine. Thank you.

Dr Matthews—I would point out that I am an academic, not a medical practitioner, so I do not know as much as I may sound as though I know, but I know about benzodiazepines. My daughter was dependent on benzodiazepines, or prescription sedatives. For example, just to fill you in: Valium, Serepax, Mogadon, Rivotril, Normison and Rohypnol for several years. As in so many cases, she was prescribed these originally because of sleeping problems. She is now in remission, which is the best you can ever say where these drugs are concerned. These drugs are legal and handed out without question. With heroin, they make a lethal combination. My daughter could doctor shop when using and collect several scripts in a short time, with no questions asked.

Benzos are one of the hardest of all drugs to beat because of their cumulative effect and because they blot out unwelcome thoughts. They are depressants, they are tranquillisers. Very few users succeed first try and virtually none succeed without family or medical help. Because these drugs are legal and are prescribed in great numbers they do not get the coverage that the illegal drugs attract. But living with someone who is on them is hell. The mood swings are terrible; the lies; the downers—I should add probably the theft—and the desperate search for more of the same is a big shock to any family. My wife and I discovered FDS in the phone book and through it the freedom to talk with others in similar drug related plights. The support and non-judgemental approach was vital to our getting through the bad times. That support did much to save our family ties.

I have spoken to numerous callers on our crisis line who come to us because they can find nobody to help them. For the user, yes help exists, but not for the family. Nothing saved my daughter's marriage or custody of her baby, who was taken from her in favour of a father who does his best to prevent her ever seeing the child. Uninformed judges and registrars hear of the savagery of drugs and the effects on children to the extent that they have sided with him when no evidence exists as to her ever having been a danger to the child. We have heard Family Law Court registrars struggle with the word benzodiazepines and some have asked for explanations. They mistrust our denials—my wife and I have unblemished teaching records totalling 60 years between us—because drugs must be a threat. These arbiters need to be educated in drug types and effects, as they clearly don't know much at all in that regard. Yet they are being asked to make monumental family decisions.

One further point—and I think this is absolutely vital—is that anything a person undertaking rehabilitation says to a psychiatrist can be read out in open court and used in evidence against them. It is reasonable to ask in many cases such as our daughter's: how can they hope to make a recovery knowing that they cannot talk openly to these professionals? This amazing fact of life stunned us when we became aware of it. Now, not to mince words, we sat in court, and anybody could sit in court, and we all listened to everything she had ever told psychiatrists read out for the open court. Nothing is sacred. Short of talking with a Catholic priest, no addict is safe in making any confessions that might assist the processes of unloading and rebuilding. At present, all they have is family.

I might just add one comment, which I think is apposite because it is something that has been said today: with regard to the drought of heroin, that it is common to read in various books such as this one, our own notes, et cetera, that heroin users who cannot get heroin will doctor shop and get benzos. Thank you.

Mr Havas—My story is one of life, not death. My son is 21. He is today stable on methadone. The story started in December 1998. He was 19 then and I was in hospital, and my bank manager rang me and said, 'Did you sign this cheque? Someone came in and presented this cheque.' It was on an account that I had just closed a week before. I then realised that my son and his girlfriend, who were living separately in a flat in Canberra, were on drugs. It was something that we knew or we thought we knew, but we were not sure of. By February 1999 both decided to return to their respective homes. Within a fortnight, both he and his girlfriend admitted to large habits, by then close to $1,000 per week. You can only guess how they financed this habit. What emerged was that they were addicted for four months in 1997-98, then detoxed by themselves and did year 12. Towards the end of year 12, they both started their addiction again. That was towards the end of 1998. Both families were in shock when we discovered what was going on. There has been no story of addiction to drugs or alcohol in my family and, although I am now working as a counsellor, I was never interested in drugs and alcohol. This was something that was taboo to me at the time.

So my ex-wife took him to Lennox Head and his girlfriend was taken by her parents to the Central Coast, and there they detoxed cold turkey and it worked. My son came back to Sydney and I was with him. I saw someone I had not seen for a couple of years, a beautiful boy again, and he insisted on going back to Canberra, where his girlfriend had gone back to. I tried to warn him, but he wouldn't listen. So he went back to Canberra and within a fortnight after seeing his

girlfriend again he was back on. So he decided to come back to Sydney with me. Then started an eight-month struggle.

As a counsellor, I had been to Langton and I had attended a narrative therapy group there, so I took him to Langton. I was in a privileged position. I went to see Alex Wodak and a number of other people and tried to develop the best possible strategy for him. I still thought that this could be done in a few months. I must say that after four detoxes, one Naltrexone treatment and so on he was still on it. I was still going to the Cross with him, trying to protect him so he would not get into any harm; buying heroin for him and getting him to take it home. And sometimes I gave him the money and he would lose the money and come back absolutely desperate saying, 'Please give me another $50.' We would go down to the park in Rose Bay and for four hours, we argued and argued and argued, and in the end I had to give in because the appeal of the drug was such that I could do nothing against it. He did not want to go on methadone because it would have been to admit defeat.

By the end of 1999 he was so exhausted and I was so exhausted that we both decided that he would be better on methadone. I must say that in between I met Tony because everybody who is in the trade knows that there is only one organisation really which looks after the families of drug addicts. Tony gave me invaluable advice. He said, 'This is not a matter of a few months, it is a matter of years.' When I accepted that I accepted that I must go on living my own life. In the meantime I lost a relationship with a young woman who had a young child because it was impossible to go on with an addict around. I decided I was going to live my life and what's happened now is that today my son is still struggling, he has got his ups and downs. In December he went back to university and he did the summer school of science, but he didn't finish. In fact he could not even get the right date for the exam. He missed the final exam, but he is trying.

I realise that the struggle with drugs, with addiction, is one of every day offering kids a different opening to the one that they use so they can see that there is enjoyment in life. Take them to concerts; take them to other things. My son, when he was 12, was a solo singer with the Canberra Boys Choir. Today he tells me, 'When I was 12. I looked at the music and I could hear the music singing in my ears. Today I don't know whether I would still be able to read music.'

I would like to say in summary: I have this card from Christmas 1999, after the eight-month struggle we had together. I don't know whether he had the money to buy this card, whether he pinched it from the local newsagent or what, but this is what he said:

> Dad, Christmas is a time to remember especially family. I'd like to thank you for your support particularly over the last eight months. Although it may not be perfect my life now is 100 times better than it was 12 months ago. I wouldn't be here had it not been for your support. I might not show it much but I love you and I am forever grateful for your understanding and support. Merry Christmas, love, Stefan.

Mr Gordon—My name is Bruce Gordon, I am basically here because I have been asked to come along and talk. Unfortunately my story is not quite as happy as Tom's. I lost my son in November to an overdose. This was somebody who was trying to keep up a job. We battled. He moved down here from Queensland unfortunately. Fortunately or unfortunately I live at Smithfield. He moved down from Queensland, where he learned his trade. He was a carpenter by trade. He moved down to try and get a start in life. He was 23 years old then. He had not long finished high school, concluded his trade, his apprenticeship, learned his trade and started.

He not only worked with me, he lived with me. Unfortunately his drug problem escalated when he came here to the area. Maybe it was a lack of money or something. The problem had slightly started before in Queensland but it wasn't noticeable basically because he didn't have the money. I think that was part of the problem, as was the fact that it is a lot more expensive to buy there than what it is here, from what I found out.

To be honest with you I knew practically nothing. I think the general public out there knows nothing. It is a problem that they don't really want to know about if they can brush the users aside or brush them away off the street and out of sight. I was ignorant, even when the problem confronted me and I knew what he was doing. I never had any violence, I never had anything, I had a loving son. I tried fighting the problem on my own with my son but I often had a job trying to get him to work.

Unfortunately for me it got to the stage where I had to get help. My partner had left; it had just become too big. I got to Tony for help but it was too late in things—the education I got, the knowledge that I gained in how to deal with the problem, was right at the very end of things. A lot of it was out of sheer embarrassment for the things that he had done. He had never stolen from other people, but he basically hocked everything in my house. I was buying it back. I have a very good job. I was lucky in lots of ways. I have a very understanding employer.

I found that nobody wants to talk about this problem, even when you are open. I am fairly open, I am very black and white. When you talk to people it nearly knocks you down, the number of people that are affected by this. I couldn't believe some of the people that I ran into, and a lot of these people are trying to hide the thing. Why? I don't know. I think it is something that needs to be brought out into the open. People need to link up and speak about it more often. I am not here to say that it is good or bad but it is certainly here that the users need help—and the families need help too. I am now on my own but there are a lot of other people in, I should imagine, a worse place than where I am.

It is strange to hear Thomas talking there. That is the first time I have met Thomas and it is strange to hear him talk. His story is similar to mine. Unfortunately mine had an unhappy ending and his will be, I hope, a happy ending for him. But I tell you it is really something that gets you down. I am a person who fixes problems all day long for a living, but this was one problem I certainly could not handle. And I think I'd just like you people to take it on board. I think that it needs a lot more funding in it, from what I can find out. My problem is still pretty raw, but that's about it. Thank you.

Ms Inta—My son was 15 when he dropped out of school and battled heroin addiction for four years. When he was 19 he, in one year, attempted to detox nine times and he was actually successful in September 1998. He was clear from heroin and then he had to do a stint in prison. When he came out he started a TAFE course. He attended TAFE in 1999 and 2000 to gain a university admissions index, and now this year he has got into a course at university with a minimum requirement of 98.4. So I am full of admiration for his courage and his bravery and his fight. But I just feel really incredibly sad that Damien Trimingham and all these other children have lost their lives. They were as deserving of a good future as my son. And it just seems really unfair that some make it and some don't. Thanks.

Ms Morritt—I guess am one of the lucky group of families too, because my son is still alive. He had a very heavy heroin problem. He started off, I think, when he was fifteen or sixteen on alcohol and speed. Unfortunately they—or fortunately, I am not sure—made him sick. He was then introduced to heroin, which didn't make him sick. However, he was unaware of how addictive it would be. By the time he was aware it was too late, so he went on a life of heroin use that included living a very chaotic life both at home and on the streets at certain times. He, I think, did a lot of things that I still don't know about and I am sure he doesn't want me to know. I think he would have most likely ended up doing a jail sentence if he hadn't decided, at one stage, that that was enough of a chaotic life and that he should try and get himself together. He decided that he needed the family's help. We'd all gone through the same as everybody else at this table—the loss of possessions, which really are nothing anyway, but also the loss of your child. I only have the one child and I certainly didn't want to lose him.

He then took himself off to a methadone clinic to try and stabilise himself. He had over that time tried to detox several times but found it extremely difficult and couldn't do it. So he took himself off to a methadone clinic and that was a little bit over two years ago. Whilst he is still on methadone he has got his life together and he is working. He is actually running his own business with his father. He is learning something all the time because he didn't finish his schooling. He is now becoming a worthwhile member of our community. He has a strong abhorrence of drug dealers, but heaps and heaps of sympathy for heroin users and other drug users, knowing how hard it is to live that lifestyle. He has asked me to say that he is actually here today. He was going to talk but we didn't quite get our act together properly, and he has asked me to say how hard it is for people to understand how difficult it is to come off heroin. Whilst adults seem to say, 'Look it's easy, you should be able to say no to these things,' it is not that simple. And whilst methadone is not the answer, the total answer, it allows people to get their lives together again.

We have one little complaint about methadone and that is the lack of—in the private system—counselling and/or a caseworker. It is basically, 'Have your dose go home.' Maybe they ask you occasionally, 'Are you okay?' However, it has kept my son alive and it has kept him from a life of crime and has given me back the boy that I had and always hoped to have. Thank you.

Mrs Jenkins—I live in Fairfield, quite happily. For 15 years I have been here but for 18 years I have lived with the horror of two of my four sons using drugs. It started with marijuana and speed then went on to heroin, cocaine and all sorts of drugs. You name it they used it. Tony and Paul both had very high IQs. They were high achievers and were extremely good at most sports. There was very little information if any for me to know what to do then, or how to get help for them. We would get referral after referral on the phone, but people would only give you a couple of minutes on the phone, and then they give you another phone number and another phone number, but nobody can help you. So I would ask them, 'Don't you know how dangerous drugs are?' But they don't believe it; they know better. So whom do I go to for help? I spent hours looking for help on the phones, day after day.

WHOS took Paul in because at that stage I really only knew Paul was using because of the personality change. He was a totally different 16-year-old boy. He only stayed there for a month and came home and my support person told me, 'You cannot have him living at home while he is using.' And so I put this 16-year-old out in the street. He had never had that done to him, and

it was horrifying for me, absolutely dreadful, but it was worse for him. I had him back in a week and he went back to WHOS for three months. But that support person kept her child under her roof, which now I know is the right thing to do. Anyway he stayed for three months at WHOS but the next 10 years of his life were spent in rehabs and prison, court cases galore. He would do offences when he came out so he could go straight back in. He'd do something and sit and wait for the police to come and get him but they wouldn't because he was parole; they didn't put him straight back in or anything else and he just kept reoffending and sitting there waiting for the police knowing full well they knew who he was. That was the next 10 years of his life.

But Tony on the other hand didn't give us real problems. His personality didn't change, he worked, with very rare sick days, throughout this whole time. He married a lovely girl who was raised not totally differently from most. She was sheltered, protected and he had told her what he had been like, or was, but she didn't realise what it meant. He married her and became a highly respected member of his church, counselling the adolescents in the church, coaching the soccer team, the drama club at the church and doing various other things. We believed he had been clean for eight years. But on 3 February 1997 on his way home to Mount Annan he stopped at Cabramatta and he then drove home. His wife went to the gym and she came back an hour later. He was dead on the floor from a pure dose of heroin. His favourite expression came to mind, 'I'm okay mum, I know what I'm doing. I don't need any help.'

Paul came out of prison in November 1997 and he has been leading a decent life. He has been working in a good job for three years. They know of his problem; he came out of prison on methadone. His boss actually drives him every day to pick up his methadone and then takes him back to work. He works the computer. His boss raves about him. He is now 33 years of age. But he has saved them. When they took him on, he immediately saved them $2,500 to $3,000 a week with cost cutting things that he had learned and how he was purchasing for them. But it is sad to say that it took Tony's death to bring that about for him.

The whole thing is that throughout all of this there was no help for me, nowhere to go. My stepdaughter works in drug and alcohol, or drugs mainly with adolescents. She had started it because of the boys. She was working here in the Bonnyrigg area needle exchange counselling. She went out to Dunmore, she worked there for five years, six years and now she's helping psychotic children before they get into drugs, hopefully. And she was the one that helped me get in touch with Tony Trimingham, because my daughter-in-law was suffering badly and I needed help for her. I thought she needed help. We went to our first meeting with Tony. I was talking to him and he said to me, 'Lori, I'd like you to come on our phone lines.' And here I am. If only people could realise that addiction of any type is an illness, self-inflicted yes but still an illness. But the cruellest thing is that most people believe, and say, that they are better off dead. I can vouch that they are not better off dead. No matter how others feel, they are somebody's sons or daughters, husbands or wives, or grandchildren and they are very much loved no matter what they have done. You just want your person back to a normal life. Thank you.

Ms Stratton—Helplessness drove me to my local member, Brendan Nelson, in 1997, when my need for support was immense and there were simply no avenues open, no help at all. This in turn led me to Tony Trimingham and Family Drug Support and, more than that, to be comforted amongst like people who understood and accepted without a word being exchanged. I live on the North Shore, enjoying a middle-class socioeconomic life. I offer my children the privilege of a stimulating environment, education and nurturing and yet my youngest daughter,

Sarah, has battled drug addiction for eight years. There is no drug she has not used, and she has singularly fragmented a strong family unit.

We have struggled to keep faith in Sarah, to love and protect her, to support her, to keep having hope. It has not been easy and, in truth, it has torn the family to its heart. She is nearly 20 years old now; of high intellect. She is articulate and talented and yet she prostituted herself on every level to support a heroin habit almost to the point of death, which, at the time, was acceptable to her in oblivion. But that has now become an intolerable memory and a burden almost too heavy to bear. We no longer grieve for 'what if? or 'if only'. There are no easy solutions, but in this prolonged journey of supporting them in their illness it becomes even harder to help them bridge the gap between the world they have made their own and ours. It is all part of the process.

I feel that my daughter is lucky. However, I do not believe that many family units can survive it without support and intervention. For many people, the slow realisation that their child or loved one is using drugs opens the door to a darkness of which they never quite make sense. What support do we have: the parents that deal with the day-to-day issues of drug use, mental illness, devastation, desperation and death? To date, Family Drug Support is the only visible support structure offering help and consolation in the face of reality. Community support is sadly lacking. Still, the family is regarded as a pivotal force from which all blame is apportioned and equally from which all solutions should flow. This is a misguided notion. True addiction transcends the family; it is a community problem and requires a community response.

If we are truly to call ourselves a community and you our representatives, then families cannot be left grasping for answers and struggling in isolation. The importance of Family Drug Support cannot be underestimated. We have made and continue to make a difference, to offer solace and strength to parents and carers, the ingredients vital for survival not only for the addicts but also their family.

When I asked Sarah for her reflections she said, 'Do not be ashamed; do not shun us. Give them refuge; offer a safe and sanitised atmosphere. Do not tell a family to disown their child, be there for them.' Sarah commenced a TAFE course this year to complete her HSE—another stepping stone. Thank you for your time.

CHAIR—Tony, did you want to sum up?

Mr Trimingham—Yes. I guess I would like to say we could have brought 1,800 people. We brought eight. Following on from what Penny said, I am going to take this opportunity to make a plea. Family Drug Support exists on a budget—on a state government funding—of $100,000 a year. We run a telephone line that takes calls from every single part of Australia: from the outback, Perth, Tasmania, Northern Territory and all urban cities. That telephone line is a 1300 number and we are sometimes on the phone for two hours. So, if anything comes out of this, if there is anything that you can do to increase our funding, we need more than one line. We need to employ more people. We rely on 180 volunteers who man that service. Without them we would not be doing what we are doing, and I think you have heard enough this morning to know how important and how valuable that has been.

I can assure you, in seeing people that we have worked with over four years, that that element of family support is making such a difference and people are just measuring success in a very different way from the way they expected to. What they wanted was, 'My son and my daughter are off drugs'. What they have got is something very different from that, but they have got resilience, they have got coping skills, they have got management and they have got somebody to turn to. Any of us are willing to accept any questions.

CHAIR—In the realest possible way—you make the connection—what is the service that is required? What I would like to try to understand is: what is there now? What should be there? I hear the comment about the phone line being very important. That is immediate. What is there now? You people know better than anyone, it seems to me, what is required. Do you see what I am saying, Tony?

Mr Trimingham—Yes, I do.

CHAIR—We sit and listen in this clinical way to a whole lot of systems and departments and all the rest of it. Now that is a mile away from what we have just sat and listened to. It has been a privilege and I thank everyone for their courage in the way they have presented it to us. But can you understand what I am saying?

Mr Trimingham—Yes, I do understand what you are asking. We need everything. We need an across-the-board approach. We need the sorts of strategies that New South Wales has put in place. When we look at countries that are achieving success and we look at diverse countries like Sweden and Switzerland, what we find is that they are spending $8 per head of population on this issue more than we are. And they have both got very opposite approaches. They are both achieving reductions in heroin deaths. We could talk about injecting facilities and life maintenance strategies because that's what I am known for, but that is really only a minute part of what I am about. We can talk about more detox beds and we can talk about training people to man these facilities, but really what we want more than anything is for the community to get its blinkers off and accept that this is a problem.

Some 2,700 people died as a result of illicit drugs. Yes, we believe that we have to tackle the legal drugs as well—alcohol and tobacco—but those people who are dying mainly from alcohol and tobacco are dying and have lost maybe five, 10 or15 years of life at the end of their lives. The 2,700 people who die every year from heroin overdoses are in the prime of their lives; they are aged 14 to 40. That is the cream of our future.

We have seen demonstrated even from this small number of people how important the turning point has been for just a couple of them and how they are going on to be, and will go on to be, productive people in society. We need to have an acceptance. It angers me so much to hear the mayor of Fairfield sitting here this morning spending $2 million on surveillance cameras and paying lip service to treatment, yet they will not have a treatment centre in Fairfield or Cabramatta. The state government is willing to provide them with one. Now it is just bullshit when he sits here and he says, 'It's their fault.' I commend the community of Kings Cross, who have lived with this problem for 30 years and have said, 'We have got the problem. We are not in denial; we are willing to accept it.'

