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Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Substance abuse in Australian communities

WEDNESDAY, 2 MAY 2001

B R I S B A N E

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Wednesday, 2 May 2001

Members: Mr Wakelin *(Chair)*, Mr Andrews, Ms J. 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, Mrs Irwin, Mr Quick and Mr Wakelin

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.

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Committee met at 8.32 a.m.

GRAYSON, Inspector Felix, Officer in Charge, Drug and Alcohol Coordination Unit, Operations Support Command, Queensland Police Service

LAMBKIN, Dr Kevin, Acting Manager, Alcohol, Tobacco and Other Drug Services Unit, Public Health Services Branch, Queensland Health

WATSON, Mr Douglas John, Acting Director, Social Policy, Policy Division, Department of the Premier and Cabinet

CHAIR—Welcome to our seventh public hearing into substance abuse in Australian communities. Minister Wooldridge referred the references to us in March last year and our terms of reference include: family relationships; crime; violence, including domestic violence; law enforcement; road trauma; workplace safety and productivity; and health care costs. Yesterday we visited many areas around Brisbane and talked to a number of service providers to try and get a feel for some of the issues of substance abuse in Queensland. This morning, starting with representatives of the Queensland government, with a number of other agencies to follow, we will put on the public record what some of those issues around substance abuse are. We do not swear in witnesses, but I need to point out that the proceedings today are legal proceedings of the parliament and as such warrant the same regard as the proceedings of the House of Representatives. Do you have anything to add to the capacity in which you are appearing?

Mr Watson—I am also chair of the Queensland government Drug Coordination Committee.

CHAIR—Would you like to make opening statements?

Mr Watson—Yes. We were not able, because of the timing of various things, to provide you with a submission. So we would like to make some initial comments and then open up for questions if that is okay.

CHAIR—Thank you, we would appreciate that. We have taken some materials off the Internet about the general Queensland position and we have had a glance at those.

Mr Watson—We have brought some materials with us, which we will distribute now. First of all, there is *Beyond a quick fix: Queensland drug strategic framework 1999/2000 to 2003/2004*, which is the document containing our overarching strategy. Supporting that we have *Towards a smoke-free future: Queensland tobacco action plan 2000/2001 to 2003/2004*, a tobacco action plan, which is the red document. Felix has also prepared an opening statement from the Queensland Police Service, which we will give you and then Felix can talk to it.

CHAIR—Thank you.

Mr Watson—From the point of view of the Queensland government, there are probably two essential challenges in developing government responses: firstly, the scale, complexity and prevalence of the issues involved; and, secondly, the development and delivery of appropriate

and coordinated policy responses. I particularly want to look at the issue of coordination because I think it is a very important one.

While we will mainly talk about the policy, I want to give the committee a bit of an overview, which is drawn from *Beyond a quick fix*, as to what we see the scale of the problem to be. *Beyond a quick fix*, which was published in 1999, identified that more than 85 per cent of Queenslanders aged 14 and over have used drugs of some kind in the last 12 months. For most, the chosen drugs are alcohol and tobacco. Tobacco use is the leading cause of drug related deaths in Queensland. While there have been significant reductions in tobacco smoking for men, there appear to be growing levels of use among young people and women. About 80 per cent of Queenslanders drink alcohol, with perhaps 40 per cent of these drinking hazardous or harmful quantities. In recent years there has been an increase in the use of most types of illicit drugs. However, levels of use are still less than for licit drugs. About 62 per cent of indigenous people drink alcohol, which is somewhat lower than the figure for the general population. However, about four-fifths of these usually drink in a hazardous or harmful manner.

Tobacco use is more prevalent among the indigenous population than among the general population. Respectively, 47 and 25 per cent describe themselves as regular smokers. The major causes of death among indigenous people are closely linked with smoking and/or alcohol abuse. Cannabis and inhalants use is more widespread among the indigenous population.

The use of drugs has many direct and indirect effects. It has been estimated that 4,000 people die in Queensland each year from drug related causes. Of these, tobacco accounts for 81 per cent, alcohol for 17 per cent and illicit drugs for two per cent. Queensland hospital data indicates that there are over 50,000 drug related hospital episodes each year—54 per cent from tobacco, 41 per cent from alcohol and five per cent from illicit drugs.

There appears to be a high interrelationship between the consumption of alcohol and police-attended incidents. More than one-third of incidents occurring in the Brisbane inner city area are estimated to be alcohol related. Alcohol is linked with a large proportion of serious road accidents. In 1996-97, for example, alcohol was detected in 40 per cent of fatalities, with 61 per cent of fatalities involving drugs of some kind. It has been estimated that about 70 per cent of all crime and 80 per cent of property crime are drug related.

Clearly, the direct costs to government are significant. Drug related crime and health issues absorb a significant proportion of the budgets of Queensland Health, the Queensland Police Service and the Department of Corrective Services. There are significant impacts on many other government agencies. *Beyond a quick fix* estimates that, on a population basis, the cost to Queensland could reach $3.5 billion annually.

In 1999, the Queensland government published *Beyond a quick fix: Queensland drug strategic framework 1999/2000 to 2003/2004*. This identified a number of issues and areas for action. It proposed some principles to guide how Queensland would address drug issues. They are: a whole of government approach, to deliver comprehensive, integrated responses; a focus on harm minimisation, as it provides the most holistic and balanced policy framework; a concern with drug law enforcement, to control the supply of legal and illicit drugs; community involvement, to enhance the sustainability and relevance of responses to harmful drug use; social justice principles, to ensure there is equity of access to measures which reduce drug

related harm; prevention and early intervention, to support the principle of harm minimisation; and evidence based approaches, based on sound research and evaluation.

For the government, there is a particular issue of coordination. We would argue that there are three dimensions to that aspect of coordination. Firstly, there is coordination with the Commonwealth. *Beyond a quick fix* is explicitly aligned with the Commonwealth's National Drug Strategic Framework. Queensland has already developed and implemented a tobacco action plan that is aligned with the Commonwealth's action plan in that area. Queensland is currently awaiting the release of the Commonwealth's action plans on alcohol and illicit drugs before developing and implementing its own action plans in these areas.

Recently, the Prime Minister and the Queensland Premier launched the Queensland Illicit Drug Diversion Initiative—another example of cooperation. At the local level, officers of the Queensland government work closely with Commonwealth officials, in particular in relation to drug diversion. We believe that the approach that we adopt with the Commonwealth should be as seamless as possible so that we get a comprehensive approach.

Secondly, *Beyond a quick fix* establishes a framework for coordination across Queensland government agencies. The strategy established the Queensland Drug Coordinating Committee—QDCC—which is chaired by the Department of the Premier and Cabinet and involves officers from a number of other agencies. Its responsibility is for policy development, but it also provides a forum for policy coordination between agencies. Policy options developed by QDCC are considered by CEO forums prior to going to cabinet. QDCC has the capacity to establish special purpose working groups. At present, there are three such groups: a Queensland Illicit Drug Diversion Initiative steering committee; a drug courts steering committee, and a youth alcohol and drugs action steering committee. QDCC, in addition, is responsible for monitoring and evaluation, including the provision of an annual monitoring report to cabinet.

Thirdly, there is a need for coordination with non-government bodies and local communities. Government has to work in partnerships to achieve effective policy outcomes. *Beyond a quick fix* mandates that there be two community forums held annually. Of these forums, one is to be held in Brisbane and one in North Queensland. These forums are intended to allow consultation on aspects of alcohol, tobacco and illicit drug policy. The QIDDI steering committee is currently considering a proposal for research into ways in which communication and coordination with the non-government sector can be improved. There is also a need to build capacity at the community level. Crime prevention and community renewal projects are informed by this approach, as is the groundbreaking Cape York Partnerships with indigenous communities. Cape York Partnerships is intended to empower indigenous communities to democratically determine directions for their communities through negotiation tables which inform the delivery and mix of services. Substance abuse, particularly of alcohol, is a key issue receiving consideration at this time.

These are primarily structural approaches. However, they are informed by an integrating conceptual framework of harm minimisation. Harm minimisation involves a wide range of approaches that balance demand reduction, supply reduction and harm reduction. As such, it integrates prevention, education and early intervention approaches with drug law enforcement and treatment approaches.

The Queensland government recognises that there are no simple answers to substance abuse. Caution about 'magic bullet' solutions is combined with a commitment to evidence-based approaches. For example, the government will undertake evaluations of drug courts, which are now being trialed in south-east Queensland, and of the illicit drug diversion initiative to determine how effective they are and the extent to which they should be extended or how they could be changed over time. These evaluations will contribute to the further development of policy options.

That is an overview of the government's approach.

Dr Lambkin—I refer members to the little handout that I gave them. I would like to follow Doug's overview with a perspective on the strategic view within Health and give you an insight into our thinking in addressing drug issues. I have made some copies of some presentations that I have done, and I will work my way through them slowly.

The first page just sets the scene. Doug has already mentioned some statistics on substance use in Queensland. The point of that is to emphasise that, notwithstanding the focus on illicit drugs, certainly most health harms result from tobacco and alcohol. There are some percentages about the number of people in Queensland who die each year: there are 84,000 drug-related causes, 81 per cent of which are related to tobacco, 17 per cent to alcohol, and two per cent to illicit drugs. Queensland hospital data indicate that, on average, there are over 50,000 drug-related hospital episodes per year: 54 per cent of those are attributable to tobacco, 41 per cent to alcohol, and five per cent to illicit drugs.

I am really taking a health perspective, but I would like to pick up some of the points that Doug made: drug use causes other major harms to society, families and our economic fabric. I am focusing a little on the health costs. Indeed, a lot of those other harms are caused by illicit substances.

Picking up on the coordination issue, Queensland Health strongly believes that there is a very effective cross-jurisdictional approach to drugs at the national level. We have the *National drug strategic framework 1998/99-2002/03*, a best practice document which has been endorsed by all jurisdictions. Both the Queensland government and Queensland Health take that quite seriously. Our way of thinking about and looking at drugs builds on the principles and approaches in this document.

The second page of my submission refers to the *National drug strategic framework 1998/99-2002/03* which is endorsed by the Commonwealth and all states and territories. It is based on the principle of harm minimisation and, importantly, it requires the development of action plans for the three major substances. Doug mentioned *Beyond a quick fix: Queensland drug strategic framework 1999/2000-2003/04*. As he said, it is consistent and it requires the development of Queensland action plans. I have distributed the Queensland Tobacco Action Plan which is the first cab off the rank in that area.

My submission refers to a trilogy of approaches and strategies to deal with substances. We take that fairly literally. There is some debate about harm minimisation, harm reduction and so on, but the national framework basically states that that is the way we should look at it and that is the way we do look at things in Queensland Health in determining how we move in this area.

I will skip the harm minimisation approach as I am sure you are aware of it. Within Queensland Health, we try to consider substances a little differently in terms of the illicits as opposed to alcohol as opposed to tobacco. There are some key determinants in how one addresses those substances. There are critical differences. I have chosen illicits as an example. On the page headed, *Illicit drugs: rationale for focus*, at the first dot point the submission states that our responses are shaped by the fact that they are illicit, but we also need to address the use of legal and prescribed drugs which are used illicitly in a harmful fashion. In relation to the other focus I mentioned earlier, health-related harms are only one area and may not be the predominant focus; crime and social costs are also critical. This is an important determinant because it contrasts illicits with tobacco and alcohol. We take the view that all illicit drug use is potentially harmful in respect of the nature of the substance, the method of its administration and its unknown quality and make up. There are three important shaping factors in how we address policy issues in respect of illicit drugs which, in a couple of areas, differ substantially from alcohol and tobacco and make our approaches slightly different.

The next page of the submission is important for us. It contains Queensland Health's famous triangle which describes the whole population. Using illicit drug use as an example, it says that the population is made up of a range of subgroups. The major part or proximal part of the triangle are people who do not use, and they range obviously from very young children through to older people. As we go down the triangle, and as numbers decrease, we move into experimental users, occasional users, regular users and then addicted or dependent users. There is a little arrow at the bottom which indicates how behaviour changes as one moves down the triangle and things become a lot more chaotic and compulsive.

For us, the strength of that presentation is that it reminds us continually—and this is something I stress in all the forums I go to—that the way we look at this problem is not just from the sharp end; we must be thinking of doing things across the whole triangle, right from the very early age of non-users through to people who have serious problems down the pointy end, so to speak. I like to emphasise that continually because it reminds us that our business is not just at the sharp end; it has to be at the proximal end of the community.

In accord with the national strategic framework, our approach in Health is based on that trilogy of approaches. For illicit drugs, there is a range of supply reduction strategies, a lot of which are undertaken by the police. The first dot point refers to legislative controls on supply with criminal sanctions for the possession or manufacture of the substance. The next component is the inculcation and education about those controls to let people know that these things are illicit in that way. Monitoring and law enforcement, which are police activities, are also important. Queensland Health has an important role in monitoring the use of prescription substances which are often misused.

The next part of the trilogy for illicit drugs is demand reduction strategies; and, again, in Queensland Health we like to look at this in three major categories. The first one is really coming to the fore now—and that is a very healthy development—and that is building those protective factors and addressing risk factors for illicit drug use. This has really come to the fore in recent years in the literature and in the debate about drugs, and it emphasises that a lot of the fundamental things we have to do with people are done at a very early age and, if those things are done well from a family, school and society infrastructure way, we build factors in people such that they indeed do not have problems with drugs in their teens and later in life.

It is a healthy development, I think, that that has really entered the debate quite strongly now. There have been a lot of very impressive longitudinal studies which have shown that high quality interventions very early in a child's upbringing can have substantial effects with respect to their behaviour later in life. Indeed, that is something that Queensland Health particularly is beginning to focus much more on, in recent months and years. We have a range of programs which are pertinent there. I will not go into the details of those; I am happy to take questions on them later.

The second two issues in reducing the demand for illicit drugs particularly—I am using that just as an example—are firstly influencing the decision to start using drugs; really at that point of commencement. Hopefully we have got our protective factors right, so that that is not such an issue; but if indeed it is an issue we have a range of approaches there: best practice school drug education, and a range of community education and peer and family support programs. Finally in demand reduction is the strategy of influencing and supporting the decision to reduce or cease illicit drugs. Again, this is done at population level, through school drug education and a range of strategies, such as mass media and community education. Of course, the issue that is most prominent in the debate is individual interventions, and these are really the core of treatment services: parent education, support programs, and drug diversion initiatives that allow us to access people and give them opportunities to access treatment. The last page has a list of those risk and protective factors, and I think I have mentioned those already. The literature really describes them quite clearly: factors to do with the child, the family, the school, major life events, and community and cultural factors.

Lastly, with respect to illicit drugs, are the more controversial harm reduction strategies, and these come in two categories. Firstly, there is influencing and/or supporting the decision to use illicit drugs in a less harmful manner—and needle and syringe programs are the most controversial example, I suppose. Again, peer and family support programs have a role in this, as well as education and information about less harmful use.

In the thinking we have done in Health, we have reconceptionalised a little bit, and the next category of harm reduction is really that immediate reduction of harms associated with illicit drugs. It is interesting to raise in the debate that work in crisis, A and E departments, ambulance services et cetera are indeed harm reduction strategies. They do not indeed make any moral judgment about people's use or whether they should or should not use them—as they should in the best way society should function. We simply respond to those harms when they occur and respond in the best possible way.

I have tried to give some idea of our thinking within Queensland Health across that spectrum, and I would like to emphasise two things. Firstly, the triangle diagram in the material provided is a constant reminder to us to get as much as possible down to the other end of the triangle and try to look at factors which can be brought to bear across the whole population; and, secondly, there is the relatively new area of factors in early life. There are some very good examples in Queensland Health of congruence happening now with respect to programs in primary school. It has found that across mental health, drugs or a whole range of other factors for kids, the kinds of things we can do with young kids are identical: we really do not need specific drug programs, we do not need specific needs programs, but we need a good set of interventions about support, about family, about resilience, about self-view; and they are the things that build the factors in people so that later in life they have got those skills to deal with the situations as they arise.

CHAIR—Thank you very much.

Insp. Grayson—I would also like to table two documents, prior to giving my opening statement. One is the police department annual report for 1999-2000 and the other is its accompanying statistical review, which may be able to provide some useful statistics with respect to substance abuse and associated problems. The document that I have prepared to present this morning will initially outline what the Queensland Police Service strategy is doing to address substance abuse. It will outline a very strong commitment on behalf of the Queensland Police Service to the principle of harm minimisation of which we have heard a number of times this morning. I will just work my way through that document and make some further explanation as we go.

The Queensland Police Service develops its policies and programs to address substance abuse in line with the National Drug Strategic Framework and within legislative requirements. The QPS is a signatory to, and strong supporter of, the National Drug Strategy, both at national and state levels through its participation in the Ministerial Council on Drug Strategy, the Intergovernmental Committee on Drugs and the Queensland Drug Coordinating Committee.

The service supports the underlying philosophy of the National Drug Strategy, harm minimisation. I will not go into that any further. We have spoken about that already. The service recognises the need to develop strategic alliances with government and non-government sectors in addressing the harms caused by drugs, both licit and illicit, including alcohol and tobacco.

Within the Queensland Police Service, the responsibility for minimising drug related harm rests principally with the Drug and Alcohol Coordination (DAC) unit within Operations Support Command and the State Drug Investigative Group (SDIG) within State Crime Operations Command. The State Drug Investigative Group obviously has the supply reduction role and the Drug and Alcohol Coordination is looking at the policy and overall direction the service is taking and some of the projects.

Drug and Alcohol Coordination, established in 1993 with funds from the National Drug Strategy, develops and coordinates strategies and initiatives dealing with drug and alcohol law enforcement issues in Queensland. It operates in five main areas, such as the development and management of drug and alcohol projects, of which we have 22 statewide at the current time. We provide administrative support to the National Drug Strategy Queensland Law Enforcement Fund.

We are somewhat unusual throughout Australia, in that Queensland is one of the few jurisdictions that has been able to maintain the 10 per cent of the health budget with respect to policing and addressing the drug and alcohol problem. I think that reflects, in some way, the success that we have seen in the past years and also the close working relationship that we have with Queensland Health.

We also provide advice to officers of the Queensland Police Service, the minister and external agencies regarding law enforcement drug and alcohol issues. We represent the service at national and state drug and alcohol forums and we coordinate policy development and training for police involvement in community drug education.

Drug and Alcohol Coordination receives funding from the National Drug Strategy, which I have already mentioned. We distribute those funds, after running our own unit, through the National Drug Law Enforcement Funding Committee, which is chaired by the Assistant Commissioner, Operations Support Command and has representatives from Queensland Health.

Another key task of Drug and Alcohol Coordination is to develop a drug and alcohol prevention strategy. This strategy informs the policy and practice of DAC and impacts on drug and alcohol programs and projects statewide. We have a draft prevention strategy, which I can also provide to the committee this morning. Much of what is included in that draft document has been factored into the presentation that I am providing this morning.

Queensland Police Service prevention initiatives cover the harms associated with both licit and illicit drugs. A high proportion of police work is aimed at addressing alcohol related harm, such as drink driving, domestic violence, assaults and public disturbances. Illicits, particularly cannabis, are addressed by a number of initiatives, with other substances, such as steroids, pharmaceuticals and tobacco, also included in the overall efforts of the Queensland Police Service.

Queensland Police Service drug and alcohol initiatives occur in a variety of settings, including public spaces, roads, homes, schools, communities and workplaces, and in urban, rural and remote areas. The Queensland Police Service conducts the programs in support of the national drug strategic framework. I have listed them in the demand and harm reduction areas, because some projects cover both arms of the philosophy, and I will address supply reduction later.

Towards increasing the community's understanding of drug related harm, we have the Police in Schools Program. We currently have 18 police officers situated in schools throughout Queensland. They have multiple roles within the school community. One of their roles is to contribute to alcohol and other drug education, by providing information on the legal consequences of alcohol and other drug use. These officers also participate in the day-to-day management of drug related issues that arise at the school, including situations in which students commit drug related offences.

We have developed a community drug education package—the Drug and Alcohol Community Education Resource—to make sure that the police have available current information on drug related matters so that they can provide information at a standard satisfactory level to members of the community. We train our police throughout the state in the delivery of that information, and it is available on our Intranet.

We have a number of youth-centred activities—for example, Schoolies Week activities. The Queensland Police Service has a long history of working collaboratively with other government departments and non-government organisations to address problems associated with Schoolies Week. This support includes financial support, expertise in planning, and personnel to ensure a safe event. There are a number of competitions. Other specific initiatives for young people include school based activities such as video and film-making and public-speaking competitions in which the students research and present on drug and alcohol issues. A number of drug and alcohol prevention initiatives are also conducted through the police citizens youth clubs, such as

drug and alcohol-free dances, sport competitions, dance and drama workshops, concerts, musicals, and, recently, a young women's safety project.

We have the Springfield Camira Project, which is part of the peer counselling, mentoring programs and leadership courses, and camps are sometimes undertaken throughout regions across Queensland. An example of one of the national drug strategy funded multi-strategy initiatives is the Springfield Camira Project in two adjoining suburbs of Brisbane, which brings together stakeholders to address the needs of at-risk youth, through the provision of drug and alcohol-free events, leadership camps, peer support and mentoring programs.

Other programs include Rock the Mountain, Rock the Beach and the Natural High Driver Safety programs. I will not go through them all, but one that I would like to mention is the Drink Rite program that we conduct through our unit. We conduct Drink Rite events in licensed premises around the state, in response to police and community needs. Drink Rite events promote a responsible approach to drinking and driving, and educate the public on standard drinks.

With respect to building partnerships, the Queensland Police Service has developed and implemented a water and alcohol safety project—a WASP—which we run in partnership with stakeholders and the community. We have developed kits to assist police, in partnership with other stakeholders and the community to implement water and alcohol safety project activities at the local level.

The Drug and Alcohol Coordination Unit developed and maintains a project entitled *A collaborative approach to major public events*. This project assists local communities and event organisers to reduce the harms associated with alcohol consumption at major public events such as Schoolies Week, bachelor and spinster balls, rodeos, rock concerts and other major sporting events.

We have an Indigenous Diversions Grants Program, which the service administers. It is an Aboriginal and Torres Strait Islander Diversions Grants Program, which distributes amounts up to $2,000 to fund drug and alcohol-free activities for at-risk youth in rural and remote areas. We have the Goondiwindi/Toomelah project, which is being conducted in partnership with New South Wales police. This project takes a community based problem-solving approach to addressing the harms related to alcohol and other drug use amongst Aboriginal communities in the Goondiwindi and Toomelah areas.

With respect to preventing use and harm, we have resources committed to the development and dissemination of a range of resources designed to be used by police to prevent the harms associated with drug and alcohol use, and we provide those resources to police officers who are going into the schools and into the community to provide information on the issues relating to drug and alcohol abuse. The Queensland Police Service are also developing a substance use policy and are currently undertaking research and consultation to facilitate the development of a workplace drug and alcohol policy. That is being considered by the minister and a working party at the current time.

With respect to our road toll, you heard earlier the number of alcohol related deaths on the roads. The main prevention activity I suppose is that of the State Traffic Support branch, and

that is random breath testing. From 1 July 2000 to 31 March 2001, Queensland police breath tested 1,967,374 motorists. The annual report states that we now have one drink-driving offence for every 115 breath tests conducted, and that compares with one offence for every 38 breath tests in 1996-97.

In 1998, the Queensland Police Service targeted 70 per cent of licensed drivers. We increased the target in 1999 to 85 per cent and in the year 2000 the target increased to 100 per cent. The Queensland Police Service have projected a target of testing 100 per cent of licensed drivers. That figure of 2,365,000 will be accomplished by 30 June this year. We now have, as a jurisdiction, the highest percentage rate of random breath testing in Australia. Since the introduction of the 100 per cent testing of licensed drivers, there has been a seven per cent reduction in injury related crashes.

A further problem, which has not been previously addressed, is the issue of drugs—other than alcohol—and driving. The Queensland Police Service is exploring strategies to address this issue. Technological advances and practical policing techniques, which rely upon a person's indicia, are currently being evaluated. The State Traffic Support branch participates in the Austroads drugs and driving working group, which has developed a national approach to drug driving, and all members of the Queensland Police Service receive training in the use of roadside breath testing and field impairment testing to detect drug drivers.

I will move on to the issue of petrol sniffing. We recognise that sniffing of petrol and other inhalants is causing harm in communities of the state. A number of projects have been conducted in remote communities in the past to address this issue, including the Doomadgee Petrol Project and the Reactive Inhalants Workshop in Mount Isa, and information is available on the police intranet to enhance police participation in local collaborative initiatives addressing the issues surrounding inhalant use.

On domestic violence, whilst we do not know what the exact percentage is of domestic violence that is drug or alcohol related, and it is difficult to measure, it is recognised that those things certainly are involved. It is worth noting that while alcohol and drugs may not cause domestic violence, they can intensify the level of abuse. From 1 January to 31 December 1999, Queensland police investigated 19,802 domestic violence incidents statewide. Between 1989 and 30 September 2000 a total of 116,725 applications for domestic violence orders were made in Queensland courts. Forty-three per cent of these applications were made by members of the Queensland Police Service on behalf of members of the community.

In an effort to address the domestic violence issue, the Queensland Police Service has a state domestic violence coordinator, who coordinates the development of policies and procedures for the handling by police of domestic violence. This position also monitors and reports on the Domestic Violence (Family Protection) Act 1989 and related legislation, and contributes to a coordinated training strategy for police in providing domestic violence information and educative strategies to the public. District and station domestic violence liaison officers also coordinate and support Queensland Police Service domestic violence strategies at a local level. In support of harm reduction strategies and treatment, the Queensland Police Service supports help initiatives and has implemented policy and procedures that encourage access to needle and syringe availability programs and methadone treatment programs.

In keeping with the principles of harm minimisation, amendments were made to the Drugs Misuse Act 1986 by deleting the self-use of dangerous drugs as an offence. In addition, the Queensland Police Service does not routinely attend non-fatal drug overdoses unless requested. These policy and legislative changes are aimed at encouraging persons overdosing to seek medical assistance.

Already, we have heard a little about the police diversion of drug offenders. The Queensland Police Service has developed a Queensland Police Drug Diversion Strategy in association with Health and other agencies. Police diversion aims to divert first-time offenders for possession of 50 grams or less of cannabis to assessment and education or treatment. This has obviously entailed consultations with Queensland Health and other key stakeholders. The program will be supported by training for police and a data management system. It will collect data for the national diversion minimum data set, and our diversion will commence on 24 June this year.

With respect to handling intoxicated persons, we now have drunk diversion. We are able to discontinue arrest for offences of drunkenness and we now can divert these people to places of safety. We also link in with a number of other strategies such as the Directions in Australasian Policy strategy, the National Heroin Reduction Strategy, the National Supply Reduction Strategy for Illicit Drugs other than Heroin, the National Illicits Action Plan, the National Alcohol Action Plan and the National Campaign Against Violence and Crime. Youth Suicide Awareness Training for Police, provided by Drug and Alcohol Coordination, links with the National Youth Suicide Prevention Strategy.

In respect of professional education and training, material on Aboriginal and Torres Strait Islander issues has been developed and incorporated into our DACER training package for police. During the year 2000-01 Queensland Aboriginal and Torres Strait Islander police will receive specialist training in the drug and alcohol prevention area.

Training in drug and alcohol issues is also provided to recruits, the Juvenile Aid Bureau, police-citizen youth club managers, human resource officers, peer support officers and school based police officers. Training has been provided to 160 police in youth suicide awareness and the links to drug and alcohol misuse.

Over 500 police recruits have received drug and alcohol training. Approximately 310 police Queensland wide have been trained in the use of the DACER package. An additional 300 police have received specialised drug and alcohol professional development, including training in management of alcohol at major public events, and project management training for police conducting drug and alcohol projects.

A Clandestine Laboratory Awareness Project has been conducted throughout the state, with training and presentations made to members of the Queensland Police Service and the chemical and pharmaceutical industry. This project educates personnel on issues surrounding the ever increasing problem of the clandestine manufacture of methylamphetamine.

The Queensland Police Service also conducts specialised in-service training in the better management of alcohol related incidents in and around licensed premises. We have also just entered into an association with the National Centre for Education and Training in Addictions

and the South Australia Police to develop a monograph on best practice with respect to liquor enforcement in and around licensed premises.

All Queensland police officers received training in the Queensland Police Service Drug Diversion Program during the latter half of 2000. Training will continue for recruits and will be available as a computer based training package. We have also developed training with police on harm minimisation principles. With regard to harm minimisation, it is fair to say that there has been some form of reluctance on behalf of some police to adopt that philosophy. But it is interesting to note that, when you talk to groups of police around the state and actually explain what harm minimisation is, probably 99 per cent of all police would certainly support that philosophy.

On research and information development, Drug and Alcohol Coordination, through the National Drug Strategy Law Enforcement Funding Committee, has recently commissioned a number of research projects to better inform policy and practice. Recently funded projects include an analysis of the impact of drugs on Torres Strait Islander culture, development of drug and alcohol community profiles, a study of the epidemiology of drug overdoses across Queensland and a project identifying prevention strategies targeting young siblings of drug users.

Another significant research project has been an evaluation of the implementation of the Liquor Enforcement and Proactive Strategies project. This project has been implemented in a number of police regions throughout Queensland. It is an alcohol incident information management system which assists in identifying trends in liquor related problems in and around licensed premises. It assists police to identify strategies aimed at reducing alcohol related harm, particularly alcohol related violence.