It is not just Fairfield. I have just come back from Vancouver and met with families just like these families over there, doing great work, battling the same sort of thing and a community over there that is polarised. I believe the mayor and the parliamentarians there are trying to get something up and running and it is the same thing—the business community and so forth. We have had the United Nations today bring out a report condemning Australia for its focus on harm reduction. We have a three-pillar policy: supply reduction, demand reduction, harm reduction. We do not take resources out of supply reduction and put them into harm reduction, which is what they are claiming we do. We are so underresourced in that third area. More than 80 per cent go to supply reduction. Then we have the problems that the drought brings about. I am sorry that I am getting angry.

Mr EDWARDS—In terms of the questions that may be put to you, this committee was established as a group of backbenchers on a very strong bipartisan basis, and one of the reasons that it was established was simply because of the frustration that we felt as backbench members of parliament dealing with parents coming to us and saying, 'I have a child who is addicted to a substance. Where do I go? Who do I turn to?' We felt frustration and anger in not being able to provide the sort of support and help as frontline people dealing with the community that we felt we should be able to provide to you. So just in the context of everything that you have said this morning—and I must say that you have had a very strong impact on everyone and it helps to remind us why we are here and what we are about, and I can assure you that your time here has been very well spent—I just wanted to assure you that the main reason that this committee was established was in answer to the sorts of pleas that you have echoed here this morning.

Mr Trimingham—And just on one document we have given you—that purple book—if you have a supply of those in your electorate offices and get them around to your colleagues, that is a practical, helpful book that you can hand out to people who come knocking at your door and even that little thing will make a difference.

Mrs IRWIN—I don't actually want to ask any questions because I think you have covered it beautifully, but I just want to thank you for sharing your stories. I know it is sad that you have lost Damien and I think Tony was mentioned and there are the Carols and the Sues out there. I've got a 17-year-old and a 24-year-old and there, but for the grace of God, go I—that could be my child. I am going to actually share something with you.

I have only been in parliament since 1998, and I've been fairly vocal to a certain degree on drug law reform. Sometimes, Fairfield Council and Liverpool Council have not been happy with the stance that I might have been taking—as have various state members of parliament—but I also blame the media a lot. The media come into Cabramatta and walk the streets with their television cameras. They are only interested in that addict in the gutter with the syringe in his hand—they are not looking at that person as a human being; they don't realise that that person is crying out for help. I walk the streets of Cabramatta and go up to these addicts and I'm telling you that, nine times out of 10, these people want help and they want resources. The saddest thing about it is that they haven't got the resources and sometimes it can be too late.

The story I want to share with you is that a gentleman—and I cannot mention his name because he was a high profile person in the Fairfield area and there are people in this room that would know him; he is no longer living in the area—was completely against the sort of stand that my husband, the previous member for Fairfield, was taking on supporting a methadone

clinic. This was back in the 1980s in Fairfield. I would be at public meetings with my husband and I'd get up and speak and he was completely against anything to do with drug law reform. I met this gentleman just after had I come out in the papers supporting a safe injection room at Cabramatta, and he actually phoned me for an unknown reason—and he had finally found out that I was in federal parliament.

He said to me, 'Hey, Julia, it's a pity that I didn't listen to you and I didn't listen to your husband in 1984 or 1985 because I have lost my son. I thought it only happened to other people. He was a good boy. He was going to university. He had a part-time job. I didn't know that he was on drugs until it was too late. I only found out six months before he died.' I am telling you that stories have got to be told, and that's why I'm saying to everybody here, everybody sitting up there in the public gallery—and I notice that there are one or two councillors up there—'It could be your child, it could be your son, it could be your daughter.' I think we've got to work together—and this is the most important thing—to educate the community. We've got to tell the community, 'We have got a problem and we have to save these beautiful lives.' Thank you again for sharing.

Ms ELLIS—I have just got a couple of questions for Elli and, I think it was, Faye—but I stand to be corrected. I hope you don't mind me asking this. Was the reference to your child going into prison? Can you just very briefly, either or both of you, give me an idea of what we are talking about: what were the charges? Just tell us as much as you want us to know; if you don't want to bring it out in the public eye, I will respect that as well. What sort of prison were they in and for how long? What did you think of the release mechanism in relation to the drug addiction, because I am assuming they were in there for drug related reasons.

Mrs IRWIN—Before you answer, Annette and all of us are actually involved in jails. This is why we're asking the question.

Ms ELLIS—We are getting a little mixed up about the incarceration.

Ms Inta—Okay. The first time my son was in Minda for only a couple of weeks, but—

Ms ELLIS—Where?

Ms Inta—Minda. The juvenile detention centre has been closed down now. He had been in for, I think, 24 hours before he was bashed. That came as a bit of a shock. It had no connection with any of the stuff before, and in fact he was in because the police accused him of stealing a car. He was in Minda, and then at the end of the two weeks it turned out that he hadn't stolen the car and there was no evidence supporting any of that. That was the first time. The interesting thing is that they were not drug related offences—they were only drug-related in that they were caused by his lifestyle but they were not actual drug charges. He was actually on home detention with his dad, and that didn't work out so he got taken away to Silverwater, first up. Again, he got bashed within 24 hours—

Ms ELLIS—So this is an adult incarceration?

Ms Inta—Yes. He had just turned 18.

Ms ELLIS—Okay.

Ms Inta—He got bashed within 24 hours again, then a few days later he was bashed again and then he got shifted to Long Bay because they thought he would be safer in Long Bay. Then he got shifted up to Muswellbrook, and he was also in Cessnock. I think within the space of a couple of months he had been assaulted on four separate occasions. By this stage, he had actually cleaned up his addiction.

Ms ELLIS—Had he done that with help from the inside—from staff or from counselling?

Ms Inta—No, he had so many court things piling up that he thought he might have a better chance of a good outcome if he was clean, but he still went to jail. When I picked him up he was on crutches from an assault, but he was determined that he would not be going back because he is a fairly intelligent boy and he was just really scared.

Ms ELLIS—Do you want to add anything briefly from your experience, Faye?

Ms Morritt—My son did go to jail on charges of stealing, but it was drug related—he wanted to get money to buy heroin. All his charges were like that and there were a lot of them. He spent a little bit of time in Silverwater before he went to court, et cetera. While he was in there he was still using. I don't know how, but he was. He was seeing the drug and alcohol person in there. He actually convinced him that he would be okay, and that he should be let out into my care. He was but it was just farcical, it wasn't true; he absconded after that and we went through a lot of processes. He was very lucky that he had commenced on the methadone, he had changed his ways. There were a whole heap of things that made it very good for my son.

I would like to mention that I have a friend who has two sons that have both just been put in jail. One was sent to Goulburn. This boy had never done a thing wrong in his entire life until he started taking drugs. He didn't have a criminal mind at all. He actually took a weapon because he didn't know how to rob a store or anything without that. He was caught, he was sent to Goulburn jail, and he got a sentence of six or seven years, I think. I've forgotten exactly how long now because it was very traumatic. He was sent to Goulburn jail. He has had no counselling or anything there at all. He is now being sent to Kirconnell—

Ms ELLIS—To where?

Ms Morritt—Kirconnell, which is between Lithgow and Bathurst. He is still not receiving any counselling or any treatment for his heroin addiction. He is off it I believe, but in Goulburn he had absolutely no help whatsoever. No one talked to him. He was still getting hold of drugs and it's just a sad thing. This boy is 24 and he has absolutely no help.

Dr WASHER—Thanks Tony and thanks everyone. I am glad you sorted the bogey out when we have problems with young folk who are drug addicted. There is this concept that there is something wrong with the parents and there is something wrong with the parents—they suffer terribly—and I am glad you put that message across.

The second thing, Tony, that you put across is something we understand very clearly. We need education. We covered that and you heard that covered in many areas, but the area that we

need it most is in the general community. We have major problems in instituting harm reduction programs in any region in Australia. Everyone says it is a great idea until you want to put it next to them. Until we can sell the concept that this is everyone's problem, we cannot identify who is at risk yet. We don't have the medical knowledge and everyone's got to share in trying to help on this issue and take some ownership of this or we will never solve it. I thank you for your comment. That wasn't a question, sorry; it was more of a statement.

Ms HALL—Thank you. I usually never make a statement when we have witnesses before the committee but I am going to break that tradition. I must say that I would like to thank you. I really found your contributions overwhelming, to put it mildly. In your children, I saw my children and I'm sure Harry saw his children, and they deserve the same love and care that all our children deserve. We really thank you for what you've given us today.

CHAIR—Yes, thank you very much. I don't have anything else. I think it has all been said by the committee members. I would just like to finish up by asking if there is anything that you would like to say. At the beginning I said that the connection between the reality that you tell us about and all the other stuff you imagine we have already heard and are going to hear in the future—because we are 12 months away from our recommendations. Tony, could you just put on the record where we can get the book?

Mr Trimingham—If you ring our office at (02) 9715 2632, we can make arrangements to get you copies. We will have to charge you for them because we need the money.

CHAIR—Thank you. We are going to hear all the grand plans and all the things you know about, but when it came to the crunch, it wasn't there for all of you. And what we've got to do is get it where it matters at the crunch. We haven't got the answers—that's why we are doing it. We do not know the answers. Before we finalise this little bit, do you know anyone who wants to have a go at this? Is there something you would like to add? You've heard the discussion, heard the members, you've heard your friends and, as I understand it, many of you don't know each other and it is the first time you have been together.

Mr Trimingham—Most of us know each other.

CHAIR—Okay, most of you know each other. So, just in finalising it, is there anything anyone would like to say?

Mr Havas—We have just started a process of debriefing our volunteers to give them support. I have just finished doing it with 10 of our volunteers. One message that came out, which is very relevant to the political situation at the moment, is the terrible isolation of parents with addict children in regional or country areas. One of the people had a desperate call at 10 o'clock in the evening. She was absolutely shattered for a couple of hours afterwards because that father didn't know what to do. He had nowhere to turn to and that is an issue that needs to be addressed.

Mr Gordon—I basically came into the family support group in early October last year, I think it was—things are still a little bit hazy. I lost my son in November. Unfortunately, my son was not found for several weeks after he had overdosed. During those several weeks, I spent most of those nights sitting down in Cabramatta talking to the users, trying to find him—because I live locally. I've lived here for fifty-odd years. Talking to those young people I found

e I live locally. I've lived here for fifty-odd years. Talking to those young people I found that most of them are on the street, they've been kicked out by their parents, basically because, I believe the parents—not all of them, but a lot of them—didn't know how to handle it. This is an insidious problem; it really is. I was only able to carry on for so long basically because of the job that I have. I was able to make my own time, sort of thing, but I can tell you that you really need help. I still go to the family support group and, over that very short time, the things that I've learnt would have been of incalculable help to me. Unfortunately, I was too late. It is certainly education that people need—they need to talk about it.

Ms Stratton—I would just like to add one thing which seems to change the perception when you're dealing with families on the lines. A few years ago there was this desperate sort of call saying, 'I've found a bag in my child's room,' or 'What is this?' or 'What do I do; how do I stop it?' Now, perhaps through education, media programs, et cetera, the calls are more like, 'How do I survive?' and 'I have a drug addict in my family, how do I survive?' Those are the sort of questions now being asked, more so than, 'We have to put it under the carpet, we've got to solve it quickly and make it go away.' I think it is quite interesting to see this shift. It is still an area that needs immense resources and response.

Ms Morritt—I just want to say how much I agree with that because, if the parent doesn't have some support or help from somewhere, they are no use to their child either and so everybody flounders and Family Drug Support is just incredible for that support.

Mr Havas—In a commercial world, perhaps, if you wouldn't mind, I would like to draw your attention back to what Tony said about funding. I am one of the few people who can speak right from the coalface here, because when Tony and his partner Sandra were invited to Los Angeles and San Francisco and then up to Vancouver in January, I discovered that I had volunteered to run the show for a fortnight. He chose our Christmas barbecue to announce it. I say that, in a light vein, just to make the point that we have become a bigger family. It really matters—it matters to the voters, it matters to the families out there, to the constituents—that there is something accessible to them. What I did discover in those two weeks was that running that program 24 hours a day is absolute hell. I simply do not know how Tony and Sandra do it, week in, week out, all year. To add to that, you have every third or fourth caller saying, 'Oh, I tried to call you yesterday,' or 'I've been trying for ages, I can't get on.' For God's sake, FDS needs funding. Thank you.

Mr Trimingham—A lot of parents who have gone to our meetings have gone away and not come back. I think the perception is that we have been too negative. We haven't supplied the answers they wanted. One thing I want to stress, and I say it over again: we believe in treatment. We believe that detoxes should have places available immediately. We need resources for all forms of rehab, all forms of pharmacotherapy.

Having said all that, I still want the basic message to get through that the cycle of drug use—which is a process and we know it is a defined process; research has told us that over years and years and years—is a process that takes time: on average, 10 to 15 years—10 to 15 attempts. Some people never make it through; some people are fortunate enough to do it in two or three years.

As well as resourcing all those areas that need to be there immediately people want treatment and people want help, I have just one final plea for the life maintenance stuff: we need to keep them alive to the point where they make that decision, and we also need to be responsible enough to say, 'Because we are providing you with a clean needle or an injecting facility or even prescription heroin, that does not mean we like doing that, it does not mean we condone that, it does not mean we understand that—it just means that that is there for you because we don't want you to die.' Thank you.

Proceedings suspended from 1.10 p.m. to 1.19 p.m.

WODAK, Dr Alexander David, President, Australian Drug Law Reform Foundation

CHAIR—Welcome, Dr Wodak. As you are no doubt aware, the proceedings are legal proceedings of the parliament and as such they warrant the same regard as proceedings in the House of Representatives. I invite you to make an opening statement.

Dr Wodak—Thank you very much. Can I firstly begin by congratulating you on the establishment of this committee—it was a pleasure to meet you all yesterday. I think it's very significant that this is the first time the federal parliament has comprehensively looked at these four areas of alcohol and tobacco and prescribed and illicit drugs since the 1977 report, which a Senate select committee prepared. It was an excellent report which galvanised a lot of very useful outcomes.. I think it's important to note a couple of things about that report before I go on to stay some other things.

The first thing is to say that this is a difficult area that we have had something like 20 or 30 major official inquiries into over the last 20 or 30 years and, increasingly, they are coming to an identical set of conclusions. And this is not only true in Australia; it's true around the world. The typical pattern is that people such as this committees start off with very diverse points of view. As you become acquainted with the evidence there is a shift in opinion towards favouring some changes. Quite often, committees such as yours make excellent recommendations and, I regret to say, almost invariably the recommendations are not accepted. If you want me to quote examples of that I can quote many such examples, such as the Schafer committee in the United States in 1972, the Pennington committee and many others. Nevertheless, I think this is a very important process that has a cumulative effect and we're slowly getting there. So, that's a remark about the committees.

If I could just make a remark about those four areas—alcohol, tobacco, prescribed and illicit drugs—I quoted in the statement that I released to you, that I think has been distributed, that when an independent evaluation of Australia's performance in these four areas was conducted, for the 1993-1997 period the results showed that we were doing quite well, in fact very well, in alcohol and tobacco–the legal drugs, which are of course responsible for most of the problems; we were doing moderately well in prescribed drugs; but where we failed lamentably was in the area of illicit drugs.

I think it is very clear that around the world there has been a huge shift in public opinion over the last six or 12 months. More and more people I think are coming to the conclusion that the path this and most other countries have embarked on over the last few decades not only has not worked in the past and is not working now but cannot work in the future. And indeed, a Joint Parliamentary Committee of the National Crime Authority in 1989 came to that very conclusion—the Cleland committee report *Drugs, crime and society*. And a paragraph which I quoted in my submission said just what I've noted: that the path that we have embarked on cannot succeed—that is, relying so heavily on supply control cannot succeed and has not succeeded in the past. That committee included three people who are now senior members of the current federal government. So I think they are conclusions that have to be taken very seriously. But these conclusions are now coming around the world, and I think there is a huge shift in public opinion occurring not only in this country but all over the world.

If we look at North America, for example, in the elections in the United States on 7 November 2000, the voters in California had the opportunity to register their response to proposition 36 which mandated a shift of US$120 million from drug law enforcement to drug treatment, and that got a vote of 61 per cent in California, which is the most populous state in the United States. This is one of 19 state-based referenda that have gone to the voters in the United States in 1996, 1998 and 2000, and the result has been that 17 of those 19 state-based initiatives have supported drug law reform, and I think that speaks for itself.

We have now seen a shift in the United States—and I emphasise the United States because it is clear that the United States has a critical influence on many other countries including us—so that in the 1980s the first person who really spoke out as a senior politician in this area was the mayor of Baltimore, Kurt Schmoke, in 1988, and all 50 governors of the states were silent on this issue. Now we have got two governors supporting legalisation: the Governor of New Mexico, Gary Johnson, a Republican and Jesse Ventura in Montana, an Independent. So the process is shifting up the tree. In the shadow conventions held in Philadelphia and Los Angeles last year as part of the process of nominating presidential candidates, there were shadow conventions on drugs, and senior members of both parties, Republican and Democrat, spoke in favour of ending the war on drugs and having a more pragmatic approach. We have seen this in South America. The presidents of several South American countries and Central American countries—Mexico, Columbia, Uruguay, Venezuela—have all made similar kinds of statements. In Europe, we are seeing country after country shift its position and we are seeing this at the level of the population. People have realised that relying as heavily as we do on drug law enforcement is going to be very expensive and has terrible outcomes.

Finally, can I make the point that I think one of the problems that we have in this area is that we are not clear about our objectives. Illicit drug policy should be primarily about helping young people, and yet the measures that we use are often poor measures that we rely on. How many drugs got seized? Well, that's not really the critical issue. The critical issue is how many deaths there are, how much disease there is, how much crime there is, which affects all of us, and I think all of us are very affected by corruption. Those four areas, I submit to you, should be our objectives—getting those down and also those areas where we have failed miserably over the last several decades, with the exception of blood-born viral infections like HIV and, to some extent, hepatitis C, where we've done well.

Dr Wodak—I think it is also important to not only talk about the comprehensive failure of these policies but to also talk about the magnitude of that failure. If this magnitude of failure occurred in the commercial area, the board of directors would go, the chairman would go and we know what would happen to the share prices: the company would be wiped out. The kind of failure we have seen in drug policy over the last three or four decades in Australia has been—and I am not making the next comment on party political grounds—has been of the magnitude of what we saw in Queensland last weekend. And we have had results like that in the drug policy area, not just in one weekend; we have had those year after year after year for 30 years. And I think we have to recognise that we have to change: the fundamental change, the most important change, is to adopt a framework where illicit drug problems are recognised primarily as a health and social issue. Of course, law enforcement has, and always will have, an important role but it should not be given the burden of having primary responsibility for bringing better outcomes for this country.

CHAIR—Thank you very much. Just, to add an international flavour, could I ask about the Swedish experience and your knowledge of that? And I understand it ebbed and flowed a bit over the last couple of decades and there was, if you like, a more strict regime, whatever that might mean, in recent years. Could you just comment on that and your knowledge of it?

Dr Wodak—Certainly. I am familiar with the situation in Sweden, I have visited Sweden and I followed the results closely and I think it is important not only to look at Sweden's ideology—which is very firmly in the zero tolerance camp, and has been for a long while—but also to look at their outcomes, and their outcomes are miserable. If we look at those outcomes, deaths particularly, Sweden has in the order of 200 to 250 overdose deaths a year and they are steadily increasing. And this is for a country with a population of eight million. If we look at the Netherlands, for example, we find a country with a population of about 15 million, and they have somewhere between 50 to 80 deaths a year. Most of those people, incidentally, are people not from the Netherlands; they are people who have come to the Netherlands and who die of a overdose, so they haven't got used to the Dutch system. But, in any case, if we accept the total figure, it is about 50 to 80. If we look at that in population terms, it's a tenfold difference.

Now, people say, quite appropriately, that it is difficult to make comparisons from one country to the next, and we always have to be cautious about that because of differences in, sort of, finer techniques by which statistics are compiled. And cautions are always welcome but they do not explain a tenfold difference, and the Dutch figures are stable, the Swedish figures are going up.

In Sweden itself there is a vigorous debate now about the wisdom of clinging on to this policy, and the other comment I would make about Sweden is that in the early 1990s there was a major economic crisis in Sweden and the argument was whether or not Sweden could afford to maintain its very generous social welfare provisions. And the conclusion of that was that they couldn't maintain their generous social welfare system, and it has been progressively dismantled as Sweden has integrated into the European Union. The consequence of that has been that Sweden has become much more like Western Europe in several respects, and one of those respects is that the drug problem that is emerging now in Sweden far more closely resembles the drug problem, for better or for worse, of the rest of Western Europe. So I think that one of the things that may have been protecting Sweden 20 or 30 years ago may have been a more generous social welfare system, and I think that is important for us, because I think it means that, when we balance up all the factors about how we're going to try and have better lives for young people in the future, we had better make sure that we look after our young people.

CHAIR—The experience of the Dutch—just remind me: do they have any injecting rooms, and the record in those injecting rooms?

Dr Wodak—Yes, they do. There are 45 injecting rooms spread across three European countries. It first started in Berne in Switzerland, the federal capital, and then they spread to the Netherlands and also to Germany—and more recently to Madrid in Spain and Prague, the Czech Republic. Madrid has started and the Czech Republic is committed to starting. And so those injecting rooms have been increasing in numbers in recent years. The evaluation of those injecting rooms has been according to the European tradition of doing research, which is different from our own and is much more, sort of, qualitative and impressionistic and less, sort

of, quantitative and rigorous. I think it's a shame but that's how it is, and I think from what we can see of the results that have been published—and I've been involved in looking at those carefully—there's a reasonable case that they save lives. It's very difficult to prove that. There are something like three million people visiting injecting rooms and injecting in them each year in Europe and we can come to that kind of—

CHAIR—Can I be clear? Three million people or three million—

Dr Wodak—Sorry, three million injecting episodes. And the average number is around about 200 per injecting centre per day and, if you multiply that by 45 by the number of days in the year, that's how you get those kind of figures. It might not be three million, it might be 2½ million, but it is somewhere in that ballpark. And in the 15 years that injecting rooms have been operating in Europe, we haven't had a single death in an injecting room; yet roughly 1 in 500 injecting episodes results in somebody keeling over and requiring some attention from the staff.

So, I think that tells us that if those three million injecting episodes were to occur outside of those injecting rooms, and 1 in 500 of them were to result in a collapse and an overdose occurring in a park or a lane or a shop or supermarket somewhere, the likelihood is that a considerable number of them would, unfortunately, end in a fatal overdose or, also very seriously, in a non-fatal overdose where the person goes to hospital. And very often people with a non-fatal overdose have crippling injuries, and I was terribly moved last year when several patients admitted under my care at St Vincent's Hospital had amputations of legs and fingers and sustained injuries that really are dreadful. And these are the outcomes we are seeing, and the result of all of this is that you have the very moving array of people who were speaking to you before lunch.

Ms ELLIS—Thanks, Dr Wodak. Just a couple of questions. You mentioned in your preamble a moment ago the importance the US has in where people see this whole discussion. Can I ask you to elaborate for me on the question of where the US are going in terms of incarceration? The reason I ask this is because of an article I read in a weekend newspaper two or three weeks ago—you may have in fact seen it. It was very shattering and very explicit in terms of the growth rate in the building industry with the construction of prisons and the enormous proportion of prisoners who are there purely and simple because of drugs—I can't remember the figures now, but two or three million Americans alone or some such extraordinary figure. I'd hate to think that we ended up going down a similar path. Could you discuss that aspect for us?

Dr Wodak—I certainly can and, just to pick up on your last point about us going down a similar path, you might be interested to know that I got interested in drug policy because I ended up spending a night in a shooting gallery in October 1987 in Williamsburg, Brooklyn, in New York City. I was there, obviously, as an observer, not as a participant. I went there to see what was going on and I watched two men and two women, Hispanic, injecting speed balls, combinations of heroin and cocaine, for the whole evening in a deserted tenement building. And the whole neighbourhood was beyond description. It is like in a war zone and, had I not been with people who knew the area, I would never have gone to that neighbourhood. And there was no electricity in the building and so on.

I saw these people injecting in circumstances that were so disgustingly unhygienic. AIDS was around—they all knew about AIDS. I asked them about AIDS, and they all had lost friends from AIDS, and yet they injected in this disgusting way. That really started me thinking, and I came to the conclusion, as the father of four children, that I did not want my country to go down that path, that we have basically the same sorts of drugs in all countries, some a little bit more, some a little bit less; we have the same sorts of people in all countries and the reason why the risk behaviour of drug users is so much more dangerous in the United States than in Australia is because of our differences in our drug laws. That's the difference. And that is really why I decided when I came back to Australia that I wanted to work on making sure that Australia didn't go down that path. So that's why I'm here today.

To answer your question about prisons, I follow that closely. The United States, last year, passed the two million mark of inmates. They have, apart from Russia, the highest rate of incarceration in the world, in the developed world. The rate in population terms is around about 700 per 100,000; the rate in Australia is about 100 per 100,000, and there's a vastly disproportionate rate of incarceration for people of different races—much lower for whites, intermediate for Hispanics and the highest of all for African Americans. And the Americans now have the unenviable record of having more people behind bars than they do serving in the armed forces. But there is now a reaction developing to this, and the Governor of New York State, a Republican, George Pataki, has just pushed through some laws, with the assistance of people on both sides of politics, to amend the draconian Rockefeller laws that were introduced three decades ago. So they are being introduced now. They are bringing in changes to try and reduce the number of incarcerations, and there are signs that the rate of increase is starting to level off but at a level that is seven times higher than ours.

California spends more on corrections than it does on higher education. Those spending paths have crossed. It costs us about $50,000 on average to keep a person behind bars for a year and, if we look at this in commercial terms, in terms of the investment for the taxpayer, it is miserable. As a British Home Secretary said recently, it is an expensive way of making bad people worse. People get very little help in our prisons here, even less than the United States. They come out of prison, and the correctional health system and the health system in the community don't connect up, so that person is stranded and has difficulty getting on to methadone programs or other forms of drug treatment. It is a system that is really designed to set people up to fail and, of course, they do fail and when they fail they are blamed for it.

Ms ELLIS—One more question which is very much tied into that. Do you suggest, in your submission to us, that zero tolerance may not be as popular with Australians as it might be supposed and that the public may, in effect, be quite supportive of what you describe as modest reforms? What sort of modest reforms do you think the public would, in fact, entertain at this point?

Dr Wodak—On the reframing of our approach to drugs, illicit drugs, and reframing that as a health and social issue, I am sure the public is way ahead of the politicians on that. And if we look at the issue of cannabis, for example, which in Australia is a $5 billion a year industry, one per cent of our gross domestic product, the public is again—this is not meant to be insulting—ahead of the politicians.

Ms ELLIS—I bet.

Dr Wodak—It depends how you frame the question. If you say to the respondents in a survey, 'In the state you live in, the penalty for being found with x quantity of cannabis is y, do you support this or do you not support this?' a very high proportion of people don't support it. So, if you put the facts to them, when people learn the facts, there is very little support for current policies; people want change. If you use the slogans—decriminalisation, legalisation—people get more confused by that and the politics of fear starts to take over. And one of the problems we deal with is that this area has really been dominated by the politics of fear and fear-based politics are effective. I am sure you know that better than I, but fear-based politics don't last for ever; they reach a use-by date and then the politics of rationality and logic and data start to have more and more impact. And I think we're into that phase.

Mrs IRWIN—Dr Wodak, thank you very much for having us to St Vincent's yesterday; you're doing an excellent job there. This is going to be two questions in one: do you want to legalise cannabis, if so, why, and do you want to legalise other drugs?

Dr Wodak—I have got a problem with the word 'legalise', because it doesn't tell us very much. Alcohol is a legal drug and can be used illegally, cocaine, morphine are legal drugs and they can be used illegally. So the legal status of a drug doesn't actually tell you all that much. What tells you much more is how we actually regulate the drug. And in the case of cannabis, at the moment it's regulated by the black market, by the criminals and corrupt police, if we are honest with ourselves. Call me old-fashioned but I would rather see one per cent of Australia's economy taxed and regulated. I would like to see that market separated from the market for heroin and cocaine amphetamines. At the moment, if one of our kids wants to go out and buy cannabis, chances are they'll buy it from somebody who can also sell them heroin, cocaine amphetamines, and that clearly is crazy, in my opinion.

I would also like to see cannabis taxed and regulated so that we could give health warnings just like there are on the tobacco packets—let's give credible health warnings that are based on science. Let's also give information with the cannabis that says, 'If you are developing these symptoms, you really need help and this is how to go for help'. So, it is really treating it as a health issue and trying to get better outcomes.

I also would like to tax it because the fundamental problem we face in this area is that drug treatment really works but it's inadequately funded. We cannot get capacity, quality or the range of treatments up with the funding that we have got at the moment. So we really need to fund drug treatment. When we try and fund drug treatment through conventional sources—that is, through your munificence—we run into problems because no politician has ever failed to get elected because they were soft on drug treatment. It's easy to be soft on drug treatment and get elected. So we have to have some way of funding drug treatment that really makes it easier to get into drug treatment than it is to get to a drug dealer. And the only way we are going to do that, in my opinion, is to hypothecate some taxes, and the best way to do that would be to tax cannabis—broaden the base and lower the rate, all that stuff. So, that's why I would like to see cannabis taxed and regulated.

It is a pipe dream to imagine that we would ever tax and regulate heroin, cocaine amphetamine. I don't support it; I don't want to see crack cocaine sold at the supermarket checkout counter, any more than anyone else does. I am opposed to that. But, on the other hand, when we see drugs of dependence handled through a regulated fashion, through medical

prescriptions, to drug dependent people, the results generally are highly satisfactory. How do I know this? Well, I know this because of clinical experience, I know this from research, and I also know this because of 15 years experience in the drug regulating business.

I have been a member, and I am now the chairman, of the medical committee under the poisons act, which is a New South Wales statutory committee, and my committee regulates this in New South Wales, so we regulate the prescribing of drugs of addiction to people thought to be addicts. In other words, we are dealing with prescription drugs, not with heroin. And what we see with that is generally good results, all done on a shoestring. So I am convinced that a regulated system through medical prescription is something that has to be looked at. I would be opposed to introducing it without research, and that is why a heroin trial is absolutely indispensable. As Justice Wood said in his excellent royal commission, all roads pass through a heroin trial, and he is absolutely right.

Mrs IRWIN—Thank you for that. You seem very convinced that your arguments for drug law reform are correct. If your arguments are as sound as you seem to think they are, why are we still debating these issues in 2001?

Dr Wodak—I think the arguments are sound, but one of the problems we face is that the debate has to go through the political process and, in the political process, the short term is valued more highly than the long term. The members of the House of Representatives have to think within a 36-month time frame—and that is not to be commended or criticised; that is how it is and if I were in your shoes I would not be doing anything else—but this is a long-term problem.

Any change will have—as most change does—long-term benefits, I would argue, but at the expense of short-term costs of changing over. And the trick is to get change to happen within that framework. I face the identical problem when I deal with drug dependent patients. It is exactly the same argument. The arguments for change are tremendously logical and I sit there with my patients, trying to convince them that what they are doing is leading to terrible outcomes for them and their families, and they sit there and they acknowledge that their health and the social and economic consequences for them and their loved ones are going to be awful. And then we sit about and talk about the processes of how they are going to get there, and what it boils down to—why it is difficult for them—is that that change will be very painful and difficult and the benefits will only be in 2002 or 2003, and people want the benefits up front and the pain buried in the long-distant future.

This is why it is difficult to get this through the political system. But what is happening over time is that the pain of the present—as you just heard before lunch so eloquently—is being heard more and more because it is affecting more people—and more middle-class people, I suspect—and it is becoming clearer that the long-term consequences of change are going to be better and better.

I come from a conservative background, a conservative profession, and I make no apologies for that; my professional approach is always to introduce change only after it has been tested on a small scale first. Therefore, we have to go through the process scientifically of testing what I am saying. Is it better for a medical practitioner to prescribe someone heroin or amphetamines, or is it better if that person is supplied with heroin or amphetamines by the black market? We all

know the benefits, such as they might be, and the costs of heroin and amphetamines prescribed by criminals and corrupt police. Now we have to find out what the benefits and costs are of heroin and amphetamines prescribed to selected drug dependent people by medical practitioners.

I also make the point that it is very important that we remind ourselves, and keep on reminding ourselves when we are dealing with drug users, that we are dealing with a very heterogeneous population. They differ just like members of parliament: some are tall and some are short, some are thin, some are fat and so on. So we are dealing with a very different population and within that group is a small proportion of people who consume most of the heroin. If we all get alcohol, for example, 20 per cent of the drinkers in the community consume 70 per cent of the alcohol. Without that proportion, the alcohol beverage industry would go bankrupt. It is difficult to make the same kind of estimates for the heroin-using population, but it is almost certainly going to be very similar to that. In other words, the 20 per cent heaviest heroin users probably consume 70 per cent of the heroin and probably account for 80 per cent of the crime. And one of the things we should be doing in this whole exercise is focusing on that 20 per cent. They are the people we have to get into treatment and keep in treatment.

We need a broader range of options because they are not happy with just one option or two options. Everywhere else in medicine we have six or eight or 10 options for diabetes or blood pressure or breast cancer, and we should have the same kind of approach for dealing with heroin users, particularly oriented towards the heaviest users, so that we get as many of those people into treatment as possible. One of the benefits of getting people into drug treatment is reducing the onward selling to other people because we have to keep on reminding ourselves of the structure of the illicit drug market. It is a pyramidal system, just like Avon cosmetics or Tupperware that we are all familiar with. So one person becomes a consumer but then becomes a retailer and looks for other consumers. And so it is a pyramid that keeps on spreading, so getting people into treatment means that there will be less recruitment of new users and ultimately there will be fewer people using in the streets. And that is why getting at that 20 per cent heaviest heroin-using population is so critically important.

Mrs IRWIN—If I said you have a wish list and you wanted to convince us about one recommendation for this committee, what would you recommend?

Dr Wodak—Without any hesitation I would say that we have to reframe this issue as a health and social issue. It is unfair to the police to put the whole burden of this policy so heavily onto the police. They cannot succeed and in fact we all have to work together—health and social measures have to be implemented and integrated with law enforcement—but the bulk of the burden has to be placed on the health and social areas.

Dr Don Weatherburn, who is the director of the Bureau of Crime Statistics and Research in the Attorney-General's department in New South Wales, argues—and I agree with this very strongly—that one of the reasons why we have failed so poorly in this area is because there has been so much demand sloshing around the system in Australia because the drug treatment system is so inadequate for the purposes that it is just impossible for law enforcement to have any impact on the huge drug market that is present in the community—$5 billion for cannabis and $2.5 billion for the other illicit drugs. Something like 300,000 people are using heroin today. It is a huge market and the law enforcement authorities, no matter how much resources

we give them, will always be inadequate for that task. We need to get the number of heroin users down by getting more and more people into treatment.

To answer your question, I think we have to do for heroin what we did for public drunkenness 20 years ago, and that is to say, 'This really isn't a criminal justice problem; this is fundamentally a health and social problem,' but law enforcement has had, has now, and always will have an important role to play—as it does with alcohol, tobacco and prescribed drugs.

Mr QUICK—I guess the national approach is thwarted by our rail gauge mentality of New South Wales trying something or Victoria trying something. Then we have crazies like Zemanek and Jones and Laws who try to influence public opinion. So things like euthanasia will be tried in the Northern Territory but we will quash it in the federal parliament. How do we get a national approach? Do we have a national summit? In my state, Martin Bryant killed 35 people and two weeks later we had national laws and the whole thing was sorted out, no questions asked—everybody had a bipartisan approach. What do we do to get a national approach? Drugs don't just stop at the New South Wales border to the north or the River Murray down south.

Dr Wodak—The Commonwealth-state problems certainly add to the complexity of trying to get better outcomes, but they also enable certain things to be possible that wouldn't be possible if we insisted that all nine governments sign on for absolutely everything, because—

Mr QUICK—But we insist on that in so many other ways, you know. This competition policy and all the other things that are inextricably grinding to say, 'We're going to deregulate this and we're going to deregulate that and it's a level playing field.' Why can't we have a level playing field about drugs and perhaps change people's minds by saying, 'We've got this untaxed $5 billion thing. Your petrol will go down by 10c a litre, you'd have more beds in hospitals, you'd have detox units and that sort of thing'?

Dr Wodak—I think that what is even more important than a national approach is getting a bipartisan approach in the federal parliament. If we had that, then I wouldn't mind so much if we had a maverick state or two or territory doing something completely different. But we really need to start the process of recognising that the outcomes from our current policy are just dreadful—and they are rapidly getting worse. If we look around the world, we can see that other countries with a different approach have very quickly got good results.

If we started to get a bipartisan approach at the federal level, we would start moving rapidly in that direction. This is really how we handled the national response to HIV infection, and that started with maverick states, in that case New South Wales, doing things that the other states at that stage were not prepared to do. That drove, ultimately, the national approach, which resulted in tremendous savings of death and disease, tremendous savings in hospital beds, and tremendous savings in dollar costs to the taxpayer.

All that happened because of this complicated state-federal system. But it also happened, let me point out, because the members of different parties in the early 1980s were prepared to put commonsense and public health above partisan political interests. I commend people in politics at that time for what they did. That was a great service to the people of Australia. It has been a tremendous benefit, and I am convinced this is what is going to happen with drug policy

reform—ultimately, sooner or later, whether it will take another one or two or three royal commissions I don't know, we will have the same process happening at the federal level.

I think we are embarked on a process of reform already in several states. People don't say that that is what they are doing, but in effect that is what is happening. I think also it is worth while looking at what is happening around the world in this area, in political terms. And what happens is, the reform process starts in smaller communities and spreads upwards. If we look, for example, in Europe, the reform process started with the capital city mayor, with big city mayors. It is happening in Australia with the capital city mayors, it started happening in the United States with Baltimore and then with Salt Lake City and then it spread to the states. So I think the process will actually start with small communities and will then spread up until we get a national approach, ultimately, but it will take a long time.

Mr QUICK—You mention a study done by White in 1998 on drug education that showed that 73 per cent of youth drug education intervention demonstrated no effect on drug consumption; and 27 per cent showed that there was only a minor reduction. We pour tens of millions of dollars into that. What are we doing wrong? What innovative 21st century message do we send? Is it through the Internet, is it on T-shirts and caps or what do we need to do—because that's a hell of a waste?

Dr Wodak—First of all, we need to be realistic about what drug education can do. And it does have a role, it is an important role, but the benefits are always going to be modest; they are not going to be heroic. Drug education is not all that expensive. The cost-effectiveness of drug education has been estimated to be $2.60 for each dollar spent. That's for cocaine in the United States and that came from the Rand Corporation. That compares with 15 cents, 32 cents and 52 cents per dollar for cocoa plant eradication, interdiction and for customs and police. And it also compares with $7.48 per dollar for cocaine drug treatment. So drug education is not as cost effective as drug treatment, but it is a hell of a lot more cost effective than even the most cost-effective form of law enforcement. So it is well worth doing, and it is well worth doing as well as we can.

One of the problems with drug education around the world—not so much in Australia, but to some extent here—is that we break the rules in drug education. We know what works, we know what doesn't work, and we implement things that do not work. In the United States the most common form of drug education that is delivered is a program called DARE—Drug Abuse Resistance Education—and there are numerous studies that show that DARE not only does not work, which would be bad enough, but is actually often counterproductive. Yet DARE has been phenomenally popular with police, who are involved in delivering it, and with politicians.

The Premier of New South Wales came back, unfortunately, from one of his trips to the United States and said that Australia should implement DARE. This is the problem—we often implement things that sound fantastic and are done in the United States, hard sell, but they break the rules and we get lousy results. If we follow the rules that we have learnt from research and if we stuck to those rules, we would get modest benefits from drug education. And in public health we often get aggregate results, which are very satisfactory, from a series of interventions, each of which on its own is not terribly impressive but, when you put the lot together, you get, as a whole, a result, a package, which is quite acceptable.

This is where drug education fits in. It fits in with all the other things that we need to do, and we should be doing it. I do not want to sound antipolitician—I'm not—but I think that it is just as important that we keep politics out of the decisions about setting interest rates, which we now do in Australia, I understand, that we also keep politics out of drug education. It is one of those things that really is better handled away from politics.

Dr WASHER—Yes, Alex, can I empathise with what you have said—from a medical point of view I think we both agree on the issues. And you are right about America; it is a sick society when you have got more Afro Negro populations in their prisons than say in their schools, which is also a statistic that is often quoted. The biggest problem I have is that it would make sense to legalise cannabis—marijuana—because of the amount of consumption, the estimated revenue that we would use effectively to help in the drug war. The big problem is—and I would love to pass it off to some autonomous script in Hamlet—we have got a couple of problems.