I turn to the Drug Use Monitoring in Australia program, known as DUMA. In 1998, the Australian Institute of Criminology secured funds to establish three sites in Australia to pilot the DUMA program. The Queensland Police Service nominated for, and was successful in gaining, a pilot site at the Southport watch-house in the south-eastern region. The New South Wales and Western Australian police services are also involved in DUMA. DUMA uses objective data obtained from voluntary urinalysis and interviews of arrestees, rather than relying on self-reporting rates that fail to accurately reflect drug use by arrestees detained at watch-houses. Drug use information is then cross-matched with offending, demographic and socioeconomic data.

With respect to supply reduction, I turn to the role of the State Drug Investigative Group. This document is not inclusive of all those efforts that are also made by regional and local police. We have eight police regions. Whilst they all conduct significant operations with respect to drugs and supply reduction, the predominant role—I suppose the major investigative role—is the responsibility of the State Drug Investigative Group. The Queensland Police Service has a mandate to enforce the provisions of the Drugs Misuse Act. Generalist police are involved in the arrest of offenders who possess illicit drugs and other simpliciter offences. State Crime Operations Command, through the State Drug Investigative Group, is responsible for the statewide investigation of major and organised drug related crime, particularly targeting the trafficking, manufacture and production of dangerous drugs.

To facilitate this function, the group has a number of references. They include an Illicit Laboratory Investigation Team, which investigates those persons involved in the clandestine manufacture of illicit drugs. The predominant substance manufactured is methylamphetamine. In the 2000 calendar year, there were 96 clandestine labs detected in the state. For 2001, there were 93, and for the year to date there have been 26. The Illicit Laboratory Investigation Team works in conjunction with the Chemical Diversion Desk, which has the responsibility for establishing and maintaining an information network with those groups and industries involved in the sale and supply of chemicals and equipment that may be used in the manufacture of illicit drugs. We have a plantation reference that investigates those persons involved in large-scale production of cannabis sativa in Queensland.

The South-East Asian Task Force investigates those persons of Asian ethnicity involved in major and organised crime. We have an Asian reference, which performs a liaison role with the Asian community to facilitate information gathering and fostering of policing relationships. Further, the recommendations of the National Supply Reduction Strategy for Heroin and other Illicit Drugs are currently being implemented.

With respect to strategic assessment of drug markets, the service has been instrumental in driving a number of projects specifically aimed at gaining an insight into the illicit drug market in Queensland. These projects include the Illicit Market Scan Project, which has developed a method for analysing and quantifying illicit drug markets so that the law enforcement effort can be directed at destabilising entire drug operations. A further study, the community based drug reporting work group project, aims to draw together a range of stakeholders throughout Brisbane to pool the information from a number of data sets to better understand changes in the drug market.

With respect to sly grogging, the service facilitates the Sly Grog Steering Committee, which includes representatives from the Liquor Licensing Division, Department of Tourism and Racing and the Department of Aboriginal and Torres Strait Islander Policy Development. This committee was formed as a result of the recommendations of the Aboriginal and Torres Strait Islander Women's Task Force on Violence report. The purpose of the Sly Grog Steering Committee is to define the concept of sly grog, to review processes to counter this practice, to develop new strategies to address the phenomenon, and to develop performance indicators to measure success with these endeavours. As a result, penalties for unlicensed sale of liquor have been increased significantly and the relevant enforcement provisions under the Liquor Act have also been strengthened to address sly grog issues.

In conclusion, the Queensland Police Service takes a proactive problem solving approach to addressing the harms associated with drug and alcohol use. Proactive problem solving encourages police to look beyond individual crimes to patterns of recurrent incidents and the community problems associated with them. This approach has the ability to reduce calls for service, to involve the community more closely in solving the problems which directly affect them and to enhance the ability to work intersectorally. Thank you, Chairman.

CHAIR—Thank you very much. In relation to coordination with the Commonwealth and this issue of national strategy and local differences, I think we accept there are differences in Queensland as in other areas. Each region, state, or territory has its own distinctive issues. How well

do you think the coordination is working? It no doubt takes a lot of effort to get people together in the whole structure.

Mr Watson—I think it takes a lot of effort to build it and we have to sustain it.

CHAIR—Is that working?

Mr Watson—Yes. I am fairly new to this field and I am impressed by the level of cooperation that we have across agencies, particularly where it is project focused. In terms of, say, the drug diversion initiative, there is a lot of cooperation. We are working jointly with NGOs to deliver what will be probably a distinctive Queensland approach and to evaluate that. I am quite impressed by the level of cooperation and the willingness to share resources and ways of solving problems. I do not know if my colleagues have additional comments on that.

CHAIR—Are you happy with the coordination with the Commonwealth? Does it seem to be going all right?

Mr Watson—Yes, we are very pleased. I think it is good because it sits in Health and Aged Care and, therefore, there is a degree of overlap, for example, with youth suicide. It is useful that we are getting a fit, not just between levels of government, but also across particular target groups or particular issues. Perhaps my colleagues have additional comments on this.

Insp. Grayson—Certainly, from the national level, the Intergovernmental Committee on Drugs, for instance, provides a very useful mechanism for the sharing of information and policies and the cooperation between state jurisdictions and the Commonwealth is excellent at that level. There is currently a review being undertaken on the effectiveness of the National Drug Strategic Framework and the reporting structures under that and the preliminary findings are quite positive. It certainly is a very useful tool to be able to share our strategies and information at that level.

CHAIR—For example, you have a South-East Asian Task Force. Would you discuss that with other state agencies and would there be a regular sharing of information on that?

Insp. Grayson—Not at that level through the Intergovernmental Committee on Drugs. Certainly, through the Bureau of Criminal Intelligence, that sort of information is shared, as well as the wide range of drug and alcohol issues, strategies and programs that exist throughout the country. Networking is set up through the Intergovernmental Committee on Drugs. We also have a national drug and alcohol coordinators forum, made up of my equivalents in each of the jurisdictions. It is a simple task for me if I want to know what the issues are or need advice on policy in other jurisdictions with respect to an issue to get on the telephone and find out. We go through all the agenda items for the Intergovernmental Committee on Drugs prior to the meeting and discuss these issues. We are frequently in touch.

CHAIR—From the statistical data available to us from 1992-93 through to 1998 it seems that the level of incarceration in prison in Queensland has doubled, with there being over treble the number of women prisoners in jail. I know there are a whole lot of reasons given for that but it is out of kilter with the national figures. It seems unusual to me that we have got a very signifi-

cant rise in the prison population. I may have misread the data, but I do not think I have. Could you enlighten us a little more as to what you think some of the reasons are?

Mr Watson—I do not have specific information on that. I would need to take it on notice. I do not know whether my colleagues have any information.

CHAIR—Is it a surprise to you to hear those figures?

Mr Watson—No, it is not. We know that that is the case but I will need to seek advice. I can get you a written reply with respect to that.

Mr EDWARDS—Is it drug related, Mr Watson?

Mr Watson—I will need to get advice on that.

Mr EDWARDS—You do not know why?

Mr Watson—Not at this point in time. I can seek advice for you on that.

Insp. Grayson—The number of recidivist offenders that we see with respect to drug related matters is of concern to the Police Service. I think that is reflected in the level of incarceration.

Mr QUICK—When we talk about being drug related, are we talking about illicit drugs?

Insp. Grayson—Illicit.

Mrs IRWIN—Just following on from the question the chair asked, I have been looking at the statistics and about 85 to 90 per cent of people who are in the prison system in Queensland are there for drug related crime—and they are repeat offenders. What I am hearing from various other states throughout Australia, especially through the prison system, is that there are not the resources provided when that prisoner comes out of the jail system. The system just turns its back on them. They have no housing or follow-up counselling. They might have counselling for only three or four weeks. What is the Queensland government doing for people who are released from the jail system?

Mr Watson—Once again, can I take that on notice?

Insp. Grayson—I think it is worth noting at this point the Queensland initiative with respect to drug courts. We have diversion for cannabis and minor drugs about to commence in Queensland and there is a clear recognition that people at the other end of the scale—the recidivist offender, the drug addict—have a significant problem. That has been recognised, as has the need to provide support for these people rather than just simply sending them through to the corrective services and into the institutions. It is very much on a trial basis at the moment with limitations on the numbers of placements that are out there for these people to be directed to, but I think that is certainly a positive move instead of just simply incarcerating these people.

CHAIR—Recidivism is actually increasing, according to the statistics, and you would be aware of that.

Insp. Grayson—Yes.

CHAIR—If there is nothing more on the jail system I will go on to a couple of other questions and then other members will come in.

Mr QUICK—I have some questions on jails. On the training of correctional officers, you mentioned in *Beyond a quick fix* the training of police officers. That might be fine but what training, if any, is there for correctional officers? On page 8 it says:

> Under a proposed legislated Intensive Drug Rehabilitation Order (IDRO), illicit drug dependent offenders will be diverted from imprisonment to treatment by suspending their sentences and ordering them to undertake assessment and treatment. To remain out of prison, offenders will be required to comply with the assessment and all scheduled treatment. The IDRO will be supervised by the Department of Corrective Services (DCS) through the community corrections program.

Has there been a monumental shift in the training of correctional officers to understand that rather than being just a punitive approach there is some sort of rehabilitation?

Dr Lambkin—With respect to drug courts, there has been a significant move with respect to correctional officers. The officers who are undertaking the drug court trial have been specifically recruited as professionals in that area and are fairly well locked in to that program. That program is really about diverting people away from prison into legitimate treatment options. There is a range of support services for them, and corrections officers are just one of those support services. Health provides substantial support, and as well there is the support that comes from the court itself through the court team. Those people come back to the court every week and are reviewed, and their individual issues and problems are talked about in a group led by the magistrate. Then in the period that they are in treatment, whether as outpatients or in-patients, they obtain intensive support, both from Corrections and from Queensland Health and from non-government agencies, if they are receiving treatment in that forum.

Mr QUICK—What is their link with FYCCQ?

Dr Lambkin—The link is that, if a drug court client is not in a residential treatment setting but is in a community setting, they will need housing and social support; and Families, Youth and Community Care supply an aspect of that social support for those purposes. The drug court model takes a holistic view of the individual. It says that to address the drug issue—which is the classic treatment approach—one needs to take a view from not just the substance itself and its effect on the person but from that person's functioning in the community and society and also with respect to their family and personal circumstances. An intensive drug correctional order tries to place that person in a holistic treatment setting. Sometimes that is a residential setting; and, in a sense, a residential treatment setting looks after most of those aspects for that person. A lot of best practice says that maybe for some people that is not the better option, and that the better option is to be placed in the community and receive ongoing outpatient care. These particular clients have very high needs. Not only do they need ongoing outpatient care but they need support with respect to the very living circumstances of their daily lives, and that is where Families, Youth and Community Care have a role in the drug court model. Housing also has a role in supplying appropriate accommodation.

Mr QUICK—Is this of the highest priority when it comes to housing? From my experience, if you can put them in a family oriented situation with community support, the chance of recidivism will decrease enormously; but, if they cannot access housing, for a variety of reasons, they are behind the eight ball and they quite often relapse and are then back into the system.

Dr Lambkin—It has certainly become a higher priority as the drug court model has rolled out in Queensland, with the particular way we have looked at it. We have really learnt in an incremental way about its implementation. It has been operating for about a year now. I do not mind saying that in a sense we have realised that the intensity of support that is needed is much more than we might have thought. In a sense, it was a new way of doing things, and we did not have a very clear idea of the kind of people who would be taking advantage of the program. The point you are making is a valid one, because it is only in recent months that the government has made an increase in funding to the drug court model to enable the kind of residential support that you mentioned to be put in place.

Mr QUICK—People quantify the cost per year to have someone housed in a correctional institution. Is the cost more or less, to divert them away? Have you got to the stage, after 12 months, of being able to quantify the cost for prisoner A, who is out of the system and has not gone back into the system? Or, as whole of government, does it disappear into the ether, so that we cannot quantify it, but perhaps we should?

Dr Lambkin—There are two aspects of that. One is that the quantification of that kind of information is part of the evaluation of drug courts; and at this stage drug courts are in that early stage in Queensland. The second is that from the early data that we have just on the cost of having someone in a correctional institution, as opposed to doing a fairly overall costing of the kind of settings that we have people in, the diverted person comes out at much less, in a cost sense, than if you have them in a correctional institution. I still must emphasise, though, that the intensity of support that is needed for those people is quite substantial; that is something that has become clearer and clearer as the pilot rolls out, and the government has responded to that additional need with additional resources.

CHAIR—I suppose that leads to the issue of detox and rehabilitation generally. What sort of situation exists there? Does Queensland Health run any rehabilitation services? Or is that mainly done by the NGOs?

Dr Lambkin—I probably prefer to answer your question in terms of treatment rather than detox and rehabilitation. The general association with rehabilitation is for people to think of residential treatment services. Basically, the treating of alcohol, tobacco and other drug issues can range across a whole range of methodologies and interventions. Queensland Health offers most of those. We do not offer long-term residential treatment services.

CHAIR—None at all?

Dr Lambkin—No.

Mr QUICK—In the short term?

Dr Lambkin—Yes; there is some short-term stuff. The Mater Hospital, for instance, offers a short term, which is half private and half us—

CHAIR—Can I say that I prefer to ask the question in terms of detox, because that is at the very sharp end of the issue at times. What is coming back from many NGOs and communities that we visit is that, at that very critical point when people might be inclined to have a crack at getting out of the scene, the access and negotiation could occur there; and we are trying to understand, for want of a better phrase, detox at that critical point and whether it is being picked up on by the police or whether it is an individual making a decision: 'I have had enough of this.' There seems to be a real challenge in there about how that links up.

Dr Lambkin—Yes, there is a challenge; and I concede that with respect to that entry point issue. The fact is that a lot of people can say, at 2 o'clock in the morning, 'Yes; I have a problem and I want to do something about it.'

CHAIR—It is not easy; I concede all of that.

Dr Lambkin—Yes, it is not easy.

CHAIR—It is at the cutting edge.

Dr Lambkin—Yes, it is at the cutting edge. Our view is that we maximise the opportunities for people to access some form of assistance, even at that particular time. Sometimes that is not possible: sometimes things are closed and there is nothing available. In a sense, the literature says and people in the business say that if you are fair dinkum you will come back the next day—not always—but if you are serious about it, it is not just a 10-second job.

CHAIR—It is quite a legitimate point of view; the commitment has to be there.

Dr Lambkin—I take your point. On the specific issue of detox, there is a range of settings that detox can occur in. Detox can occur with the assistance of a doctor in a home setting, or it can occur in an institutional setting like residential detox. Detox can be done these days, with the opportunities of naltrexone with respect to sedated detox, fairly quickly over a very short period. I have to emphasise that it really depends on that top quality assessment of the person as to what the best course of action is for them.

Mr EDWARDS—Can that rapid detox be done safely?

Dr Lambkin—I will not presage the findings of the evaluations that have been done by the national evaluation program on the new pharmacotherapies—and a report will be coming through the Ministerial Council on Drugs Strategy shortly—but the early data seems to be showing that under sedation it is a fairly acceptable process.

Mr QUICK—Why were the three jurisdictions in south-east Queensland chosen for the drug courts? Is there any reason? Does it relate to the highest incidence of drug related crime?

Dr Lambkin—I am not passing the buck, but it was a government decision. I am trying to think back now as to what the rationale might have been.

Mr Watson—There was a need to have them reasonably geographically contiguous, so that we could support the magistracy appropriately. There is an intention to extend to Cairns and Townsville. The idea was to start in the south-east corner where we could concentrate support services more effectively to ensure that the trial got a reasonable start. The whole drug diversion approach is an attempt to deal with the drug problems that we have in different kinds of ways. We have police diversion starting in June. We are now exploring the legislative and operational framework for court diversion, and we have the drug courts in place as well. There is an attempt to build a range of alternative approaches, rather than just whacking people straight through into Corrections or whatever. All of those are built around the idea of having appropriate support. Clearly, in the south-east corner, we are more likely to be able to concentrate a range of support services.

CHAIR—This is on a slightly different tack. On page 3 of your framework paper, you observe that Queensland drivers are two to three times more likely to be over the legal limit when tested for alcohol than drivers in other states. A whole lot of issues might arise: maybe the RBT is in a more strategic position, the RBT is done differently or the consumption has a different pattern. What comment would you like to offer on this issue, which seems to be inconsistent with national evidence?

Insp. Grayson—What is the document that you just referred to?

CHAIR—I am talking about page 3 of *Beyond a quick fix*. I was so surprised, I checked it.

Insp. Grayson—At this point in time, I do not think I am in a position to make a comment on that. Those sorts of figures come as somewhat of a surprise to me. But I would be quite happy to take that question on notice and to provide you with a written reply.

CHAIR—Under the heading of ‘Social’, page 3.

Mr QUICK—This is an excellent document, but nowhere in it are any goals set. We have heard of evidence based evaluation. We are pouring hundreds of millions of dollars into this program—both state and federal funding—and yet nowhere has anyone bothered to set a goal of, say, 50,000 hospital beds. I have worked that out, with my long division, to be 137 beds per day across Queensland. The health department said, ‘We’d like to get that down to 40,000 over the next five years and the number of overdoses down to one-third.’ To me, this seems rather strange: you have put out this wonderful document with more acronyms than I can shake a stick at and with a whole of government approach but nowhere has anyone mentioned any targets or any goals.

Mr Watson—If you turn to the tobacco action plan, there are targets in there. The intention is that the targets actually sit in the specific action plans on particular areas—so, tobacco—and then, when we have the illicit drugs and alcohol action plans from the Commonwealth, we will build targets in there. So we are actually trying to target at that level rather than at the overarching level. The overarching document is providing a strategic framework. In the tobacco document—the red one—there are a series of key action areas—

Mr QUICK—So, can you tell me the targets for the decrease in hospital beds, the decrease in the number of overdoses and the decrease in the number of people being road tested—that the one per thousand is down to one per whatever it is? Is that here anywhere?

Mr Watson—If you turn to page 4 of this document, there is a list of performance indicators. You will see what we have identified as short-term indicators, which are the percentage of the population that have never smoked and the percentage of people who smoke regularly, going down to longer term indicators, which are reducing the number of deaths and reducing the level of disease caused by smoking. When we have the illicit drug and alcohol action plans, we will align our strategies with those and we will have a series of targets in those too.

CHAIR—I just want to touch on the police work. How much of your work is related to substance abuse? I am talking about anecdotal evidence. In the police profession all over Australia, how much do you spend in resources—percentage of time and whatever measures you would like to use? Most officers are reluctant to be too specific, and I respect that. But what would your comment be about substance abuse and police resources and how do we best manage it?

Insp. Grayson—I hear your question, and it is a vexing question that has been asked across all jurisdictions—it has certainly been at the heart of policing for some time. The straight answer is that we do not know exactly what percentage of police work is related to either alcohol or illicits. We know anecdotally that it is a very high percentage. The consequences with respect to alcohol related violence, domestic violence, assaults and road trauma and the percentage of work that is invested in or required by police in responding to the wide range of results of substance abuse is quite substantial, but, as far as being able to quantify it, it was reported by—

CHAIR—We hear that it is up to 80 per cent; someone might indicate 60 per cent.

Insp. Grayson—It varies from geographical location to geographical location. In some communities, for instance—

CHAIR—You are right—up to 98 per cent in some areas.

Insp. Grayson—It could be up as high as over 90 per cent—in other areas it would be much less—but, unfortunately, at the moment we do not have available to us the methodology to be able to quantify that.

CHAIR—That is the purpose of my question. In terms of the Australian Institute of Criminology research, what sort of structure should we be aiming for to get some measurement?

Insp. Grayson—Certainly, research is required in this area—I have been a very strong advocate of that. In fact, only a matter of weeks ago we had discussions within our unit with respect to this very issue—looking at some of the funding that we have within the national drug law enforcement funding committee and developing a research project looking at Queensland, perhaps, but obviously that could be picked up and carried on through the rest of the country. It is a question that we need to answer more clearly so that we can better allocate our resources and lobby for further—

CHAIR—It may not change anything that you do, but it was quite a surprise to realise that of this huge resource that we have in our police forces all over the country—and all over the world—so much of it is linked to this issue.

Insp. Grayson—That is right. It is not a simple question, and the nexus between an offence or an incident and the consumption of drugs or alcohol is not always clear. It may or may not have directly influenced an incident, but certainly it is an area that we need to concentrate more on insofar as knowing what the answers are.

CHAIR—There are statistics, statistics and damned lies. I presume that petrol sniffing is not illegal in Queensland.

Insp. Grayson—No, it is not. In parts of the Northern Territory, for instance, they have changed the legislation with respect to petrol sniffing, but to my knowledge we do not have any such legislation in Queensland.

CHAIR—It is a small point, but should we consider sending the message that it is illegal? With that type of issue, it would be back to focusing on one particular group, or perceived to focus on one group.

Insp. Grayson—That is right. It may be an issue on which legislation could be locally based or across the board. The problem, whilst it exists, is not widespread throughout Queensland.

CHAIR—How are the $2,000 grants for alcohol-free activities for youth going? You can take it on notice, if you like, but it was one of your points about the small community grants for alcohol-free activities for young people. It seemed like quite a sound idea.

Insp. Grayson—I cannot comment on the overall results to date, but certainly we are trying to get across the message and influence youth to conduct safe drinking habits and to create the environments in which they do not necessarily have to embark upon the bingeing practices that they have these days. Anything that we can do in those areas to encourage police and other community groups throughout the state to promote that, we do wherever we can, and I cannot comment any further on that.

CHAIR—In terms of the range of issues and the emphasis on abstinence, and we heard earlier about the sharp point right through to the whole population which is a fairly practical and logical approach to the community, how strongly do you think the issue of abstinence comes through? In other words, that it is okay not to get involved with this stuff. It seems that there is a huge amount of peer pressure in relation to many of these issues. Are we saying to people strongly enough, ‘You don’t have to be involved with this. You don’t have to have a drink if you don’t want to’?

Mr Watson—I actually think that it is broader than that. In terms of young people, it is about giving them a sense of themselves, a sense that they can make choices and that they are in control of their own lives. The target audience for this would probably be young people. At the moment, one of the issues with drug education is that it tends to be reasonably narrowly focused on drug education. Over the last couple of years, Education Queensland has started the New Basics Project, which is a completely new curriculum framework. It came out of a sense that we

were teaching kids a curriculum based on 19th century organisers of knowledge. We needed to build something new. Professor Allan Luke from the University of Queensland, Head of the Graduate School of Education, led a project which put together a new curriculum framework which is now being trialled in 38 schools. The first organiser for that project is ‘Life pathways and social futures. Who am I and where am I going?’ The second is, ‘Multiliteracies and communications media. How do I make sense of and communicate with the world?’ The third is, ‘Active citizenship. What are my rights and responsibilities in communities, cultures and economies?’ The fourth is, ‘Environments and technologies. How do I describe, analyse and shape the world around me?’

What is exciting about that is that ‘Life pathways and social futures’ and ‘Active citizenship’ provide you with a place in the school curriculum where you can talk about drugs, suicide and relationships in an holistic context rather than having those areas added to a number of existing curriculum areas which would give a bitty approach. Taking you through the broad headings, the headings for ‘Life pathways and social futures’ include ‘Living in and preparing for diverse family relationships.’ That heading gives you a place to talk about those issues. This is a P to 9 curriculum framework so it would organise what happens across nine years of schooling.

Mr EDWARDS—Perhaps Mr Watson can table that document.

Mr Watson—I can certainly do that.

Mr EDWARDS—We could then take it with us rather than go through it now.

Mr Watson—Okay. But my point is that it actually gives you a place to build for students, through the educational process, a much clearer sense of who they are, and a context in which they can make those choices. I think that is a more fundamental approach than just trying to assume that you can tell young kids to abstain.

CHAIR—I just want to know whether ‘abstinence’ appeared in the discussion from time to time or whether it was an option.

Mr Watson—I think we need to say it is an option, but I am not sure how effective it is going to be with many people.

CHAIR—Were students consulted in the analysis or preparation?

Mr Watson—Yes, they were.

CHAIR—Dr Lambkin, there is always the discussion within government revenue expenditure that so much is collected from cigarettes and alcohol, and ‘You miserable government, you are not spending it where you should.’ Community members will make comments from time to time about this sort of structure and its fairness and justice or otherwise. We could talk about Commonwealth or state expenditure, but my impression is that the collection of revenue does not match the cost in health et cetera. That could be debated, but that is my impression at this stage and we are still gathering the evidence on that. However, would you care to comment on the balance of revenue expenditure from the state perspective and from the broad Commonwealth-state perspective?

Dr Lambkin—It is a difficult issue to comment on.

CHAIR—Yes, it is.

Dr Lambkin—I am a public servant and I will comment in those terms. As an advocate for the area and as an adviser to my minister and to the government, we submit appropriately, as far as we are concerned, with respect to the needs of the area. I am going to sound very bureaucratic here and I apologise for that.

CHAIR—I understand that. You are here in a political area and it is not fair to go any further.

Dr Lambkin—The cabinet budget review committee makes its decisions in accordance with its budgetary priorities. I can only say from our perspective that we are an advocate for the area; we submit accordingly in accord with the processes, and I really do not want to comment any further on that, if that is okay.

Mr EDWARDS—I have got three specific questions. The first one is to Inspector Grayson. Inspector, is there any evidence that marijuana is being grown on a large scale in conjunction with more legitimate crops anywhere in Queensland?

Insp. Grayson—My involvement in the investigative area some time ago might enable me to provide some background to that answer. There is certainly evidence that there is large-scale cannabis production taking place within Queensland. That has been evident through the number of cultivations that have been located in previous years. With respect to it being grown in conjunction with other legitimate crops, I am not aware of any evidence, but I would have to qualify that statement by saying that I am not across the current information and intelligence that are available to, for instance, our State Drug Investigative Group or the regional criminal investigation branches.

Mr EDWARDS—The second question is to Mr Watson. You mentioned there were three specific areas of coordination on which you place great emphasis: Commonwealth, state agencies and non-government organisations. As part of that strategy you have a forum twice a year. How many forums have you had so far?

Mr Watson—We have had one so far, at the end of last year.

Mr EDWARDS—How long ago was that?

Mr Watson—That was last October.

Mr EDWARDS—Has a report been published?

Mr Watson—Yes, there was a report but it has not been published. I could provide a copy of that.

Mr EDWARDS—Could we request that?

Mr Watson—Certainly.

Mr EDWARDS—If the report is available, is it your intention to publish it? If so, when?

Mr Watson—We intended to make it available to participants, and it is available to members of the drug coordinating committee and non-government organisations. We had not intended to publish it per se. There is no reason why we could not, but it certainly was not our intention. I think it was really a feedback thing for the people who were there. Our next forum will be in North Queensland, hopefully in the next month or so. It will take people through the kinds of strategies the government has and then provide a forum for people to respond to that. Our forum in the second half of the year will probably be based around either the illicit drugs or the alcohol action plans. It will be focused more specifically on getting feedback on what we should do there. I can certainly make that available to you.

Mr EDWARDS—I would appreciate that. There are a number of questions I would like to ask but in deference to the time and my colleagues, I will not do so. My third question relates to detox. We met with 30-odd agencies yesterday. I must say I was very impressed with the agencies with which we met, the people involved, the energy, the professionalism and the dedication. But they seemed to be as one in saying that they lacked resources and support. I think the major point we picked up yesterday was the lack of detox. Dr Lambkin, you mentioned that people can detox in the family home, which they can, but it should be remembered that a lot of kids do not have access to family homes because they are on the streets. You also mentioned detox through doctors' surgeries, in conjunction perhaps with a naltrexone program. That would be very expensive; I understand it costs at least $3,000 to get into such a program. You might have a more accurate cost for that. Where does that leave the kids on the streets who do not have a family home or access to doctors' surgeries when they need immediate access to detox? If that is the message that we are picking up, why aren't you picking up that message and acting on it? I do not want to put you on the spot, but it is something I would like to have clarified in my own mind.

Dr Lambkin—I suppose you have to be on the spot, because it then relates back to the earlier question which I reflected slightly upon. I can only tell you what is in place and what we have put in place in recent times. We come from a position where we have introduced a significant new training program for general practitioners so that they can undertake detox in those community settings. We have recently commissioned the promulgation throughout the state of two sets of protocols for residential detox activities, as well as community settings detox activities that will go state-wide.

A couple of years ago, we funded the establishment of an alcohol and drug withdrawal service for young people, based at the campus of the Mater Hospital but in a community setting. That does focus on young people, in the teenage years particularly. Over the last two years, we have funded a considerable number of additional residential detox beds in non-government facilities.

I suppose I can point to that record with respect to Queensland Health, but acknowledge some of the issues that you have raised and also maybe refer to the earlier question from the chair. I cannot answer that question. All I can say is that, with the resources we have available, we have

used them as effectively as we can in providing that particular service. There have been considerable enhancements in recent times.

Mr EDWARDS—I have a concluding question for Mr Watson. With these forums and the other work that you do—the consultation and the cooperation with NGOs—how do you go about responding to the issues they put before your government?