The argument against that is that we need supply lines to provide that to this massive consumption, because there is a big consumption of marijuana. And the obvious people to pick that up are going to be the large tobacco companies—they will promote it like Joe Camel—and then it is hard to know whether consumption would not increase with that sort of level of promotion because they are legitimate, legal companies. We can ban some of their adverts, but we cannot ban them totally. And it is very hard then to switch it off back there. We get the revenue dependency syndrome on this. I want you to really comment on that, because my gut feeling, like you, is to legalise this. It is a massive problem, so let's get it legal.

The thing I have as a realistic problem presented to me that the big corporates will then handle this and where do we go and how do we switch it off? From what was asked by Harry, can we really market against that effectively with our own marketing programs to stop it? Can you comment on some of that?

Dr Wodak—Yes. It is a dilemma. It is a definite dilemma and we have many warnings about that system, as you've rightly suggested, and I think I am not alone in feeling that whilst I do not want gambling to be run by criminals, as we used to have in Australia 30 years ago, I am sure I am not alone in Australia in feeling deeply uncomfortable about the dependence of state governments on that revenue and the social cost of that to innumerate people. As somebody said, this gambling is, in Australia at the moment, there as a tax on innumerate people—which is true.

So there are lessons from tobacco, there are lessons from gambling. This was picked up in the *British Journal of Psychiatry* where there is an article by McCoune and Reuter, originally from Australia. They make this very point and make the point that in the United States this would be a particularly perilous course to embark upon because of the extraordinary protection of commercial freedom of expression in the United States. But I think we have learnt from the tobacco debacle and, if we go down this road, we should have all the safeguards in place, and I would like to see, for example, some way of preventing donations from the cannabis industry to political parties. I would like to see—

Dr WASHER—So would I; it gets me in to trouble every time I have an interview.

Dr Wodak—I would like to see a ban on generous tax concessions to the cannabis industry. I would like to see a very open and transparent process of accountability for that. And yes, you are right to be concerned about that, and what McCoune and Reuter recommended in this piece in the current edition of the *British Journal of Psychiatry* is that, because of those risks, there should be an intermediate position, which is that people would have the possibility of basically growing their own, like the South Australian system, up to three plants or ten plants, up to some level. That has advantages; it has certain disadvantages.

I think this is really where we need to have the debate. I gave evidence to your counterparts in the ACT Legislative Assembly on this very question. I suggested to them that my solution for this would be to hand the franchise over to Australia Post for two reasons: one reason is that they have probably got the most widely-dispersed retail network in the country, and the second reason is that no commercial organisation can equal Australia Post in driving away customers.

Ms ELLIS—That is a good answer.

Dr Wodak—But I think that is a legitimate question and I feel that we have to look at this long in advance and really come up with safeguards that are as foolproof as we can get them.

Dr WASHER—What I want to say is that it is not something we can put to trial, so it is not like an outcomes trial. Either we do it or we do not; we have got to live with the consequences of it, so you can understand the anxiety. The temptation is there, the logic is there, with outcomes we cannot judge until we have done it. And that makes us nervous. I guess that is a comment on that.

Dr Wodak—Well, can I just comment on that and say that in drug policy reform the approach is always incremental, so I do not think we will ever come to this response—that is, commercial production and commercial sale—with a revolutionary step; it will by a series of evolutionary incremental steps. So I do not have the same fear that you have about this, because I think we will go through those intermediary steps. And we will go through a period of decriminalisation in the middle, and what will be the undoing of decriminalisation will be the fact that half the market consumption will be legal and half the market production will be illegal. And the boundary problems between the legal and the illegal market will be continuing, and they will be a constant irritant and a constant problem. Ultimately, that policy will either flip back to the current situation, where production and consumption are both illegal, or it will flip the other way, where production and consumption are both legal. So, I think we don't need to worry about that question about regulating the commercial operators just yet, but it certainly is something that bothers me.

Dr WASHER—With the legalisation of heroin, which also has appeal, you would put that with the preface, of course, that that would have to be utilised before that person leaves—so they cannot trade on. That would be a part of it?

Dr Wodak—Absolutely, absolutely.

Dr WASHER—And can I ask a very unusual question: now, with new technology, we have the availability, as you know, to use vaccinations to make drugs like cocaine not effective; can you envisage a time when we do not have treatments like for cocaine, that are by any means

satisfactory from a health point of view, that we may vaccinate our population so it does not work?

Dr Wodak—Yes, the cocaine vaccination is on its way; people are also preparing vaccines for nicotine and I am pleased about that; I think the more options we have the better. My worry about them though is that when we approach drug users with solutions which, to them, are totally unacceptable, what happens is that we have people who then have a lot of time on their hands, not much else to do, and who think about other ways around it. So, what will happen is: yes they will not use cocaine, but they will use methyl cocaine or something that will not be picked up by that vaccine. That is maybe a bad example, but what will happen is that they will think of lateral solutions.

The other problem with this is that—and it is a fundamental point—the world is changing now from a world where the illegal drugs were plant-based and increasingly, the world is shifting to a world where we have chemical-based drugs. This is not a happy course we want to encourage. So if we develop a cocaine vaccine and then compulsorily vaccinate all young people, let us say, all that will happen is that we will accelerate the process to having a wider range of chemical-based drugs, which are alternatives to cocaine. And there is no end to human ingenuity, and when there's an illicit drug market worth $7 billion a year, as an operator you only have to have a very small niche of that $7 billion market, and you are a very wealthy person indeed. You do not have to work for the rest of your life. So there is a tremendous incentive for people to capture a small percentage of that market.

So that is one of my worries. The other worry about this is that when vaccine types of solutions get into the hands of people who want to compel people to use these kind of interventions, we run into tremendous ethical problems. Who bears the responsibility if things go wrong, and somebody, against their wishes, has an adverse reaction to that vaccine, which might be fatal? And there are things like that that we really have to think very deeply about before we embark on that course.

Ms HALL—I will only be asking two questions. The first one is something that Alby Schultz, the member for Hume, brings up quite frequently, and it is to do with hep C and the needle exchange program. Why is it that the needle exchange program has been so successful in combating AIDS and HIV but, to date, does not appear to be as successful with combating hep C?

Dr Wodak—Well, that is a very important question, and I am sorry that Mr Schultz is not here. I would love to go through this with him. Let me take this step by step. Firstly, it has been extraordinarily successful with HIV, and the evidence on which that is based is compelling, it is consistent, it is extraordinarily impressive. There have now been seven reviews conducted by the United States government or its agencies, which have reached the conclusion that needle syringe programs are highly effective for HIV without increasing illicit drug use. So those two conclusions were reached with increasing conviction in each successive review by the United States government or its agencies. So we have no question about that.

We know also that not only is this effective but it is also cost-effective. The estimate by Professor Richard Feachem for the 1991 Independent Evaluation of Australia's Response to HIV-AIDS concluded that Australia spent $10 million in 1991 supporting our needle syringe

programs. That resulted in 10 million needles and syringes being provided and that prevented 2,900 HIV infections, and that saved $270 million. So that's the HIV side of things.

We have two research trials which have directly asked the question about whether this benefit occurs with hepatitis C, both were conducted in the north-western state of Washington in the US, and both by the same authors, and they came to contrary conclusions. The first one said there was a seven-fold reduction in hepatitis C and the second study said there was no difference. So that's what the research tells us: score of one each at the moment.

The Australian experience—and this hasn't really ever been fully discussed publicly—is that the prevalence of hepatitis C among injecting drug users is falling in Australia—that is, the number of old cases of hepatitis C per hundred drug users; in other words, it's a rate, like speed, a numerator over a denominator. In the nearly 1990s, 10 years ago, it was of the order of 90 per cent, it is now of the order of 60 per cent. The incidence, that is the number of new cases per hundred drug users per year, is also falling. And I have recently looked at all of the data on hepatitis C in Australia, and I've got no doubt in my own mind that these results are quite clear-cut for Australia, that prevalence and incidence of hepatitis C is falling significantly in Australia—not fast enough, but it is definitely falling. Why hasn't this been announced publicly? Because the health system, health professions generally, are conservative—rightly so, no embarrassment there. And they will only call these results when it is absolutely unarguable and when its been looked at every which way.

Is there any problem that I am worried about with hepatitis C? Well, I have said already that I would like the prevalence and incidence to be falling faster. The other problem that is deeply concerning is that the number of people who inject drugs in Australia—heroin, amphetamine and all the other drugs—is increasing, very rapidly.

The group that I chaired for the Australian National Council on HIV-AIDS and Related Diseases concluded in 1997 that in that year we had 100,000 people injecting drugs regularly and an additional 175,000 injecting on an occasional basis. And we concluded that over the 30-year period up until 1997 the rate of increase on an annual basis was seven per cent, which gives us a doubling time every 10 years.

Now all the indications are, I am sorry to say, that in the last five years the number of people injecting drugs in Australia is increasing at an even faster rate than it has for the previous quarter of a century. All the indicators are pointing in the same direction—each indicator's not terribly reliable on its own, all the indicators together are very powerful. I think it is clear that the number of the injectors is increasing rapidly, that is to say that the population most at risk of hepatitis C in Australia is increasing very rapidly. So although the rate of infection per 100 people might be slowing, because the population at risk is expanding so fast the total number of hepatitis C cases is still going up. That is one answer; it is very complicated.

The other answer is that hepatitis C is a far more infectious virus than HIV, by an order of about 10. If you're unfortunate enough to have a needle stick injury when you're working in the health care system and the blood from the other person is HIV positive, you've got about a three in a thousand, a 0.3 per cent chance of getting HIV infection. If that person is hepatitis C infected, you have got a three per cent chance of getting infected. So we face the battle that we've got a needle syringe program that is trying to contain a virus that is much more infectious

by blood to blood spread than HIV. And we also face the problem that at base line, when we started with HIV, there were very few cases, and it's not difficult to keep an epidemic under control when the epidemic has not occurred. It is much more difficult to bring an epidemic under control when it's been going since the 1970s, and the hepatitis C epidemic in Australia began in the 1970s.

So, to summarise, we actually are making progress with hepatitis C in Australia, and the needle syringe programs deserve a huge share of the credit. The problem with the progress is that the population at risk is expanding so fast, and the reason it is so difficult and we cannot go much faster is that the virus is much more infectious than HIV is. Also, when we started with hepatitis C, 90per cent of the drug users were infected, compared to only two per cent, one per cent, when we started with HIV prevention.

CHAIR—I am sorry I had to miss part of your evidence, but you were talking, about the need for change. This morning we took evidence from Professor Ian Webster, Chair of the New South Wales Expert Advisory Group on Drugs. And he said that he felt that the drug summit here was a watershed, and one which helped achieve consensus. Geoff Barnden, Director of the Office of Drug Policy, said that he felt that the drug summit reinvigorated government action, and that led to an additional $176 million of funding. Given your talk about the need for change, do you think that a national drug summit could be a means of achieving change across Australia?

Dr Wodak—The answer to both questions is yes I do think the New South Wales drug summit was a watershed and, yes, I do think a national drug summit, potentially, could be as successful nationally as this one was for the state. And it was a triumphant success on many different measures. The most important one is that it has unleashed large sums of money and garnered the necessary political support for large sums of money to go to drug treatment, where it is badly needed.

Of course, you might say that I say that because I'm working in drug treatment, but I think that the evidence is just overpowering that really the intervention above all else brings a huge return on the dollar, and it has been massively underinvested in the past. So it is difficult to garner that political support without going through some kind of exercise where the community is brought on side. And it was dramatically clear during that very powerful week that not only people in the parliament that week taking part in that exercise but the broader community had a huge shift in their opinion, in their response. It was also a week which was a great success for the government, the New South Wales state government, politically. And as somebody who observes politics distantly, it was an extraordinary experience to be an observer in the chamber that week.

I do not wish to make comments that are partisan—any political views I have when I do my work are left outside. But here we had a Premier whose views on drugs and drug policy were well known and had been communicated to the people, many times. His own family circumstances are presumably the reason for his views, which are also equally well known and very tragic. Many people reacted to that the way he had. And he was able to go through this exercise and stand up in front of the chamber on the Friday, and say, 'I've listened to all the evidence and the evidence is clear-cut and I have changed my point of view.' And that may have been an exercise, it may have been totally sincere, it may have been both. But, the fact is, that

politically, it was an extraordinarily big win for him, because he was able to handle a very sensitive political issue in a way that made him a clear winner. And I don't wish to sound negative about his political opponents: for whatever reason, they did not take that opportunity and in fact the leader of one of his opposition parties stood up on the Monday and said, 'Whatever the evidence that comes out this week, my party is not going to change our point of view.' We can't afford that. I don't want to be negative about that person or that party, but I think we have to recognise that what has gone on in this country in drugs for a quarter century or more has been a colossal failure.

We have to all recognise a responsibility for that and we all have to honestly, without looking at our own advantage or disadvantages from a party political nature, develop a way of dealing with this which leads to better outcomes. That has to include a preparedness for flexibility for everybody—all of us around this table, myself included. We have to look at the evidence, see what works and be prepared to try different things. So, I think the drug summit, like the one that happened in New South Wales, is a wonderful formula and I think it will work brilliantly at the public health level and at the political level. I am sure that the outcomes are going to be a great success. I would have liked to have seen further change, but I recognise that politics is the art of the possible and people elected to parliaments have to make difficult judgments about what rate of change can be accepted within a time frame. Those are the judgments the government make and people like myself will be continuing to press for more change, because more change is needed.

Mr EDWARDS—But you do feel that a summit could have success at a national level?

Dr Wodak—I definitely feel it could have success at the national level, but I would emphasis that the preparation for the drug summit began, as far as I know, in January. The elections were held in March and the drugs summit itself was held from 17 to 21May, so there was at least five months of solid work preparing for this. It was a magnificently orchestrated event, a tremendous lot of careful thought and attention to detail had gone ahead, and it would be a very dangerous exercise to recommend unless there was equally careful attention to detail. The processes I think were excellent. During the week in parliament, you could see that the people who changed their views were basically the members of parliament. The delegates from outside didn't change their views much.

CHAIR—We are running out of daylight; I'll have cut it off there. Dr Wodak, we very much appreciate your wonderful presentation.

Mr EDWARDS—Thanks for your views.

Dr Wodak—Thank you.

[3.23 p.m.]

MOTT, Mr Terry, Consultant, Australian Associated Brewers

CHAIR—Welcome, Mr Mott. My apologies for the lateness of the hour, but it is just the way we tend to run sometimes, unfortunately. Although the committee doesn't swear in witnesses, the proceedings are legal proceedings of parliament, and so warrant the same regard as the proceedings of the House of Representatives. Would you like to make a short opening address?

Mr Mott—Thank you. I am a consultant to the brewing industry and the former executive director of the industry association and of the Brewers Foundation, which I will be talking about during my short commentary. I have handed out a short paper this afternoon, which is in addition to the original submission and will simply summarise the comments I am about to make. The members of the Australian Associated Brewers and the AAB Medical Advisory Group recognise that responsible and moderate consumption of beer or any other alcohol beverages is associated with positive and superior health and social outcomes. It is clear that there is a wealth of scientific evidence to suggest that moderate alcohol consumption has an overall positive impact on the general health of the community. Therefore the industry supports the need to focus policy development on drinking patterns and individual responsibility, rather than on overall per capita consumption alcohol.

The majority of Australians drink alcohol and the vast majority of those drink responsibly and within NHMRC guidelines. The industry accepts that the NHMRC drinking guidelines broadly define responsible and moderate alcohol consumption. The new draft NHMRC drinking guidelines are a further improvement upon that because they are more focused to individual responsibility and offer better advice regarding patterns of consumption rather than simply a general recommendation for the whole community. The nature of the association between alcohol consumption and matters such as violence and crime, family and social disruption, and the poor health status of some indigenous communities is complex and involves many factors.

The Australian brewing industry recognises that some individuals do misuse alcohol beverages and that this misuse can have serious consequences for both the individual and others. Moreover, the industry is concerned about, and through the AAB and Australian Brewers Foundation it is acting to address, the potential public health impacts from alcohol misuse. The per capita consumption indicators of change in alcohol consumption alone cannot indicate the changes that have occurred in relation to alcohol problems and hence the economic and social costs to the community from alcohol. There is a growing acknowledgement that government alcohol policy formulation must also recognise that alcohol consumption provides benefits as well as costs and that future alcohol policy development should incorporate a shift to patterns of consumption and individual responsibility.

I have then summarised some of the ways in which the industry has demonstrated that it is keen to cooperate with governments, community and professional organisations to minimise the harm caused by alcohol misuse and maximise the benefits of responsible alcohol use in society. The Australian Brewers Foundation fund alcohol related medical research. This was a grant scheme that was developed in 1978, so it's been running now for some 23 years. Since that time, over $4.5 million has been provided to researchers through the scheme. Research grants

are evaluated and awarded by the Brewers Foundation's Medical Research Advisory Committee, an independent body of senior Australian medical scientists and then a large number of independent referees from within the medical and scientific research community. Those awards are made under similar guidelines to the NHMRC's own funding for medical research. So the industry takes no part in making those decisions. The current areas of special interest for the foundation are the biological basis of craving and appetite, genetics, Aboriginal health and epidemiological research assessing the outcome of intervention studies. In 2001, $220,000 has been made available to fund medical research grants. That $220,000 includes GST so the amount that goes into the institutions is around $200,000. School based education, Rethinking Drinking—You're in Control was a secondary school alcohol education curriculum which was developed by the University of Melbourne's Youth Research Centre, with funding from the Australian Brewers Foundation. Rethinking Drinking was launched nationally by the current Commonwealth Minister for Health and Family Services, Dr Michael Wooldridge. During his launch he described it as a perfect model for future cooperation between government and industry in the field of drug and alcohol education.

CHAIR—Mr Mott, do you intend to read the full document?

Mr Mott—I will just make a few more points if I could.

CHAIR—Okay.

Mr Mott—That program is now in use by around two-thirds of all secondary schools in Australia, across all states and territories and has also been adapted for use in Canada and New Zealand. The brewing industry has also worked in conjunction with the Distilled Spirits Industry Council of Australia since July 1992 to run an alcohol advertising self-regulatory system called the alcohol advertising pre-vetting system. We have more recently combined with other members of the industry, including the Wine Federation of Australia and the Liquor Merchants Association of Australia, to develop the alcohol beverages advertising code and a complaints management system. So there is a very strong commitment from the industry there for advertising self-regulation.

The industry has also, in conjunction with the spirits industry, developed responsible service training packages such as No Worries, and the brewing industry and medical advisory group of the Australian Associated Brewers maintains a research database on the latest international alcohol medical research and social studies. An important development by the industry also was the evolution of low-alcohol beer, and low- and mid-strength alcohol beers have, with the development and promotion offered by the Australian industry, developed from around 10 per cent of beer consumption to almost 30 per cent now. This is a unique achievement not reflected anywhere else in the world. That has been made possible with the support of taxation incentives by federal and state governments in the past.

The industry is very committed to working in partnership to reduce harm associated with misuse and, through membership of bodies like the National Alcohol Beverages Industry Council, we are represented on the National Expert Advisory Committee on Alcohol, which advises the Intergovernmental Committee on Drugs and, in turn, the Ministerial Council on Drug Strategy. We are involved in many other ways in helping to develop policy. The industry

has also provided funding for support programs developed by governments around the country in education, drink driving and other matters.

Ms ELLIS—Mr Mott, I did not hear what position you hold in the AAB.

Mr Mott—I am a consultant to the industry, a consultant to the AAB. I am a former executive director of the Australian Associated Brewers.

Ms ELLIS—So you are acting as a consultant to the organisation, not an employee of it?

Mr Mott—Correct.

Ms ELLIS—How do you measure the success of your school based education program Rethinking Drinking?

Mr Mott—The fact that the program was first researched in 1993 and identified that there was a lack of a common approach to alcohol education curriculum across Australia, and there were very few programs actually being delivered in the classroom in any consistent way. There were a number of different models that were being implemented, and there were very few that were being implemented very well, according to the research done by the Youth Research Centre at Melbourne University. The subsequent development of the program and its acceptance by schools and systems around every state and territory in Australia and the fact that, since its national launch in 1995, it is still in use in over two-thirds of secondary schools—and that is growing—I think is fair evidence that it has been a successful initiative. There is also current negotiation going on with the Department of Education, Training and Youth Affairs to develop an adaptation of that for use with indigenous communities. So I think the program has proven its worth.

Ms ELLIS—What is its target; what is its point?

Mr Mott—Harm minimisation.

Ms ELLIS—So the question is: how do you measure that? I do not believe that the success of the program is its inception; the success of the program is its measure of outcome. If it is harm minimisation, how are you measuring that if the program has been in place for coming on six years?

Mr Mott—That will be very difficult to measure in the short term. In the longer term, that, in conjunction with many other aspects of education for the community, will ultimately be able to be measured. But in the short term that is impossible to measure.

Ms ELLIS—When is it going to be measured? What is the long term, because six years is fairly long?

Mr Mott—In Western Australia, a study was undertaken to determine how it had both been accepted and what the outcome was, and that study did reveal in the short term that it was very

positively reacted to by students. It was also very well accepted by schools and systems, and that points to the program is being both useful and effective.

Ms ELLIS—Thank you. Do you find a conflict on the perception that the community may have about the picture of younger people drinking beer in ads on television versus that program?

Mr Mott—When you say 'younger people', could you please—

Ms ELLIS—I am not going to be age specific, because I do not know how old they were. I just want say that there are ads on television with young looking people, very glamorous, trendy young people, drinking beer. How does that equate in the industry with the Rethinking Drinking program?

Mr Mott—I would be very surprised if that were the case.

Ms ELLIS—I am not saying that they are school aged; I am saying young adults.

Mr Mott—Okay. Alcohol is a product that is legally able to be purchased and consumed by adults over the age of 18 years.

Ms ELLIS—Absolutely.

Mr Mott—The alcohol beverages advertising code quite clearly states that people must look over 18. In fact, any actors that are used in alcohol beverages advertising must be at least 25 years old. To answer your question, it is the belief of the industry and also the reflection of complaints that are coming back through the complaints system that has been put in place that that aspect of the code is being adhered to.

Ms ELLIS—I would not imagine—and I will be very brief, Mr Chair—that the code is being broken, Mr Mott, and I do not want to infer that. I would just like to make the statement that there seems to be, in my view, a little bit of conflict: in one sense you have secondary schools, so you could have young people up to 17 or 18 participating in the Rethinking Drinking program, which is to harm minimise, in some way, their alcohol intake where beer is concerned, in this case, and then at the same time—I take it that it is beer or similar—

Mr Mott—All alcohol—non-specific.

Ms ELLIS—And then, on the other hand, you have an over 18 person—or whatever the age the code requires—actually having a really good time in a pub with friends and a lot of alcohol. I am not asking the questions so much as making the statement that there may appear to some people in the community to be a perception of conflict on that point.

Mr Mott—The education program is all about responsible and moderate consumption and trying to educate young people in the pitfalls of excessive consumption and irresponsible consumption.

Ms ELLIS—An interesting point made in a submission is that, while Australians are drinking less alcohol, a greater proportion of the population, particularly women, are consuming alcohol. Does the AAB acknowledge that, for women, drinking can be risky, particularly during pregnancy? What is its position on putting warning labels on alcoholic beverages to that or to any similar effect?

Mr Mott—I think that is an issue we will probably get some better advice on when the revised National Health and Medical Research Council drinking guidelines are finalised. As you are probably aware, there is a draft set of guidelines out at this point in time. Public comment on those will be coming back over the next few months, I believe, before that is implemented. That revised set of guidelines, based on science, currently has included in its draft guidelines that ladies who are either pregnant or seeking to become pregnant should closely monitor their alcohol intake and that a low consumption—I think it has indicated around about one drink per day—should not be exceeded.

I think the science and understanding of those issues is changing. The old NHMRC drinking guidelines certainly recommended no alcohol intake for pregnancy, but the understanding by the community and by the scientists has been changing on that score.

Ms ELLIS—To allow alcohol consumption of one a day?

Mr Mott—A very low consumption, yes. That is what the new draft guidelines are indicating at this point in time.

Mr QUICK—There is a perception—and I do not wish to be facetious—that you are a socially responsible bunch of people. That might be fine, but it is a given fact that 11 deaths a day and 260 hospitalisations a day, every day, year in and year out are related to the misuse of alcohol. With the tobacco industry we had to drag them kicking and screaming, incrementally, to put warnings on cigarette packages and they fought it every inch of the way. Wouldn't it be nice for an industry like you and the tobacco industry to actually do something without regulation and without them kicking and screaming? You are investing money in school programs. As a former teacher I would say that that is fine, but are you going to make the quantum leap and put things on before we as politicians make you do it? Where does the social responsibility start?

Mr Mott—I am not quite sure what your point is. As is pointed out in the submission, moderate and responsible alcohol consumption provides positive social and health outcomes.

Mr QUICK—Could you elaborate on that?

Mr Mott—There is a wide body of evidence and I am happy to provide it at a later stage. I do not have the papers with me, but I can certainly give you a list of references that support that moderate consumption of alcohol beverages does in fact provide a cardiovascular protective effect and also provides positive benefits for other health outcomes as well. The key word, of course, is moderate. That is what the programs that we are implementing and working with government on are all about—moderate consumption. So to put a warning label on alcohol beverages that say, 'This is dangerous' or 'Do not consume' would be and could be adverse to positive health outcomes in the community.

Mr QUICK—When I was a boy and I lived in Victoria—all right, it was years ago—people bought single large bottles of VB. Now the six-pack is easy to grab and drink, and now it is into the slab and the slab has gone from 20 to 24 to 30. You have now introduced those sophisticated 12 cans with mixers so the young kids, who are under age, can easily access those. Obviously you are a very successful industry, but along with this social responsibility appears to my mind a lack of responsibility in that, if you take a slab and they all disappear in one night and you are responsible for knocking off half of them, you're a bloody idiot—a drink-driving bloody idiot. I would like to see you put some of those things on for the young kids who send their elder siblings to the bottle shop to get those mixer tall drinks. I am not too sure what some of the names are, but I have seen the kids binge drinking, and they are under 18—

Mr Mott—Well, I can only speak for the brewing industry because that is who I am here representing. To take your first point, you are quite right that the pattern of consumption in days gone by, when we both were boys, was that our fathers probably consumed beer out of large 750 millilitre bottles. Now the opportunity is there to have one drink and stop. There is no incentive there to finish the bottle, or finish two bottles, or three bottles, or whatever the pattern of consumption may have been. And the patterns of consumption have changed. Also, people do not stay at the establishment any more drinking because of things like drink-driving and also changing health and social norms.

Mr QUICK—Increased taxation?

Mr Mott—There is the increase in taxation. And they take packaged beer home. So they can have one can or stubby rather than the equivalent of two or three or four or whatever as you indicated before. I think that consumers have been given more flexibility to moderate their consumption by the smaller packages. And the fact that they are available in slabs is no different in that cans always were available in 24 packs, as were stubbies. So that has not changed since we were lads. The only thing that has changed is that consumer demand for those smaller packs has increased. And the demand for the 750ml size bottle has reduced dramatically.

Mr QUICK—With regard to the perception that I have of binge drinking and schoolie weekends and that sort of thing, what is the industry trying to do to send a message out? You are sending all this stuff to schools and saying, 'Don't do it,' and yet, at the end of every school year in northern New South Wales, Queensland and down around the peninsula in Victoria it seems to be: open the slab, get drunk and wipe yourself out. What's the industry doing to say that that is bloody stupid? Or rather than do that will you put some money in and have a rock concert or do something to get the kids away from wasting themselves? In lots of cases there are unwanted pregnancies and drug use. It really worries me as a parent of teenage kids that no-one stands up. The tourist industry in northern New South Wales and Queensland cannot do enough to keep the kids up there. The airlines and bus companies encourage people through cheap fares to go up and waste yourself for a weekend or a week.

Mr Mott—Again, I cannot speak for the tourism industry, but what I can say is that the brewing industry certainly does not promote those sorts of activities. In fact, the school education curriculum, Rethinking Drinking, is all about trying to inculcate responsible approaches and responsible behaviour. Again, I cannot be responsible for what you do outside this hearing or for what anybody else does, apart from myself, and that is really what it is all

about. It is trying to teach individuals to be responsible for their own behaviour. And if school communities condone that or some other community condones it, it is not something that the industry can be responsible for.

Mr QUICK—It would be nice for an industry like yours and the tobacco industry, which contribute, through people's misuse of your products, to a huge social and economic cost to our society, to occasionally think outside the square and do something for the social benefit—something imaginary or innovative. That is the word that seems to be bandied around here at the moment. You could say to the kids, 'For Christ's sake, don't do it. Drink responsibly.' Do you talk to the liquor outlets in those towns and cities that have schoolies and say, 'Be responsible'?

Mr Mott—The brewing industry, as I also described, works closely with other members of the industry, including the Hotels Association and the registered clubs. Through those organisations we have distributed the responsible server training program, No Worries, which is also designed to encourage service staff to understand that those sorts of practices are not encouraged, nor are they satisfactory or desirable outcomes for either the community or their own businesses.

To answer your question, we have tackled it more in a longer term way and also from an overall sort of perspective. We have also worked with government and, as I have mentioned before, we are working with the national expert advisory committee on alcohol in developing and inputting commentary on how best to communicate, not only to kids in this particular case but also to the industry members, what is acceptable and what is not acceptable behaviour. So those sorts of things are being undertaken. And just to perhaps put one issue at rest—that is, tell kids not to do it—if you tell a kid not to do it, that is the prime signal for them to go out and experiment and do it. The education system has discovered that that does not work.

Mr QUICK—But I mean things like providing schoolies with T-shirts and caps. The industry can do that. They can write it off as a tax loss. But you are doing something positive, something innovative—the message is there. I am finished; I can get off my pulpit.

CHAIR—It is an important issue.

Ms HALL—I have two quick questions, one to follow on from Annette Ellis's, when you were talking about alcohol and pregnant women. One of the issues that was identified as a problem, I think it was particularly when we were in South Australia, was the incidence of foetal alcohol syndrome. I am wondering whether that is being looked at by your association and if there is any conflict with now increasing it from a zero alcohol level when you are pregnant to one standard drink. I wonder whether or not that is research based and whether you could point us in the direction of the research.

Mr Mott—There was an extensive body of research undertaken by that NHMRC committee and I am sure that is available to this committee. I am not an expert in that field at all and don't profess to be, but the development of those guidelines was based, it is my understanding, on that research that supports the science. My understanding of foetal alcohol syndrome is that it is usually a combination of a number of things. One is, yes, excessive alcohol consumption; two is probably also tobacco use; three is that there are often likely to be illicit drugs; and, four, it is probably also poor prenatal care for the mother and poor nutrition. So there are a number of

contributing factors and it is my understanding that one of the former national health ministers, Dr Carmen Lawrence, participated in some research in the west. It was she who told me that was their finding from the research they conducted in Western Australia.

Ms HALL—My other question relates to cask wine. I notice in Dr Wodak's submission that he highlights the fact that the favourable taxation the cask wine is given is, as he sees it, a problem. When we were in South Australia—once again I seem to be referring to South Australia—we had some representatives from the wine industry come along and argue in favour of that low taxation regime for cask wine. I was wondering if the association you are representing today has any opinion on that, and throughout the whole of the industry, and what justification you would have for supporting the low tax regime for cask wine.

Mr Mott—First and foremost, taxation is not one of the issues under discussion here today. However, I would say that the brewing industry is currently taxed at the rate of around about $2.5 billion a year and I would suggest to you that taxation alone is not a measure that will either improve outcomes or reduce abuse. There are—

Ms HALL—Could I just interrupt for half a second? A glass of cask wine works out cheaper that a glass of soft drink. Are you aware of that?

Mr Mott—What I am also trying to say is that, given the already high taxation on beer, we have many times pointed out to government committees, Treasury and government, that the taxation anomalies are certainly there between beverages.

CHAIR—Mr Mott, in terms of the changing pattern of consumption for beer over the last two decades, one presumes that, when we say beer in barrels has fallen from more than 40 per cent to less than 25 per cent in consumption over the last 20 years, that therefore implies less beer consumed in the front bar. How much of an impact do you think RBT and that sort of thing has on that?

Mr Mott—If you look at the time frame that that has occurred over, RBT has certainly had an impact, there is no doubt about that. It has encouraged drinkers that were drinking in the front bar and then driving home not to do that but rather to buy smaller packages and take them home. But there have been other things. There have been changing social norms. There has been a changing awareness of health. Overall the consumption of beer has dropped by around 30 per cent per capita, from highs of 134 to around 95 litres per capita. So there has been a tremendous shift in consumption and also in the place of consumption.

CHAIR—With RBT are you aware of the variations in the states? It is said that Victoria has a higher policing rate than, say, New South Wales. Do you know whether that is accurate or not?

Mr Mott—We certainly monitor the figures. You would have to ask the experts the reasons why. I am not sure, but—

CHAIR—Do you accept that there is a higher RBT policing rate in Victoria than in New South Wales?

Mr Mott—There may well be, I am not sure.

CHAIR—Okay. Just on the issue of road trauma, what do you think the brewing industry might do in terms of positively reinforcing the drink-driving rule? There is a real emphasis, but what are some of the things that brewers might do in there that might just bring the message home at this stage?

Mr Mott—It would be the development of and promotion of low alcohol beers. For many years low alcohol beer comprised less than 10 per cent of the beer market. It was trailing along at about eight or nine or 10 per cent of the total beer market. It now comprises almost 30 per cent of the market. This has been a quantum shift in changing patterns of consumption. Also there has been a very major push by the brewing industry to develop products that are not only acceptable tastewise but are also acceptable from an image point of view and from a branding point of view to the average consumer. So those people who are drinking and then planning to drive have the option of a low alcohol product, which means that they do not have only one product of choice; they now have a number of different products of choice. That has been combined with many members of the industry being actively involved with government drink-driving programs. I know the Hotels Association was actively involved with the federal Office of Road Safety, promoting low alcohol beer and responsible consumption through rural pubs. There is a real difficulty for young people in the bush who have to travel often long distances for any sort of social interaction and then drive home. So there are positive moves being made by the brewing industry and others to push that message.

CHAIR—With the foundation, the 220,000, one of those beneficiaries is the issue of Aboriginal health. One of the great issues of Aboriginal health is of course the consumption of alcohol, and some of it is beer. Does your organisation have any sort of impression about Aboriginal health and the consumption of beer?

Mr Mott—It is another one of the very complex issues that health policy makers face as well. I think the industry is approaching that on the basis of working with governments and working with the research community to better understand what the forces are at work there. In fact, in the current round of funding for this year there are two programs under way. One is an evaluation of the Northern Territory Living with Alcohol program, looking at the success of that and how best to learn from that experience. There is another one looking at the evaluation of population level research as a health intervention. It is a 12-year follow-up of a survey of alcohol, health and lifestyle for Aboriginal residents in the Kimberley. So we are actively involved in funding those sorts of programs to better understand and also help others to see where policy can go in the future. As an industry alone I think there is very little that we can do directly.

CHAIR—Thank you very much, Mr Mott; that is much appreciated.

Ms ELLIS—Just as you are leaving the table, I would like to ask another question, and, if you do not have these figures now, you could supply them if they are available. What amount of money does the industry spend on advertising per annum and what proportion of that is spent advertising the lighter strength product? Just as a reflection of your 10 to 30 per cent increase, it would be interesting to see the figures. Could you take that on notice, Mr Mott, and supply those figures if they are available.

Mr Mott—As an industry body, just to answer your question, I do not have access to those figures, but I will see what I can obtain. It is not something that we monitor.

Mr EDWARDS—I just want to confirm that low alcohol beer, light beer, is taxed at the same level as normal strength alcohol. Are high alcohol beer and low alcohol beer taxed at the same rate per volume?

Mr Mott—This is a question at a difficult time: the taxation of beer has undergone a fairly traumatic transformation over the last eight months. As wholesale sales tax was removed and GST introduced, the excise on beer was almost doubled. That has resulted in about a 25 per cent shift and an increase in the taxation on beer. Concurrent with that, the federal government decided to retain the rather awkward system of rebates being provided by state governments for low alcohol beer, when this was previously a responsibility of state governments, who charged a state licence fee. It is further complicated by the fact that, a year before, the High Court decision outlawed or made unconstitutional the collection of state licence fees. So the federal government introduced a safety net provision that was understood to expire when GST was introduced. That did not happen. A long and roundabout way of explaining it at the moment is that any price differential in taxation is supported only through rebates that are provided back through state governments under this rather cumbersome system, and I could not give you the rates and how that translates right at the moment.

Mr EDWARDS—It just seems to me it is an issue that the industry ought to be taking up. If you are going to adopt the more responsible attitude, which I notice you are adopting across Australia, particularly in Western Australia, it seems to me that you ought to be arguing for a reduction in the tax content of lower strength alcohol. If governments are collecting these massive amounts of tax windfalls, why isn't your industry out there arguing for government to put some of that into harm minimisation?

Mr Mott—You might note that the industry is being very active in talking to the government about taxation issues. In fact, it was the industry that pointed out to the government that the rates that were actually released by the government, which were announced late in June, would in fact have resulted in higher taxation on low alcohol beverages—and low alcohol beer particularly—than full strength beverages. Again, the only reason there is now any benefit is that it is provided through the rebate system, through state governments. It is a very cumbersome system.

Ms ELLIS—Could you also give us a copy of the Rethinking Drinking program? Is there a book or a kit?

Mr Mott—It is a comprehensive curriculum and it is currently distributed by ACHPER, the Australian Council for Health, Physical Education and Recreation.

Ms ELLIS—That is fine; if that is where we get it from, we can try there. Thanks.

CHAIR—Thank you.

[4.05 p.m.]

McGUCKIN, Ms Susan Mary, Information Officer, New South Wales Users and AIDS Association

STEELE, Ms Maureen Anne, Acting Coordinator, New South Wales Users and AIDS Association

WARHAFT, Mr Gideon, Hepatitis C and HIV Support Officer, New South Wales Users and AIDS Association

CHAIR—Welcome. Before you introduce yourselves, I need to point out that the committee does not swear in witnesses, that these proceedings are legal proceedings of the parliament and that as such they warrant the same regard as proceedings in the House of Representatives.

Ms Steele—Thank you. I would like to start with a brief statement, which I am going to read, because I am not the best public speaker, so bear with me. The New South Wales Users and AIDS Association is an independent, community based organisation that is funded by the New South Wales Health Department's AIDS and infectious diseases unit—it is a branch, actually. NUAA was established in April 1989, initially to provide preventive education to injecting drug users about HIV-AIDS issues. This was in the era when needle and syringe exchange programs were being funded. User groups and needle exchange programs were both considered harm reduction strategies, that is, aimed at reducing the harms caused by drug use. So, though NUAA is there to offer people information about detoxification from drugs and other treatments as well, we believe our main client group is people who are currently injecting drugs. We believe that, by teaching drug users how to use drugs more safely, they will remain free of viruses like HIV and hepatitis C, which has to be in the best interests of the community as a whole, not just the drug users.

I will just quickly outline our main program areas. We run a needle and syringe exchange program which provides free injecting equipment and safe sex equipment as well as information and referrals about safe drug use. We have an advocacy and policy section where users can ring up with complaints around discrimination or maybe some problems they are having in treatment and we can assist them—write letters of complaints or sort out the problem. Then we have an education section where we run a number of projects which are peer education based. The idea is to encourage drug users to run their own projects and focus on the issues that are of relevance to their particular area. Finally, we have a quarterly magazine called *Users' News*, which contains a lot of stories written by drug users themselves about the kinds of issues they are dealing with; we also provide in the magazine current information about drug use, hep C and HIV-AIDS. Finally, we have a policy officer; we comment a lot on government policies, both state and federal, when governments are coming up with new policies and strategies around drug use or HIV and hep C. That explains just a bit about who we are. Today we are here to represent the drug users' point of view, I suppose.

CHAIR—Okay. Thank you very much.

Ms Steele—I have a few more things to say, if that is all right.

CHAIR—Oh, fine.