Mr Watson—That would depend on the nature of the issue, obviously. But I suppose the way that the Queensland Drug Coordinating Committee works is that it provides an opportunity for the various government agencies, in the first instance, to examine proposals, issues and ideas, and explore possible policy options. Then we provide advice through a forum of chief executive officers of agencies, and there may well be some sort of toing-and-froing there before proposals go to cabinet.

In the end, we have a reasonably direct link to cabinet and they will make the policy decisions. Our job is to try and provide them with the best advice that we possibly can to address the issues. This is not a static area. It is one which we know is difficult. I think it is one in which the government at the moment is probably exploring a range of different approaches—including drug courts, diversion and so on. Our job is to try and provide government with the best advice we can. Obviously, part of that will, at times, involve issues to do with budgeting. So there will be submissions going to government across a number of agencies in relation to funding support for particular initiatives.

Dr Lambkin—Could I just say a couple of words about that with respect to feedback from community forums and NGOs in other areas. I suppose I am making a plea for government here—which I am loath to do, but I will. Many of the issues that come up in those forums and in the discussions I have with NGOs and community members are simply not consistent with the present position of government policy or the kinds of resource decisions which governments make. As a public servant, I suppose, I am pleading the case that our job is to balance all that up and put the options forward as best we can with respect to taking the advice that comes from the community. At the forum in October last year, a range of issues was raised that are simply not on the government's agenda and are not government policy. They were quite radical harm reduction strategies which the government has a clear position about. They are simply things which cannot go forward.

Mr QUICK—So how do you feel about federal money that suddenly jumps out of the ground at you and says, 'Here is $10 million or $20 million,' when it bears no relationship to the Queensland government's strategic plans, as detailed in *Beyond a quick fix*? And you have to slot it into a certain area when you can see obvious needs elsewhere. There is whole of government in Queensland and whole of government nationally, and you have these wonderful meetings with all these people at senior bureaucratic level and yet governments of all persuasions—mine included; and Barry's, at the moment—suddenly say, 'We will give $2 million to deal with the problem of petrol sniffing' or 'We will put $146 million into something else.' How do we stop that happening, because you people must be as browned off as we are?

Dr Lambkin—I suppose I will give a respectful answer to that question.

Mr EDWARDS—Give us an honest answer.

Mr QUICK—I would like a serious answer, please.

Dr Lambkin—I will give as honest an answer as I can. I respect the right for the Commonwealth and the state to make their policy decisions and their funding allocations. We provide the best advice we can. With respect to some of the issues, I imagine you are talking about the substantial allocations under the illicit drug package. In the context of the points you make, where you are saying that they are not consistent with a lot of the vibes and feedback you are getting from people out there as to what the priorities should be, in the end some of the things that were suggested in that package were fairly innovative. They are not inconsistent with the strategic approaches at both national and state level. Particularly the police diversion one is a fairly innovative way of opening the door to getting a whole range of people into treatment, which is a very valid thing to do. It really needs strongly evaluating and examining down the track.

Mr QUICK—We have the ACT and South Australia where you can have your half a dozen plants; and yet you have a diversion, if I walk out with my 40 grams outside and someone taps me on the shoulder. We have this state and territory approach, and there is no consistency. We supply every householder in Australia with a brochure and we flood the television channels of a night, and yet South Australia and the ACT have got something totally different. What sort of message are we sending out to the kids?

Dr Lambkin—I suppose I am taking a broader view of consistency. To us the consistency is offering a whole range of new opportunities for people to access assistance. It is going to be at a different level in South Australia, and it is going to be for different substances in Victoria. It is initially going to be for cannabis in Queensland. That is a level of inconsistency but I suppose that, as health professionals, the key issue for us across all those jurisdictions is that it is now enabling a whole range of people, who maybe did not have the opportunity before, to access assistance and possibly treatment. That is where the consistency comes, for us.

Mr QUICK—A lot of these people that we are talking about, especially with illicit drugs, are wandering across states. They do not just live in my state of Tasmania.

Dr Lambkin—In that sense, they will not get the same opportunities across those borders.

Mr QUICK—That is right. You probably could not tell me how many people who are in rehab, detox or whatever it is in Queensland, are actually residents and sons and daughters of taxpayers in Queensland. Half of them could be coming from New South Wales or Victoria. This cost sharing and so on—

Dr Lambkin—I am loath to go back to ‘we have different states’, but—

CHAIR—Our time is up on this, but perhaps Mr Watson might like to comment, and then Mrs Irwin has questions.

Mr Watson—There is police diversion, but there is also court diversion too, which is dealing with more serious drugs. I suppose that from our point of view the police diversion provides us with an opportunity to build an infrastructure, or support an infrastructure, of people to provide education and advice. For us that is actually quite powerful, because we can use that not just for

the police diversion of cannabis but also for other drugs too. As public servants, we look and see what the opportunities are within the particular policy framework we have and how we can maximise the best possible outcomes we can get within whatever are the resourcing and policy frameworks that we operate within.

Mrs IRWIN—Going back to your *Beyond a quick fix* submission to the inquiry, on page 1 you state:

The Queensland Government recognises that families of drug dependent people can feel isolated from the support of their community. The Government is seeking to increase the availability of options for families to obtain support and information.

What I am hearing across Australia is that there is not that much support, for families with a drug addicted child who might be in detox or might have come out of detox, on how to handle that child once it comes back into the family home. Can you tell me what options are available to families in Queensland?

Dr Lambkin—The major program of which I am aware—and there are minor ones in our various health districts—is our Prince Charles district's fairly successful best practice program for helping families. That is the one that we have submitted to the Commonwealth for roll-out statewide under the families initiative of the National Illicit Drugs Strategy. I suppose I concede that there is not a comprehensive structure and framework of the kinds of support that you are talking about. There is a range of NGOs which provide such support and which Health assists in some ways. The major best practice model that we have here is one offered out of one of our largest health districts in Brisbane, and that is the one that we have examined and have decided is a fairly good model. And we will be hoping for a more extensive roll-out with the assistance of Commonwealth funds.

Mrs IRWIN—I am just going to jump to another topic. I think it is on page 9 of your submission where you refer to changes to the Police Powers and Responsibilities Act 1997 which will enable the diversion of people who are intoxicated in public places. Has this happened already and where do you propose to divert people who are found to be intoxicated in public places?

Insp. Grayson—Yes, it has already happened. Places of safety are defined in the act but they can include hospitals or residences. It is virtually up to the police officer concerned to make sure that, wherever intoxicated people are diverted to, there is someone to look after them and that they are going to a place of safety. Virtually, it is making an attempt to take more care of these people and to divert them out of the criminal justice system. It is a very strong proactive strategy, I suppose, with respect to intoxicated people and trying to reduce the harm. Just putting intoxicated people into watch-houses is not the solution.

Mrs IRWIN—So they are virtually taken to a public hospital?

Insp. Grayson—They can be—depending on their condition.

Mrs IRWIN—What happens if no beds are available?

Insp. Grayson—I cannot answer that because I have not been directly involved. I could take the question on notice and find out for you. But certainly in the majority of cases they are released to people—relatives and the like—who are prepared to take care of them.

Dr Lambkin—I will just comment on that. The major thrust of that change of legislation was to give police the option of not taking a person to the watch-house. The watch-house is still an option for people if there is nowhere else to go. One of the major strengths of the change in legislation was that people can be put in the care of their friends or their families, or even be taken home and be looked after there. That is the preferred option. There is throughout the state—in Rockhampton, Brisbane, Townsville, Cairns and Mount Isa—quite significant sobering up services which operate for the diversion of such people. But, really, the major thrust of that legislation was to increase the power of police to make choices about care for people. Sometimes the watch-house is the safest place for a person. Rather than lying on the side of the street, it is safer than being out there in the environment.

Mrs IRWIN—You have been talking about state, federal and local government working in partnership, and I thoroughly agree with the comments that you have made. I just want to go to page 5 of your submission, *Beyond a quick fix*, where you talk about community involvement and local government and about sharps disposal bins. Are councils involved in this—every council throughout Queensland?

Dr Lambkin—Yes, I suppose very significantly in the very near future. We have recently taken a fairly comprehensive view of sharps disposal and one of our major partners in that is local councils throughout Queensland. Queensland Health has a formal protocol with the Local Government Association. There are, I think, three or four priority areas under that protocol. The No. 1 priority area is sharps disposal. We are working with the Local Government Association of Queensland and the major local governments, at this stage, to look at the establishment of a sharps hotline to promote the more easy collection of sharps that people may find lying about the place, and also to promote the further distribution of sharps disposal bins. We are in the early stages of that at the moment but, in a sense, it is modelled on some initiatives taken in other jurisdictions. We have had the opportunity—and I will acknowledge the assistance of Commonwealth funding here in the needle and syringe program—to really bump up our efforts and commitment to sharps disposal. It is an ongoing issue for us, as you would well know, and it is something that we are strongly focused on.

Another one of our initiatives is to work more closely with pharmacies to make them more amenable with respect to sharps disposal. We have recently had a very positive interaction with the Queensland Hotels Association. We have corresponded with them with respect to further placement of sharps disposal bins in licensed premises.

Mrs IRWIN—In toilets.

Dr Lambkin—In toilets. It is a major issue because a lot of injection happens at licensed premises. The association has made a very positive response to us. I suppose we are looking at it on a range of fronts. It is a critical issue for us to examine, not just for the sake of having no sharps lying around but because we very strongly support and believe in that program with respect to its positive effects on disease uptake. We really need maximum community support for it, and addressing the sharps issue is part of the strategy to get that kind of support.

Mrs IRWIN—Do you have any statistics at this stage on the number of sharps collected, say, in bins or on the ground?

Dr Lambkin—The fact is that we will not have statistics on that. We promote appropriate disposal to users. They return their sharps in a container, which is then put outside our services into a bin which is then disposed of. We are not in the business of counting them. I do not think we will ever be able to give you that kind of indication because we do not count them.

Mrs IRWIN—Where do you feel that the young ones are shooting up? Are they shooting up in alleyways, in toilets or in the family home?

Dr Lambkin—The research that has been done in Brisbane is limited, and it is based on ambulance figures—the places to which they are called for overdose incidents. The research that I have seen, which I think was for last year, provides an interesting contrast with other major capitals in that most—not all, of course—of our injecting does not happen in public places; it happens in private places. That is where most of the incidents occur. From what I have seen of the research, it is quite a contrast with what occurs with respect to public injection in the major capitals in the south.

Mrs IRWIN—By private places, are you talking about the family home?

Dr Lambkin—Not necessarily the family home, but not in a public street, alleyway or whatever.

Mrs IRWIN—No alleys or parks?

Dr Lambkin—No, I am not saying it does not happen. I am saying that what they found is that, when they have looked at the data, most things do not happen in those kinds of public venues.

Mrs IRWIN—How many fatal overdoses have you had?

Dr Lambkin—I cannot cite the exact figure. The figures that we use are the NDARC figures which come from the Australian Bureau of Statistics. I do not have the precise figure in my head at the moment.

Mrs IRWIN—My final question is: you would know about the controversy in New South Wales at the moment regarding a safe injection room in Kings Cross. Is the department or the government looking at what is happening in New South Wales? Do you think they might consider having a safe injection room here in Queensland if that is successful in Sydney?

Dr Lambkin—I can only say that the government made a very clear decision about safe injecting rooms and heroin trials with respect to Queensland. Those issues went to cabinet either last year or the year before. Clearly, the government decided at this stage that it is not on the government's agenda; I think that was the expression. But they did say, to their credit, that we would closely examine the results and the evaluations of injecting rooms. The one in Sydney has just started, hasn't it?

Mrs IRWIN—They are trying to start it. Hopefully, it will be started within the next two weeks.

Mr Watson—We should indicate that on 3 April the Legislative Assembly, on an all-party basis, passed a motion which contained the following sentence:

> Rejection of injecting rooms or the legalisation of marijuana or other illicit drugs as effective measures to address illicit drug trafficking and use.

That is the government's position as of a month ago. In fact, it is not just the government's position, because it was across party lines.

Dr Lambkin—In the government decision that was made, they did specifically say that Health should monitor how those facilities go, what the evaluations say and feedback to the government. Obviously, there is some interest in how things go.

Mr QUICK—On the Police in Schools program, with 18 police officers, why were the schools chosen? How many other schools are planned to be involved, if any? Are you guys paying, or is the education department kicking the tin?

Insp. Grayson—No, we are paying. I cannot answer your other two questions, but I will certainly find out for you.

Mr QUICK—Can you give us the protocols and any reporting mechanisms back to your hierarchy about what is happening and future developments? Are these 18 police officers chosen from the best recruits who have done their training through your training regime? Is there a consistent message with the training of GPs through medical schools, teachers through universities, police officers, and correctional officers? Are they receiving the same message in its various forms? Is anyone coordinating that to ensure that that is the case?

Dr Lambkin—Certainly, any training that Health funds and provides is consistent with the kinds of principles and approaches we have talked about today. That training ranges from a quite generalist provision of skills and knowledge to generalist providers in the social sector.

Mr QUICK—In other committee hearings, we have discovered that in the six-year training of GPs, only so many hours go into this. I would be interested in details of the training course for police recruits and what percentage of time goes into this. Could you give us the same details for correctional officers and the like.

The other thing goes back to domestic violence and the reporting techniques and protocols. You say it is difficult to measure, but it is well recognised that it is involved. Can we get some up-to-date figures for the year 2000 so we can see whether the figures are going up or down, and compare between states and see what the numbers are so far this year?

Also, I am interested in the protocols and linkages with FYCCQ and—this is something you might have to take on notice—the whole of government approach to, say, Fortitude Valley. I do not know where it is and I do not want to stigmatise any regions in Australia, but it seems to pop up a lot. Have you got some examples of whole of government approach to Fortitude Valley

where, rather than a silo mentality and six case managers, we are actually seeing some concrete things from this excellent document *Beyond a quick fix*, with a view to our expanding that as we wander around Australia? You would probably have to take that on notice at this stage.

Dr Lambkin—Interestingly, Fortitude Valley is the venue of a major new partnership we have with the Brisbane City Council in providing a mobile needle access person who patrols the streets of the area that you are talking about. It has been quite an innovative thing for us to work with local government in that area.

Mr QUICK—If you can give us some information about that, that would be appreciated.

CHAIR—I would like to hear about those officers within the police force who have a second language. This is particularly pertinent to the issue in your paper relating to officers of Asian ethnicity getting involved in fighting major and organised crime. There are some European connections as well. Could you comment on second languages and cultural diversity within the police force.

Insp. Grayson—I will comment on two fronts. We have a cultural liaison officer group, which looks at a range of the various cultures we have in Queensland and liaison with them. But with respect to the South-East Asian ethnicity, we attempt to target people with specific cultural and language abilities in that area and utilise them to the best of our ability within the Asian desk. For instance, within the State Drug Investigative Group, there is very strong emphasis on building relationships with the community and being able to develop intelligence information and informants within the community. But when you are dealing with people of South-East Asian ethnicity, it is culturally very difficult to break down those barriers because of the policing background.

CHAIR—Do you know how many of your officers are of Vietnamese origin and how many speak Vietnamese, for example?

Insp. Grayson—I cannot give an exact figure now, but we do have Vietnamese police officers working within that group.

CHAIR—On page 11 of this document, we read about the Aboriginal and Torres Strait Islander Women's Task Force on Violence, established in 1998 to identify the issues underlying violence towards women, children and families and to recommend solutions. Is anyone able to just give us a quick snapshot of how that is going? Have you been able to make a little bit of progress?

Mr Watson—It is still going. There was a government response to the report last year. At the moment there is a range of interdepartmental working parties looking at the way we can address these very complex issues. The challenge is to adopt a whole of community approach. I mentioned the Cape York partnerships, which is an area where the government is working with indigenous communities in really quite different ways of governance and delivering services. We are really looking to see the effect of that so that we can build a knowledge base to use in other communities, so at the moment a lot of attention is actually going into Cape York. I know that one of the key issues they are focusing on is the whole issue of alcohol and its effect on those communities.

CHAIR—Gentlemen, thank you very much for your time this morning and, once again, I say thank you to the representatives of the Queensland government. Can I have a resolution that a subcommittee comprising Mrs Irwin, Mr Quick and myself be appointed to take evidence at the public hearing on the inquiry into substance abuse in Brisbane on 2 May 2001 any time that a quorum of the committee is not present? Agreed. Thank you.

[10.38 a.m.]

BOLTON, Dr Michael, External Adviser, Drug Awareness and Relief Movement

DOBBIE, Mr Mitchell, Queensland Manager, Drug Awareness and Relief Movement

ROULSTON, Dr John, Chair, Queensland Committee, Drug Awareness and Relief Movement

SOLOMON, Mrs Rowena, Intervention and Support Coordinator, Drug Awareness and Relief Movement

YOUNG, Mr Dennis Charles, Executive Director, Drug Awareness and Relief Movement

CHAIR—Welcome to our committee meeting today. I need to point out that, while the committee does not swear in witnesses, the proceedings today are legal proceedings of the parliament and as such they warrant the same regard as the proceedings of the House of Representatives. With those few words, I will simply thank you very much once again for your wonderful hospitality Do you have comments to make on the capacity in which you appear?

Dr Bolton—I have been associated loosely with DRUG-ARM for a very long time. I work as medical adviser part time to Damascus Alcohol and Drug Unit at the Holy Spirit Hospital. My background includes 10 years as director of the Queensland alcohol and drug services in the 1980s and early part of the 1990s.

Dr Roulston—I am also the executive director of the Association of Independent Schools here in Queensland.

Mr Young—And they are all very modest.As you may know, John was also the former moderator here in Queensland for the Uniting Church. Mitchell is also an ordained minister in the Assembly of God church as well and maintains that position with us. Dr Bolton is a very distinguished medical practitioner in the state and we have been very pleased to have him as an adviser.

First, we would like to thank you. Having some time to share with the members of the committee, we can see that you share our passion and motivation in this area. It is really encouraging for us to see members of the federal House committed to making a difference and we thank you for that. Our organisation under many names can trace our history back to 1930 under our current incorporation but we have indirect links back to 1849 so we are probably one of the oldest organisations here in Queensland.

To speed the process up, we would like to highlight a couple of areas from our submission. All the members with me at this table will be expressing their own views. They are not being limited in any way to an organisational point of view. It may or may not agree with the submission but we feel that it is more important for each of us to present how we feel personally rather than just to present a view.

The other thing I would like to add is the ANCD—I am sure you are aware of this but I feel it is worth while mentioning again—has commissioned research by Dr John Fitzgerald at the University of Melbourne to look at what is uniquely the Australian approach to drug policy and practice. I believe this document will be released about June and this may also provide some background information of benefit to the committee.

Something else I would like to add about the NGO sector being involved in policy development is that we need to build a structure in which NGOs can provide this advice and governments can access the advice and expertise of the non-government sector. The men and women working in these agencies often do so with very little or no funding and quite often have a different perspective from the policy makers in the various departments. The ANCD is the first attempt we have seen in this nation for any government to build into its structure a process where a second opinion can be sought. For this reason I believe the process needs to be applauded. I believe it is a uniquely Australian approach and, whether it is the ANCD model or another, I think incorporating NGOs into state, federal and local government policy advice will truly give the elected members a view on the non-government sector role.

As a point of clarification, in our submission we referred to non-government and independent schools making up approximately 30 per cent of schools in the nation. You would be aware that the independent schools nationally are about 11 per cent and the Catholic schools make up about 19 per cent but the total non-government school sector of 30 per cent was accurate.

As an organisation we work for and support harm minimisation. We support the Commonwealth definition which is a fairly broad definition and there has been a broad definition under a number of federal governments. We see that the definition needs to include a continuum encapsulating both non use at one end and the dependent high-risk use at the other. We get concerned when there are discussions that perhaps the agencies that incorporate abstinence approaches only may be separated from agencies that have a mix of abstinence and harm minimisation approaches. We feel that dividing the sector would not necessarily benefit the sector. We see the work we have been doing recently with community capacity building as one of the key success areas that we have had in the area. We are basing the work we are doing in Ipswich in western Brisbane on the work of Professor Hawkins from Seattle and the caring community model. I believe this model is being trialled in Victoria.

The Macarthur Youth Drug Project in Camden, New South Wales, is also applying this model with a degree of success, and I believe a couple of their interventions have been evaluated. We do not have any informal evaluations at this stage. This is an approach which identifies risk factors, identifies protective factors in communities, and develops strategies to reduce the risk and increase protection. One of the key outcomes is to increase the bonding between young people and adults, young people and their community, young people and their schools. We feel that this is one strategy that needs further investigation.

We would also like to write into the record that, from Griffith University in Queensland, Professor Ross Homel's 'Pathways to Prevention' model, which focuses more on crime prevention, is also a model of community capacity and is one that needs to be perhaps investigated and included, because we feel it has tremendous potential as well. We have been impressed by the outcomes that we have witnessed. We have been impressed by the limited

amount of evaluation that we have seen in this nation, and we think that that is something for the future.

We have a fairly broad-based organisational approach, and for the benefit of the members I will run very quickly through some of the things we do. Our major focus is information dissemination. We have a library and resource area. We support teachers, clinicians and front-line workers. We are the only free alcohol and drug lending library in Queensland. If you are a parent or a pharmacist and you want to do an awareness display, you come to us. Our education, prevention and research division focuses on school based education and community and youth forums. We provide training for the field and we have developed resources, one of which we presented to the committee yesterday with Youth Week-Youth Speak. We have also worked with the TAFE students to develop an interactive CD-ROM for tertiary students and upper high schools.

In Western Australia we have developed a fairly unique youth skills training centre, where long-term truants are referred by the education department to the Drug-ARM skills centre, where they are slowly integrated back into the school community over a period of time. With the support and intervention program that Rowena looks after, we have our street van outreach, we have our support education and referral clinical outreach for workers in the sex industry, and we have what we call a FILTH van—Further In Life Through Health—which is a mobile outreach for young people in shelters. We also have the home visitation and response program, which Rowena looks after as well. With family support, we manage the Ipswich street-aspect of public intoxication and we are involved in Urban Renewal. We are piloting a school homework program in Toowoomba, because it was identified that family stress was a major issue in some of the families we are working with up there, in relation in drug and alcohol. Parents were having difficulty coping with the pressures of homework, and they did not understand what their young people needed support with. By our providing support within the school from retired teachers and community leaders, it has reduced stress considerably. We also have the Time Out Zone in Western Australia, where police and other government departments refer young people for a short period of time. We are involved in Western Australia, at Armadale, Geraldton, Fremantle, Perth and Victoria Park; at Hallett Cove in South Australia; in the ACT; at Sutherland, Fairfield, the Hills, Epping, Blacktown, and Gosford on the Central Coast, in New South Wales; and in Brisbane, Logan, Ipswich, Toowoomba and Bundaberg here in Queensland. We have a mix of programs in those various areas.

What worries us is that quite often we see prevention being overlooked. We can get caught up with the treatment, and we are the first to support treatment, but we think there is a need for a more direct focus on prevention. The numbers of purely prevention agencies in this nation are few and far between, compared with treatment options. If we want to have an impact, we need to focus on both ends of the continuum, both the prevention side as well as treatment. We certainly do need more treatment beds, as they say, and we were talking about it previously. The window of opportunity that presents itself is very small, and we need to be able to place young people. But we also need to develop strategies to motivate a willingness to change in order to keep the frequency of these windows of opportunity.

I guess the other thing we would like to stress is an increased focus on school based drug education and/or prevention. I will summarise—because I am conscious of the time—by saying that in this field we are separated by far less than what joins us together. You will find that the

vast majority of folk working in this field will agree on a wide range of areas. There are some areas that we do have disagreement on, but we are all very committed, very passionate and very dedicated to what we do.

I think my closing comment should be that we should not overlook the fact that Australia has made major contributions to the alcohol and drug debate internationally. There are many strategies that we have introduced in this nation that are recognised internationally and, even though there is a lot of doom and gloom, there are some tremendous and positive stories out there in the communities where we work. Again, Mr Chairman and members of the committee, we do thank you for taking the time to visit Queensland and, if we can be of any further assistance to the committee, I am sure my colleagues around the table will be only too pleased to share their experience with you.

CHAIR—Thank you very much. I will just start a couple of points back from where you concluded. On Australia's international contribution, could you describe a couple of areas where you think we have shown the way?

Mr Young—It is in the harm minimisation side of things, and I think we have really done some tremendous work in that area with the needle exchange. I can remember when our friend and colleague Michael Bolton was leading the charge with methadone quite a number of years ago. It was quite a different area then. When you look at the way we have handled a whole range of issues, you can see we have had some real success, and I think without some of the harm minimisation interventions there would have been a far worse impact on the nation.

On the other side, though, I would not like to see us completely move away from the demand side. We have really got to look at the demand or the prevention side as well and whether we really want to try to set back the prevalence or uptake of drugs and alcohol by young people. I guess what I did not say is we must not forget that alcohol and tobacco use is also a major cause of concern in this nation and not get swept away with just looking at the illicit drugs, because I know that alcohol and tobacco bring into play a whole range of other problems that impact upon elected members in other areas which I think we need to address as well.

CHAIR—There are two parts to my question on education, a broad part on what appears to be working and what is not working, and a part on the issue of those people doing home work, those retired teachers going to the homes. It seems like a wonderful idea. Going back some years, I have had experience of organisations like the ICPA organising retired teachers to go into pastoral properties to support the education of children, so I know that works. I would be interested in your views on how it is going.

Mr Young—I will hand over to Rowena in just one moment, but I would like to say that Ross Homel has done a literature review of over 400 home visitation type programs from around the world, and I think there would be very few people who would say they are not successful. Most of the research though is done on nursing mothers and intervention before and after birth. Some of the literature from that area is remarkable. Of mothers who have received support before and after birth—young people in their teenage years—a significantly lower percentage have been involved in anti-social activities. There is certainly a lot of evidence around to support home visitation.

Unfortunately, with drugs and alcohol and mental illness, it has often been felt to be too high risk to get involved in, and that is why we have had to be very careful when we have introduced home visitation. But we would certainly support not only supporting the person with the problem specifically but also the families that are trying to manage the situation, because if you are in a family, and a member of your family has a problem, the whole family has a problem; and we need to work with that.

Mrs Solomon—I would like to comment on the home visit program that I am responsible for. We feel that this is a fairly innovative program in that we are actually going to the clients rather then having them make an appointment and hoping that they will turn up. We rely very heavily on volunteers so, in that respect, it is quite an economic program. Our volunteers are fairly carefully trained and selected. At this point in time we are endeavouring to get our training program TAFE accredited so that we can have a range of volunteers and there is some sort of carrot at the end of it for them so that we can maintain a consistent number of volunteers.

Our main point of contact is our telephone service, our 1300 number. But we are also finding that quite a number of people just access us through the phone book. When people ring in—it can be either a user or a significant other—and say, ‘I cannot cope any more,’ we say, ‘We would like to talk to you about this. Could we come and visit you at home?’ The response is, ‘Would you?’ Our experience is that people are so distressed and they have let the thing go for so long that at the point where they cannot cope they are almost incapable of any sort of rational thought. In that respect, we feel we are doing a real service.

We are finding that it is not just a straight drug and alcohol problem that we are facing. We are picking up people who are exiting detention and they are totally unprepared for reintegration into the community. There are people who have mental health issues. There are people who have mental handicaps that we are facing, and all of this is mixed in with drug use. We are actually having to maintain constant retraining of our volunteers so that they are able to cope with whatever situation we face. Sometimes it can be a violent situation and we have to train our volunteers to know when to call the police, what to do, how not to get involved and how to protect themselves while, also, at the same time how to be able to handle the issues that our clients are raising that underlie substance abuse. This is an excellent program from where I am sitting for I really feel that we are getting some feedback.

We did an internal survey. We had one of our volunteers ring all of our clients. Out of 85 clients that he rang only eight had a problem with us. We thought that was a fairly good rate of success. Part of this process is referral is well. We do not want to reinvent the wheel; we want to make sure that we are using whatever existing services there are. Part of my job is to network with other agencies so that we can say, ‘Can we refer you to here or there?’ The problem that I am sure you are aware of is that there are not many places to refer people to so we have had to rely on our own resources. At present we are developing protocols to assist families to deal with this problem themselves. We keep mentioning families. They have a problem and so has the user.

Sometimes we do not even see the user but, because of the strategies we encourage parents or significant others to employ, we are actually contacting the user indirectly. Our evidence for this is families ringing us and saying, ‘What you suggested we might do has worked. Our child has done this or that.’ They are not right through it but they have started to take hold of the problem

themselves. So we are really into empowering parents or significant others to deal with this problem themselves with a little bit of push and support and suggestion. I do not want you to think that we tell people what to do—we do not. We offer suggestions.

CHAIR—Dennis mentioned the risk factor.

Mrs Solomon—There is a risk factor because you are often dealing with drug addicted people who are never rational.

CHAIR—How did your organisation come to the view that it was worth the risk?

Mr Young—We were frustrated internally because, as you would have known, five years ago if someone rang in with a problem you would say, 'You have to get the person to accept the responsibility; they have to be ready and they have to come to the agency.' We were getting so many people ringing us up and saying, 'Nobody cares; you are going to wait for my son,'—or daughter or husband or wife—'to be in a serious situation before somebody does something.' So the staff were thinking about how to do it. We had been very successful on the street with our street outreach and so, to us, supporting clients in their home or in the community—we do not always go to the home because they may not feel comfortable in the home; we can do it in an agreed community location as well—is what we focused on. Because we had so many clients begging us to do something, or begging us to be able to refer them to someone to do something, we took it upon ourselves to do a pilot and we were very fortunate to pick up some funding in one of the NIDS rounds.