Ms Steele—I just want to briefly discuss some of the points we made in our submission which relate specifically to illicit drug use. For a start, the words 'drug use' and 'drug user' usually conjure up stereotypes for most people; often that image is someone who is pretty smelly, pretty dirty, usually commits break and enters, bag snatches or other crimes like that to support their drug habit. We at NUAA believe that this image is false for the majority of drug users. There is a wide spectrum of types of drug use from people who might use heroin or speed once a year, through to people who use heroin or alcohol every day. Our society perceives a large difference between illegal and legal drugs. Alcohol and tobacco are considered okay. Why are others not? On TV, we often see the stereotype of a drug user as someone in the gutter. Basically, that person is in the gutter probably because they have already lost everything. A drug user who has a job and has children has everything to lose by going on TV or coming out about their drug use and saying that they are a drug user. That is why often we only see the stereotypes of people who have already lost their homes, lost their families, lost everything—people who do not have anything else to lose. Most families in Australia have a family member who has used drugs or is currently a drug user. Drug users are our children, our sisters, our brothers, our parents; they are not faceless people that we do not know. Drug use affects all Australian families.

I will just briefly mention some economic costs. This inquiry, I believe, focuses on the economic costs of drug use. Put simply, NUAA believes that our current system of prohibition costs Australian citizens millions of dollars each year in policing, Customs, the court system, and the prison system, where, if drug use was treated as a health issue and not a legal issue, we would not have a black market and we would not have to spend money on policing and the court system. If drug use were treated as a health issue, basically a lot less government money would be spent on it. For example, as we all know, there was a proposal a few years ago to trial a heroin program in Australia. Some people argue that making drugs available in a health setting is sending the wrong message and promoting the use of drugs, but at NUAA we believe that many people are making informed choices today. For example, there is a lot of information about tobacco smoking, and a lot of people choosing not to smoke tobacco based on that information provided to them, even though tobacco is still legal. Possibly it could be the same for other drugs. Research shows that by making drugs available in a clinical setting does not mean that more people will be attracted to drug use. For example, in Switzerland, heroin use among young people has been shown to have decreased since the introduction of a heroin prescription program.

The next part of our submission concerned workplace issues. I just want to briefly bring up a few issues around drug testing in the workplace. Basically we believe that what an employee does outside of work hours is really their own business. As long as that employee turns up to work on time and is able to function well in their job, drug use should not really be an issue of the employer.

CHAIR—There shouldn't be any drug testing in the workplace?

Ms Steele—We believe that it should be treated as a performance issue. If someone is performing badly in their job or turning up late every day, then they need to be disciplined, regardless of why they are doing that—whether it is drug use, or whether they are tired, stressed out or sick. It should not be the drug use itself that is looked at; it is their performance in the job that is the issue.

Ms McGuckin—Or the impairment.

CHAIR—Okay.

Ms Steele—The next part of our submission looked at some issues around DOCS and guardian and parents. NUAA would argue that there is really no direct correlation between drug use and bad parenting. Drug using parents are capable of being the best parents you could imagine, while sometimes the children of non-drug using parents can be treated very badly. Many drug using parents will not contact welfare and support services when they need to, especially if they are in need of respite care or are having troubles coping, because they basically fear being reported and having their children taken away by DOCS. We believe that a whole of government approach is lacking in this area with regard to this issue. DOCS' policies conflict with other health department policies. For example, the aim of the methadone maintenance program, and I quote from the guidelines, is to:

> Reduce the health, social and economic harm to the individual and the community that is associated with illegal opiate use. More specifically, the methadone program aims to assist opiate users to regain a stable life in terms of their employment, in terms of their family, to gain financial security and social functioning.

But it appears that a lot of DOCS workers around the place do not think much of methadone program. NUAA has received numerous complaints from drug users which illustrate the inconsistencies in some of the decisions that DOCS workers make. For example, one woman rang NUAA recently and was told by her DOCS worker that she would not be getting her child back until she was off the methadone program. This directly seems to contradict health department guidelines.

Just to talk quickly about methadone treatments—I am running out of time—people on methadone programs are often treated differently from people who are receiving treatment for other conditions, it appears to us. For example, how many diabetics would be made to pick up their medication every day, be asked to sign a treatment agreement or be unable to go on holidays because they cannot pick up their medication from a local pharmacy? These are all issues affecting people on the methadone program.

CHAIR—So you would like methadone to be more available on demand so that they can carry it over.

Ms Steele—Where you need to work. People who need to travel for their work, find it very difficult. We feel it should be treated like any other medication, I suppose.

CHAIR—Is there an consistency in the dosage of methadone?

Ms Steele—Sorry?

CHAIR—Is there an consistency in the rate given to individuals? Is there an issue around that?

Ms Steele—Not really. Each individual will be assessed by their doctor once they start on the program, and given a dose of methadone.

CHAIR—That they think is appropriate?

Ms Steele—Yes.

Mr QUICK—How do you tie incentives in with that, because there are going to be some people who abuse the system? How do you rap them on the knuckles and say, 'Look, you have let the rest of the tribe down'?

Ms Steele—We certainly agree that individuals need to be treated like individuals, and we feel that the methadone program does not really cater to the needs of individuals. So with someone who is unstable and is still using and bit out of control, you would not want them to get lots of take-away doses. You might want them to come into the clinic every day. But then there are other people who have been on the program, maybe for four or five years, have had jobs for a long time and are very stable, but maybe they are not ready to get off methadone yet. It appears that they are still being punished because they still have to go in every day. They have to see the doctor once a week, when actually they are doing quite well. So we think that, yes, that unstable person probably does need to pick up their methadone every day, but then others do not.

Mr QUICK—So how would put in place a system that is national? Do you pull it out of where it is at the moment and put it into somewhere else—perhaps have card identification with a photo so that people get to know you? People do doctor shop.

Ms Steele—There certainly are systems being put in place to deal with those issues, including doctor shopping. There is a register now to ensure that that happens less. We feel that it is a matter of doctors treating people as individuals, I suppose. At the moment, in New South Wales for example, there are a lot of big clinics set up, and they are trying to move away from that style into more GPs and community dosing. We sort of feel that GPs probably would be able to give someone that individual care that they need and that moving into the GPs and pharmacy dosing may be one way of doing this.

Mr Warhaft—I think also perhaps there is a bit of a punitive attitude built into the structure of it. If you were prescribed, for example, valium for whatever reason, you would not need to go through anything near the hoops that you have to go through to continue getting your methadone each day, year after year. You could argue the same with most people who have been prescribed valium: most people who are prescribed valium use it very responsibly. Maybe some sell the valium or give it away or somehow abuse it, but essentially we regard valium users as members of the community who will use it responsibly; they have been prescribed it for a certain reason. Methadone users should be accorded the same dignity as someone—

Mr QUICK—In my mind, it is part of this corporate image of drug takers. We wandered around Cabramatta yesterday. You spoke about an education program and the peer group thing,

and yet there are hundreds of thousands of things lying around, jeopardising people's safety. The perception is: there it is, hard evidence. On the one hand there are those who are responsible. As part of your educative process, are you saying to people, 'We need to dispose of syringes properly in order to change the mindset and in order for a lot of things to happen—doors to open and behaviour to change'?

Ms McGuckin—We run disposal programs. But when you look at the number of needles that are handed out compared to the numbers that are in the street, it is not good that they are there but it is still a small amount compared with the numbers that are actually handed out to people. But we do run programs, like through our magazine, et cetera, encouraging drug users to dispose—

Mr QUICK—One in five is a lot, though, isn't it?

Ms McGuckin—Sorry?

Mr QUICK—One in five syringes in Cabramatta are being disposed of improperly.

Ms McGuckin—In the street, if people do not have places to dispose of the needles. That is why even having safe injecting rooms, et cetera, is beneficial because people will then inject off the street and they will have somewhere to dispose of their equipment. When people are injecting in public, on the street, that is what happens. That is when the unsafe behaviour occurs.

Mr Warhaft—In fact, I would argue that the sorry state of syringes in Cabramatta is more of a function of restrictive policy rather than unrestrictive policy. People use and they throw their needles away because they want to minimise their chances of being caught by the police. Cabramatta attracts perhaps the more desperate end of users; it is certainly not representative of the majority of probably even heroin users. It creates a culture which includes disposing of syringes and other paraphernalia in a non-responsible way because of restrictions and the heavy-handedness of the law.

Ms Steele—I will keep going briefly and talk a bit further about some treatments for drug use. Though we have recently seen the emergence of Naltrexone as another treatment option and Buprenorphine will be available soon as well. You would still argue that really there are not enough treatments available to suit the needs of individuals and that we need to do more research into more treatments. For example, there are some drug users who are simply not ready to stop using drugs yet; this is what we believe. And it does not matter what you do. You can try to force them to stop using drugs and you can even get them to consciously believe that that is what they want to do too, but often these are the sorts of people who do fail at abstinence programs, and that often creates further harm to their self-esteem and their sense of self-worth. Surely, then, if that person just decreases the amount of drugs that they use, this would be a step in the right direction and a positive step. So this is why we argue that there is a place for a heroin treatment program as one of a range of options for drug users.

I will just talk quickly about crime and violence and law enforcement. The criminalisation of people for minor drug offences is very costly, and more harmful than useful to individuals, we believe. There is a lot of research to support this idea. Just to quote a few statistics: 60 to 80 per

cent of prisoners are incarcerated for crimes related to supporting their drug use, and the majority of these crimes are non-violent. The research also shows that violent crime is more often caused by alcohol use than any other drug use. There was also an interesting report in the paper after this year's New Year's Eve: the police were reporting that violence around the Sydney city area has dropped over the past few New Year's Eves. They actually have this hypothesis that it might be the drop in alcohol use and the increase in ecstasy use that has resulted in this drop in violent crime. So that is an interesting hypothesis.

Also at the moment, I do not know if you are aware of it, but there is a heroin drought happening across Australia. There is no heroin on the street, and we wanted to talk a bit about that, briefly. There is very little heroin available. In Sydney, a lot of the heroin users are actually turning to cocaine use instead because it is there. Cocaine is an up drug; it means that often people binge on this drug, they take a lot of it at one time, they stay up for days on end. If any of you guys stayed up for days on end you would tend to get a bit psychotic, a bit paranoid, a bit violent. We do believe that there is a bit more violence happening in a lot of the drug areas now, and this could be why. The second point is that, if there is a bit of heroin out there, it is being sold at twice the price, and there is usually a very minute part of heroin there. So users need to do twice as much running around, twice as much scamming to get the money together, maybe even twice as much violent crime, to get the same hit that they were getting a few weeks ago. So basically we are arguing is that this lack of this heroin on the streets has resulted in a big increase in violence.

ACTING CHAIR (Mrs Ellis)—Have you got much more to do? I am just conscious of the time and one of our witnesses has to leave in a few minutes.

Ms Steele—I might even just table the paper, if you like.

ACTING CHAIR—Yes, that would be excellent.

Dr WASHER—The first thing is that I agree about individuality. I think that is quite important. People who take drugs are also individuals and need to be treated as individuals, so I support that totally. I was just a little interested in the tradition now that is coming in at a lot of workplaces—to say this is a drug-free workplace. That does involve legitimate substances, and it involves tobacco and alcohol as well, so it is not just illicit drugs that they look at. But I would be a little anxious, for example, if we did not screen, say in a workplace agreement, pilots of massive jets and things like that. I think that, at the end of the day, there are going to be certain jobs for which it is needed—when you've got the responsibility of people's lives. I think that would be the exception. That is where we should be doing this.

I had some friends who naturally, because I am a doctor, were doctors. They were surgeons and, unfortunately, they had alcohol abuse problems. That was not recognised by our profession until they had done quite extensive damage to themselves and to patients. It often gets covered up. Knowing this, it is tempting to consider whether we should be routinely screening certain professional groups or certain people doing certain jobs, for the safety of the public in general. I want your comment on that.

Ms McGuckin—Certain legislation already covers some areas like that. People who fly planes, and prison workers and some train drivers, et cetera, are regularly screened. Our concern

is more that unregulated testing of people can lead to more harm than if you do not test. And it is not only drug use which impairs people. A lot of things can impair people, such as psychological issues, stress, tiredness, et cetera. A lot of unions are fighting against drug testing but are trying to bring in something to test people's impairment—I am not sure how you would do it—rather than just test what drug is in their system, because that does not necessarily show how impaired they are. Someone could have smoked pot weeks before and a drug test would still come up positive, so it really would not show how impaired the person was. There is also the question of different amounts of drugs that people take: someone could be on heroin and not be impaired that much at all, or methadone, if they are stabilised on that drug. It is very difficult to see how impaired someone is just by testing for the drug.

Dr WASHER—I agree there is a range of causes—fatigue, et cetera—but you would agree that in certain areas it probably is reasonable to do that.

Ms Steele—A lot of professional bodies have impairment panels now. We have worked with a few nurses who have drug and alcohol issues and they front the Nurses Registration Board Impairment Panel. I still believe that maybe if society was a bit more open about drug use and a bit more accepting, then maybe guys like the pilot with the cocaine habit would actually feel a bit more open about talking about it and being honest about it, and not so fearful about losing his job. If we had a better attitude in general he might be dealt with more fairly and therefore feel a bit more open to talking about it.

Dr WASHER—You mentioned jails and the increase in hepatitis C, B and AIDS. It is stated, and I guess it is true, that the commonest cause of spread of infection, particularly for hepatitis C and B is within our jails by blood borne transmission. I guess that would indicate that prohibition in jails, like prohibition in most places, does not work very well. You indicated that we should have clean needle exchange programs within jails. That is going to mean a lot of emotional anxiety because the state government is responsible for jails. I happen to agree with that statement because the evidence seems to suggest that this is a health issue that we are not addressing. How far have you been able to proceed that in talking to state governments?

Ms Steele—Thing move very slowly with prison issues. One of our working groups did get condoms into some of the prisons. We are still working on needles and syringes in prisons. As you say, there is a lot of concerns there, such as if they will be used as weapons. The issue is still on the agenda; it is still being moved slowly along. We would like to believe that we will see a day where needle exchange is available in prisons.

Ms McGuckin—Or at least a trial in different sized prisons.

Ms Steele—The thing about a trial is that you try something out and if it does not work, ditch it, don't use it. I cannot tell you exactly where that issue is at the moment.

Ms McGuckin—Not very far advanced.

Ms Steele—It is a very difficult fight, that one. It has not moved along very far.

Dr WASHER—We now have needles and syringes that cannot be used as weapons.

Ms Steele—Those are all options. A safe injecting room in the prison environment is another option. At least then the needles would not be leaving a certain area and could not be used as weapons at later date. There are a few options like that we believe should be looked at. My final statement was going to be that we cannot control drug use in the prison environment, so how can we expect to control it outside?

Mrs IRWIN—I apologise for coming in half way through your presentation—I was doing an interview at the time—so you might have already covered in your presentation some of the things I want to ask you about, so I do apologise. I heard you say that you are not happy with the child protection policies that aim to remove children from parents who have got a drug addiction. Can you give us any examples of cases you might know, and tell the committee what policies you consider to be appropriate?

Ms Steele—Basically, we believe that parents' ability to be good parents should not be based on drug use alone; there needs to be a lot more to it than that. A particular case example I can think was a guy and a girl who had a young child aged about four. He overdosed, and his father actually came around and rang the ambulance. The ambulance driver had a duty of care to report that there was a child in the house and that she could be at some risk. That guy has said to me, 'I am never going to call an ambulance again—if someone overdoses and there are children around, I am not going to call an ambulance because this is what happens.' That is what we fear, that we may end up with overdose deaths, with people not accessing services, because that is their main fear.

Ms McGuckin—It is not saying that parents who use drugs are necessarily better or worse parents than anyone else, but just that drug use is not the only thing that is seen. Even though DOCS policy states that drug use alone is not enough to take a child away, it often happens that it is the attitude of the workers towards drug use that ends up informing their decision. They do not always have a lot of information about that child being badly treated, but they assume certain things because of the drug use of the parents. Our main concern is, as Maureen said, that so many parents ring us up and say, 'I am about to do something to my child, I need some respite care, but I am not going to ring anyone,' because they are so scared they will lose their child. So it is very difficult to help them in that situation.

Mrs IRWIN—You were talking about prisons earlier. We were in Goulburn Jail on Monday and we told that 85 per cent of the prison population are on drug related crimes. What concerns me as well is that there is a large increase in the number of female prisoners going into our jail system. Can you say why? Are they stealing to get their drug money?

Ms Steele—Interestingly, a lot of those women are on sentences of less than a one-year turn. That makes me think they might not have gone in there for anything major. As you said, a lot of it is drug related. I thought we had some statistics here on prison rates but we do not have the statistics on women, I am sorry.

Ms McGuckin—I am not sure of the reasons, but it has been a major concern of ours that that population has risen.

Ms Steele—I have just found a figure here. The female prison population has risen by 40 per cent, while the male population has risen by 12 per cent over the past five years.

Ms McGuckin—It does not give reasons.

CHAIR—You could take that on notice.

Ms Steele—Okay.

Ms ELLIS—In your submission, you refer to the New South Wales government response by announcing a parliamentary inquiry into the increase in the prisoner population. Can you take on notice to let us know where that inquiry is up to and, if it is available, where we can get hold of a copy of the report?

Ms Steele—Yes.

CHAIR—I have a few questions on the methadone program. Starting from scratch, what have we got at the moment and what would be the cost to have methadone? Do we have it publicly available? Just give us the picture of what methadone is available, and the impact on low-income people.

Ms McGuckin—Different states have different systems. In New South Wales the public program is small; most people are on private methadone programs.

Ms Steele—And then they pay about $50 a week.

Ms McGuckin—That is a lot if you are on income support. It is $100 out of each cheque, and it has a monumental effect on people in terms of poverty, et cetera. Most of these people go along to private clinics and they pay sometimes over $50, if they pay on a daily basis. In New South Wales there are no concessions in the private clinics for people on low incomes.

CHAIR—Can you give us a picture of the little bit—or perhaps a fair bit—of public?

Ms Steele—There are only a few public clinics. There tends to be one in each area health service, and they tend to service high priority clients: people who are coming out of prison, pregnant women, people with HIV. They tend to be filled up very quickly with people with very particular needs.

CHAIR—And that is a free service?

Ms Steele—That is a free service. So most of the people on the program cannot get into those public free clinics.

CHAIR—I am interested in the rates of dose. We are hearing 55, 65, 100. Perhaps you have already covered that. If so, I apologise

Ms Steele—I know some people who are on about 15 and 20 milligrams; I also know people who are on over 200.

CHAIR—That gives us a pretty important picture.

Ms McGuckin—It depends on a doctor's individual beliefs, too. Some believe in high dosing. Some clinics–

CHAIR—Thank you. I developed an interest in it because I could pick up this variation, and I am trying to understand what it means.

Ms Steele—Different doctors have different theories on methadone. Some doctors really believe in high dose methadone and can see a place for it; then the next doctor will say, 'I don't put anyone over 120.'

CHAIR—You have been fantastic. Anything else you would like to say? If not, thanks very much.

[4.36 p.m.]

CRANE, Dr Richard John James

DALEY, Ms Helen Mary

DAWSON, Dr Michael

FAUX, Dr Steven, Delegated Fellow, Australian Faculty of Rehabilitation Medicine, Royal Australian College of Physicians

GRIFFITHS, Mr Mark Allan, Deputy Coordinator, Eastern and Central Sexual Assault Service

LENNANE, Dr Katherine Jean

O'NEILL, Mr Kevin Arthur, Director, Regenesis

ROBERTS, Mrs Lynette

ROBINSON, Reverend Michael Dean

ROSEWOOD, Miss Jennifer, Drug and Alcohol Services, Canterbury Community Health

SHINN, Mrs Sonasri

STOJANOVIC, Mr Micheal Stojanovic

STUBBS, Mr Matthew Lawrence, Training and Research Officer, Ted Noffs Foundation

THOMAS, Mr Evan Birchall

WALSH, Mr Robert Allan

WILLIAMSON, Mr David, Woolooware Branch Delegate, New South Wales State Council, Liberal Party

WILSON, Mr Ian Keith

CHAIR—I welcome to our table any witnesses that would like to give three-minute statements. The committee does not swear in witnesses. The proceedings are legal proceedings of the parliament and they warrant the same regard as the proceedings of the House of Representatives. First we call Ms Helen Daley, Dr Michael Dawson and Dr Jean Lennane. Over to you, Ms Daley.

Ms Daley—I am here on behalf of my two brothers. One died in 1994 of a heroin overdose, and one died in 1999 of a heroin overdose. You have actually met my brothers today: they

featured in the slides that Mr Trimingham presented. Justin was the handsome blond one with no shirt on, and Philip was the laughing one, close to the end, with his arm around my mother. I did not know they were going to be here today and I wasn't even going to mention them, but it seems relevant. It is probably also relevant that I myself was a social heroin user in the early 1980s, for four or five years.