We certainly use volunteers. It would obviously be much better if we had fully trained clinicians, but there are a whole range of reasons why we cannot: (a) we cannot afford the money and (b) there are not necessarily sufficient trained and experienced clinicians in the nation. As an agency, if we put an ad in the paper, sometimes we have to take folk that are well academically qualified and train them, and then you lose them to other agencies. It is every hard to find experienced folk because there has been an expansion in some of the treatment areas, and there are not so many highly professionally trained frontline workers.

CHAIR—So the need became the overwhelming drive, and it was worth the risk, and then you developed the protocols and the skills to do it.

Mr Young—We have been on the street since 1989. We have never had one volunteer hurt on the streets, and we send them out in teams of four or five. On their own, they are obviously in telephone communication and they are well trained. If they get into difficult situations, they retreat. Our long experience on the streets, not only in Queensland but at Cabramatta and a number of hot spots around the nation, gave us the confidence; but we did set things in place. We will not respond instantly: I have a police background and, as you know, a lot of police sustain problems by going into domestic situations in the heat of the passion. So one of our policies is that we will respond within 24 hours, but we do give a cooling-off time in case there is an issue. The only exception to that is if the police or other agencies call us in for suicide concerns, and then we will send our people in to sit with the clients.

CHAIR—I will just offer one comment on dealing with these dangerous situations. In Western Australia we talked to someone that deals with prisoners, and I asked him whether he had

had difficult circumstances in terms of comeback on him or his staff. I think he said it had only happened only the once in nine or 11 years. We seem at this stage to have a reasonable balance of those people who are in such terrible difficulty not reacting. It comes back to training and a lot of other things—as you would know better than I do—but so far, touch wood, we seem to be able to go in without damage to our people working in that field. I have two further questions. On dual diagnosis, would you care to offer a comment on that area and how it is going?

Mr Young—Of course, this is a major growing concern, and most of our clients would have dual diagnosis. Rowena and the volunteers have a wonderful relationship with Wolston Park Mental Health Unit, where they train all of our volunteers in mental health.

Mrs Solomon—Yes, we have an interchange with them and so, as well as we can equip ourselves, we get trained in mental health issues as our new batches of volunteers come. Could I also add—

CHAIR—Yes, I could see you wanted to say something.

Mrs Solomon—When Dennis talks about training clinicians that sounds wonderful, but most people do not want to talk the jargon; they want someone who will come in and say, ‘I care about you enough to make the effort to come to your house and listen,’ and not tell them what to do. I think that the real success that DRUG-ARM has had is from not putting ourselves up as a super-duper professional organisation that has all the people with 22 degrees but who cannot listen.

Mr Dobbie—Just to follow up on that, one of the issues that we always seem to pick up is the continuity of care. As Rowena said, the program is fairly simplistic. If contact is with the user and they are referred either to detox or rehab, at least when they come out of detox and there is a waiting period, our workers go back in and support them until they get into rehab. Once rehab ends, they come back out again. They have somebody to keep contact with and there is that continuity of care, so they understand that it is not a stranger from detox or someone from rehab who gets them, and things like that, and it seems to work fairly well.

CHAIR—But your diagnosis is that it is something that must happen and that we must go forward with this?

Mrs Solomon—We just have to cope with it.

CHAIR—My last question is about the sex industry and prostitution. Do you have much contact—it is quite a difficult analysis, but I am trying to develop an understanding—with those who are linked to substance abuse and those who are there out of choice, if I can put it that way? Could you make a comment about that?

Mr Dobbie—Probably 90 per cent of those with whom we come into contact on the street who are sex workers would be users. Just in the conversations that we have had with them on the street, we have found that the majority were users first. We are talking about street-level workers, not those who are in the parlours.

CHAIR—That is a different part of the industry.

Mr Dobbie—Yes.

Mr Young—To add to that, we are worried about our clients, because it does not matter what the prostitution law is here in Queensland, the people Mitchell is dealing with in his special outreach will never fit into any legalised form of prostitution—they have all the exclusions. We are just worried about what is going to happen to our group.

Mrs IRWIN—I have three questions. One is about women prisoners and sex industry workers. On page 14 of your submission, you drew attention to a survey that reports that many people who are involved in prostitution do so in order to fund their drug use, which you have just stated—I think you said it was 90 per cent. What age groups are they?

Mr Dobbie—The unfortunate thing, as we keep saying, is that it is getting younger. The youngest we have been in contact with is 12 years of age, and then it goes up from there. The average age is probably in the 20s.

Mrs IRWIN—What strategies does DRUG-ARM recommend to break this nexus between prostitution and drug abuse?

Mr Dobbie—There are a number of issues in relation to sex workers, and the first is the industry that they are in. It has a double-whammy in the sense of stigmatisation: from society's point of view, firstly, they are drug users; and, secondly, they are also sex workers. Even within the industry itself, when you are a street-level worker, there is even a third one. They are isolated in that way, so we need to come up with some strategies. The SER van—the support educational referral van—that we run on Thursday nights has been successful in the sense of making contact with workers and then leading them to agencies that have been able to introduce them to support when they are ready. This is one of the big things about them: when the opportunity is there, as we have said, we are able to take it straightaway and we are able to get them out of that.

In the past there was funding available to introduce training, so if they wanted to get out of the industry they were able to do so. I think that under the Queensland government at the moment that is not available, but they are looking at reintroducing it. That is one of those things that need to be reintroduced. Night-time services need to be there for people who are working. They might be out during the day, but very rarely, because most of their clients are usually there at night, so that is when they are out, and that is when we are out and when we make contact with them.

Mrs IRWIN—You are virtually saying that from 14 years of age they have needed money for their drug habit?

Mr Dobbie—Yes.

Mrs IRWIN—That is sad. Sometimes you wonder whether there should be a trial of heroin on prescription for heavy users. What are your feelings on that?

Dr Bolton—I do have feelings on that, really because of a background of working in the alcohol and drug field, and certainly with methadone. I certainly think that one of the virtues of

methadone is its acceptability and accessibility. While I am no longer associated with the state in this regard, I think there are probably still two or three people on the intravenous methadone program we had in Queensland. In relation to the experience of that program, while there are still probably one or two people on it, in the late seventies and the eighties there were only about a handful of people, probably 20 or 25 people, involved. It was extraordinarily difficult in a number of ways and I have therefore become concerned about some of the talk about heroin trials, which differ slightly from prescription heroin to which you are alluding.

A number of issues strike me about this. There are enormous logistic difficulties, even with intravenous methadone and, as you will know, as heroin is a much shorter acting drug, the problems are likely to be compounded in that area. I was worried about how much more difficult the availability—the sort of utopia of an intravenous drug program—made it for people to settle on oral methadone. While they thought that there was any prospect or any real chance of being registered on an intravenous program, that was something to aim for. While I am not labelling them all as purely drug seeking, because of the nature of dependence it was natural that they would try to do that. The availability made it harder for a group of people in those years to settle on good oral methadone programs. That issue would concern me about so-called heroin trials.

What really concerns me is that people talk about scientifically rigorous heroin trials. It strikes me as enormously difficult to have what is indeed a scientifically rigorous heroin trial. It would be enormously difficult to evaluate the unexpected negative consequences of this as they would be cropping up for a very long time. It would be very difficult to get a handle on the increased difficulty of people accepting methadone programs if there was a prospect of being registered on a heroin program.

Mr QUICK—Not impossible, though.

Dr Bolton—It would perhaps be close to impossible.

Mr QUICK—How do you compare the impossibility or the difficulty to the 1,000 heroin overdose deaths last year? How do you weigh them up? People could have said the same thing about HIV-AIDS, but suddenly there was this inordinate cooperation, outpouring of money and setting up of expertise. We did it so much better. In your submission, you mention all the literature about safe injecting rooms, or injecting rooms; heroin prescription; and more trials. Surely to goodness we are being trialled to death—Holland, Switzerland, Sweden and England. Surely you get to the stage where you say, ‘Look, there’s that many pilots; let’s land some planes and actually do something and come up with an Australian model.’ A thousand young people are dead.

Dr Bolton—I could not agree more that it is important to have programs that are acceptable and readily available to them. However, part of introducing things in a major policy sense like this is to be alert to the possible unexpected negative consequences and disadvantages. A lot is happening in Australia in this area in terms of other pharmacotherapies, buprenorphine, LAAM and the availability of methadone—a very tried and true, and long acting drug which therefore lends itself to substitution, unlike heroin. These are important considerations. While I take your point that it is frustrating and things need to continue to be done where they are acceptable to the young people who use the drugs, I think a range of options is available. One needs research

and evaluation to accompany major policy changes and initiatives like this so you can be attuned to the unexpected negative consequences. There is danger in transposing from one country to another in that regard.

Mr QUICK—So assuming that the New South Wales trial goes ahead—

Dr Bolton—Are we talking about the injecting rooms?

Mr QUICK—Yes, the injecting rooms.

Dr Bolton—That is a bit different from heroin trials.

Mr QUICK—Yes, but from your personal expertise and opinion, how long does that have to go on before you are happy that there is no flood of people and there is no increase? Is it a one year thing, and at the end of the year we say that we are happy? Or is it two years and we then draw the line and say, 'Look, we've trialled it for two years'? What if people say, 'No, it needs to go for three years'? Referring back to my pilots, in relation to NHMRC, people want to do another trial or research project and you see the poor kids—day in, day out—dead on the streets of our capital cities.

Kids on drugs want detox, rehab—a service. You are the experts, and I will be guided by you, but I have some gut feelings about and personal expertise in dealing with heroin first-hand. Do we say that 20 per cent misadventure is acceptable to you as a professional, or does it have to be down to 10 per cent before you are happy? At what stage does DRUG-ARM say, 'We are happy with 10 per cent fatalities' or that you are happy with 20 per cent or with 30 per cent fatalities?

Mr EDWARDS—Can I just add something to that before you respond, because it is in the same vein? I note in your submission that you are opposed to the injection rooms. Why not just adopt the position of keeping an open mind? I think I am probably opposed to them myself, but I am prepared to support the trial and I want to see the trial go ahead and then make my mind up, particularly in view of the incredible courage of the women from the Uniting Church who are prepared to step into the breach and run that trial. Why not keep an open mind?

Dr Bolton—Can I just say a couple of things about that? Firstly, I do not want poor old DRUG-ARM to be labelled with my views. Secondly, I think they are two very different things, and I would like to point that out. I too have misgivings about injection rooms, but I also think, from my experience working in the illegal drug scene—both as a clinician and as an administrator—for many years, that one has to do something about these kids dying on the street, and it is reasonable.

I am conscious, as I am sure you are, of the questions about what is going to be injected, what the duty of care is and what the real practical logistical difficulties will be. I am speaking as an ex-manager of methadone programs. I think we have to predict those things we think may be difficult, and put in place what we think might be reasonable strategies to counteract them. But, at a personal level, I am not opposed to the trials of safe injecting rooms. I do think we have to be vigilant and alert to the very nature of unexpected negative consequences. We have to be tuned in to them. I do not think one can just say, as you did, 'What is a 20 per cent or 10 per

cent attrition rate?' It depends on a whole range of circumstances and careful examination and constant monitoring as you go along.

I am suggesting that heroin trials—which are rather glibly talked about—are a little different. And prescription heroin is another issue again because heroin trials, I think, suggest clinics like we used to have with our intravenous methadone program, where people were probably coming in twice a day and self-injecting clean heroin. I think there are logistic problems and problems of reinforcement of the whole needle thing, which we are in a sense contributing to, but those are not the major issues. My major issue with the methadone program was sitting there day by day seeing very young people thinking how good it would be to get onto intravenous methadone rather than oral methadone, and the very fact that we made it more difficult for them, in some ways, to accept what a good range of treatment options there were.

I think we also have to be cognisant of the wide range of things that are being introduced in this country and their merit. As you say, the AIDS initiative in this country is to be applauded. It has been bipartisan, it has been across the board and it has been excellent for many years—

Mr QUICK—But do we need that approach to drugs?

Dr Bolton—Do we need a bipartisan, across the board, integrated, intergovernment approach? Yes. I think that to some extent Australia has had that, compared to some other places, like North America.

Mr QUICK—But the funding of therapy is so expensive—for example, for naltrexone. If that is the only way to treat client A or client B, rather than spending $1,000 or whatever it is, do we fund it and say—

Dr Bolton—Naltrexone?

Mr QUICK—Yes. Do we trial it across the board or do we have to have another lot of pilots?

Dr Bolton—I do not think you can trial something like naltrexone across the board. I think good clinicians will assess people and work out who is most appropriate. Naltrexone, as I am sure you know, has a number of uses. In the media it is talked about in a rapid detox context. It is used for decreasing alcohol craving. The other use is for the prevention of relapse when people are withdrawn. It must be readily available to people at the moment they are going to seek it. Then you capitalise on that moment of help seeking and channel people into treatment. The range of things that we will trial are far broader than naltrexone. There will be a group of people who will go best on naltrexone. They will go well on it for six to 12 months and then do well in the community, providing all the other work that will be useful to them is done at the same time. It is the same principle as methadone. The principle of methadone was always to keep people safe while they could do the sort of work on their lives that gave them some realistic chance of quality of life and the ability to make a contribution to the community, which is very important to these people, as it is to all of us.

Mr EDWARDS—Your organisation engenders immense respect across Australia. You are doing some great work. I was talking to some young people who came through the prison system who speak very highly of the work that Rowena is doing through the prison system. I hope

we can get on to that. With the credibility and influence that you have, and having regard to all the work that you do, why don't you keep an open mind on the injection program? Why say before the trial has concluded or even started that you oppose it?

Mr Young—The organisation reflects, from a policy perspective, the policy of the organisation. Before the trial started, we have had—and still do, I guess—some concerns about injecting rooms. In the submission we said that, if a government introduced them, and depending upon the outcome, our organisation would review our position on injecting rooms. As a conservative drug and alcohol organisation with a history in that area, it is not unusual to expect us to have that position. If you were to ask our key staff members, it would be a view that would be reflected by our people at the sharp end. As an organisation, our policies come from our people in the field and from our clients. There is a whole range of views in the community. You will find agencies which are very supportive and promotive of that, while there are others that have some concerns—and we are one of the agencies that have some concerns. Because of our information centre, we try to play a straight bat. It is our policy to play a straight bat with all the information we disseminate. It is very difficult to find literature on both sides of the injecting room debate. There is plenty of research supporting them. But it is difficult to do that.

Mrs IRWIN—On page 18 of your submission you argue that rehabilitation involves resolving the underlying issues that have contributed to the individual turning to drugs, but that this is difficult in the prison environment. I have two questions on that. In your experience, what strategies are effective in prisons? What resources are there for those people being released from our prisons? I am very concerned because we have visited a number of jails.

Mrs Solomon—My experience over the last 10 years relates to running programs in and out of the prison system—drug education programs and also as a drug and alcohol counsellor. I feel very strongly that when someone is employed by Correctional Services and you are expecting a client to talk to them about their drug problem, you are going to get nothing from them because these people are obliged to put this on their file. The parole board does not want to know that you really have a drug problem in jail, that you are using and that such and such a person is giving it to you.

I have always been a private drug and alcohol counsellor. I got told everything because I did not have access to their files, nor did I want it. I have been concerned for a long time and I come up against a brick wall as far as saying to Correctional Services, 'These people want to make a relationship with someone who will be there for them when they get out.'

Mrs IRWIN—When they get out, that is right.

Mrs Solomon—I was talking to Bob Aldred yesterday about preparing the bridge. I think we may have been a bit at cross purposes. What I did was present programs in jails. I felt I was successful if one or two of them came and said to me afterwards, 'I've got a bit of a problem. Can I talk to you about it?' This is where you do the hard work. But in that time I am making a comfortable working relationship. They trust me, so the day they get out I am at the door to pick them up to take them through this horrendous business of going to Centrelink, not having enough ID, not being able to get a bank account, having nowhere to stay, no clothes, no Medicare card and none of the little simple things that we all take for granted. Who is going to

look after them? If they get whipped off to jail and they have got a Myers debt, who is going to care about that? I have been accused of paying drug debts because I got one bloke's income tax cheque and paid off his Myer account when he asked me to do it. Who is going to do that unless they have got someone in the community they trust? Most of them have lost their families through their own bad behaviour, but the point is they are going to come out and be put in the community. I hope I am answering your question.

I really feel that the prisons should open up a bit and allow more community in for the sole purpose of making a comfortable relationship, not necessarily a counselling one but one in which someone is going to be at the gate when they get out and give them a bit of a hand to get started. That is what I mean by bridging into the community, but at the same time you need to do the work on the drug and alcohol issues and the underlying causes. This is why in our home visit program we are picking up so many people coming out of prison; perhaps it is because they already know me because I have been about for 10 years or so, but they say, 'Can you get me some help? Can we visit you?' or 'Can we deal with the issues?' because we are not part of the correctional system. This gets me back to the idea that, if we are really going to treat people in jail, then we must have people from the outside doing the treatment—the health department, independent organisations or whoever you like, but someone that does not write things on their file or you will never get truth. The prison issue counsellors get told that what the prisoner expects will be fine for the parole board.

Mrs IRWIN—What percentage in Queensland jails do you feel have drug related problems?

Mrs Solomon—The estimate from Corrective Services is something like 60 per cent. The prisoners themselves would say 90 per cent.

Mrs IRWIN—This is what I am hearing.

Mrs Solomon—I am talking about drug crimes as such or drug related crimes like bank robberies in order to sustain a heroin habit or whatever.

Mr EDWARDS—In your view, does the lack of support lead to or hasten a process of reoffending?

Mrs Solomon—Of course it does. When I was doing a drug program at Curtin University, we had to do some research. Mine was talking to all the prisoners I could get hold of and saying to them, 'How did you come to relapse?' These were people who were back in jail for their eighth or ninth time. The two things that came out of this were, 'I had no-one to talk to about my problems,' and 'I got back into drugs.' I know that there are some blokes, with the best will in the world, waiting for their mates, with a girl and a syringe already filled in the back of the van to celebrate when they get out. If I collect them, they are not going to do that; at least we have got a bit of time. I think there is a quick return to drug use, because what else is there for them? We use chemicals to medicate pain, don't we, whether it is emotional pain or physical pain? So if you are bewildered, you do not know where to go and you do not know what to do, what has worked for you in the past is a shot or a smoke or whatever. Am I answering your question?

Mr EDWARDS—I want it on the record. That is why I have asked you the question.

Mrs Solomon—I think that that is the problem. They quickly go back to what they know because they are not comfortable, because they have not been prepared, because there is no-one to care. They say, 'I had no-one to talk to. I was lonely. Someone rang me up and said, "How are you, are you okay?"' I have found that a letter and a birthday card are the best things in the world, because I care.

CHAIR—You may or may not be aware of it, but from about 1993 to 1998 the Queensland jail population doubled.

Mrs Solomon—I know.

CHAIR—For women it has trebled. Bearing in mind the increase in the general population, that is quite remarkable.

Mrs Solomon—It is, and the crime rate has not escalated all that much. But we have some strange politicians in Queensland who believe that the answer to the problem—

CHAIR—I couldn't possibly comment on that!

Mrs IRWIN—There are some strange politicians in Canberra!

Mrs Solomon—I have actually heard a corrective services minister, when I approached him—this is why I got so ruffled with Mr Edwards yesterday, because I had done this before—

CHAIR—He was the de facto Queensland politician.

Mrs Solomon—I actually went to the minister and said, 'This is not working—people are dying in jail because people won't tell someone that their mate has overdosed.' I have had to give evidence in coroners courts because one of my clients died and their mate would not tell someone about it. If they did they got a week in solitary, no contact visits, and it was all written on their record—so who was going to dob a mate? They are dying. I went to see the corrective services minister and he said, 'Yes, I understand what you are saying, but in the long term I will listen to my constituents, and they want me to be tough on crime.' What sort of solution is that?

Mr EDWARDS—Earlier, we asked why the prison population had trebled in that short period of time. Can we ask you the same question?

Mrs Solomon—Why has this happened?

Mr EDWARDS—Yes.

Mrs Solomon—I think it was because they were not letting them out at the end. The parole boards are too scared, and I have evidence of that. In front of a father and a client, as advocate I went to the parole board. The chairman of that board said, 'If we let them out too soon, we will get sacked.' You will remember that there is a history here of a parole board being sacked: the total board went because somebody those people had let out had reoffended. Of course you are

going to have this happen, but what about all the ones that are successful? There was that big blockage at the external end where people were not let out when they should have been.

Mr Young—The longer you keep them in, the more you add to the problem. The thing we have not mentioned about that same incident is that we do a lot of work in the Ipswich area, and around these prisons you have the families moving in, with a whole range of issues as well, to be near the one who is in prison. They need an enormous amount of support—not only drug and alcohol support but a whole range of support—because, quite often, their main income source is now inside. Quite often, we forget the needs of the families associated with them and, when hundreds of these families move into an area, the impact that has on the general community as well. We need to broaden it from just the inmate perspective to that of the community and the families.

Mr QUICK—So the whole of government approach in *Beyond a quick fix* sounds nice, but it is not operating?

Mr Young—We have bandaged around this whole of government approach. What we would like to see, of course, is a truly whole of government approach. We would love to see a minister with responsibility for at least illicit drugs—it would be great if we could get drugs and alcohol included—with the issue taken out of all departments and somebody singularly focused on coordinating that tremendous effort. I know that we have a go at our government colleagues, but the workers in government departments have enormous stresses, strains, workloads and caseloads. They are doing a great job, but they are under pressure. It would be good to have a minister who had power, at whatever level, to pull those resources together so that we do not have the boundary issues between families, health, police, transport and all the other issues involved in the question.

You may say that in Queensland that is the Premier and that federally it is the Prime Minister, but it would be good to formalise that. What I have said previously is that we certainly need to look at the linkages between mental health, homelessness, youth suicide, and drugs and alcohol. They are just four different factors of the same issue. If we separate them like we do at the moment, we will need to get better linkages and we will need to get them more interrelated, and that would be a big benefit.

Mr QUICK—One of the things that I am really interested in is the message that parents are putting out—the reluctance of parents and their abrogation in not coming up with something—and the whole issue of kids' peers sending the message rather than the parents: second and third marriages are the norm rather than the exception, and the kids are losing it. What message, if any, would you send out to parents? That it is hopeless? That it is a crisis?

Mr Young—No. We do not believe that it is hopeless. When I talk to parents and say that there is a body of literature out there that really does suggest that parents with a good relationship with their young people can in fact have a major influence and can, in some cases, counteract peer pressure, I find that a lot of parents do not believe me: they have thrown up their hands and are thinking that the situation is lost. I would encourage the idea that we need to resource parents, not necessarily with money but with skills and knowledge. Parents are probably the greatest untapped resource. I am not meaning the traditional family structure, but we need to resource families and extended families so that they can better cope with and manage the issues.

That is what Rowena Solomon is doing, in part, with her home visitations. By going in and taking some of the stress out of those family situations, we can reduce the interaction in that family where the whole family functions at a different level. We would certainly encourage more resources to be focused on families, to strengthen them and give them increased skills to better cope. I know that is being done in some areas but, across the board, we probably do not resource the communities sufficiently. We are finding that, when we have been brave enough to stand back and allow young people to run the forums, decide the issues and come up with strategies—and you have met some of those young people all around the nation—they come up with tremendous strategies and enthusiasm, and they do make a difference. I really believe that the communities can do the same thing.

Mr QUICK—I can cite an example of a parent with two young siblings, 15 and 13, and a heroin addict of 20 who has come home and disrupted the whole place again. Mum cannot cope. The education of the two boys is suffering in the vital years. The only solution is go to the doctor and be prescribed antidepressants. That is one of tens of thousands of cases. The education department are trying to cope but they do not know that mum is on antidepressants. The GP does not talk to the education department. The school counsellors at the high school do not understand. The heroin addict cannot get into detox or rehab because there are no vacancies for a couple of weeks. He wants to make a difference in his life. There is nothing of value in the house because, if there were, it would be sold: the temptation is too great. This is a microcosm that is replicated in tens of thousands of families around Australia. We have the whole of government approach—

CHAIR—We need to starting winding it up.

Mr QUICK—What do we say to that mother?

Mrs Solomon—Well, they can ring up the HART program.

Mr QUICK—But that is in Tasmania. We do not have it.

Mrs Solomon—But the HART program is the prototype. What you describe is exactly what our volunteers are meeting four or five times a day. What we are saying to them is, 'Let us sit down with you and help you with strategies. What are you doing that is making it easy for that person to continue what they are doing? Are you paying the fines? Are you ringing up work when they are hung over?'

Mr QUICK—Or buying the heroin?

Mrs Solomon—Yes. Some of them are doling it out, so they will not do too much. We have to sit down and say, 'Let us look at your behaviour. We will help you design strategies that make it difficult for the user to keep doing what they are doing.' People do not change until it gets bad enough. Make the negatives pile up and get the whole family involved in this—the kids, grandma, every significant other—and all working to the one plan.

Mr Young—Rowena is not talking about kicking people out on the streets and things like that. We do not have that sort of objective.

Mr EDWARDS—Something you said earlier, which I fully agree with and support, is the need for greater prevention. In summary, is your home visitation and support program one of your most positive prevention types of program?

Mr Young—We would see that more as a support program than as a prevention program. We would see our community capacity building more in the prevention side where we get in early, identify risk factors and work with, and empower, the community. Some communities need leaders, and I do not mean elected leaders.

Mr EDWARDS—Some nations need leaders!

Mr Young—To give you an example, the Anzac Day monument where I live was destroyed. The community was devastated. Two or three natural leaders, who had been just other folk, took the lead. Within six months, they had raised an enormous amount of money to rebuild it and the community now has a focus it never had before. These folk had been in the community for 30 years, but had never before had or seen the opportunity. There are many folk out there in these communities who can assume leadership roles. Perhaps we need to identify them, give them a bit of training and encourage them. I think you would find that these unsung leaders out there are unresouced capital that we are not using.

CHAIR—On that note, I think it would be appropriate to thank you. It was very much appreciated and it was an excellent session for us. Thank you all very much for your contribution today.

[11.43 a.m.]

ALDRED, Mr Robert Keith, Chief Executive Officer, Alcohol and Drug Foundation—Queensland

CHAIR—I welcome you to this public hearing. Perhaps you would like to make an opening statement.

Mr Aldred—I will give just a bit of background, for Julia's sake more than anyone else's, as you have all seen a lot about what we are doing. The foundation has existed since 1974. We run a range of programs which we attempt to integrate into a continuum-of-care model. They range from prevention with a natural high alternative program for young people which promotes activities as alternatives to drugs through to a program at Logan House for people who require rehabilitation after detox. A families program, in alliance with the Holyoake Institute on Alcohol and Addictions, is addressing the family members of users and it is integrated into our Logan House program. We have a program of assessment towards treatment for people in prison. They are assessed over a three-week, full-time program prior to release and are then assessed in respect of the best treatment and exit strategy on leaving prison.

We also run the Winter School in the Sun, which is in its 14th year and which last year attracted over 700 delegates. There is the Queensland Drug Forum, which has a mailing list of about 400, and we videoconference across seven centres in Queensland to link people, primarily in the not-for-profit sector but we take in the government sector as well, on professional development training information resources. That is a major part of our networking role. We produce a range of professional and for-public-consumption magazines and resources. That gives you a bit of the flavour of where we are coming from.

Philosophically, we believe that drugs are highly beneficial to society; that without drugs we would not have the tools to treat a lot of mental illness such as depression. Drugs are useful socially, as we have seen with alcohol, whether it is commemorating a wedding or celebrating the Eucharist at church. Unfortunately, however, many of these drugs are also the drugs which are used illegally or have their counterparts which are regarded as illicit drugs. Therefore, we are committed to a harm reduction and responsible usage approach. In terms of our submission today, we have attempted to address your terms of reference under the headings of family relationships, crime and violence, road trauma, et cetera. We have made a number of recommendations in which we have not only tried to look at the deficiencies in programs but also at some of the causal issues of drug abuse and some other alternatives.

To understand the drug problem, we try to get across the concept that this is not just a health problem or a social problem; it is very much a political problem and an economic problem. In this country we place a tremendous number of barriers against being able to reduce the harm. These are often political barriers, from international treaties to the difficulties in the political scene of being able to placate the electorate. There is often the temptation to take the 'get tough' approach rather than a far more balanced approach. We believe that there is an out-of-weight distribution of funds, with 84 per cent going to crime reduction and a very small amount going to treatments. We believe that supply-demand needs to be balanced and that far more demand reduction strategies need to be put into place.

We see a resistance to research, as is seen from the resistance in the community and by many politicians to such things as heroin trials and injecting rooms. We would support those as trials. We would like to see a lot more research and a lot more innovation carried out. We are also very concerned that many things are seen as not working whereas in fact they are legitimate strategies which do not work, not because the strategy is wrong but often because the resources are not there, the wrong people are doing it or the strategy is not being implemented in a sustainable and continuos way.

Mr QUICK—Can you give us an example?

Mr Aldred—One of those would be the Safety Action Program in Queensland, which was able to reduce alcohol related violence in Townsville by 83 per cent but which fell over because it did not have the resources to back it.

CHAIR—How much money would have been required to sustain that program?

Mr Aldred—It was running in Townsville on less than $100,000 a year. It started off in Surfers Paradise, it has been in Mackay and it has been proven in other places. You can also look at Patron Care, which originated in Queensland and which has now been reduced to a video sent out to hoteliers. There is a range of those types of programs which are prevention programs. They are interventions that prevent things from happening.

Mr QUICK—Are we getting towards the American system of having political pressure imposed on state and perhaps federal members of parliament by lobby groups? In a particular area there might be a particular industry that needs protecting. I refer, for example, to the club movement and the pokies issue in New South Wales. Coming from Tasmania, the club movement in New South Wales seems to have an inordinate influence on state politicians and political parties because of the huge number of patrons that frequent clubs. If you cut down the number of poker machines or increase the franchise fee, you suddenly have 10,000 people at club A putting pressure on their local politician. Are we seeing those sorts of decisions being made in Queensland?

Mr Aldred—I think vested interests are very much part of the toing-and-froing of the political field. I would not have said that in the example I gave, because that was an effort of nightclub owners, local government and police. But, for reasons one cannot always understand, the pot of money was not seen as being there to go by somebody who made a decision. But, overall, the political barriers are certainly there within the field and those barriers come just as much from the influence of the International Narcotics Control Board, which pushed the Prime Minister to veto the decision of six health ministers to go along with the heroin trial. So international pressure is something that this country is subjected to. This is something, of course, which we would expect when we are talking about the globalisation of drugs, eight per cent of world trade, and Australia laundering over $3.5 billion—most of it drug money—and spending over $7 billion on illicit drugs.

We are part of a global drug economy, and one of the biggest problems that we have in being able to curb the supply end of the market is money laundering. In this country, the protection of client confidentiality of law firms and of financial institutions—and this is all well documented—means that money laundering is almost impossible to detect. Where it has been

detected, very little action has been taken against those sorts of people. The penalties are fairly small and the risk of getting caught is very small, so we are pushing money out of this country and around this country.

CHAIR—What about in the state of Queensland, for example, with marijuana—I understand there are some publicly available CJC figures which suggest that marijuana is probably one of the big cash crops of Queensland and is not that far behind sugar cane even.

Mr Aldred—That is right. The report you are referring to—the green discussion paper—came out in 1992. I was on the committee. It was the second largest cash crop at that time. As a committee, we were able to see and to track how the growers who picked up the wholesale price of cannabis to supplement their income were then spending that money in the local economy. If that money stopped flowing into the local economy, it would have had a devastating effect on those local economies.

CHAIR—To pick up Mr Quick's point—there are vested interests. Are you suggesting, therefore, that the vested interests are such that vigilance against this sort of illegal trade is not as vigilant as it might be?

Mr Aldred—Absolutely. You are talking about so much money that you have to ask yourself the question, 'How can we spend, in Queensland, $400 million on amphetamines?' And they are old figures now. The figures on cannabis are even older, but we are spending $360 million at street level prices—and nobody is doing anything about it. There have got to be vested interests in it. From a political point of view, any politician who does anything that significantly impacts on that sort of money is going to have a lot of vested interests trying to protect those interests, because we are all going to suffer by it. We have been able to show that.

In the economic side of the debate on drugs, most of the time we concentrate on what we could save if we did not have this problem. In other words, we have 900 hospital admissions a week in Queensland for alcohol, tobacco and drugs. How much could we save if we could cut that back? We have got over 80 per cent of property crime. How much could we save on all of that? But there is the other side of the ledger that we also have to consider and that is how many jobs would be lost if that 80 per cent of property crime was significantly reduced and we did not need the tradesmen to repair it. You have got those issues. How many jobs would be lost if we reduced the hospital admissions per week by half? Those issues are the pressures that people in politics have to weigh. The best example, going back to Harry's question on vested interests, is that it took us six years in Queensland to raise the age at which you can purchase tobacco from 16 to 18. To my knowledge, we have now had two prosecutions for those and hundreds of warnings. Those two prosecutions are the first prosecutions since 1906. We are really doing quite well statistically on that. One of those prosecutions—

Mrs IRWIN—I would rather none.

Mr Aldred—One of those prosecutions was a chance one by a policeman who happened to be shopping at the time. Vested interests are there. They are the major things. This is not just a social and health issue. It is also very much a political and economic issue until we can do something about that huge money flow. On the supply side, by the crime commission's figures here in Queensland, we are only intercepting about one per cent of amphetamines. That is all we

are intercepting on supply. There have been two studies done, one out of South Australia and one other. Both have come up with an intercept rate on heroin at about three per cent. The big hauls of recent times would be blips on the market and usually do not really interrupt supply for very long as we have seen with the local heroin drought that has hit across the country and up here as well. We suspect that is more about market forces and market manipulation than about intercepts.

Mr EDWARDS—Do you base that on any evidence?

Mr Aldred—There has been evidence even in the illicit drugs report. You need to start looking at international drug and money flows and how long it takes before the drugs can flow back onto the market. Some of the work by people like Paul Dillon and others for NDARC also has been able to show just where drugs have been able to come in and plug a hole in the market fairly quickly. The other issue, which we touched on yesterday but it is worth saying again today, is that if we do have a major interruption of supply—and this was demonstrated by the heroin drought up here—we then have a huge pressure placed on already overloaded treatment services. We saw that within 48 hours we suddenly had too many people queuing for methadone, wanting to get into Logan House and wanting to find other alternatives. You do have some major problems there which come down to the necessity for us to have a drug strategy in Australia, both at a national and state level. I am not talking about the paltry documents and papers that have come out under those headings at the present time which do not constitute strategies at all. Certainly I would never run a small business on them. We need strategies which have got goals and objectives in terms of harm reduction and minimisation.

We have to come to a decision in this country as to what is the minimum level of drugs that we can achieve which the country is going to have to accept that it can handle and what are the reduction steps to get down to that. Until we come up with those things—until we can say, ‘Here is another $200 million and this is what it is going to achieve in real terms’, then we are not going to get anywhere. That is, until we can equate the figures that we do have in a similar way to the way we equate unemployment figures and say, ‘If we’ve got 25 per cent smoking now, we are going to get to 20 per cent. We’ve got 900 hospital beds, we are going to get down to that. If we have got 50 per cent penetration of the market with needle programs, are we going to get 75 per cent of the market?’

If we do not do those things, we are going to set ourselves up for some major problems in the future, particularly on the needle programs, because we are setting ourselves up for a five to seven-year lag time before the epidemic hits. We have got a huge increase in the number of users and the number of injectors—and we are getting the injectors here at 13 and 14 straight into amphetamines in Queensland, different from other states—and we are frightened they are going to move across into the heroin market. Because of the amphetamine levels in Queensland we have our needles programs in the far west and the far north-west of the state, not just in the heavily populated areas, and it is more difficult out in those places to push the programs of needles and not using dirties, so we really have to put a lot of those things into place.

Mrs IRWIN—What do you mean you find it harder to implement those programs in those areas? Is it the councils, the local officials or the community as a whole?

Mr Aldred—People will not work out there. You have got low levels of GPs and health workers. Who wants to work in a place where you are hundreds of miles from anywhere and your family is back here in Brisbane? Half of our population is in south-east Queensland. Most of the rest are scattered along the coast and when you get outside of that, what have you got? The drugs like amphetamines are easily mobilised into those areas. The market is good and they are injecting. We are setting ourselves up for some pretty horrific future unless we can come up with a major plan. The other thing I would like to say on this side too is that it is very easy in these discussions to go down the track of all the negatives. There are many positives there. We are seeing a lot of those positives. We need to get positive messages out. That is one of the reasons we have chosen to go down the way of a natural high as against get tough on drugs and say no to drugs. At Logan House, in our program, we have pushed our completion rate up to over 60 per cent. Last year we had seven people accepted to university.

Mrs IRWIN—Fantastic.

Mr Aldred—Some of you people met those people yesterday. One fellow you met started his university course in prison and will complete it after he leaves Logan House. We have got links with service clubs. We are getting people back into work. My staff is saying that last year anybody who wanted to go into a study or training program or into work achieved it. We can do that with people. There are many positive things that we can do. There are programs out there which could achieve a great deal. We need to concentrate on those positive achievements. We are doing that through setting up strategic alliances with people such as Holyoake. We have negotiated with a number of private hospitals at the present time to try to deliver a whole continuum of care approach. We have got away from the defeatist attitude that we have in places such as education where up here we say we can get no behavioural change in terms of drugs in drug education. We can only get education outcomes. It is a defeatist attitude and we put $50,000 into drug education from the state this year for the whole of Queensland. That is defeatism. We have got to find other ways of doing things.

Mr QUICK—Are there too many players in the field? I say that advisedly because to my mind there seems to be a patchwork out there. Federal and state governments tend to fund drayloads of NGOs that never have enough money. There are not enough cars and counsellors. You build up the expectation of success—

Mr Aldred—I do not think that there are too many players. There is too much fragmentation. I heard Dennis saying earlier about having a minister for drugs. That is getting down to one of the problems we have. It is the lack of coordination, of a strategic plan and of people working together.

Mr QUICK—We had the Queensland government today saying this is a whole of government approach and all the answers are in there.

Mr Aldred—Can I swear? That is just nonsense. That book that you have has nothing at all in it in terms of goals, objectives or outcomes that are measurable. When we have challenged that, they have said, ‘That comes out in the action plans.’ We have now had two action plans produced—one on tobacco and one on alcohol.

Mr QUICK—Yes. That is what they said to me.

Mr Aldred—And they do not have it, either. I have had discussions with Professor Lowe on the tobacco issue, in light of the achievement in California of a 12 per cent level of consumers. He has far more insight than I have, but his estimate is that an achievable goal with tobacco would be to bring down the number of consumers to 18 per cent. Why do we not put that in there? Even if we reduced it by two per cent in the next five years, it would be far better than aiming at nothing and getting nowhere. Queensland is famous for the fact that we have had a series of dirty ashtray awards, and then we get cock-a-hoop because we changed that and came only second. That is not good enough. We have to set those goals and we have to be able to say, 'This is what we are going to achieve.' The government expects it of us. Every three months, we give government reams of evaluations on which we get no feedback, but we are able to show and able to argue our case, because we do have that and things are achievable. That sort of document is getting us nowhere.

We are advocating that we should have a coordinating body that is independent of government—such as, say, a drug commission, similar to our children's commission or to our Crime Commission—and that it should not be an all of government approach, it should be an all of community approach, and that we should recognise that there is expertise outside of government. If government wants to talk about an all of government approach, government should take the blame for all the drug problems that we have and not blame somebody else for them. We want to go into an all of community approach. We want to be part of the drugs strategic plan development. We were promised two places on that from the community sector, but that was changed, and now we have four hours consultation every 12 months, which is an insult to the expertise that is out there.

CHAIR—There seems to be a culture of denial—barriers, location and a lack of openness, and I think you have your own example: you have to have some serious scrutiny. It is standard practice across the country—I was listening to my colleagues—that you can barely breathe without getting something signed off. I understand that you have service agreements.

Mr Aldred—We have not signed our service agreements, because the service agreements contain clause 19, which says that we cannot publish, print or electronically put anything on the Internet without the government's approval. We are not prepared to abide by that, so we are still negotiating on that issue. That is part of the total managerialism approach that governments unfortunately impose on us.

CHAIR—It goes two ways: if there is a solution, the government should be in there and doing it, and that is what people expect, but what you have described to us is that it is not going to happen under this sort of approach unless you get this external capacity to have a total-community approach.

Mr Aldred—That is right, yes. I have been in the field for 15 years. When I first came into the field, we did not have to put in reams of evaluation. What we did have was a person like Mike Bolton, who was director of our alcohol and drugs service, sitting on and chairing some of our committees. We had a program in the workplace with a mix—

CHAIR—That was a government official?

Mr Aldred—By mixture: he was there officially, but he was also a member of our foundation.

CHAIR—He was an equal member?

Mr Aldred—There was a total integration, so that the programs that we ran were evaluated by the committee which contained both groups from government and non-government sitting on the same committee. My service agreement now states that I cannot say that we are in partnership with government; we cannot say that. The concept of partnership has now been dissolved. To quote Julie Nylan's work from the Third Sector Research Association, we are now the little fingers of government. This is a great concern. If the charity and community sectors are simply the people doing the work which is managed by government, we are going to cripple the spirit of community which wants to come and do things. What is already happening is that an array of other groups, about which you are going to be concerned, are coming from all sorts of angles, philosophies and perspectives and they are not receiving government funding. They are placing their clients and themselves in jeopardy through common law.

CHAIR—Some of this defies logic. Why would you not simply say 'in partnership'? What is the motivation? Is it an excess sensitivity or total control?

Mr Aldred—I think lawyers have drawn up service agreements and they have used partnerships in the legal term of shared liabilities.

CHAIR—Okay.

Mr Aldred—But in so doing they have worded that to protect government to the point that we cannot use the word 'partnership'. Government still uses 'partnership'.

CHAIR—Yes.

Mr Aldred—But legally we cannot use the term 'partnership'. And one would have to question a partnership which is very much a partnership along the lines of, 'This is what you're going to do, and this is how you're going to do it,' instead of genuinely sitting down and developing a Queensland strategy which recognises the things that work, how they work best, and the things that probably are not worth pursuing, and looking at a definition of the problem. Even that is a problem up here. There was a huge timelag in recognising that we had an amphetamine problem. Crime commission figures show there are 85,000 amphetamine users, but if you talk to people in the field, they will say that those figures are three years old. The figure is probably much higher because of methylamphetamine being on the market, because of the huge rise in injecting and because we doubt whether the trucking industry's figures have been included. We really have to have that sort of benchmark. We have to define our problem, determine what is achievable and then put a strategy in place for achieving that goal. We have to have the resources to make that possible.

CHAIR—Returning to benchmarking and research, who should be out there, independently, doing that? Should it be the Institute of Criminology or a combination of academics and industry? What structure will give us the outcome on research that we just have to have to get down to developing some of this stuff?

Mr Aldred—The institutions you mentioned are all very competent researchers. The issue we need to face in research—an issue about which a number of the media people, including Tony Koch in his column in last Saturday's paper, are currently asking questions—is why this information that we do know is there is being withheld. The other issue which was not covered in that article, but which concerns us, is that research is being controlled by government. In that regard, I am talking about withholding data and the fact that the final report will only release the results which are palatable to government. In relation to control of the outcomes, it was stated to me that the section 19 that I referred to before was more relevant to research. In other words, the researcher cannot state exactly what he has found unless it has the approval of government. We sought to investigate this and we have a number of cases of researchers who have intimated to us their concern about this kind of control or manipulation of research, but they are not willing to come out and say it openly. There is an awareness among the media that this is happening and it is going to hit the fan at some point in time.

CHAIR—This will challenge the whole credibility of the effort.

Mr Aldred—Absolutely. We have been concerned for many years about pharmaceutical companies and the brewers funding research, but today we have to be very concerned about government funding research. A recommendation that certainly we would put up would be that any research that is commissioned has got to be commissioned one step removed from that sort of government influence.

CHAIR—At the very least there should be an understanding that the results have public ownership.

Mr Aldred—The data has to be public. I have a report now that has just been produced by the police, and the researcher looked at the national household survey data and came up with a different result to the national household survey, and made mention of that publicly in that report. So we are not talking about just opinions here. The reason for the difference was that they saw fit to recategorise some of the data. That puts the antennas up. If you are getting even two and three per cent differences in outcomes, that can be significant in terms of population numbers. I do not think that is a tolerable situation, because if we do not have reliable data, we cannot define our problem. If we cannot define our problem, we do not know what we are up against, so we cannot get a strategy or an outcome. Eighteen months ago, the Premier in Queensland said that there were 9,000 heroin users. Now we say there are 17,000 heroin users. How the hell do we know that we have not got 170,000? That is not good enough.

Mr EDWARDS—You spoke about a Queensland strategy, and people often say to us that what works in Western Australia might not work in Queensland and vice versa, and I accept that, but do you think it is beyond us to come up with an Australian strategy?

Mr Aldred—No, I do not think so. I think they have all got to be integrated. Our foundation is currently running forums around the state with a model adapted from New South Wales on local strategies. That will bring together business, media, educators, government and non-government in each local community. Our aim is to facilitate the development of local strategies. There should be an integration up the pile, because the way our system works is that the tax money goes firstly to the feds and comes through in various ways to other groups. It may come to the state or come straight to us or to another not-for-profit organisation or another

service provider or to local government for development there. But, in all of that, we need to be able to track that money.

That is another issue that a couple of us had a talk about yesterday—we have absolutely no idea here in Queensland of how the federal money is being spent by the time it gets through Queensland Treasury, Queensland Health and 39 health districts. I have talked to people in the regions and said, ‘How have you got so many staff?’ and they said, ‘We got them under public drunkenness funding.’ And I say, ‘How are you dealing with public drunkenness?’ And they say, ‘We are not dealing with public drunkenness, we are doing treatment.’ Where is that dollar going and how much of that is being absorbed in the administrative process? From a charity point of view, I can be questioned very publicly and openly on how much of the charity dollar goes into service delivery. I wonder what would be the answer if I asked that about the money that starts off in Canberra by the time it ends up in Cunnamulla.

CHAIR—You mean, what is the percentage on the ground delivering that service?

Mr Aldred—Absolutely. I think all of that is part of this integration and I think it has to be independent. As one politician here in Queensland said to me, the problem we have here is that government has too many vested interests in the drug trade. And that politician is right. Whether it is the legal trade or the illegal trade, for reasons we have already said, it is hard for government to be independent in its policy because it is pressured by a whole range of vested interests in both the legal and illegal area, and it is also pressured by the impact on the economy from both the legal and the illegal area. So they need to be far more transparent by having far greater independence.

Mr QUICK—Can I bring back you to data in areas that we have not covered or spoken much about: road trauma, workplace safety and productivity? Are we facing the same problem of not having any statistics and not having a ‘testing regime’ to say how large the problem is, therefore we need to allocate a certain amount of money? Have we got Queensland not doing something on road trauma with drug and alcohol and substance abuse testing because they cannot afford to do it? We have to wait until the feds come up with a testing program for marijuana. I notice some figures in here. It varies from 10 per cent in Tasmania to nearly 20 per cent in Victoria but no-one really knows because there has not been a test yet. We can have one for the Olympic games but we cannot have one for the roadside. What are your views on this issue of data collection and testing for road trauma, workplace safety and productivity?

Mr Aldred—The core of that problem is the fact that we do not keep statistics and there are some legal reasons for some of the problems. We do not test comatose patients for blood alcohol levels, let alone any other drugs. Doctors want to have protection against charges of assault should it go to court. Doctors really do not want to go to court anyway to testify. The problems of being sure that the tests were taken in time in an accident emergency department could easily be challenged in court. It is the same as an Olympian will challenge the procedure as to whether a test was tampered with or not. The problem is bigger than what you are alluding to. The problem in Queensland is one in which we have no central collection of data from coroners’ courts. Each coroner’s court collects their data. Macquarie University is having great trouble trying to do some research because of that. We have been given examples such as every single vehicle road accident is recorded as fatigue. We would say it could be a whole range of issues and probably alcohol would be a part of it. It is the same with the collection of all crime

statistics. If there is a statistic that says it is a hold-up, is there anything there to tell us that it was drug related? We do not know. We get a very poor picture.

Mr QUICK—Yet if you ran a business like that, on that inference and hypothecation and the like, you would not survive. But somehow governments and departments seem to have this never-ending supply of money to fudge around the edges.

Mr Aldred—That keeps coming back to the issue. I do not think the issue that we are facing here in trying to reduce the drug problem is just centred on the resourcing of programs. That is one of many issues that is in there along with training, qualifications, experience, location and integration of services et cetera. The problem keeps coming back to the fact that we cannot define the problem and we have not got the political will to come up with goals that will hold us to an evaluation as a country as to what we should be achieving. We have some terrible situations. You know it in Cabramatta. We have been able to hide it up here much better than you have been able to do down there. But the time will come when this will become a far more visible problem. At the moment it is just needles in parks and the occasional story that comes up. We also need to address some of the causal problems. I have put a couple of things in my submission. The issue of responsibility of parents could be addressed. For instance, for a child to receive a youth homeless allowance today, the parents in normal cases have to say that the child is not welcome back in the home. If that is not the case, then the Centrelink social worker should obtain three reports as to that child being in danger before they can get a youth homeless allowance.

That is fairly strict legislation. We would recommend in such a case that the parents of a homeless child should be forced to pay the homeless allowance through the Child Support Agency, so there might be some more responsibility taken there. We would also like consideration given to making parents—as a prevention measure—complete a parenting course before they can get family allowance. These are fairly contentious issues, but I think we have got to start being a bit more lateral in looking at the causal problems of some of these issues and not have children tipped out on the street simply because the de facto does not want them, they do not get on with their siblings, they have got a boyfriend or they do not like to play by the rules. Some of those reasons are not acceptable. Why should we be picking up the tab? More importantly, as a community we should be saying to those parents, 'Hey, just a minute, this is your responsibility. If you want support, we will give you support, but we are not going to make it easy for you to tip your kid out on the street.' I speak from a daily experience of having a wife who is a senior social worker at Centrelink dealing with these parents at a very high rate. I hasten to say, on the public record, that we observe total confidentiality within that. I hope that does not jeopardise anybody!

The other area that I think we need to look at is that a lot of our problems come out of poverty traps. One of the things which I would like to see considered is that all welfare payments be made tax free. At the present time, if you lose your job at this time of the year and you have been working up to now, all of the dole payments from now on are going to be taxed because that is added on to your total income. The result of that is that the backpackers pick up the short-term work, because it is not financially viable to pick up two days here and three days there and have to go back to Centrelink and have your amounts adjusted and all of those sorts of things. If the sums were done, my guess is that we would get more people off welfare and so we would save more money than we are by collecting the tax from the few who get there, even if

we got all the money that they could earn. I think that is the way that we have got to go. We have got to find some ways of encouraging people into those things and getting people out of those poverty traps and working those systems.

Mr QUICK—You mentioned 800 divorces each week on average in Australia.

Mr Aldred—We actually hit over 1,000 a week for a while after the Murphy Family Law Act, but it has come back now to around 800. That is now accepted as being about the minimum we are going to have. That is an indictment of society. Our families program is trying to break the cycle. It is often two or three generations of people not knowing how to deal with their problems.

Mrs IRWIN—I just want to go on to your submission and the recommendations you have put in. Some of them are excellent. What concerned me was recommendation No. 5 on page 4, where you state:

> As treatment facilities and services are grossly inadequate, we recommend that there be a short-term increase in the number of treatment beds in Queensland to 1,000 ...

How many treatment beds are there at the moment?

Mr Aldred—You cannot be exact. There are two documents in Queensland: one is the inventory of services done by Queensland Health and the other is our directory of alcohol and drug services in Queensland, which is broader. They pick up specialist health services and we pick up specialist as well as other services, which may be part of a general service. Our estimation is that, without the indigenous services—which are mostly accommodation based—we would have probably around 450 rehab beds.

The reason for that is that Queensland regards rehabilitation beds as not being cost effective. There is some justification for that. If you cost out all rehabs on long-term programs—I am talking of programs such as the ones we used to run which were nine-month to 18-month programs—we would have to agree that the cost effectiveness there is pretty hard to justify. We have changed ours to an intense three-month program, so it is costing about $5,000 per person for those who complete the program. That is what we are seeing with the drug caught people that we have. That is very cost effective. If you put a person through for $5,000 and have them in employment or into education and training, you have a very effective program. Even though the relapse rate is much better than we have ever had before, it is still around 40 per cent on early figures.

I do not have figures because the program has not been in long enough to really come up with firm figures. But, even at that, it is still far better than what we are getting on, say, a methadone program, where we know 50 per cent of people are still using heroin anyway. They will be on that for three, four, five or 10 years. The Queensland policy is that we ought to treat methadone like insulin so it can be a lifelong thing if they want it. We are not against methadone but we certainly think it does not have the counselling, support and guidance at a level that it should have. It is often a matter of stabilising people and putting people on to the program and letting them sit there. Those 1,000 beds are still only going to scratch the surface. For a facility to be

economical, in our estimation it needs to be up to around 70 or 80 beds. We are getting a submission ready—to go up to about 80 beds—for counsel at the moment.

Mrs IRWIN—What is the waiting time at the moment for someone to get a treatment bed?

Mr Aldred—I wish you would not ask me those questions. Waiting times are a bit of a furphy. It is more accurate to say that it is very difficult to get in. If a person is on a waiting list of 24 to 48 hours, the chances are they will not stay on the list anyway, or a person will be on three or four waiting lists at the one time. If their motivation keeps them there and they do not give up and go back to using, they could still wait for some time, but it is difficult. At Logan House, because of our program—because of the way we put them through—we graduate people every week. We have some beds coming up every week. But some people may still have to wait three or four weeks. Something can go wrong—for instance, somebody might do the wrong thing and we might tip out four or five because of their behaviour—and suddenly we will take people in. It is more a matter of being in the right spot at the right time with the right attitude to get a bed, rather than to say that we have a six-week thing. Everybody is full. My staff say that, if I had 80 beds tomorrow, they would fill them.

Mrs IRWIN—I bet they would.

Mr Aldred—Yes, without a problem. It is an absolute tragedy and heartbreak in Queensland that we have no beds for under-18s. We have five detox beds. Those five detox beds require a Brisbane residential address. So, if you live at Cleveland, Beenleigh or Redcliffe, you do not get in. We have a few other places that are taking those who are under age, mainly in the more fundamentalist church area, where there are requirements for a strong religious background. With the uptake of injecting drug use now frequently around 13 and 14, we take parents down the track of having to face up to the fact that the child could get into a life of crime and prostitution—and we do this with a great deal of sensitivity.

Mrs IRWIN—Or the child could even die in some cases.

Mr Aldred—Yes, although the death rate seems to be more with the older ones. Their best chance of treatment is in prison, which is far from adequate anyway. It is a tragic situation. I presented a paper on this at the Harm Reduction Conference in Jersey last year, and I did not get full support by any stretch of the imagination. For people who are at risk of harming themselves and others—particularly minors—we need to look at a compulsory period of assessment. That naturally would include some detox with some education; it would give kids options and start intervention early.

Why should we wait until those kids have sold their bodies before we start to do something about them? If a kid fell over and broke his ribs or an arm, we would take him into hospital. The Mental Health Act takes them in for three days. That is pretty well useless. I get frequent phone calls from parents who are being threatened and abused by their drug-taking children—who may be 34, not 14—and do not qualify under the Mental Health Act. The only advice we can give them is to escape out the back door and find a motel. That is just not good enough.

CHAIR—There is a real gap in the under 18s.

Mr Aldred—For the under 18s you have nothing. If you are the parent of a child who is under 18, your best option is to go and buy the drugs for them and make sure they take them safely—and that is what parents are doing.

Mrs IRWIN—That is actually happening in my electorate.

Mr Aldred—It is happening everywhere.

Mrs IRWIN—A mother is actually buying for her 14-year-old son and he is injecting in the bathroom. She says that at least she is there if something goes wrong and she can save his life while she is trying to get some sort of facility that will take him. It is sad.

Mr Aldred—That is happening far more than people understand.

Mrs IRWIN—That is right.

Mr Aldred—That is the dreadful part about it. If you go and kidnap your daughter from Kings Cross and take her to Lismore you can be placed in prison.

CHAIR—What is the response from civil libertarians? Have you publicly spoken about a compulsory period of detention for these under-age people?

Mr Aldred—I would not like to use the term ‘detention’. What we have to talk about is compulsory assessment. We are talking about a diversion program. In Jersey my main opposition to that came from the users who were politically advocating normalisation of drugs so they could use them when they liked and who said they should be part and parcel of life. I do not happen to accept that position, nor am I talking about the person who is safely using drugs and doing nobody any harm. I am talking about the people who are a definite harm to themselves or others, including minors. The state takes no responsibility for its wards in this area.

CHAIR—What would be a very reasonable time? If we were to advocate this—

Mr Aldred—A reasonable time would be a minimum of two weeks, with the opportunity to do the same thing you can under the Mental Health Act; take them before a magistrate. If we can argue a case for a further period of time, that is worthwhile. I think the three days under the Mental Health Act is worse than useless. I worked in that area for some time under the Richmond report. We have created so many problems. In Queensland we are now talking about 80 per cent of mental health patients having a drug addiction. Then we have the forgotten people that we brought up yesterday, the ethnic groups. We have nothing here for them. People are saying the acquired brain injury group is at the 50 per cent level. Intellectually handicapped people are another group. The more we take away services from those groups, the worse it is going to get. This is one of the problems. Dennis Young brought this up before. We need to have this interface between suicide, mental health, drugs and all these other groups. We have to keep reminding ourselves that drugs are a symptom of a lot of other problems as well as being a cause of problems.

Mrs IRWIN—I did not have the pleasure of going to Logan House yesterday because I was in my electorate and did not get here until last evening. Is Logan House in a drug affected area?

Mr Aldred—No, it is a rural property. That means we take people right away from the drug affected area.

Mrs IRWIN—That is what I really wanted to know. My electorate of Fowler has Cabramatta within it. People are saying we need a safe injecting room or detox facilities. I agree with those sorts of facilities if they are going to save lives. But it is like having an AA meeting in a brewery. You are saying it is better to move those facilities outside the area?