Abuse means 'misuse, or make bad use of'. Use means 'application to a purpose'. People use mood enhancing substances for relaxation. Alcohol and tobacco, narcotics, cocaine, amphetamines, hallucinogens and cannabis are all used for relaxation and enjoyment. There is no reason why such use of any of these substances should be more or less socially accepted than the use of any other. They all have some risks attached, and it is important to educate people on how to relax safely—which does not necessarily mean without drugs. People also use these substances to alleviate psychological pain.

To remedy the negative effects of high-level use of such substances, we have to bring down people's general stress levels. Excessive consumerism and a society that has become reliant on it are fundamental factors in many of society's problems today. We need serious commitment to the education of the population in all forms of relaxation, communication and effectiveness training. Communication skills training teaches you how to treat people you do not like with respect, civility and equality. Parent effectiveness training teaches you how to treat individuals over whom you have absolute power with respect, civility and equality. Assertiveness training teaches you how to treat someone who is abusing their power over you with respect, civility, and equality.

Our social and political leaders should lead by example and undertake this type of training themselves, and these courses should be available at schools, colleges and tertiary and corrective institutions of all sorts, and at community centres throughout society. Lack of these skills is a fundamental cause of the epidemic of depression sweeping modern society.

The health issue, then, becomes a matter of: why are we not researching safe methods of ingesting mood enhancers? The hypocrisy of the way society is handling drug use is extremely damaging for families. It is propping up black market and organised crime activity, and incurring completely unnecessary law enforcement and correction costs. There is no reason why current prohibitions relating to driving while drunk cannot be extended to cover all mood enhancing substances. The same applies to current warnings and education about workplace safety, in relation to alcohol and prescription drugs that cause drowsiness.

The health care costs of illicit drug use are a lot less than the health care costs related to alcohol and tobacco. Consumption of sugar, junk food and caffeine should also be brought into the formula. Taxation at selling point would be the most efficient way of collecting contributions towards these costs. This can only be effected if all mood enhancing substance use and behaviours, including gambling, are on the same legal footing. Thank you.

Dr Dawson—I am an academic in the Faculty of Science of the University of Technology, Sydney. I would like to talk about changing the law so that doctors are able to prescribe heroin to addicts. Some colleagues and I recently conducted a study in street-level heroin, and we found that its purity arranged from 30 to 95 per cent. This variation causes a large amount of harm to users. Let me explain why.

If a user buys heroin from their usual supplier on the street, they know that the strength is fairly constant, because the supplier wants to keep them happy and wants to keep them coming back as a repeat customer. But, if the user changes supplier, they have got no idea about the strength of the heroin and may end up injecting a fatal dose. This variation of impurity in heroin was a major factor in the death of 958 people in Australia during 1999 from drug overdose. This tragic waste of human life is nothing short of a national disgrace, and something must be done about it. I am pleased that this committee is hearing submissions.

Let me put the purity issue in perspective, using alcohol as an example. It is probably a drug that most of us use. Australian law states that suppliers of alcohol products must label containers with the content of alcohol. This is because, as a society, we realise the harm that alcohol causes and so letting people know how much alcohol they consume when they have a beer reduces the possibility of harm to drinkers and to others. Imagine if you went into the pub and you had what you thought were three low-alcohol beers but were in fact high-alcohol beers. If you then got in the car and drove off, the consequences could well be fatal, not just to you but to innocent bystanders, and would devastate your family. Hence the need for the regulated sale of alcohol.

Very stringent controls are applied to pharmaceutical drugs to protect consumers. These regulations are administered by a section of the Commonwealth department of health, which relies on input from a number of expert committees. I am a member of one of these, the pharmaceutical subcommittee of the Australian Drug Evaluation Committee. We meet every two months to review quality issues concerning new drugs. Any application that fails to meet stringent standards set for purity is rejected out of hand. Unfortunately, the illicit drug market has no such controls. This might be a good situation for criminals and others who profit from it, but it has devastating consequences for society. The losers are drug users, their families and everyone in Australia who pays taxes and property insurance.

In my opinion, it is time to start thinking again about regulating the supply of heroin to registered addicts. I say ‘again’ because this was the system in Australia until 1953, when heroin was banned. Before then, doctors could prescribe heroin to patients addicted to it. Some countries have already reversed the ban on heroin prescription. In the 1990s the Swiss government, alarmed by the number of people dying from overdose, trialled heroin prescription to 1,146 severe addicts. The trial was an enormous success: not one participant died from heroin overdose during the 18 months that the trial ran.

On average, from one to two per cent of heroin users die each year from overdose, so it is clear that prescription heroin saved at least 26 lives in Switzerland over that period. Australia could get the same kinds of benefits that Switzerland now has by changing the law to allow doctors to prescribe heroin to treat heroin addiction. It is time to stop pussyfooting around this issue; it is time to start saving lives by letting doctors prescribe heroin to people dependent on the drug. Thank you.

Dr Lennane—Thank you. I was a physician originally and then a psychiatrist. I have worked in the drug and alcohol field for 21 years. During my time at Rozelle hospital I have treated many thousands of people in detox and rehab and I have pioneered treatment or rehabilitation of people with alcohol related brain damage which has given me a very keen appreciation of the importance and vulnerability of the brain, particularly the developing brain. I was one of the first people in Australia to alert to the problems with benzodiazepine dependence. I have written

this book—which unfortunately is out of print or I would have tried to give you a copy—about alcohol, which of course is our major social problem drug. You were talking about workplace drug testing. One of my suggestions is that this would be very well to be pioneered by politicians to say that you do not drive drunk and that you do not make laws that affect hundreds of people drunk either. You could do this very easily and cheaply and it would have an enormous impact.

I was sacked in 1990 for opposing cuts to drug and alcohol and other mental health services. I would like to make the point that I was not the only one excluded from the system at that time. It was not just cuts to services that were part of the problem but other orthodoxy about the line to be taken. I think your committee, therefore, has heard rather less than they should about some aspects of the problem, because people following other lines have been removed. You must have heard enough, though, to realise that there is no simple solution to complex societal problems, and I think you are all clear about that.

The legalisation thing worries me greatly. My line is always that we have two legal drugs that cause enormous health and other problems. Why not try to control them first and show that we can? For example, you could have cigarettes made available only through specific outlets to authorised registered addicts. You could see if it works with that before you venture into something like cannabis, which in my opinion—particularly, again, affecting the brain—is a much more dangerous drug than is commonly recognised.

The things that I want to bring to your attention—I also did so in the paper I gave you—are the taboos that there are in the current debate: that you are not allowed to talk about alcohol as a carcinogen; that it is a major carcinogen that causes cancer. This is not mentioned. The Cancer Council does not do anything about it. This is something that your committee could well take up. There is the question of genetic vulnerability; that is, that people have a risk of dependence which is partly genetic-inherited and they should be warned about this. This is something that, again, can very easily be done, but the current dogma will not allow it to be done. The other big taboo is abstinence. This is virtually not mentioned; you just have this harm minimisation controlled drinking, even for groups of people such as those with brain and other organ damage, those who are pregnant or who are intending to become pregnant and children. This is my particular beef.

I will only have time to hand out this paper which came from Western Australia and was published last year. I only have three whole copies and some of the cover sheet. I will tell you what I thought when I saw the abstract of that paper initially. This is where the gentleman from the breweries says they have been running their program about responsible drinking. This paper talks about what I thought initially must surely mean years 11 and 12 children. It is in fact a very large survey of 11- and 12-year-old children who are experiencing enormous harm from alcohol. There is no mention in that paper that an option that should be explored is to say that kids should not be drinking; children with developing brains should not be exposing those brains to alcohol. Thank you.

CHAIR—Thank you very much everybody. I invite Mr Kevin O'Neill, Mrs Lynette Roberts and the Reverend Michael Robinson to come forward. Mr O'Neill, over to you.

Mr O'Neill—I represent Regenesis, a community based organisation previously called Essential Crossings. It is an impulse fostered by concerned individuals—parents, professionals—in the Southern Highlands of New South Wales and also in Sydney.

At this public meeting the focus of Regenesis is to raise awareness of the issues of access and treatment. We believe that the impact of addiction on families and individuals in particular and society in general is best addressed by these primary issues. In dealing with access, Regenesis holds three basic beliefs to be true: timing, proximity and motivation. Firstly, timing. We should take advantage of the spontaneity of the addicted person when they want to do something about their addiction; that is, we need to respond in that opportunistic time. Secondly, proximity. Any program or intervention needs to be accessible and available. For example, even transport needs to respond to the addict's spontaneity. Thirdly, motivation. We need to provide the motivation for the addict and their family and not constantly challenge it. To challenge an addict's motivation to change simply lends itself to a process of self-fulfilling prophecy. The challenge for Regenesis is to not react to the addicted person's challenging behaviour but to apply a positive attribute and response to it. In dealing with treatment, Regenesis holds four basic beliefs to be true: flexibility, generic content, empowerment and facilitation.

Firstly, flexibility. A program should have flexibility to adapt to the particular needs of the addict rather than cater for the needs of the service providers. A Regenesis program would have a mix of residential, outpatient and after-care, extending any intervention into the stable life of the addict after their program. Secondly, generic content. A program should be generic enough to deal with all forms of addiction and should not be only substance specific. Thirdly, empowerment. A program should have the power to unlock the potential of the addicted individual to define their individualism and creativity to achieve a positive outcome. Fourthly, facilitation. A program should facilitate change in an individual to optimise their capabilities and inner strengths, empower them in their ability to problem solve and develop resilience to all life issues.

I believe that Regenesis has addressed the foregoing issues. It proposes a program that not only permits a diversity of solutions but also is adapted enough to enable a speedy response to any addict seeking entry. The Regenesis program facilitates the addict to take control over and responsibility for their own life. Improving responsiveness, connectedness and a personal spirituality in addicted individuals is improving not only the present time for these individuals but also the present and future time for individuals, their families and society.

We make as a recommendation to this honourable committee that the Health Insurance Commission designates as item numbers day-only treatment and residential care in approved addiction treatment centres. We believe that this will increase accessibility and responsiveness to treatments, reduce costs to families and ultimately to society. Thank you.

Mrs Roberts—I am a mother of teenagers. I have worked with DOCS disability for over nine years, I have been conducting parenting courses voluntarily in the community for over six years and I am a facilitator of a course that helps parents to help their kids say no to drugs.

The nightmare of drugs affects families in many ways. They feel they are swimming against the tide, just waiting for that phone call to say their child has been found dead. The *Journal of Diseases* states that 40 per cent of adolescent suicide has used pot within eight hours. Suicide:

what guilt that leaves parents. When finally a child admits they have a problem, the parents must contend with the ongoing frustration—and we have heard that today—with the lack of services. They become completely consumed by the drug abused child and the other children suffer with such conditions as bed-wetting or acting out.

As drug dependency takes over in teens, it delays or impairs their maturity and fulfilment in life. This shatters whatever hopes or dreams that parents have for their child. There are so many answers to the drug problem, but there is one area we need to look at seriously: the education of parents on how to develop a strong relationship and grow good character in their children, so they in turn will have power over the need for drugs and develop into responsible, caring adults. A study on adolescent health found that kids who felt connected to their families were less likely to use drugs. If parents learn how to encourage good character—for example, self-esteem, the lack of which is one aspect that can contribute to a child wanting to take drugs—their children are then more empowered to think about not just what is best for themselves but how they can help others.

The textbook on life given to us by our creator, God, encourages us to love our neighbour as we should love ourselves. How can we have a caring society of adults if they are not first taught how to love themselves? If parents develop good communication and conflict management skills, it will give open lines of communication with their children. The law does not allow people to drive cars or become doctors without education, yet we allow parents to bring up children, who are our future, without any training. It is time we had laws that parents attend parenting classes when their children turn certain ages—it might be, say, age 1, 4, or 12—and those classes should include teaching about drugs and where to get help. Thank you.

Rev. Robinson—Mr Chairman, at this time, I will address my comments to preventing illicit drug abuse and related matters. Last year, I made two submissions to federal governing inquiries, and the first to this committee detailed the extent to which harm minimisation policies have failed with increased drug abuse, hepatitis infections and needles distributed and discarded. This must not continue. Harm minimisation is like trying to get dye out of a bucket of water. It is far easier and infinitely more effective to put a lid on the bucket and stop the contamination in the first place. History is the evidence, and that evidence shows us that harm prevention, with a comprehensive plan for effective supply reduction and effective demand reduction measures must be pursued.

The second submission was to the current Coastwatch inquiry and included a blueprint on how to stop the supply of illicit drugs to the community. I draw your attention to that material, as it exposes the ineffectiveness of Customs—the total failure of its current structure—and those things being exacerbated by the harm minimisation policies in the community.

It also exposes cover-ups in Customs that have led to false and misleading information being given to various people and to committees. I direct you to pages 2518 and 2523 of the submission—details of the latest incidents released through the Prime Minister's office to the Queensland Premier. I draw your attention to these lies and criminal actions by the Customs administration and submit these extra documents as exposing them as the only way to find the solution to stop supply. I urge this committee to effectively ensure that harm is prevented. Do not accept the responses given to you by Customs advisors. They have lied, misled the parliament, misled the people of Australia and, for years now, have acted to silence, gag and

actively prevent their own Customs officers from carrying out their lawful duty. I quote the case of Customs officer Peter Bennett as merely one example.

As a result of such misdirection, some have looked at treating the symptoms and not the real cause. On any view, supply is currently unlimited and unimpeded, and dealer networks flourish by an addiction pyramid scheme which can only be addressed through genuine national supply reduction combined with effective harm prevention strategies. Also, the enforcement of the law and effective compulsory rehabilitation must be implemented for the good of the person and the wider community. No reasonable person can view ongoing addiction as something acceptable. The Coastwatch committee's chairman has refused to expose Customs, and I urge you to recommend a royal commission into its effectiveness. Do not be caught up in fallacious myth and lies that Customs cannot stop drugs with an effective single border protection agency. Safe drug abuse is a myth in itself and it is only the symptom. Stop the supply of these substances and also address effective demand prevention measures. We are doing all manner of things about this drug problem except the most important thing: addressing the supply problem. Do not let this opportunity pass, once and for all, to address this.

Miss Rosewood—My name is Jennifer Rosewood. I would like to thank the committee for the opportunity to address it, and I will attempt to be succinct, acknowledging that many others have also taken this opportunity. I am a member of Family Drug Support, and I work—and have done so for over 10 years—as a professional in the drug and alcohol field.

The main focus of my work is methadone maintenance treatment, and I frequently receive calls on this topic in my capacity as a volunteer of the Family Drug Support phone line, which receives national calls. I would like to draw the committee's attention to the financial inequities in methadone treatment for clients. Methadone maintenance treatment has the best outcomes for opiate dependency, compared with any other treatment. However, it is also the preferred treatment for most chronic, recalcitrant and disadvantaged groups of clients. Rehabilitation may be a long process for people with fractured lives as they adopt healthy social patterns for a better lifestyle. This is not assisted by the unrestricted charges for methadone by community pharmacies.

The maximum charges for Commonwealth subsidised medications are: for those on benefits, less than $200 per annum; and, for people who are not means tested, $800 per annum or the equivalent of the cost of a weekly prescription times 52. Because methadone syrup is supplied by the Commonwealth government free of charge to any agency prepared to dispense it, it is not on the subsidised pharmaceutical list. Clients on methadone services are being charged between $2 and $7 per daily dose, resulting in an annual cost of up to in excess of $2,500. This is justified on the grounds that it is cheaper than heroin. Many clients who are in treatment have moved on from their heroin using lifestyle and are frequently partnered by another ex-user and have children. This places a huge financial burden on their resources. The most popular option is to try to stay at a public clinic, but this is not conducive to rehabilitation, independence or the opportunity of employment, as most public clinics have restricted hours. Public clinics are the best places to stabilise clients and engage them in conjunctive therapies. But, for a long time, places have been restricted due to the glut of long-term clients, who, for financial reasons, are very resistant to going to community pharmacies. As the flow of younger, dependent people are presenting for treatment at public clinics, this is no longer an option for services and stable clients are being transferred to pharmacies.

When this system was originally instigated in New South Wales with the support of the Pharmacy Guild, a recommended fee was accepted by most pharmacists. But the current trend is to charge what the market will allow, and clients remaining opiate-dependent on methadone have no choice. This results in clients commencing a relationship with the pharmacies on a bad footing, as they resent being forced to transfer and endure genuine financial hardship. This situation will inevitably lead—if it has not already—to a black market as clients sell their takeaway doses to pay for their pharmacy account. This has been the situation with the private methadone clinics and has resulted in a huge cost to the community as black market methadone is diverted for injection and accommodates the spread of hepatitis C.

There are other issues I would like to draw to the committee's attention on the inequity and financial exploitation in the delivery of treatment by the private sector but, acknowledging the demand on the committee's time, I will focus on the unrestricted fee for services from pharmacies. Thank you.

Mrs Shinn—I wrote this myself as the mother of a person who was addicted to drugs, mainly heroin. The issue of drugs is not just my problem; it is everybody's problem, because crimes such as stealing and violence are created from drugs. In my opinion, heroin addiction is highly infectious. I like to compare the infection of heroin with the infection of leprosy. It is a disease that we are ashamed of. The more secretive we are, the faster it spreads. The families of heroin users feel shame and try to cover it up, and that is exactly what the drug dealers want. We are ashamed, so we will not speak out. Some people are even too ashamed to ask for help until it is too late.

In the middle of 1999, I found out that our daughter, Ann, which is not her real name, was addicted to heroin. She is bright, fun, happy, easy and pleasant to live with when she is not using drugs. We noticed her changes in early 1999, but my husband and I thought that her behaviour was of a normal teenage girl. We did not realise that drugs had made Ann aggressive and depressed, which became her everyday behaviour. She also lost motivation, and made up excuses for needing money, which led to stealing and handling stolen goods.

It was such a shock, when we found out that Ann was addicted to heroin. We were anxious, angry, ashamed, guilty, isolated, depressed and confused. A few weeks later, we found out that Ann's boyfriend was also addicted to heroin and physically abusing her, but we could do nothing about it, because he was 16. Any mother in this room will understand how it feels. The tension was so great that our family was nearly broken up. I have not been able to run my business properly, and it is still in financial difficulty.

I have survived this ordeal and I am able to talk to you today because of the help that our family gets from the Ted Noffs Foundation. The counselling we receive helps reduce our anxiety and enables us to deal with the problems better. More knowledge on drugs and on user behaviour helped us to be able to break the dark cycle. The support within our family, relatives, and friends has also helped us to cope and get through the last two years of hell. I would like to mention that it is not easy to get free help. The first few days I was looking for help I was told I had to wait for at least two weeks. We could not get help because we do not fall into some organisations' criteria, such as Ann not being a street kid, she was not under DOCS or the juvenile justice program.

Ann and I were highly depressed, and we could not wait two weeks. With my depression and frustration, we asked our local MP for help, and she acted immediately. I am proud to say that we have our happy daughter back, but we still have some work to do. Ann has a few odd jobs, and started part time last year. Now she needs a full time job, and if anyone can help, I would appreciate it. I hope the law is changed and the authority is given back to parents until the child is 18, or when they finish high school, or are employed—whatever comes first. As the law stands, a 16 year old person can be independent, but most of them cannot support themselves. They become confused about being independent, and do what they want. They become a burden of their families and society. Another point I would like to make is: just please do not give young people, school leavers, unemployment money; please give them a job, education and dignity. Thank you.

Mr Stojanovic—I am a concerned resident of Cabramatta. I have lived in Cabramatta for 30 years, or so. I remember how nice Cabramatta once was. You could walk down the shopping centre and feel safe and also a general sense of happiness in the community. Now, when you take a walk through Cabramatta, you see nothing but broken dreams, hardship, selfishness, and yet no compassion for the weak, not to mention the needles, people intoxicated temporarily through heroin and a lack of direction. Most of the people in the streets of Cabramatta have been misled either by their friends, peers, parents and even authorities.

Single-parent families, underprivileged families, and well-off families suffer equally because of the basic lack of education, direction and compassion. Most of the community has come from a new Australian background, which sometimes allows new information and conflicts which time usually heals. But the way and the speed that the world is moving today seems that a trend for non-performers and non-understanding which creates a need for alternative lifestyles, creating such situations as we have in our communities today. Basically, we have a lack of strong peers and some form of misdirection. Maybe we can create a direction through immunisation, counselling, and education.