Mr Aldred—Yes, that has worked out well for us. It has created other problems for us in terms of transport, and the drug court has caused us heaps of problems. I think it has been far better. It is very therapeutic to sit by the river. It is relaxing and it is a stress reliever. If people want to go for a walk they have to really want to walk and they have a long way to walk. Let me just say on those injecting rooms that I think one of the big problems we have with the injecting room debate is that people do not understand what an injecting room is. An injecting room really is an intervention—

Mrs IRWIN—It is a safe place.

Mr Aldred—Yes, it is a safe place but it also is an intervention. It is an education and it is offering people other alternatives. A success criterion for an injecting room would be how many people who use the injecting room moved into treatment. That is often forgotten. I am talking to the media a lot about that these days to say that that needs doing. It is the same with the heroin trial.

Mrs IRWIN—Yes. It is going to be very interesting to see what happens with Kings Cross. If you look at the statistics from overseas countries where they have safe places, I do not think they have had one death and a number of people have got off the drug. I will be interested to see what happens there.

Mr Aldred—Just to finish off, I saw a very interesting one in Jersey presented by a Dutch presenter in which they use the logic that we use here in Queensland on prostitution. You have an injecting room but you license the dealer so you control the dealer—the dealer runs the injecting room. Up here we license the brothel owner and, of course, in the logic of Queensland, we give licences only to highly respectable citizens to run brothels so that we have a high quality.

Mrs IRWIN—Thank you for sharing that with us.

CHAIR—Thank you very much. It is much appreciated. Once again, on behalf of all of us, we really appreciated yesterday.

Mr Aldred—I loved to have your invitation.

Proceedings suspended from 12.42 p.m. to 1.32 p.m.

KILROY, Ms Debbie, Director, Sisters Inside

WARNER, Ms Anne, President, Management Committee, Sisters Inside

CHAIR—Welcome. We do not swear in witnesses, but I need to point out that the proceedings today are legal proceedings of the parliament and as such warrant the same regard as the proceedings of the House of Representatives. Would you like to make an opening statement about where you are coming from and what you see as the issues?

Ms Kilroy—I would like to start by giving you some background history on Sisters Inside. We are a community organisation and we work with women in prison in south-east Queensland. We started in 1992. Our management committee is made up of women in prison and outside prison. We are now an incorporated body—it has taken us many years to become incorporated because of different legislation and the problem of allowing women in prison to be on a management committee. We have, and have had, a number of programs over the years. We continue to receive funding from Queensland Health for sexual assault counselling, and that has been going for seven years. We have programs for drugs and alcohol, and hep C. We have a transition program working with the women while they are in prison and when they are released, and working with their children and their families to bring them back together. We have a number of publications—journals, reports and research.

We apologise for not getting permission from the Department of Corrective Services to visit the women on the management committee inside the prison yesterday; however, we did not receive the information until 5.30 p.m. Monday night to say that the request had been declined by the Director General of Corrective Services. The women inside really do want to speak to you directly about their concerns with drugs, and that is what we try to facilitate all the time—that women have access to people like you to do that. Other than that, we have permission to speak to you and to bring information from those women. That is how we operate.

Mr QUICK—What is the name of the director—the guy in charge of the prisons, so I can send him a rude note?

Ms Kilroy—It is a her—Helen Ringrose is the Acting Director General at the moment. She declined. The letter said something to the effect that they deal with the drug issues in prison and if the members of parliament want to visit then they should ring them and organise it. But they had the dates, and it was too late. The fax was sent the night before, after work hours. Anyhow, that rests on their shoulders, not ours. But we are disappointed, and so are the women because they wanted to speak to you.

Mr QUICK—I can assure you that we will go into the prison because, as a federal parliamentary committee, we have powers that Ms Ringrose does not know exist.

CHAIR—What reason was given?

Ms Kilroy—They said that they address drug issues themselves and that, with regard to protocol, you as members should have approached them directly.

Ms Warner—They should have said that earlier.

Ms Kilroy—Yes. For the record, we have invited members of parliament into the prison before and this has never happened before. This is the first time the request has been rejected. And they asked for a copy of the submission, which I sent to them two months ago.

Mr EDWARDS—Perhaps you could provide us with a copy of the letter.

Ms Kilroy—Yes, I will.

CHAIR—Were they federal or state parliamentarians that visited the other times?

Ms Kilroy—There have been state and ex-federal members: Margaret Reynolds, Anna Bligh, Tom Barton, Judy Spence, as well as a number of state ministers.

CHAIR—From your perspective you were observing the normal protocol but they denied you?

Ms Kilroy—I think there is a lot of nervousness.

Mr QUICK—It sounds like the Northern Territory.

CHAIR—It had a familiar ring.

Ms Kilroy—When we did speak to the Director General, Ms Ringrose, about this she told us to put it in writing and that there should be no problems. So we did that. Her suggestion at the time we initially raised it was that an officer would have to sit in on the meeting to make sure everything was all right. We said, 'Well, you let us know what has to happen,' but it ended up being knocked out. This is not the first time, basically, that Sisters Inside have been locked out of things as regards the prison, and I have no doubt it will not be the last.

CHAIR—Is this a privately run prison, or a public one?

Ms Kilroy—It is a state one.

Ms Warner—To give you a bit of background, we have been on a bit of a warpath recently because we heard that they were going to introduce mandatory strip searching for women in prison, so we have been running around lobbying people and arguing and making ourselves thoroughly unwelcome. This may well be a little tap on the wrist for us.

Mr EDWARDS—Is this for visitors?

Ms Kilroy—No, women in prison—all prisoners, actually. In 1999 they introduced a new corrective services bill and stakeholders were asked to put a submission in with regard to the new bill. We did that, and we took a female gender focus and focused on the strip searching. The bill that was drafted said that all prisoners in a secure facility must be strip searched after every personal contact visit. In the Acts Interpretation Act, 'must' means that it is mandatory

and there is no discretion. The legislation that is in place now says ‘may with reasonable suspicion’. So we lobbied and lobbied.

Ms Warner—This was last August.

Ms Kilroy—We actually got it changed, through cabinet, but there was a leak and we were told just recently that it was going back to cabinet because the second reading speech did not marry up with the cabinet decision and the legislation. There were a number of stories but, to cut a long story short, we were told that it was going back to ‘must’. So over the last couple of weeks we have lobbied again, and we put together that submission I have faxed to you. We put it together around relevant law, FOI information, international law and responses to their argument that it was to stop drugs coming into prison. But it has gone through and it was in the paper today that it has been changed, through cabinet, to mandatory strip searching. That means that every woman or child in that prison will be strip searched, fully naked, hands against the wall, squat, cough, et cetera.

Ms Warner—Half naked—top half and then bottom half. They do not do them both at the same time.

Ms Kilroy—Yes. But we know from FOI that from August 1999 to August 2000 in the Brisbane Women’s Correctional Centre, which is the maximum security prison in Brisbane and which can hold 272 women but usually has 180 women, they carried out 12,136 searches. Out of those, 5,346 were full body strip searches—fully naked, hands against the wall, squat, cough, remove your tampon if you are menstruating and give it to the officer. In that information they said that they had strip searched a baby. Contraband found that was documented in their records was some tobacco, two cigarettes, some earrings, a pad—no blood—and a scratch from the window to the door. No drugs were found. This is our whole argument. Research that Sisters Inside have done shows that 89 per cent of those women in prison have been sexually abused—and it is usually multiple. So it retraumatises them. It is sexual assault by the state—now they have made mandatory legislation to sexually abuse women day in, day out while they are in prison.

CHAIR—They are sexually abused in the prison?

Ms Kilroy—In their life time.

Ms Warner—They are women who have experienced sexual violence.

CHAIR—Just to verify the timing, you approached the prison some weeks ago?

Ms Warner—Months.

Ms Kilroy—About the bill?

CHAIR—No, about our visit.

Ms Kilroy—It was two months ago, now.

CHAIR—And she said, 'no worries'?

Ms Kilroy—She said, 'Put it in writing, send us the submission.'

CHAIR—Then, when you checked on the day before we were to visit, they said, 'No, the appropriate protocols have not been followed.'

Ms Kilroy—They sent a fax. They said that your request has been denied and that they do address drug issues and that if the members want to come in it is protocol for you to contact Corrective Services directly.

CHAIR—But on precedent you would have normally expected us to be allowed in?

Ms Warner—Or that, at least, they would have said, 'Don't do it this way; get them to send us a letter.'

Ms Kilroy—I also sent them all the documentation that Shelley sent us.

CHAIR—I take it that there is a blatant blockage of our attempts to do what we are trying to do. You would not take it that way?

Ms Warner—I would not if I were you—we take the blame, not you.

CHAIR—We have the authority.

Mr EDWARDS—You have to be cognisant of the fact that they have to continue to work in the environment—although I think it should be followed up.

CHAIR—Yes, so do I. Absolutely. I am not happy. Regardless of the politics around this, there were plenty of other options for them to come to us. I take a very dim view of them blocking us—whoever they were. They should have had the courtesy to say, 'No, we need to do it differently.' I am quite put out by it.

Ms Kilroy—It is a lot better for them if you go in under their banner because they can filter who you see and talk to. If you had straight access to our management committee you would hear it as it is.

CHAIR—Yes, and that is exactly what we are about. Thank you for that background. Did you want to continue on with anything else?

Ms Warner—The strip searching is quite germane to the matters before this committee because it is, yet again, a government response that looks at the question of supply and not at the question of demand. If you are looking at drug usage and you look only at supply, you are never going to solve the problem. That is all they ever do in prison. We have a little bit of funding from health to do some drug and alcohol counselling but, apart from that, there is hardly any counselling. We did an informal survey of 100 women in the jail a little while ago

and 51 per cent said that they were still using in jail. I cannot remember the percentage of women who said they were not getting counselling.

Ms Kilroy—It was 80 per cent.

Ms Warner—Yes, 80 per cent of those women were not getting any drug and alcohol counselling. Our argument and that of our management committee is, ‘Why don’t you look at the reasons why people are taking drugs and try to address some of those concerns rather than being punitive and saying, “We’ll stop you getting them and if you get them we’ll punish you.”’ The punishment people get in jail for dirty UTs—dirty urine tests—is to be locked up in solitary confinement for a period of time. Again, all these strategies only serve to reinforce drug-taking behaviour. It is interesting that 85 per cent of women are in jail for drug-related problems, and the reason for that is that the typical profile of a female prisoner is not at all the same as a male prisoner. As we said before, 89 per cent experience sexual violence—either incest or other forms of sexual violence—which causes a serious level of emotional discord when they are young adolescents growing up. One of the ways you deal with that is to turn to drugs to deaden the pain of the emotional insecurity, lack of self esteem and the misery you feel as a result of sexual abuse.

So the drug taking goes on and then of course you are in need of the financial wherewithal to be able to feed your drug habit. You turn either to prostitution or to petty crime to try to feed it. So either drugs themselves or drug-related crime is very much the profile of women in jail, which is why traditionally women in jail are actually bigger drug users than men in jail. There was a television program not so long ago called *Beds of Steel*, which was about the movement from an old jail to a new jail. In that, a previous general manager said, ‘The reason there are more drugs in women’s jails is that women have more orifices,’ which is rubbish. A physical, quick, obvious answer comes out—

CHAIR—A smart alec answer.

Ms Warner—rather than looking at the real reasons why women in jail actually take more drugs, and that is because of the profile of the section of the community they come from.

CHAIR—I will take you back to the 85 per cent.

Ms Warner—Eighty nine per cent.

CHAIR—The research that establishes that—

Ms Warner—Is ours.

CHAIR—Can we have access?

Ms Warner—Yes, I can give you a paper. The research and the paper were presented at the Australian Institute of Criminology conference in November last year. I will fax it to you.

CHAIR—Thank you. I will ask a very straightforward question, and I am sure that the answer will be nowhere near as straightforward. I was staggered to learn that in the last five or six years the rate of women in prison has gone up about three times as much.

Ms Warner—Yes, and that is across the country.

CHAIR—That is amazing. You would be aware that it is out of kilter with the increase across Australia—or you may not be aware.

Ms Warner—No, I am not aware of that.

CHAIR—Yes—in the statistics available to us. We have heard one reason this morning. Firstly, do you accept that this is a fact?

Ms Warner—Yes.

CHAIR—Secondly, do you have any reasons to offer for that?

Ms Warner—There are a number of reasons. I think the courts do not have enough options other than to sentence people to prison. So their options have been cut back severely. Also, the number of young women being incarcerated is what is increasing rapidly. Over 40 per cent of young women under 25 are being incarcerated, and it was never like than five to 10 years ago. A lot of it is drug related. There is a war on drugs. 'Let's get hard on drugs and we will punish these people, especially the women,' and that is who they get. Many times laws are about getting the big-time drug dealers, but they never do. They get the people on the street, and that is usually women with their habit of self medicating because of previous abuses, living in a domestic violence situation or a number of reasons—or that they are supporting a male partner in their drug habits, drug use, drug trafficking or whatever it may be. So the women are taking the full brunt of it.

In the last few years the media have been running a hard line: 'Women are bad, mad, evil, so don't bother taking into account what has happened in their lives; we need to be hard. These women are just as bad—let's treat them equally with men.' But their crimes and their histories are so different that we argue that everyone needs to be looked at as an individual; we cannot all just be one lumped into one bag. The problem that we have—we go back to the strip searching again—is that 51 out of those 100 women told us that they are still using heroin in jail. The scary thing is that between five and seven are using the same syringe, so we are talking serious health issues.

Mrs IRWIN—So they are not supplied with clean syringes?

Ms Kilroy—No.

Ms Warner—Of course not.

CHAIR—Not in the jail!

Ms Kilroy—There are no drugs in jail!

Ms Warner—You are not supposed to have drugs in there.

Ms Kilroy—That is right. No, no syringes. Corrective Services did have a policy that you could ask for bleach, but if you went and asked an officer for bleach they knew exactly what you wanted the bleach for, so you were gone, and you got punished for it. But the thing about strip searching is that these women, with their abuse histories, come into jail and take drugs to self-medicate, and they continue to take drugs in jail. Some want to stop the drug use, but they get strip searched every weekend because they have a family visit or a visit with their children. All their self-esteem is just ripped—stripped—straight off them, standing there naked in front of officers, so they go back.

Mrs IRWIN—What happens to women who refuse that strip search?

Ms Kilroy—They will get breached or forcibly strip searched.

Mrs IRWIN—It is appalling that, in this day and age, this is happening.

Ms Kilroy—Yes, considering when we have a number of mechanical devices—

CHAIR—I think we agree that repeat offending has trebled from about 1993 to 1998, on available statistics?

Ms Kilroy—Yes.

CHAIR—The repeat offence, the repeat going to jail—

Ms Kilroy—The recidivist, yes.

CHAIR—what is the history there? What do we know there?

Ms Kilroy—It is nearly 60 per cent for women. The other thing that is crucial in these women's lives is that when they get out of prison a lot of them die in the first 12 weeks. There is research being done in Victoria about mortality among women in the first 12 weeks post-release. They are doing a 10-year study. Sisters Inside have been successful with some funding to run the same research here, but we know professionally, because of the women we know—the stats are a bit out of whack because it's nearly 12 months—that probably in the last 28 months over 20 women have died in that 12-week period. That is from suicide, drug overdose—we would not know whether a drug overdose was a suicide, because they are dead—or a violent partner. Those statistics are frightening. We are running a 10-year research program as well, and we will run the same process and methodology as in Victoria to get some insight.

CHAIR—My last question is about the children of these people. How many have children and what happens to those children?

Ms Kilroy—We know from the research that we did last year that 84 per cent, I think it is, off the top of my head, are mothers, so you have a lot of mothers in prison, and they have an average of 2.5 children. Usually, close to 50 per cent are in foster care and taken by the department; others are looked after by the mother's mother—the grandmother—and there is no support for that.

CHAIR—When you say 'no support', no—

Ms Kilroy—Government support, or even any organisational support. We will provide some support, but we are in the prisons every day, so that takes up the majority of the time, but it is about having something to try and support these carers who are looking after the children while the mother is in prison. Then we have an eight-bed prison. You will have seen on page 3 of the paper today that you have mandatory strip searching here, and then the nice picture of two women swinging a child because women's prison here is so wonderful. But I know that on Saturday, when they have—

Ms Warner—She was saying how she is appreciating her—

Ms Kilroy—She has her child with her.

Ms Warner—She has her child with her. Of course, her child would be strip searched after the visit on Saturday, too.

Ms Kilroy—That is right.

Mr EDWARDS—I want to follow on from what you were saying and this relates to why there has been such an explosion in the prison population of women. Under the heading, 'The Impact of the War on Drugs' you say:

Without any fanfare, the 'war on drugs' has become a war on women.

You then go on to say:

The imprisonment of women for drug related crimes have been the main element in the overall increase in the imprisonment of women.

You then say that the options have been cut back. What options have been taken away and what options should be there?

Ms Kilroy—Because the recidivist rate is so high and the tolerance is a lot less within the public realm, judges are opting to go for custodial sentences.

Ms Warner—Custodial as opposed to other sentences.

Ms Kilroy—I think there are about 20,000 people on community supervision and $3 per person is available for that. Women end up in prison because they have failed their community orders. They fail those community orders because they have children. For example, a single mother with children may be living in a caravan park. She would have to travel to do commu-

nity service. I know of a case where a woman had to travel and it cost here $6.80, every day, to go and do her community service. She had to make a decision in relation to her three children: should she feed her children and get milk and bread, or should she go and do the community service?

Feeding her children came first so she did not go to community service because they did not supply child care. The police came in because she had breached the order and no questions were asked. They did not ask, ‘What’s going on?’ In these circumstances, the community corrections officer does not ask what is happening. Basically, he does not care because they do not have the resources. It is a case of, ‘This is your order; you just do this. No, we don’t have child care, bad luck. You just do it.’ And then the police took the woman away and left the three children in the house. Fortunately, the neighbours had some nous and rang a service which knew us and rang us up. We have numerous stories like that. Some women try and take their children with them when they do their community service, but the organisation offering the service does not want the children. One woman had a baby in a pram, but as soon as that baby became a toddler, it was a case of, ‘We don’t want this child here any more. You can’t do it any more.’ So they end up in jail and their kids are taken off them. That is what actually happens.

Mr EDWARDS—Has the drug court made any difference?

Ms Warner—No, but SPER has made a bit of a difference recently, and I think jail numbers have been going down since December. What does SPER stand for? It relates to sentencing, penalties and amnesty.

Ms Kilroy—It is basically an amnesty on fines.

Ms Warner—If you have a warrant, SPER will write you a letter and you have an opportunity to respond to it. They have not been picking people up on warrants since December. That has had an immediate impact on the prison population in respect of both women and men. We now have a 30 per cent vacancy rate which is a bit of a problem for corrective services because they have managed to get all this money out of the budget to build new jails. A new jail is planned for Maryborough and they will have no reason for it if the way they deal with warrants proceeds. I suppose they will call the amnesty off. They have extended the amnesty for a little while, but when it ends, the jails will fill up with people who have committed all these petty crimes.

Mr EDWARDS—Can I ask another question? This relates to—

Ms Warner—Poverty is the main issue. Can I just finish this point?

Mr EDWARDS—Sorry, I thought you had finished.

Ms Warner—From a personal point of view, two of my kids received one of these SPER letters. One was for a speeding offence of which my son had no knowledge. He supposedly had not paid the fine. He rang them and said, ‘What’s the story? What car was I supposed to be driving? What was the number plate?’ They gave him the information and he said, ‘I’ve never been driving the car.’ He said, ‘Okay. What road was I supposed to be on?’ It obviously was not

him. It was obviously somebody who had given his name. But he had the opportunity to address that issue.

Similarly, my daughter was given one for failing to vote in 1995. It is interesting that it has taken five years for anybody to bother to send her a letter after a warrant was issued for an offence in 1995. She happened to be overseas at the time which is why she did not vote. She believes in compulsory voting, by the way. They had money and if they had outstanding fines, they could pay them and not go to jail. However, other people would go to jail for that kind of misdemeanour. That is the problem with the system and that is why SPER has emptied the jails. It obviously demonstrates that the jails are full of people who have committed petty, minor and trivial offences.

Mr EDWARDS—You make the point that 80 per cent of indigenous women in prison are involved with substance abuse, and that 63 per cent of indigenous women in prison have known prior adult imprisonment. Do you have any information, Debbie, on juvenile detention for the same people? If you have, would you be able to provide that for us, on notice?

Ms Kilroy—Which part are you looking at?

Mr EDWARDS—Under the heading ‘The women, their children and their families’, you say that 63 per cent of indigenous women have known prior adult imprisonment. Is there a record—I am sure there would be—that traces back to the juvenile imprisonment for the same people?

Ms Kilroy—A number of the indigenous women do come from the detention centres. We also provide a service, sexual assault counselling, in the detention centre. A number of those young women you see in the adult system. A number of them we do not see. I am not saying that they do not end up in prison system. They possibly do, but that is because a lot of them come from up north and there is only one detention centre here in Queensland, at Wacol. So young women come from across the state down to Wacol to go into detention, if they have been put in custody; and a lot of them are from up north. What actually happens is that when they are adults, if they go to prison up there, they will go to the Townsville prison. Over 95 per cent in that prison are Aboriginal women.

Mr EDWARDS—So the rate of recidivism is high within the adult population. I also suspect that it is fairly high within the juvenile population.

Ms Kilroy—I am trying to remember the stats off the top of my head; I did ask the executive director of juvenile justice—Youth Justice, they call it here—not too long ago for some information. It is interesting that probably only about one per cent of young people who commit crimes. When they go to court, a lot of them do not come back to the court system, and so it is 0.0 something that are recidivists: it is very low.

Ms Warner—A very small percentage of young people are actually in custodial care—even though those figures are probably too high compared with Victoria and other places. Out of a population of 3 million, we have got roughly 150 young people in prison here—which is too high a percentage for custodial care. The problem for the young women is that a large percentage—it varies, but it is certainly over well over 50 per cent—of those juvenile detainees are Aboriginal; and amongst women, at various stages, it is 100 per cent.

Mrs IRWIN—Tell me if I have this right: you are saying to this hearing that the women in prison today are not getting any sort of services whatsoever. A very small percentage are getting what? Counselling?

Ms Kilroy—Do you mean by Corrective Services?

Mrs IRWIN—Yes. I want to know whether when they get in there, if they are drug affected, they are given assistance with detox, counselling—

Ms Warner—Through the methadone program?

Ms Kilroy—There is a methadone program, but only a small percentage would be accepted into that program as a trial. So, if they are on methadone when they come in, they can continue their methadone use. The other thing with regard to programs that are available through Corrective Services, when the budget came out for the new prison opened in July or August 1999, there was funding in that budget for that prison to have a drug and alcohol counsellor. Still today, that person has never been employed, and we have heard that the money has obviously been sucked up somewhere else. So a number of women do not get any services. Last year in our annual report, off the top of my head, I think there was a budget for unfunded client contacts—those we are not funded for; and I told you the stuff we are funded for—with those women on a number of around $28,000. It is huge. If you start scratching the surface of the life of a woman who is in prison, you find such complex issues and concerns that they want addressed.

The other issue is that we do not believe that Corrective Services should be providing the service to women. They do not want it to happen. For us it is like Dracula in charge of the blood bank. They are here to lock you up safe and secure away from the community, that is your sentence. On the other hand, they say, 'I'll give you some counselling with the psychologist there, too.' The women do not, because that is just filed and then it is put to the parole board, or whatever else, and a lot of judgments are made that are usually misrepresentative.

There is also another prison here in Brisbane, the CSU—the Crisis Support Unit—where women are put. It is a men's prison. Women who are at crisis point in the mainstream prison will be sent to this crisis support unit in a men's prison. They are with the men inmates. We have been told by these women that they are being sexually abused and raped by those men on regular occasions. It came out and there was an investigation last year. Those women are still locked in that. We know today there is a 17-year-old girl in there who is being subjected to this. She will keep coming back to jail because what else is she going to do. She has already been in and out. She has come from detention. She goes there. She has been sexually abused by male offenders. If they lash out, they are put in body restraints or arm restraints and locked up for 24 hours or put in two to three weeks isolation to keep them away from the men. The men are not punished. There are guys in there who are convicted of rape and murder, and they are subjected to that.

Ms Warner—It is the isolation. It is the protection area.

Mrs IRWIN—You are virtually saying here that the system has let these women down. There are no resources within the jail system for these women.

Ms Kilroy—The system is abusive.

Mrs IRWIN—So this is why these women are coming out and re-offending and then virtually going back in. What happens when someone is leaving the system, say, leaving the jail? What resources are there?

Ms Kilroy—From Corrective Services?

Mrs IRWIN—Have they got a system there for housing, for getting onto Centrelink or getting their family unit together?

Ms Kilroy—No; we do that.

Ms Warner—We have only just got funding from the Commonwealth.

Ms Kilroy—We have only just got funding. Corrective Services do nothing. They wipe their hands. It is not their problem any more. You are out now. You are released. Your next port of call if you are on parole is going to your parole officer but no-one is there. They have a two-kilometre walk to get to a train station. Some of them, because they have moved from the old prison to the new one, do not even know where they are in the context of the community because they are in the middle of the bush, two kilometres out from a train station. It is probably further than two kilometres; it is probably four kilometres. It is a long way away. These women are left; we knew about women in 1994.

The reason we got funding to do some research around domestic violence and women in prison was that a young Aboriginal woman who was leaving the prison said to the psychologist, ‘I have got nowhere to go. Can you find something?’ They said, `No, that is not our job.’ She said, ‘I have to go back to my violent partner. I do not want to go back there. I am scared.’ They said, ‘It is not our problem.’ They put her out the door and she was dead within 24 hours. They wipe their hands. There is abuse happening in the prison system and their responsibility as far as they are concerned stops at the door.

Mrs IRWIN—This is not only happening in Queensland. We went into Goulburn jail—

Mr EDWARDS—And in Western Australia.

Mrs IRWIN—and, in Western Australia, they are virtually saying that, when they come out of the system, the door is closed behind them and they are not given a helping hand. I think everyone deserves to be given that.

Ms Warner—Mind you, I have to say that we would probably argue that it should be non-government organisations not—

Mrs IRWIN—That is the point that I was going to get at.

Ms Warner—the system that should be providing that support.

Mrs IRWIN—I noticed that in your submission, and that is what my next question was going to be. I think it was in recommendations 3 and 8, and I would like to just quote them so it is on the record for *Hansard*. Recommendation 3 says:

There should be a much greater coordination of a drug treatment policy and programs for women in prison so the provision of counselling and treatment meets the needs of the women. The program should only be offered by the non-government sector.

Recommendation 8 says:

That, as soon as possible, the Federal Government establishes non government post release support services for women released from prison throughout Australia.

Now you are specifying all the time non-government. Why do you feel that these should be offered by non-government organisations and not by the bureaucrats?

Ms Kilroy—As I said before, it is like putting Dracula in charge of the blood bank, isn't it? On the one hand I have a key to lock you up and on the other hand I am going to support you. Women cannot trust that. A lot of them have come from the system. We know 44 per cent of them have been under the care of the department before so there is no trust in government departments.

Ms Warner—They were kids in care.

Ms Kilroy—The thing is that they do trust us and they do trust other community organisations if they are endorsed by us in the women's prison. Some women on our management committee are in prison. They do a lot of the housing. We have women on our management committee that help them fill out their housing applications. They give them to our workers and then they are followed through on the outside. Everyone is quite active and they trust us. They know confidentiality is the core of our being, our organisation. If you are a woman in prison and you say to me, 'I do not want this information to go anywhere' that will be respected and it will not.

However, if you want me to write a letter for you for some reason to say what we have been doing in therapy or counselling I will do that, but I will show you first so you can see what I have written. If you disagree and want it shredded, it will be shredded and not passed on. In the prison it does not happen that way. Anything you do or say is on the record and used against you, so you cannot have any trust; it just does not happen. You cannot trust people who work there.

CHAIR—And it is for treatment purposes that we have gone into that this morning. You have made it very clear. It has to go on the record and then it has to be dealt with within the system. NGOs have the capacity to do it differently.

Ms Kilroy—Yes.

Ms Warner—That is right. One of the things that is unique about our organisation is that we do have women inside on the management committee, which means that we can actually understand their culture when it comes to writing things down, for example. You and I would

probably think we would write a report about it. That is a no-no for women in jail. ‘Do not write me up’ is the phrase. They really distrust anybody who is going to write anything because they feel it will come back in some way to further victimise them.

Mr QUICK—How are the people inside who are on your management committee treated by the correctional officers, at a lower level, and by the hierarchy?

Mrs IRWIN—Like a union delegate, I suppose.

Ms Kilroy—No, you have to understand the culture of the women’s prison. You could write 10 sets of encyclopaedia on that. Briefly, the culture of the prison is about the long termers and short termers. There are people in there who have been there for a long time and there are people who come and go. The short termers do not have any credibility, the long termers do. They are the women who are on our committee. There are also officers who are long termers. There is basically a silent rule between long term women prisoners and long term prison officers.

Ms Warner—Basically we have people with credibility within the prison system to be on our committee and that is respected by both sides—by prison officers and by prisoners. We want to get some short termers on the committee, but it is actually quite hard to get them because the people change over.

Mrs IRWIN—What changes would you make? If government said to you, ‘Okay, you tell us what services you need for a woman who might be drug addicted, from when she arrives to the day she leaves.

Ms Kilroy—I do not think prison is the answer for them. First of all I would not be the minister for prisons because there would be no prisons. I would close down the prisons. I know that is a philosophical debate in itself. As a community we need to look at how we can address issues for these women in other ways, rather than putting them in prison. It does not work. They keep coming back or they end up dead. The abuse is ongoing.

Ms Warner—It is a systemic failure.

Ms Kilroy—It is about looking at other ways of addressing the problem, not about building bigger prisons. We are just going down the line of America, that is all we are doing. When they built that prison it was high tech, with full surveillance and electronics. The prisoners have hardly any interaction with officers anymore.

Ms Warner—There are not many people.

Ms Kilroy—I told them I would guarantee—we would put money on it—that in the first three months we would have a death in there because of the way this prison was laid out. Sure enough, someone was dead in six weeks. Then the DG’s office said to me that I was right. It is like the rapes by male officers. Those allegations have been coming out since December. We raised that with the DG and also the manager of the prison. They said to bring us facts. The women are too scared to write statements because there will be repercussions. They are young Aboriginal women and they will end up back in prison. The problem seems to have gone

underground since we have been talking about it, but it took us a long time to get those women inside to say, 'Yes, do something; this has to stop.' That is why the women want to speak to you, so they can say it directly.

Mrs IRWIN—They want to have assistance before they even get to that stage of going into the prison system. These are women who were mentally, physically or sexually abused as young children.

Ms Kilroy—That is right—living in poverty, with racism and all those bigger social issues that need to be looked at. Then we have the children. We have done programs with young people. We got some money to do a 12-month project on crime prevention, to develop a resource. We worked with over 60 young people through that. The majority were Aboriginal young people and Vietnamese young people whose mothers were in prison. Two of those young people died during that process. They took their own lives because they could not cope anymore. We are seeing intergenerational incarceration. It keeps going and going. I have been around the system for 25 years and for the first time I have seen five mothers and daughters in prison together. This is what we have created.

Mrs IRWIN—Debbie and Anne, I believe that you were once women inside yourselves?

Ms Warner—Unless you call parliament—

Ms Kilroy—She was a minister.

Ms Warner—Different institution, same rules.

Mrs IRWIN—You were a minister in government, were you?

Ms Warner—In the Queensland parliament.

Mrs IRWIN—You have seen the system going downhill all the time?

Ms Kilroy—It was pretty bad in the 1980s in detention centres, and then a murder happened in 1990 and it put a spotlight on the women's prison and there was some reform. A great deal of reform happened when Labor was in but we have gone more conservative and backwards. We have gone further backwards than what we were.

Ms Warner—We did not have mandatory strip searching then.

Ms Kilroy—No.

Mrs IRWIN—That is appalling.

Mr QUICK—We have this wonderful document, *Beyond a quick fix,* which says on page 8:

- *Drug-free prison units* are currently being trialed in a number of correctional facilities;

- The *Criminal Conduct and Substance Abuse Program* is currently being trialed at the Brisbane Women's Correctional Centre and the Moreton A facility. This is a 3-week pre-release assessment program conducted by the Alcohol and Drug Foundation of Queensland funded under the National Illicit Drugs Strategy (NIDS);

- Three additional *Drug and Alcohol Counsellor* positions have been funded through the DSC Drug Strategy.

Ms Kilroy—That is through the Drug and Alcohol Foundation. That is not part of the prison. Is that Bob Aldred's stuff?

Mr EDWARDS—No. This is the state government's policy document.

Ms Kilroy—Is it? I have never seen it.

Mr QUICK—So there is a three-week prerelease assessment program. It is at the top of page 9. It is the Moreton A facility.

Ms Kilroy—That is the men's prison.

Mr QUICK—But the Brisbane Women's Correctional Centre—

Ms Warner—That is the methadone program.

Ms Kilroy—No, it is not. They run a three-week program. It has been run once and the women do not speak very highly of it. The problem is that community organisations from outside that are endorsed by correctional corrective services come into the prison. All right, we have had to be endorsed to a level to get access, but they know that we have our values clearly articulated and documented and that the program is quite different from theirs. They know that we have two arms: one is the program, and the other is lobby and advocacy, and we keep them quite separate.

The thing is that the women do not have a relationship with these workers and they see these workers coming in from the outside talking to psychs and passing on information and so they are 'black banned' and you do not talk to them. You tell them what you need to tell them to get the points or ticks you need to get out of prison. It is about getting parole and getting out. The women are not doing it because they want to do it. It is an involuntary program. The Drug and Alcohol Foundation would say that it is not and it would not be on paper, but I can guarantee you that the women are made to go and they are told that if they do not go they will not have their parole application put up. That is what happens

Mr QUICK—Let me refer you to the bottom of page 17, which says:

> The purpose of the Department of Corrective Services is to promote community safety, justice and crime prevention, through humane containment, supervision and rehabilitation of offenders. The DCS is building high standards of security and offender supervision. At the same time the department is working to provide an integrated and consistent focus on offender rehabilitation. The DCS is continuously striving to develop and implement more effective and innovative substance abuse programs and services where the treatment of offenders is fair and humane and where there is a strong commitment to equity and cultural diversity.

Is that a load of BS?

Ms Kilroy—Yes. Go down to the next part because that is what they do under their drug strategy. The strategy is about stopping drugs coming into prison, identifying who the traffickers are—ra, ra, ra. That is what their focus is on—the drug strategy. Everything comes under the banner of the drug strategy and that is where mandatory strip searching comes in. However, we have FOI that shows that no drugs are coming in that way. They will not strip search their officers. Under section 109 of the act at the moment they can strip search them, but we have officers come to us who have worked in the system for over 20 years and they have never been asked to empty their pockets or to open their bags. They could not—the union would have them, wouldn't they? They never look at alternatives for how drugs are coming in.

Mr QUICK—How are the drugs coming in—through the correctional officers?

Ms Warner—What we are saying is that strip searching does not pick it up. We are saying that strip searching is a very blunt weapon to use against drugs and it does not work. We know that drugs are still in jail and the women have been routinely strip searched. Even though it has not been law to be mandatorily strip search, it has been the policy. They have been strip searched after every visit since that jail opened and they have not found any contraband using that method. So what we are saying is that, if it is coming in on the persons of prisoners who have had a visit, strip searching has not picked it up.

Why don't we want women inside to take drugs? We don't want them to take drugs because we have a duty of care—I heard the minister. We have a duty of care towards women so, as part of that, we do not want them to take drugs because drugs are harmful. The problem is that the strip searching is probably more harmful than the drugs—

Ms Kilroy—And it is creating the drug use.

Ms Warner—What we are actually doing means that the cure is worse than the disease—and it is not a cure. The methods that they are using are actually perpetuating the problem and that is the illogical nature of the situation. I do not know how drugs get in. I do not know but I am pretty sure that the prison authorities know.

Ms Kilroy—And you have to get rid of drugs in society before you are going to get rid of drugs in prison.

CHAIR—Just one moment, Debbie. Can I just ask you as a point of clarification for me: what is the protocol in the male prisons?

Ms Warner—They use strip searching less.

Ms Kilroy—The only place where we know they do mandatory strip searching as policy now is in a maximum security unit, or MSU, where they have the worst of the worst.

Ms Warner—Brendan Abbott.

Ms Kilroy—Brendan Abbott. Those types of people that they say are the worst of the worst. We know there is a legal service where a man did refuse to be strip searched, because what they actually do even before their legal visits for the men in that MSU is to ask them to pull back

their foreskins, if they have a foreskin—and the inmate said no. The solicitors have got it on videotape. He was brutally thrown to the ground and knocked unconscious, and on the video you see him getting strip searched, having his clothes ripped off and having his foreskin pulled back. What is this? We are in the year 2001. This is just appalling.

Mr QUICK—And with a Labor government. I am a member of the Labor Party and I think it is bloody outrageous.

CHAIR—I am sorry. I interrupted you. Please go on.

Ms Kilroy—I have forgotten what I was talking about.

Mrs IRWIN—With Sisters Inside, do you liaise with other states?

Ms Kilroy—Yes, strongly with other states.

Mrs IRWIN—Would you say there is one particular state that you feel is doing a bit better than another state?

Ms Kilroy—Probably the ACT and that is because they have no prison.

Mrs IRWIN—Touche!

CHAIR—New South Wales helps them out a bit that way.

Ms Kilroy—There is only a small number and they do get taken, but it is interesting because there has been a push to build a women’s prison there and there has been a lot of opposition.

CHAIR—I know, because I live alongside where they want to put a prison.

Mr QUICK—How much does a new women’s prison cost?

Ms Kilroy—How much did it cost? Millions and millions of dollars. I am not sure—

Mr QUICK—Probably a tenth of that—

Ms Kilroy—It was equal to funding 14 fully staffed high schools.

Mr QUICK—So with all the early intervention money that is required to stabilise and support families, you would probably take a tenth of the prison cost and put it into early intervention?

Ms Warner—It costs $50,000 a year to keep a prisoner inside.

Ms Kilroy—Per person.

Ms Warner—You could actually look after a whole family for $50,000 and probably stop them from offending for that amount of money.

CHAIR—Would you consider that as the priority?

Ms Kilroy—Yes.

Mr EDWARDS—When we visited a correctional centre in WA we spoke with a number of the women there and I think they all said to us that the biggest concern they had was that on release they had no option but to go back into the environment from which they had come. It is a bit like being on a break. You have got the problems. You leave. You go back and the problems are still there.

Ms Kilroy—We call them ‘pit stops for life in the fast lane’—prisons.

Mr EDWARDS—That is not a bad way of putting it, I guess, but what alternatives are there? What resources do you need to try to deal with that problem of at least trying to either give them support in that environment that they have gone back to or find a different environment for people?

Ms Kilroy—We were funded a couple of years ago by Jupiters Casino.

Mr EDWARDS—Yes, I was interested in that and I was going to ask you how you got that.

Ms Kilroy—We just applied for it and they gave it to us. That transition money lasted for a couple of years and we did a lot of good work with that. However, it is interesting how we have been getting federal money now, not necessarily state money—

Ms Warner—We get some state money.

Ms Kilroy—The Howard government has given us funding now to continue that program. We have workers that will work with the women while they are in prison and support them, and the women will be having counselling around whatever issue they need to address. It could be about just being in there; it could be sexual abuse, domestic violence or, ‘I can’t go back to where I was living.’ We look at accommodation. We will pick the woman up when she gets out of jail, take her straight to Centrelink, and get her her crisis payment. We would have already found accommodation if there was some to be found, because there is not much accommodation around the country either. Usually the women will move with that support. We will put the support processes in for as long as they are needed and the women know that. That has actually worked. A lot of them have moved away from the environment because, they say, ‘I do not want to go back there because if I go back there I am going to fall down the same hole.’ We find somewhere else and then put the links in. Sometimes, if it gets too hard, they may end up in jail. We have not had any so far this year, which is good, but it is about having that ongoing long-term support.

CHAIR—How do you feel about the success rate? How do you feel about the positive impact?

Ms Kilroy—I think it has been positive and the women will contact us. There will be fairly intensive support.

CHAIR—With the relationship?

Ms Kilroy—We have already got the relationship because we have made that in the prison. Usually, if they do not have anyone to bring their children up, the workers will do that so that it is a long-term relationship depending on however long they are in the prison. Then it is about supporting them when they get outside. Some women do not need much support; other women need more intense support depending on what is happening for them. Some go back to drugs and we do not then say, 'We do not want to work with you anymore'. It is about working through that and what is going on. If they want to go to a detox or something, it is about organising that. It is not about wiping them. If you said that to your parole officer you would be straight back inside; you would be gone. That is why confidentiality is so important. It is hard. If you get out of jail when you have been in for a while it is really difficult. If you are told enough times in your life that you are no good or you are bad, at the end of the day you may as well live up to that expectation of society anyway and fall down the hole again.

CHAIR—Have you ever put a submission to FYCCQ or something to give you 10 houses throughout Queensland to use as crisis accommodation, either coming or going?

Ms Kilroy—We have discussed this because accommodation is a huge issue. We look at it as Dracula in charge of the blood bank. If Sisters Inside has accommodation then we have to be landlords. On one hand we have to say, 'Give us the rent,' or 'What happened to that hole in the wall? We have to kick you out.' On the other hand we offer support. So we cannot do it and we do not do it. We have a number of relationships and agreements with a number of community housing groups across the state. We would rather them get the accommodation, and that is what we lobby for because that is their expertise. Our expertise is about supporting the women. We have those agreements and links and have a three-way agreement with the woman.

Ms Warner—We did put in a submission for family workers with the emphasis being on reuniting families and assisting. We had a transition worker who was funded for only a year. One of the issues that we picked up was the fact that women find it incredibly difficult to get their kids back from family services when they get out, even if they voluntarily put the kids in care. They have never been deemed to be inappropriate parents but, because they had come out of jail, they had to re-prove themselves before they could get their kids back. A lot of our work was about that reunification. The housing issues, the financial stuff such as the Centrelink payments, and all that, goes to the question of whether a woman can get her kids back. We were arguing with family services that they should be funding that transition worker because it is a way of reuniting families and trying to stop the intergenerational problems emerging. But we only got $30,000.

Ms Kilroy—That was instead of $630,000. So you can employ only one person.

Ms Warner—But with the same arguments we did get some money from the Commonwealth for that transition worker. It was $90,000 or something. We are gradually building up our base level of services but, of course, the demand is much greater than we can—

Mr QUICK—What is happening in other states with regard to Sisters Inside?

Ms Warner—We are flat out.

Ms Kilroy—There is no other specific organisation anywhere in the country that focuses only on women. We are the only organisation. The only other organisation that has a quite specific focus on women, and that we have a relationship to, is a housing organisation in Victoria, and they are flat out. But all they do is accommodation; they do not actually go into the prison as such.

Ms Warner—They do not have prisoners on their management committee. We are the only organisation.

Mr EDWARDS—Do you liaise with the DRUG-ARM people at all?

Ms Kilroy—I know one of the workers there but not in that context. They are not in the jail every day; we are. It is about being at the grassroots. I do a lot of lobbying and networking everything out externally, but it is about finding other organisations that have a similar philosophy to our own.

CHAIR—If we recommend that there should be a national program for women, particularly for mothers with young children and for accommodation and NGO type support, would you support that?

Ms Kilroy—Yes.

CHAIR—Would that be a priority?

Ms Kilroy—We had a meeting with the Crime Prevention Unit in the Department of the Premier and Cabinet in the bureaucracy here. That followed a roundtable that the Australian Institute of Criminology ran with the Director-General of the Attorney-General's office about post-release issues and concerns. This is something that I have been driving home at all their conferences. Out of that, because it was a national roundtable, an urgent meeting was called by the Department of the Premier and Cabinet. All of a sudden they got a bit toey, obviously, and said, 'Oh, jeez, we're not doing anything.' The bureaucrats told us that the federal Department of Justice and Customs has given the Department of the Premier and Cabinet $1 million, and Beattie reckons that he is going to match it for a two-year post-release project. It was a very interesting process to have a meeting—and I had an email yesterday asking where it was up to—but I can guarantee you that it does not look like any prison service that we work with or have been invited to. We might not even get that money because child-care centres were invited to that meeting and some children in kindergartens have parents in prison. I know a number of them because we refer families to acceptable child-care centres. It is very interesting but I am not too sure where that is going. On that note, $1 million has been given to this government here for post release.

CHAIR—Unbelievable! Anne, I need to ask you because I cannot let it go: you were a minister of the Crown in a former life?

Ms Warner—Yes, in the Goss government, not the Bjelke-Petersen government.

CHAIR—You understand the political process. I will preface my question by saying that there seems to be some denial around these issues. For a whole range of reasons we do not want to be tagged with this or tarnished with that, or whatever. As a former practising, senior politician, what are the political barriers that we have to burst through to better deal with this?

Ms Warner—When the law and order campaign hit I was in cabinet. You may recall that it was imported from America in about 1992-93. We had been going along quite reasonably with our focus on rehabilitation. In fact, we had had a major reform of the prison system under Keith Hamburger after the dark years of Bjelke-Petersen. There had been riots in the jail and we were actually moving in a much more liberal direction. Then, all of a sudden, there was this really heated campaign that seemed to have emerged from America. I remember at the time we had a discussion about it in cabinet and the argument was, ‘Okay, how do we respond to what we don’t believe is a crime wave but is perceived as a crime wave by the community?’ There was this massive perception that the community had become incredibly lawless. The answer that that government decided on, the phrase that they used, was, ‘What you have to do is to shine a torch on the problem.’

The government said, ‘We understand what you are feeling, so we can then start to respond to what we know are your inner fears—even though we know that they are unfounded—and shine a torch on the problem and thereby look as if we are doing something about the problem, and that will save our political skins.’ What has happened is that it has been snowballing ever since. Government after government—the Carr government, the Borbidge government, the Goss government and the Beattie government—were all going to be tough on crime and tough on the causes of crime. Nobody has ever bothered to identify what the causes of crime are or, indeed, to put any money in that direction.

Mrs IRWIN—They looked at the jail system—

Ms Warner—They looked at the jail system and it exploded them. The idea of social progress is that you promise Maryborough a new jail because that might get you re-elected—it did not, actually; the progeny of One Nation did get re-elected in Maryborough. In the one place they decided to give them a lolly, which supposedly is jobs. It did not work. It is a flawed political strategy—a knee-jerk response on the part of politicians—to say, ‘If people are going to beat this very emotional drum about fear, we will have to jump on the same bandwagon, otherwise we are going to be left behind.’ It is almost blood lust. I am a previous family services minister. What sickened me most about that whole campaign was that I would go to community after community and be presented by 200 people in Rockhampton telling me that one Aboriginal boy was terrorising the whole community. He was 13 years old and they wanted me to put him on an island off the coast or just take him away. But that happened not just there; during that period it was repeated in a lot of places. I kept coming out with the usual family services response, which is, ‘We will send in some social workers,’ but of course that was never seen as an appropriate response.

CHAIR—It is a form of McCarthyism.

Ms Warner—Yes. What really has distressed me about this whole law and order strategy—it is part of the Pauline Hanson type basic thinking—is: if it's broken, we will give it a kick; if you're on drugs, we'll kick you; and if you break the law, we'll kick you.

Mr QUICK—It is a quick fix.

CHAIR—I think you have done a great service for us, because that is what we have been sensing.

Ms Warner—The thing that really upset me is that, as a society, we have turned on the weakest and on our own children, and we are reaping the benefits of doing that: they are alienated, they are taking more drugs and they are committing more crimes than ever before. If you really want a lawless population, let us keep going the way we are now.

Mrs IRWIN—You are so right. You would have to agree that the media have a got a lot to answer for.

Ms Warner—We all have; it is not just the media.

Mr EDWARDS—Politicians have to accept responsibility.

Ms Warner—They have to actually try to show some leadership.

CHAIR—That is right.

Ms Warner—They are not just followers of opinion polls; they should actually be there taking the moral position and not saying, 'We're just going to follow everybody's deepest fears.' That is why people are so disenchanted with politicians: they actually think that politicians should be better than us, not the same as us. They should not be following opinion polls; they should be leading the way forward, not sliding backwards.

Ms Kilroy—It is interesting, because we applied for drug strategy money here in this state and did not get it—it went to one organisation—however, we got national money from Howard's government again.

Mrs IRWIN—How much money did you get nationally?

Ms Warner—Nearly $200,000.

Ms Kilroy—No; for the illicit drug money, $80,000. Bureaucrats lobbied us at management level and asked us to put in for the state money, but it did not get up.

CHAIR—How did you get the federal money? Did someone lobby you?

Mr EDWARDS—Was it a separate submission for that?

Ms Kilroy—Yes, it was separate. We went down to parliament in Canberra last year and lobbied everyone in parliament on the issues of women in prison. I spoke to one of Dr Wooldridge's advisers, who was quite terrified about the rampant hep-C and drug issues.

Ms Warner—Hep-C is a big problem; that is something that we did not say.

Ms Kilroy—It was advertised. We applied for it and were successful.

Ms Warner—People were getting hep-C after they were in gaol.

Mrs IRWIN—What was the $80,000 in federal moneys for?

Ms Kilroy—It is a program called Crying Walls. It is to work with young women in prison who are under 25. It is to run drug and alcohol programs, counselling and support.

Mrs IRWIN—Was it a yearly amount or just a one-off?

Ms Kilroy—It is $40,000 a year for two years.

Mrs IRWIN—You did a lot better than me. I have Cabramatta in my electorate. Out of $50 million all I got was $76,000, which was appalling.

Ms Kilroy—Was that for two years?

Mrs IRWIN—Over two years.

Mr EDWARDS—What was the point you were making about that?

Ms Warner—Something we missed in all our deliberations is that a lot of prisoners get hep-C while they are in gaol. They are actually infected because of the—

CHAIR—Is it via needles?

Ms Warner—Apparently Corrective Services are currently arguing—I was speaking to one of them last week—that the methadone program has stopped the rate of infections of hep-C in jail, or reduced the rate. I find that hard to believe. It has not been going long enough.

Ms Kilroy—They do not test women when they come in. They used to get tested for hep-C, HIV and AIDS but they stopped it.

Ms Warner—We are a little bit confused about that, but that is what they will claim.

Mr EDWARDS—You cannot have everything; you cannot have strip searches and tests like that! I am being facetious.

Ms Warner—Yes.

CHAIR—Thank you very much and well done.

[2.43 p.m.]

CLEMENTS, Mr David Maxwell, Drug Treatment Outreach Worker, Brisbane Youth Service

McLAUGHLAN, Ms Leanne Lesley, Health Team Leader, Brisbane Youth Service

TANSKY, Mr Michael Mirek, Director, Brisbane Youth Service

CHAIR—Welcome. I point out that, while the committee does not swear in witnesses, the proceedings today are legal proceedings of the parliament and as such warrant the same regard as proceedings of the House of Representatives. Do you have an appointed representative who would like to make an opening statement or would each of you like to say a few words?

Mr Tansky—There are probably four things we want to cover. Leanne was going to make a brief reference to the survey information that we forwarded to you to compare that data with earlier data. David was going to do a brief case study and draw some implications or make some points from the case study. We are happy to answer any questions about the drug surveys. We have some other reports that have been produced in the Fortitude Valley area and I have permission to hand these reports to you. David will also talk about the kind of resources that young people have produced.

CHAIR—Do you have any additional information you would like to table?

Mr Tansky—Yes. Along with those reports, these are resources that are produced by young people, along with workers at this service.

Ms McLauchlan—They just screen out the top like using a peer education model, I guess. That just brought up young people's issues which are obviously quite similar to the issues that we have.

CHAIR—Do you want to proceed?

Mr Tansky—Yes. Leanne will give a brief introduction, particularly in relation to the survey information.

Ms McLauchlan—I have been the health team leader at Brisbane Youth Service for a little over five years now. In that time, there has been a very noticeable change in drug use patterns in the young people that we see. We are still targeting homeless young people in the inner-city area of Brisbane, however the extent of injecting and the extent of illicit drug use has very much increased since then. In 1998 we started these surveys, of which you have the last two, and we are about to start a new one. There was a survey done with the client group of the Brisbane Youth Service in 1994.

I want to draw some comparisons between the 1994 data and the 1998 and onwards data. The data we have been getting since we started doing the surveys has been fairly consistent in terms

of the high numbers of young people using illicit drugs. In terms of drug use, the only drug that had dropped in percentage use with young people was alcohol, which had actually gone down two per cent. Given that it went from 96 per cent down to 94 per cent, it is still incredibly high. Marijuana use was up 10 per cent in those 10 years. Prescribed pill use was up 30 per cent. These are not prescriptions that were prescribed to a particular young person. The young people buy prescription medication from other young people, they use prescription medication that was prescribed for other people or they misuse prescription medication. Amphetamine use was up 20 per cent. Heroin use was up 22 per cent. Hallucinogen use was up 24 per cent and the use of inhalants was up 12 per cent in those four years. We are seeing the incredible uptake of both injecting and illicit drug use by homeless young people. I will now hand over to David to talk briefly about one particular case study that brings up a few points that we really want to make.

Mr QUICK—Before you do that, is the sample all homeless kids?

Ms McLauchlan—Yes. Our sample is not a significant sample given that, in every survey, we only survey 50 young people. We select young people who come through the door at Brisbane Youth Service, so they are clients of the service. They are young people who are seeking help from Brisbane Youth Service. We have a reasonably broad definition of 'homeless' but, out of the last survey, 22 per cent were actually on the streets. A lot of them are in unstable accommodation. A lot of them are staying with friends or in boarding houses and that sort of thing.

Mr QUICK—How many homeless young people are there in the Brisbane City Council area?

Mr Tansky—Nobody actually knows. There was a one-off survey conducted at the end of last year that counted within a three-kilometre radius of the inner city area about 300 homeless people, one-third of whom were young people. I cannot remember the exact number; it was about 137 or so. We are in contact with at least 150 young people who are homeless at any one time. We get up to 60 a day who come through the doors.

Mr QUICK—What are Centrelink telling you?

Mr Tansky—We do not have information from Centrelink about the numbers of homeless.

Mr QUICK—At the press of a button, they can tell you how many are getting youth homeless allowance here.

Mr Tansky—That information would not be accurate because we are in contact with young people who are being breached, who do not even bother going into Centrelink to apply for payments.

Mr QUICK—What percentage is that?

Mr Tansky—I do not know.

Mr QUICK—This is one of the things that annoys me: how do we plan strategies, if we do not know how many we are talking about? We are just scratching the surface. These statistics,

like the previous group of people, are horrific. Are they 100 per cent of the problem, 40 per cent or 20 per cent? When you apply for submission funding and you write to Canberra bureaucrats or Queensland bureaucrats about needing to rectify this problem, how the hell do we know what we are talking about? Shouldn't we say to someone that we cannot do what we did in Tasmania with the Aboriginals and walk our way out? There must be some process to get the people somewhere to at least do a rough head count. When it comes to SAAP funding and crisis accommodation, how the hell do we know how complex the problem is?

Mr Tansky—Head counts are quite expensive and resource intensive to do. That head count was the first ever done in the inner city area of Brisbane. It involved the resources of hundreds of people and a lot of volunteers were involved. There was also a lot of money involved to enable the count to be done. They can be done, but they would have to be resourced to do it.

Mr QUICK—This committee did a national report on young homelessness. We got reports about absenteeism from schools, and we could get that information from education departments. We have computers to send things to Mars and tell something to open up its solar panels, but we cannot say how many kids there are in the Brisbane CBD that are homeless.

Mr Tansky—Because it is a much more difficult counting problem. The population is not a fixed population.

Mr QUICK—I understand that. One of the questions I was going to ask after that complex question was whether you are doing a longitudinal study of the 51 kids in 1994, 1998, 1999 and so on, and should you? Some of these people may no longer be homeless—they could be in TAFE or further education. If they are, how the hell did they do that? How did they build strategies around that and how did they get a resource allocated to them? Or these kids could be continually homeless, with second or third generation unemployed parents and third generation drug users. We would need to have strategies for that lot, strategies for this 20 per cent and strategies for that 40 per cent.

Mr Tansky—Once again, that could be built into the funding. A funding body could say said that a part of what they want you to do, as a component of this funding, is to conduct a longitudinal study. That could be build into the budget; it could be done. For example, we have some funding from the National Illicit Drug Strategy. We have built in an evaluation component and we are just doing the first write up of the first evaluation we have done. We have not got funding for longitudinal work and all we are able to do is to provide snapshots.

Ms McLauchlan—Following up homeless young people is incredibly difficult.

Mr QUICK—Yes, I have worked in the area; I know what it is like. How much did each survey cost you?

Mr Tansky—We did it with our own existing resources in the agency. We have a budget of $1,500 in two budgets—about $3,000 a year—to do an evaluation of our drug treatment work.

Mr QUICK—Your federal members could take it in turns to fund a survey.

Ms McLaughlan—In terms of the survey, we actually paid young people $5 to do the survey, which was quite lengthy. I think we paid $100 for someone to actually code the data, and then we did it ourselves because we do not actually have money to do it. We got the workers in the agency to write it up and do it. I guess it was mainly to inform us about the nature of the problem as well; because there are issues with actually trying to find out what sorts of drugs young people are using. Often they will tell you what they think you want to know. So we had to make sure that it was all confidential and that they could not be identified through the survey and that sort of thing; so it does bring its own problems. I know that Queensland University tried to do a longitudinal study, not on drug use but on young people. They found that their ability to follow up young people has been really limited, and so they have lost a huge percentage of the young people on each follow-up period.

Mr QUICK—Please excuse me, as I have to disappear to Tasmania. Thank you, and I will read with interest the rest of the *Hansard*.

Ms McLaughlan—I will hand over to David now.

Mr Clements—The figures that Leanne has discussed and mentioned here can be seen quite alarmistly. The point is that drug use amongst this particular population of young people is on the increase and has been for a number of years. On all levels of federal and state government, as well as the community sector and the community in general, we are obviously grappling with what to do about the drug issue. There are a couple of points that I want to make around what strategies may need to be addressed. That is highlighted by this particular case study.