That is why I believe we need a situation or a program such as I have suggested to remove users from a no-win situation, and to place them in a positive outcome—with a possible search for life program, and products such as a utility removable injecting facility maintained by the victims of society and victims of poor direction, mainly the heroin and the drug related cases where people have lost belief and direction within themselves, which ultimately leads to a vicious circle, especially when children are the victims. I believe by creating a direction for their brothers and their sisters, their mothers and their fathers who have fallen, we ultimately create more freedom for a child to succeed.

I also believe that the fallen need to make certain commitments as well. That is why a system such as a utility system could just create a redevelopment of society, taking care of the needs of people in similar situations and backgrounds for the ultimate goal of reintegration through effort and help and looking after their own mess—a repairing the damage approach. This would be achieved by creating a work-like environment with rewards only to be claimed by the children and victims of their mistakes, and investing any earned funds into an investment fund for education, possibly breaking the vicious circle for children, for example. If the searcher entered voluntarily into a program, the searcher would receive a small sum or wage for satisfactory work and attendance—perhaps, $1 or $2 a day for the maintenance and processing of the utility

system. In that work environment, a farming environment would be a good possibility, as produce and agricultural knowledge could be gained and also provide nutritional needs.

As the fallen develop and start to use some of their lost skills, they can progress up the ladder by claiming education and training through the program. The program, after a period of time, would be run by graduates of the program the necessary professionals. The direction or success would be determined by the searcher pursuing their general interest direction and building on it. As the reclaimed people commit more days, an individual fund is established on a family victim level nominated by the searcher—even though they are losing time away from their loved ones or children, at least they are not on the streets as intoxicated victims. I know that if I was drunk on the streets, the police could or would enforce the drunk and disorderly law and lock me up to protect me from myself. So the only rewards a searcher personally needs is a life commitment, and the children ultimately gain from the efforts and the lack of fear that this might be the last time they see their loved ones because of overdose.

I do not know if the program will solve the problem for everyone, but somebody who has made it would be the best motivation for success. Also, the courts could use this type of program as an alternative to jail for minor offenders. But I think the most success would come from volunteers ready to live again. There are many aspects that could be questioned, and probably will. I use this gradual approach, with a suitable direction, as I do not know all the answers. The trial and error solution, with a bit of recent development, might just make a workable program, combined with methadone. at the end of the day, to limit the possibilities of falling again. There is a hope; we just have to learn how to build on it. Thank you.

Mr Stubbs—I would like to thank you for the opportunity to address this public hearing on substance abuse. The Ted Noffs Foundation was founded over 30 years ago in order to assist adolescents who experience substance abuse problems, and their families. We do this in several different ways. The first way is the PALM program, the program of adolescent life management, which is a three-month residential program. We have places situated in Randwick, Parramatta and Canberra, and we are also setting up a facility in Dubbo. We also have a number of out-client programs, which are situated in Randwick, the Nepean area and St Marys. These provide individual and family counselling and also group work. We also have a schools program set up at Randwick in order to give appropriate alternatives to young people experiencing drug and alcohol problems as opposed to suspending them.

It is hard, I suppose, to sum up the 30 years of experience that the foundation has had in all of two or three minutes, so I suppose what I am hoping to do today is to say that I would like you to take away two things from the foundation's experience. The first one is: substance abuse is a complex issue. I think we have heard that again and again today already. Substance abuse has many causes and consequences, and sometimes these are one and the same thing. Such things as homelessness, social isolation, low socioeconomic status, high levels of stress and poor quality family relationships can be consequences of substance abuse—but they can also be causes of it. In order to have an appropriate response to substance abuse, then, our treatments need to be quite comprehensive and they need to be holistic. Interventions that are just aimed at telling young people to say no have been proven to be ineffective. Programs such as the PALM program, which teach life management not drug management, believe that education in such things as conflict resolution and relationship building is just as important as teaching young people how to cope with cravings and how to deal with relapse prevention.

The other message I would like you to take with you today is: when you are looking at funding programs, I would ask you to be looking at funding programs that are able to prove their effectiveness. That has already been spoken about today and I think that's great. A lot of programs have fairly anecdotal evidence of one young person doing really well after leaving the program. To me that is not evidence that the program is actually working. We need to be setting up programs that can actually prove lower rates of recidivism. We need to be setting up programs that can show less social isolation in young people and less drug and alcohol use. If we are funding programs that do not show effectiveness, then we are not only wasting time and money but I believe we are also wasting the lives of the young people that we're working with. Thank you.

Mr Thomas—I am a member of Family Drug Support, but my submission today is an independent one and not connected with the work of Family Drug Support. This submission addresses the problems of reducing smoking in the community. Governments have addressed this problem over a number of years, although the problems associated with smoking have been well known for many years. The response of governments to it has been in a manner which can only be described as 'glacial slowness'. It is assumed that it is a given that tobacco smoking is harmful and that government's responsibilities are to use the most cost-effective methods to reduce smoking in the community.

I refer to submissions from the AMA, No. 133; the Commonwealth Department of Health and Aged Care, No. 145; and the National Heart Foundation, No. 177. In Australia, tobacco causes over 18,000 deaths per year and is responsible for 82 per cent of all deaths caused by drugs. Most tobacco smokers acquire the habit whilst in their teenage years. Every year in Australia 70,000 teenagers take up smoking. It would seem logical therefore to direct efforts before they commence smoking.

I refer to page 8, priority No. 9 of the National Heart Foundation's submissions—that is, No. 177—on the move to generic packaging. Commencing smoking is in part a rebellious statement by young teenagers who copy their heroes, their older sisters and brothers and their peers by smoking, and they smoke the same brands. My proposal is that governments enact registration that forbids tobacco companies from displaying a brand or company name or logo on their packs. Tobacco companies would only be able to display an index and a packaging number on their packs. Not their brand or trademark.

The fashion element in smoking would be eliminated. Fashion looms large in the minds of many young people. The index number would be changed every six months to a fresh number randomly selected. Tobacco companies would not be permitted to divulge index numbers to the public. The huge investment which tobacco companies have in brands would be wiped out. It would be a big signal to them that they and their products are not welcome in this country. That concludes my submission.

Mr Walsh—I am a clinical hypnotherapist and I am also a retired police sergeant of 32 years service. Presently I am a board member of Youth Insearch and have been an adult leader and support person for about 14 years. As a clinical hypnotherapist I have assisted clients with substance abuse, in particular heroin, indian hemp, cigarettes and alcohol to become drug free. I use an advanced private subconscious mind healing, or PSH model, with integrated therapies for the clients to achieve their goal of being drug free.

An assessment session with up to six hypnotherapy sessions may be required. Initially, three sessions would be conducted within the first month. Three additional sessions may be required within the next 12 months. A diary is also issued to the client at the outset as a reference to the progress being made. At the second session, a mentor would be introduced to the client and I would act as the back-up mentor. The client will contact the mentor on a weekly basis or as needs require. More or less frequent contact would be agreed upon by the client and the mentor. Ideally, four weekend forums would be conducted with up to 50 participants attending each weekend. Discussion would include communication, self-esteem, trust, family hassles, drug and alcohol hassles, grief, and sexual abuse hassles. Also included are goal setting and employment obstacles and opportunities. A family member or a friend would be invited to attend one weekend forum to see first hand the progress being made by their relative or friend.

Young people, 14 to 18 and sometimes up to 20, would be referred to the Youth Insearch Foundation for their weekend forums as that program would be similar in content and would be a most appropriate association to deal with the young person's issues. The success of the therapy is dependant on the client's commitment to their own emotional healing, accepting responsibility for their healing and realising that this is a lifetime commitment. During the therapy rehabilitation, assertiveness training and ego strengthening would be given.

My 32 years in the police service, combined with my 14 years with Youth Insearch, listening to young people with substance abuse, has convinced me that PSH hypnotherapy is an ideal method for releasing those negative emotions that may have lead those people to drugs in the first instance.

Mr Williamson—I am a member of the Woolooware branch of the Liberal Party, coming from the country that established the art of world trade. I was employed on the waterfront all my life and have never been troubled by the excessive use of any substance. I would claim this to be the result of a good home life and the opportunity of a good education. Prevention is better that cure. The virtues of a good home life and the opportunity to attain a good education need money to nourish them. We will know such secret has been discovered when our government emphasises working together in our workplace practices. Please develop communication at every level. Thank you.

Mr Wilson—I hope it is an enlivening note to know that I have no qualifications whatsoever in this field. I have little personal knowledge of the drug problem, but I am a concerned citizen. I am a grandfather and a father. I gave up smoking 35 years ago. I have never knowingly taken prohibited drugs, nor do I know any person closely who has, but I will confess that I normally have a drink before dinner and a glass of wine with my dinner—and tonight I am going to have a double scotch.

I have admitted that I am inexperienced in this field and I have learnt an awful lot today. I think Tony just left but his group really impressed me. I considered changing my notes but I have decided not to because, even if they are controversial and even if they do hurt some people a little, I hope they will accept them as the sincere thoughts of a person who is deeply concerned about our drug problem and wants to help improve it.

When I received the invitation to make a submission to this committee I had already written to Mr Howard, Mr Carr and several other people expressing my views. They had replied and

none disagreed strongly with what I had to say. So all I had to do to submit to this committee was to run off another copy of that. However, I was asked by the committee to address certain items, which I will read here. In terms of family relationships, the effect is destructive. Crime and violence are appalling and making law enforcement difficult and hazardous. Road trauma is frightening and horrifying—and totally unfair to sensible law abiding citizens. In terms of workplace safety and productivity, it is grossly unfair to employers and fellow workers. The health care costs are enormous and are paid for by the taxes of non-problem families. I hope you have got a slight sense of humour when I say that I believe blind Freddy could tell you that. I believe that it is not necessary to go into these great details of the effects of the drugs. We know it is bad. Let's get on with the problem of stopping it. I believe that, rather than spending money on this sort of thing, we should be spending it on educating and disciplining our society to prevent vulnerable citizens from ever falling victims to the drug scourge.

The policeman here this morning mentioned war. No-one wants a war, but I would like to point out—and I have in my letters—that wars were won by very strong-minded people who were prepared to make difficult decisions; for example, to sacrifice part of their line-up here so that the main force could get in and win the battle. I think we might have to take some tough steps and sacrifice some things. I am sick of this business of watching television at night and seeing them showing you how to mix it up in the spoon and inject it. Why is television giving us a description of how to take drugs? I would much rather see an intensive advertising campaign which should go as far as having programs on the television each night showing the degradation and the terrible situation of people who have become addicted to drugs and are no longer able to find their drugs. I believe that this is a terrible situation. This is what should be shown and young people should be told that, if they go on drugs, that is what will happen. I believe that all Mr Howard's and everyone's efforts to solve the situation by, for example, free needles methadone treatments, act as an incentive to people who are not on drugs. If you go on drugs you'll be looked after—you'll get free needles, you get methadone; let's give it a go. I believe our educational programs should say that from now on those benefits will not be available to anyone who refuses this advice and takes up drugs. We have got to be a bit tougher about it.

Someone said to me earlier that I should not put up these proposals unless I can prove them. I will draw a quick analogy. When I had my secondary education, they insisted that we look at colour photographs of people whose genitals had been deformed by syphilis. That frightened the living daylights out of me and it's about time we started frightening the living daylights out of some of our young people. Thank you.

Mr Griffiths—My submission addresses the increasing use of drugs as a weapon in sexual assault and is made on behalf of the Eastern and Central Sexual Assault Service, ECSAS, which is based at the Royal Prince Alfred Hospital in Sydney. This is the busiest adult sexual assault service in New South Wales. Services are provided to both female and male survivors of sexual assault within the inner west and eastern suburbs of Sydney as well as the Sydney central business district. Early in 1998 the staff of ECSAS noted increasing numbers of people presenting to the service in crisis claiming that they had been drugged prior to being sexually assaulted. As the drug effects often include amnesia, some victims had little or no memory of the actual assault.

Statistics from ECSAS have been collated and confirm an emerging trend of drugs being used as a weapon in sexual assault. During 1999, 17 per cent of the people presenting to ECSAS following an assault, reported that they had been drugged as part of that assault. In 2000 the figure had increased to 21.4 per cent. Staff researched the issue and found that this trend had been noted in the US, where date rape drugs were being discussed in the media and programs aimed at safe dating were being run in some colleges and universities. The drugs that had been implicated both in the US and Australia include the benzodiazepine Flunitrazepam, also known a Rohypnol or roies, as well as the illicit drugs ketamine, or special K, and gammahydroxybutyrate or GBH. In the majority of cases alcohol had also been used.

Further investigation found that some other sexual assault services in Australia, particularly those in tourist areas, had also noted the increase in these presentations and an information program on the issue had already been run in northern Queensland. However, although some other sexual assault services and police officers where aware of and concerned by the anecdotal evidence about the issue, there was little reliable information available in Australia about this emerging trend. In July 2000 the service decided to address this lack of information by conducting a seminar on the provision of services to people who have been victims of this crime. The seminar addressed the counselling issues of the victims, the clinical detection of the drugs that are being used and the difficult legal issues around the investigation and prosecution of these crimes. Over 100 people, including health workers and police officers, attended the seminar.

During 2000 we also produced a pamphlet to provide information for people who had recently been drugged and sexually assaulted. This pamphlet has been well received and 4,000 copies have already been distributed, mostly within New South Wales. Australia enjoys wide international respect for pioneering the harm minimisation model in the alcohol and other drug field. However, apart from some sexual assault services, there is as yet little recognition of the increasing incidence of this drug related harm. For instance, the Alcohol and Other Drugs Council of Australia's strategic document, *Drug Policy 2000*, does not address the issue, even though physical violence and drug property crime is mentioned.

The use of drugs in sexual assault is an increasing trend and needs to be acknowledged as a significant drug related harm affecting our community. The issue needs to be addressed through a coordinated response across sectors including health, the alcohol and other drug field, and within the law in both policing and the courts.

Dr Crane—I am a general surgeon with an interest in substance abuse. The standing committee's leaflet asks: how are we handling drug abuse? My answer is appallingly. On average, two young Australians die each day from accidental heroin overdose. They die suddenly, often with the needle still in a vein, and usually in some filthy, squalid back alley or public toilet. The Prime Minister displayed great leadership with his stand on firearm legislation. Unfortunately he has displayed political cowardice in his decision to abort the proposed Canberra heroin supply trial. All other initiatives at present in use are having no beneficial effect at all in reducing the deaths from heroin. Mr Howard seems incapable of grasping the most fundamental fact that a trial is just that. Perhaps he might be helped by thinking of the word being spelt 'tryal'. If a trial is unsuccessful, it is stopped; if it is showing good results, it is extended, according to the most fundamental scientific principles. To refuse to try new initiatives for a solution to a serious problem not responding to other long-term ideas is

to display a poverty of intellect of the worse type. The Minister for Health and Aged Care was in favour of a heroin trial and, being medically qualified, would have known of the results of the Swiss heroin trial. The results of the trial are magnificent, with the participants not dying from overdose, not committing crime to support their habits and being able to maintain employment. Some addicts are also managing to respond to the coexisting counselling program and are able to defeat their addiction. What more could we want from such a trial? Perhaps the Prime Minister could appraise himself of the results of the Swiss heroin trial by visiting the web site: www.lindesmith.org. I would like to encourage the members of this committee to do likewise.

Alcohol probably causes more misery in Australia than all other drugs collectively, especially within Aboriginal communities which are disproportionably affected by alcohol abuse. It is appalling that members of Aboriginal communities known to be at risk are given money for their social security benefits in the sure knowledge that it will be spent on alcohol which will further degrade their personal and family circumstances, leaving them with no chance of regaining self-esteem, with the coexisting problem of domestic violence. The worse consequence is that the children of these families have no appropriate role models and will be most likely to have little or no significant schooling. Therefore the cycle of Aboriginal disadvantage and hopelessness will continue. I suggest that not only Aboriginal but all recipients of unemployment benefits be given these in the form of vouchers for food, clothing and accommodation.

As a doctor, I see so many young people on benefits throwing their money away on alcohol and tobacco, hardly what I or any taxpayer would consider is an appropriate or healthy way for our taxes to be allocated. This voucher suggestion is no more discriminatory than giving welfare recipients health care cards and travel concession passes, both of which are eagerly sought by welfare recipients and of course immediately identify the holders as in need of special help. I could probably talk about these matters for about three hours but I thank the committee for at least giving me three minutes.

CHAIR—Thank you very much. Dr Faux.

Dr Faux—Thank you very much. I represent the Australian Faculty of Rehabilitation Medicine. We are a group of consultant physicians who are responsible for the care and rehabilitation of those suffering from disabilities brought on by trauma or illness associated with drug and alcohol consumption. The Australian Faculty of Rehabilitation Medicine is part of the Royal Australian College of Physicians.

Our submission, which we have already supplied to the committee, is based on the health care costs of the newly disabled. Our submission indicates that in New South Wales at least 600 people per year suffer from moderate to severe head injuries, 60 per cent of which are associated with harmful levels of alcohol consumption. The average length of hospital stay of these patients is 50 days and the cost of their in-patient admission is between $16,000 and $38,000. The on-cost to the community of caring for somebody with a severe head injury can be up to $72,800 per year and, with a normal life expectancy, that can be expected to be $5.8 million for women and $5.5 million for men. For those who suffer spinal cord injury—more than 280 per year—almost 25 per cent are associated with the harmful use of drugs or alcohol and road trauma. The average length of stay of a spinal injury is 4.5 months and the overall cost during hospital admission is $150,000. The on-costs to the community are up to $150,000 per

year and, with a life expectancy of 85 per cent of normal, this is $10.5 million per spinal cord injured male. There are indirect costs also due to the loss of productivity and of course there are the human costs affecting families.

There are other disabilities brought on by the effects of drugs and alcohol, associated violence or overdose. These are not only seen in regular users, as you have heard today, but also as the tragic outcome of a big night out. They include brain damage from lack of oxygen, crushed limbs from prolonged lying and amputation brought on by acts of violence. To illustrate this I have two specific cases that have been presented to the rehabilitation department at St Vincent's Hospital in Sydney. A young country carpenter, having kicked a heroin habit many years ago, came to Sydney for a big weekend. He overdosed and lay on his left side in a hotel room for 30 hours. When he was finally found he was unable to move his arm or leg. Operations returned the blood supply to these limbs but the nerves were permanently damaged. For 12 months he was in and out of rehabilitation departments and lived in men's hostels so that he could be close to rehabilitation services. He is now preparing to retrain in another occupation and has to wear permanent splints; his hand will never be functional. A young accountant attended a dance party for a big night out, became intoxicated and abusive and was extricated by bouncers and attacked. He has so severely damaged his right knee it will likely be amputated in the next six to eight weeks.

The Faculty of Rehabilitation Medicine suggests that the committee considers the fact that many intoxicated young people injured as drivers in motor vehicle accidents are not covered by any third-party insurer or comprehensive car insurer, which means that the community bears the cost of their rehabilitation and other people who suffer injuries not associated with drug and alcohol miss out on resources. It is our recommendation that a proportion of money raised federally from taxes on alcohol be diverted to assist in the long-term care of the disabled in the community, particularly for services such as home care, home nursing and equipment supply. Harm minimisation approaches also need supports such as safe injecting rooms and the development of services that assist users to identify drugs that they may be contemplating taking. The regulation of security services such as dance party bouncers may prevent further drug induced violence, particularly if this group of security officers can be taught non-violent methods of defusing anger and aggression.

Finally, it is our contention that those disabled through the use of drugs and alcohol may provide a resource for the education of young men who essentially are the largest group affected by brain injury and spinal cord injury. These people could be utilised in health promotion initiatives and drug rehabilitation programs such as the New South Wales traffic offenders program. I thank you very much for your time.

Ms ELLIS—Were those figures Australian or New South Wales?

Dr Faux—They are New South Wales figures. They have been prepared by me and a colleague.

Ms ELLIS—I just wanted to get that on the record. Thank you.

Dr Faux—I have actually furnished a full account.

Ms ELLIS—In the submission?

Dr Faux—Yes.

Ms ELLIS—Thank you.

CHAIR—Thank you very much everybody. That has been very useful to us. I hope it gave you an opportunity to present your views to us. I thank you very much for the decorous way in which you did it.

Resolved (on motion by **Ms Ellis**, seconded by **Dr Washer**):

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

Committee adjourned at 5.40 p.m.