This case study refers to a 17-year-old female. She came to our attention in June 1998 through contact with our street outreach workers who access the inner city, the CBD. She had problematic drug use which was self-confessed and which came to our attention in May 1999. She was in transient accommodation for a number of years. She accessed our drug counsellors and other youth workers in the service to receive some support about finding a way out of her dependent drug use. Often, those times that she approached workers were in times of extreme crisis for a multitude of reasons, whether that be related to past issues surfacing or a lack of drug. Predominantly she was a heroin user, although she did have poly-drug use: it is common with this population and it was also her way. On occasions when she was unable to source the drugs that she needed to stop from feeling sick, she would come to us attempting to seek help.

Referrals were made to the Adolescent Drug and Alcohol Withdrawal Service, which is attached to the Mater Hospital here in Brisbane. It is a two-year pilot program of which about 12 months has gone. It is a two-week detox program. There is no follow-up at this stage, provided by that service. Obviously we have close links with that service in my role as an outreach drug and alcohol worker. This young woman stayed in that program for 10 days and then left. Approximately four weeks later, she approached me for assistance to detox, late on a Friday afternoon when obviously most services are closing. The only services available after five o'clock on a Friday are the ambulance, police and fire brigade. I made a phone call to the hospital alcohol and drug service at the Royal Brisbane Hospital. They were unable to take her because they were full. She then went back to her usual lifestyle.

Mr EDWARDS—How old is she?

Mr Clements—She is 17. That was back at the end of February. Her lifestyle maintained itself as it had been for a couple of months. Back in early April, she decided that she had had enough of the lifestyle here in Brisbane. There was a multitude of complex problems weighing on her shoulders, and she decided she had had enough. She was looking for assistance and so she decided that she would seek that assistance in Sydney. She made contact with the Oasis, which is the Salvation Army Youth Support Network service in Sydney.

Mrs IRWIN—Is that in Cabramatta?

Mr Tansky—No; they are based in Surry Hills.

Mr Clements—They have an accommodation program there. She was with that program, and again explained her situation that she was dependent on heroin, wanting to seek assistance and change her lifestyle. She stayed with them until the 13th. I have spoken with the director of that service, Paul Maulds, and he said that their staff made numerous attempts to find her a placement in a youth rehabilitation program. That was unsuccessful. She voluntarily left that program in frustration on the thirteenth, and then made a self-presentation to St Vincent's Hospital. One day into that, she was referred by staff there into Gorman House—a place you obviously know, Julia, is part of St Vincent's Hospital but is a separate program. Gorman House, as I am aware, is actually an adult rehabilitation program. It is not use-specific. She was in there, but the make-up of that program is predominantly older men who are dealing with alcohol problems, and older heroin users. So she came into contact with another fairly downtrodden group in our society.

The Oasis received a phone call at about 9.00 p.m. on 15 April from this young woman. She was extremely distressed, saying that she had been harassed by an older client in the service and wanting to leave. She turned up at the Oasis extremely distressed in crisis. Staff there were unable to placate her. She then left at about 10.00 p.m. and they did not see here again. We received notice of her death of heroin overdose about two weeks ago now. The point is that there were points of intervention such that, if services and resources were available, this young woman would still be alive. She was a fantastically gifted artist.

Mrs IRWIN—You are virtually saying the system has let this beautiful person down—

Mr Clements—Exactly.

Mrs IRWIN—We have lost another beautiful life.

Mr Clements—Exactly.

Mr Tansky—In a nutshell, here in Queensland we have one detox unit for young people that is publicly funded. There is another one that is privately operated, but there is only one publicly funded detox unit for young people in the whole state, and it has only been running for 12 months. There are no rehab centres in Brisbane for young people—none at all. You have to go to the Gold Coast—

Mr EDWARDS—How many can that cater for at once, Michael?

Mr Tansky—It is a five-bed unit, but it only takes four young people; that is all they can manage at a time. In Sydney, they were saying the same thing. There was only one publicly funded detox unit that they were trying to get her into, because detox is the pathway to rehab, and there were no beds. The only beds she could get into were adult beds. So the key points are that we need youth-appropriate detox and rehab beds. Even if there were beds appropriate for women, that would have made a difference—she would still be alive. But she was in an adult detox unit that had older men in it, and here is a 17-year-old then being harassed—

Ms McLauchlan—With a sexual abuse history.

Mr Tansky—And then she is found dead in a laneway.

Mr EDWARDS—David, this has obviously impacted on your personally, to some degree.

Mr Clements—Yes.

Mr EDWARDS—I could understand how it would—a young person like yourself committed to the job you are doing; and I am sure you did everything you could for her. We actually raised the question this morning with one of the government representatives who was here, as to the availability of detox. The view that we were given was that, if the people are really determined and have made their mind up to detox, they will go and do it in 24 hours or 48 hours, or two weeks, and so availability was not such a problem. The other area that we were pointed in the direction of was to doctors' surgeries or to the family home. We did make the point with the person that often young people do not have access to a family home, nor do they have access to the sometimes thousands of dollars that it costs them to go through a naltrexone program or whatever. David, do you think that if you had had immediate access to detox that that young lady might still be alive?

Mr Clements—Yes, I think so. I do not necessarily think she would be completely drug free. That is the process that takes a number of years. However, at the time she came to me, if she had been able to access immediate detoxification facilities, my strong belief is that, yes, she would still be alive.

Ms McLauchlan—I understand where Queensland Health are coming from, or bureaucrats or whatever, in saying that, if people are determined enough, they will seek those services, be it now, tomorrow, a few days down the track, next week or next month. However, there is a developmental issue with young people and their lifestyle, and particularly homeless young people whose whole support network are also often users. They rely on their friends and peers and their street family, or whatever, to get by and to protect them a lot of the time. There is a major issue with expecting them to wait a month for detox. I think a lot of windows of opportunity are being lost, particularly on the young ones. Older people can say, 'Okay, I have maintained this lifestyle for X amount of time now; I can maintain it for another two weeks until I can get into a detox program.' But for young people it is very different: it is a developmental issue about having assistance there when it is required. The other issue is about the pathway out of detox.

Mr EDWARDS—Before we get that far, are you aware of any legal impediments that might stand in the way of people under the age of 18 being put into detox?

Mr Clements—Not legal, as such, for example, the Hospital and Alcohol Drug Service—HADS—at the Royal Brisbane Hospital essentially will only take people 18 and over because of the group of people that are accessing it, that they are specifically targeting. As we pointed out, it is really inappropriate for young women to be in the same facility as older men because of a whole multitude of underlying issues such as sexual abuse history and the potential predatory kind of issues that can arise there. Legally, I do not think there are any major issues. It is more about issues of managing those facilities.

Mr EDWARDS—I am sorry; I did not mean to cut you off there. I wanted to clarify that position.

Ms McLauchlan—That is all right. In terms of consent to medical treatment and stuff like that for under 18s, the practitioners are legally obliged to make sure that the young people can give informed consent to treatment. They need to make sure that the young people actually understand the type of treatment that they are undertaking. After they have explained the treatment, if they feel that the young people have the cognitive skills, or whatever, to understand what is happening and that they do not have a guardian who is contactable or close, they can actually go ahead with the treatment.

Mr Tansky—It is all very fine for Queensland Health to say that a person could go home and detox. It assumes that you have a home and it assumes that you have adult support and supervision. If they are talking about a young person whose mother has a psychiatric disability, the parents have separated, they have been out of home since the age of 14 and they have been sexually abused, what support is there? Young people say to us that it is easier to get heroin than to get a feed or to get a bed for the night. They are not in touch with reality making those sorts of comments.

Mr EDWARDS—Are you aware of this document, *Beyond a quick fix*?

Ms McLauchlan—Yes. One of our surveys is actually quoted in there.

Mr EDWARDS—I would not want you to think for one minute that we supported or accepted the position that was put to us.

Mr Tansky—No.

Ms McLauchlan—We have given quite a bit of feedback in terms of *Beyond a quick fix*. There are some really good points about that report, but I also think there were no targets or strategies. I could go on about that.

Mr EDWARDS—Does your organisation feel that it has the capacity to have input into policy and to influence bureaucratic or government decision making processes?

Mr Tansky—The sort of direction I would like to see the organisation go in—and there is a bit of groundwork to do on this yet—would be to join forces with other organisations who are concerned about the same issue. I would like us to bring up people from New South Wales who have actually got a lot more expertise and experience in delivering youth focused rehabilitation programs, and really put it on the Queensland government—both senior bureaucrats in

Queensland Health and the health minister—to deliver, in Queensland, youth specific treatment options. There are a number of things we want to talk about in relation to that, but specifically long-term treatment options. They are not available here; the nearest options are on the Gold Coast, where there are waiting lists. We have to send people to New South Wales to try and get into treatment facilities.

Mr EDWARDS—But even so, from the case study that you have given us today, there probably needs to be a national focus on it.

Mr Tansky—Absolutely. There is the same problem in Sydney.

Ms McLauchlan—In terms of making input to policy, we take every opportunity that we can. Because we are funded by Queensland Health, we have one worker—David's team-mate—who is funded by the state. He is funded by the National Illicit Drugs Strategy, so the state government does have access to our data collection and reports and that type of thing. Any policy forums or any inquiries or anything that we can put submissions into, we always do. We were certainly involved in the consultations to *Beyond a quick fix* and we definitely do try to prioritise. Even though we only have a small amount of resources and they are mainly aimed at direct service delivery, we do try to give input to policy and try to let the government know what we are seeing.

Mr EDWARDS—What is your relationship with the police? What is the relationship like between the police and the young homeless people? And what strategies are the police employing which impact one way or another on the people that you are seeing?

Mr Tansky—The report that we gave you, *Drug use and safety in Fortitude Valley: a community response*, was actually prepared by the Drug Safety and Awareness Sub-Committee of the Fortitude Valley Community Consultative Committee. The police are involved in that, together with businesses and other community agencies, residents and so on. We feel as though we have a constructive relationship with the police and that the police are expressing the same sorts of concerns we are. The kinds of things that the police are saying to us are, 'The big problem with drugs is the money. If you take the money out of it, you will go a long way to solving the problem.' They are saying that publicly in Fortitude Valley, where we work.

In terms of their relationship with young people, that really varies. Experienced police officers, who have been around for a while and know the client group, have a good rapport with the agencies and with young people. But police change over quite regularly, particularly in inner-city areas and also you have a number of different types of police units that are active in a particular area. There have been times—and David could give you an instance—where something like eight police officers or four police cars surrounded them when they were talking to some young people on the street one evening. So sometimes there are completely overreactive responses.

Their relationship with young people who are homeless is usually pretty terrible, particularly with young women. If they have been strip searched in public, out in the streets or in a car park—and we are talking about 14-, 15- and 16-year-olds—they are not going to have a very positive relationship with the police. Others, who are involved in sex work, have contact with the police regularly, so there will be particular police officers with whom they feel they have a

respectful relationship and others who treat them terribly. So it varies, but in the 25 years that I have been involved in youth work, there has been an improvement generally in the response.

Mr EDWARDS—I would hope so.

Mr Tansky—I would hope that there would have been over that period. Police are taking a much more community oriented approach. They are making themselves available to speak to community agencies and businesses. We have a lot more contact with them than we ever did.

Mr EDWARDS—Thanks for that. One of the things that we have picked up here is that we are constantly told that the age of people who are abusing substances is dropping. I see that your age group is between 12 and 25. Is it your experience that kids who are getting into prostitution and substance abuse are getting younger all the time?

Mr Tansky—The average age is 14 at first use. We are seeing that in the surveys. That is the average age for first injecting.

Ms McLauchlan—I have to say that, particularly with sex work and things like that, a lot of the young women who are using actually feel that sex work is one of the more ethical ways to support their drug habit, given that they are not—they perceive—ripping people off. They perceive that by selling their services they are doing something a lot more ethical than doing break and enters, drug dealing or other ways to support their habit.

Mrs IRWIN—Is there a heroin drought in Queensland?

Ms McLauchlan—There was. It is finished.

Mrs IRWIN—How long ago did it finish?

Mr Clements—About three weeks ago, I would say.

Ms McLauchlan—At Easter time it seemed to flood back on to the market.

Mrs IRWIN—How much did they pay for their heroin when there was a drought on?

Ms McLauchlan—Some people even could not get it.

Mr Clements—Predominantly, people that access our service could not get it.

Ms McLauchlan—Prices went up at least double. People were paying at least $1,000 a gram.

Mrs IRWIN—A cap?

Mr Clements—No; not for a cap.

Ms McLauchlan—For a gram. It was $1,000 at least. That would have been probably half the purity, at best, of what had been around before that. One of the things that we were quite

concerned about as well was the overdoses when the heroin actually came back. We have seen a number of young people overdosing.

CHAIR—Now that heroin is in greater supply, what is the price?

Ms McLauchlan—I am not sure. I would assume that since more heroin has flooded back onto the market the price actually has stabilised and dropped a bit, compared to what it was in what we were calling a drought.

CHAIR—I did not know whether it was a bit of a market manipulation that the price might be staying up.

Ms McLauchlan—Quite possibly.

Mr Clements—It is.

Mrs IRWIN—On page 9 of your submission, in the section 'Route of Use', you show the percentages for injection and so on, and you note:

> These percentages would indicate that many of the young people involved in this survey, representing the target group of young homeless people, are frequently either being initiated to drug use via injecting methods or making the transition to injecting from other methods of use very quickly.

Why are they quickly taking up the practice of injecting?

Ms McLauchlan—One of the reasons for that is the expense of the drug. That is with heroin. QUT and Brisbane Youth Service are doing a joint research project funded by Queensland Health on amphetamines. One thing we have found is that amphetamine use definitely used to be by snorting it, mainly, but people have turned to injecting it. It is the economics and also that rush that is associated with injecting. To a certain extent, it is about what the peer group are doing. A lot more young people are now using heroin. Injecting has been associated with heroin for quite a lot longer than has speed. People are using speed and heroin; whereas those two groups of people used to be fairly dissimilar groups. The injecting culture has moved over into the speed-using culture as well. Something specific that we actually are looking at in this research project is why people are taking up injecting.

Mrs IRWIN—The three of you are working at the coalface day in and day out, probably sometimes 24 hours a day. If you were running a department, what changes do you feel that government should make if you had this bucket of money?

Mr Clements—There are three points that we spoke about before we came here: firstly, access to youth specific rehabilitation facilities; secondly, access to supported accommodation for young people who may be using drugs. There are no services available as SAAP does not provide those services at the moment. It is extremely difficult for a young person who is using drugs to get a bed in a youth shelter for the night. As you can imagine, this exposes them to other risks.

The other thing—personally I cannot speak too much for you guys—is, thirdly, I am particularly interested in the trial supervised injection facility. Again, that is about reducing the risk of overdose and blood borne viruses to the target group. Also, I see some benefits to the wider community with regard to reducing the unsafe disposal of syringes. That is an issue that young people continually discuss around legal matters. Being caught with a used syringe brings with it a legal charge. To be able to use in a safe facility would reduce the risk of that and also the risk of needle stick injuries to the wider community.

Mr EDWARDS—We understand that there was a place where a young street worker was charged. I queried that and I was assured that it was correct.

Mr McLauchlan—With an unsafe disposal?

Mr EDWARDS—With a syringe in a handbag.

Mr McLauchlan—There have been heaps of unsafe disposal charges.

Mr Clements—It is a frequent charge of young people.

Mr EDWARDS—Is it frequent? I thought it was a one-off.

Mr Clements—No. Injecting drug users who access our service quite regularly are coming before the courts for drug related charges around unsafe disposal and possession.

Ms McLauchlan—Basically what they are saying is that it is actually safer for them to ditch a syringe on the street, if they do not have a container, than to walk to a bin with that syringe because of the unsafe disposal charge. While we understand the risks associated with unsafe disposal, publicly or whatever, if someone has a capped syringed, possibly wrapped up in a heap of toilet paper—which they tend to do—in their bag carrying it to a bin, it is not a lot of public risk. However they are still being charged with this offence. There is a real issue in terms of unsafe disposal charges that actually helps to make worse the perception of unsafe public disposal of injecting equipment. In that respect the law actually makes the problem worse. We have had reports, as well, of the police tipping out containers. I have not heard any reports of that for a while. However we actually discussed that with our local police inspector.

Mrs IRWIN—Why would the police tip out the containers?

Ms McLauchlan—Two reasons: looking for drugs—what better place to hide drugs than in a container? We do not have the black fit-packs like New South Wales. We just have bottles that you can stick all sorts of rubbish, as well as the syringes, in. One reason might be to actually look for drugs themselves, and the other one is actually to charge people with unsafe disposal.

Mrs IRWIN—What are your feelings about the trial of heroin on prescription? Do you think that would be a good idea?

Ms McLauchlan—Yes. The whole issue of a trial for 40 people was blown way out of proportion in Canberra. One of the issues that we have here—and the question before about

what other things can we do—is really valid. Queensland Health—and I guess all health departments—talk about evidence based funding, evidence based programs and stuff. We need to gather the evidence. I would support any trials, whether they be a trial of injectible heroin, the buprenorphine trials, safe injecting facility trials, to actually gain the evidence. If you do not have the evidence you actually do not know what direction to go in. There is a situation where people are making decisions based on not having the evidence. My call about trials would be, yes, do a small isolated trial and actually see whether the early evidence supports it. Then, if evidence supports it, maybe the trial could be replicated to see if it supports it again in another place. We need to look for the best alternatives.

Mr Tansky—For example, the heroin drought would have been a perfect opportunity to run some trials on crisis access to methadone. What better opportunity could there be? Here was a window of opportunity to get people on to some pharmacotherapy options, but that window of opportunity was lost. I think that is a real tragedy.

Mrs IRWIN—I have told other people who have come before this committee that I represent Cabramatta which is touted as the heroin capital of Australia. I love the feel, the taste and the smell of the place and I am actually moving my electorate office there. However, the number of break and enters went up and we had two murders there—crime on the street.

Mr Tansky—Yes.

Ms McLauchlan—Yes. Young people were reporting a lot more use of guns and people producing guns. We also saw that people were hanging around needle exchanges and then following these people and stealing their drugs. Instead of stealing money, people were actually stealing drugs.

Mr EDWARDS—Do you have any clues about the reason for the drought?

CHAIR—We discussed manipulation earlier, but do you think it was the market?

Ms McLauchlan—Quite possibly it could have been a ploy by some of the really high up suppliers or importers to force up the price. We heard all sorts of rumours from young people and from various people on the streets about—

Mr Tansky—Including the police.

Ms McLauchlan—Yes, including the police.

CHAIR—We need to get back—

Mr EDWARDS—I have to go. I have to catch a plane back to Perth, but I will read the rest of the transcript. Thank you very much for your attendance and for putting a very human face on what is a great tragedy.

CHAIR—On the representation of the people on the streets, ethnic or Aboriginal, what is the mix like? It is possibly in your data.

Mr Clements—In the inner city of Brisbane, we predominantly see an Anglo-Saxon population. About 15 per cent of the young people that access our service are indigenous, predominantly Aboriginal. There is a very small number of South Sea Islander people, I would suggest only one per cent to two per cent, and a similar number in relation to the Vietnamese community and the South-East Asian community. That is specific to the inner city of Brisbane.

Ms McLauchlan—However, in the Goodna-Ipswich-Brisbane corridor there is a higher ethnic population. So there are some services out in Goodna, or half way between Brisbane and Ipswich, that probably deal with high numbers of young people from different ethnic backgrounds. Just anecdotally, from some of those services we are hearing that quite a few of the young Vietnamese people are now using heroin.

Mr Clements—And injecting rather than smoking, which was more culturally traditional.

CHAIR—I will just run through two or three snapshots because I need to wind up. In respect of local government, as I recall, Brisbane City Council is the largest in the world or—

Mr Clements—It is definitely the largest in Australia.

CHAIR—What is the relationship with local government and how does it participate in this issue?

Ms McLauchlan—They have been very strong on the drug issue. They have given us various bits of funding aimed at addressing parts of drug use. They funded one particular resource that we had with a group of young people, details of which have been tabled here. For a while, they funded us to employ young people to do syringe sweeps of the valley city area surrounding the needle availability programs. However, that funding has now gone to Pacific Waste Management which actually empties the bins. They have been active in responding in terms of disposal bins and that sort of thing. They have taken some responsibility for some of those issues. However, they are also very keen to demarcate their areas of responsibility in relation to Queensland Health.

CHAIR—I wanted to refer to Queensland Health and the relationship between local government, Queensland Health and yourselves. Could you describe that relationship?

Mr Tansky—Queensland Health funds half the service. Twenty-one staff work in the agency and Queensland Health and the Commonwealth are involved in a number of different programs. For example, of the two drug treatment positions, one is funded—

CHAIR—Is it run as part of the urban region or is it run as a separate program?

Ms McLauchlan—No. Statewide health involves non-government services. We are actually part of the corporate office. They oversee our funding through the corporate office.

CHAIR—I am trying to focus on Queensland Health in terms of its approach.

Mr Clements—We are in contact with two main arms of Queensland Health: the communicable diseases branch and ATODS.

Mr Tansky—Yes, ATODS—Queensland Health Alcohol, Tobacco and Other Drug Services.

Mr Clements—From my perception as an outsider, it seems that those two branches, which should be responsible for the main focus of addressing drug issues in Queensland, do not particularly get on. They do not seem to talk very well and I do not know what that is about. It seems that there is a bit of competition between them. From my federally funded position, I do not have a lot of regular contact with Queensland Health. However, I was involved in a youth drug summit initiative. Essentially, we are involved in short bursts of focused projects, apart from funding—

Ms McLauchlan—I really feel that something needs to be done about the treatment services in Queensland. If you look at percentages of budgets that are put into treatment, you will see that Queensland has a pretty poor record.

CHAIR—When you talk about treatment, are you talking about detox and rehab?

Ms McLauchlan—Yes, and counselling.

CHAIR—They have indicated very clearly to us that rehab is not their area; they are out of there.

Ms McLauchlan—Yes, and I cannot understand that.

CHAIR—No, and I found it surprising that they had that very unequivocal view. I would have thought that there were a lot of issues around a whole of government approach—

Ms McLauchlan—Yes.

CHAIR—which is the popular jargon, but nevertheless I think it is important—which they would have been facilitating and which would have been able to assist the problem more positively. I am surprised that I have not heard today, particularly from Queensland Health, a much stronger approach to that.

Ms McLauchlan—I think they are disillusioned.

Mr Tansky—The tragedy is that we do not have basic infrastructure in place to ensure that traumatised young people are properly cared for in the community to the age of 18. The infrastructure is not there.

CHAIR—That's it.

Mr Tansky—We have a situation where children are cared for in foster care and some limited residential care. By the time they hit their teenage years and we start to see them coming on to the streets, there is nothing except shelters, which are short-term, two-week stays funded

under a joint Commonwealth-state arrangement. In the whole of Brisbane we have two places on the north side of the city that provide long-term supportive accommodation. There is nothing else on the south side. We cannot move kids from shelters or from detox into long-term supportive accommodation. They shelter hop or they go back on the streets. We do not have the infrastructure in place.

CHAIR—This constant tension, and the Commonwealth coming in and helping out where it can, and the state saying, 'No, we don't go in there,' bothers me.

Mr Tansky—Is it a waiting game, waiting for the Commonwealth to drive it? I mean, we do not know what is happening. But at the moment, nobody is prepared to take responsibility for ensuring that adequate infrastructure is in place to care for kids who have been traumatised. We do not have that.

CHAIR—I need to wind it up there. Thank you very much. You have reinforced Graham's comments. Thank you for sharing with us what is at the sharp point of this issue.

Ms McLauchlan—Thank you for inviting us to do that.

Mrs IRWIN—You made some very good points.

[3:46 p.m.]

BLACKFORD, Mrs Peta (Private capacity)

DAVEY, Mr Jeremy David, Deputy Director, Centre for Accident Research and Road Safety: Queensland, School of Psychology, Queensland University of Technology

ENTERMANN, Mrs Marjorie Ruth, Superintendent, National Women's Christian Temperance Union Christian Outreach

CHAIR—Welcome. At this stage of the proceedings, I will invite people to make three-minute statements. I need to point out that while the committee does not swear in witnesses the proceedings today are legal proceedings of the parliament and as such they warrant the same regard as the proceedings of the House of Representatives. With those few words, I will ask Peta Blackford to lead off, please. I will give you a warning bell so that you know you have 30 seconds to go.

Mrs Blackford—I would like to amplify what has been said by previous speakers this morning, especially by Rowena Solomon from DRUG-ARM and the speakers from Sisters Inside, regarding problems encountered within the prison system in terms of rehabilitation. The outline that I provided earlier is a broader submission, but I have actually written these notes in conjunction with that.

The Queensland state government's crime prevention strategy in December 1999 outlined the links between alcohol, drugs and crime and the challenge for crime prevention, and outlined the costs of crime. In its Building Safer Communities action segment, it outlined the expansion of methadone and other drug treatments. The federal government in its drug prevention program has recently spent millions of dollars, and it outlines in its booklet the statistics of teenage drug use, obtaining drugs, property crime, hospitalisations, drug deaths and so on. If federal and state governments are genuinely committed to assisting our community and prison community then matched funding, as was allocated to Prime Minister John Howard's drug prevention program, also needs to be provided for our Youth at Risk and medical rehabilitation programs and facilities and for relevant health care and assistance for persons who may have contracted blood-borne diseases, such as hepatitis or HIV, through shared intravenous equipment.

Following early submission to the inquiry secretary in July 2000, I would like to indicate that naltrexone medication in tablet form does have merit for individuals who have opioid or alcohol abuse and, when provided in a controlled setting such as a correctional facility, it has proven useful in stabilising an individual's health. I would also like to discuss in this outline the difficulties which may be experienced by persons within correctional facilities in their attempts at further rehabilitation. After initial correspondence in December 1998 and later liaison with corrective services staff by our family, a naltrexone policy was introduced in April 1999. Under section 52 of the Corrective Services Act, my brother was able to access and commence his naltrexone medication in prison. Our family paid $180 per month for this medication. He successfully completed this in approximately July 2000; he has been drug free for two years. In

correspondence to us of 5 February, the Queensland Corrective Services health and medical consultant, Dr Tony Falconer, indicated:

> I feel Naltrexone will continue to have a role amongst motivated groups. For these reasons, it may therefore be possible to offer Naltrexone treatment in some form to people within secure correctional centres.

It is important that correctional facilities support individuals who are motivated to maintain a healthier lifestyle. Ongoing medical and workplace rehabilitation within the general community and the prison community for people with substance abuse problems is imperative. Many people are sent to prison for crimes committed whilst using drugs or for committing crimes to finance their drug habits. Whilst people should be reprimanded and sent to prison for crimes committed against the community, I do believe in a restorative justice model for the benefit of victims, community and offenders.

On being sent to prison these people with substance abuse problems often find that there are some education programs to assist but little assistance with regard to medical rehabilitation, such as naltrexone, buprenorphine or methadone maintenance. Delays in accessing education or substance abuse programs, from lack of funding to run programs, causes frustration and often leads to anger, upset and ongoing depression. In prison it is difficult to remain motivated, and present corrective services facilities are not designed as therapeutic communities. People do become bored, frustrated and depressed and often turn to the ‘feelgood’ things on offer when and if in that frame of mind. There have, in the past, been instances within prison of ‘turning a blind eye’ to drug taking by inmates. This does not assist people with substance abuse problems. Random urine tests are conducted by correctional centre staff and, when a urine sample taken from an inmate returns positive to drugs, that person often will receive punitive treatment, by being placed in a detention unit for up to seven days and also, usually, by being reprimanded with points added to their existing classifications, or being charged in an outside court for the use of drugs or possession of utensils, et cetera.

As medical treatments such as those mentioned earlier are not readily available at all correctional facilities, and because there is often a lack of follow-up information for inmates as to how they may access medical treatments to assist them in their recovery from drug addiction whilst in prison, the cycle of illicit drug use in prison remains. Substance abuse programs provided by correctional centres are effective if run in conjunction with medical treatments as described above. When a person is motivated to undergo medical and/or work rehabilitation, ongoing support and further encouragement by correctional staff is imperative.

Sentence management reviews are usually conducted twice a year by correctional centre management. When reviews are conducted, aspects of an inmate’s behaviour and their attempts to rehabilitate are taken into account. Points are deducted if an inmate is seen to have made good progress. However, problems are encountered in this system, as a certain amount of points recommended for reduction from a person’s classification may not be fully reduced. This may mean that a person may not achieve a certain level of classification required by the Parole Board and, in effect, does not enable a person to progress through the system readily, even after completing recommended educational and/or substance abuse programs.

The Parole Board in Queensland will not approve parole applications if a person’s classification does not meet the criteria outlined in the ministerial guidelines. These guidelines

specify that an inmate has to reach a certain level. Rehabilitation is important as a health recovery process—for a person's self-esteem and for their reintegration into the community. Further encouragement and provision of adequate follow-up services is necessary for motivated individuals. It is essential that individuals are supported and given the necessary assistance by qualified professionals from relevant drug/alcohol support teams, counsellors and/or other medical rehabilitation centres and workplace rehabilitation within general and prison communities so that recidivism may be alleviated.

Mr Davey—I approach this committee in terms of two positions I hold—one as the Deputy Director, Centre for Accident Research and Road Safety and the other as a lecturer in substance abuse within the School of Psychology and Counselling at QUT. The topic I want to address is drug driving and, by drugs, I am referring to illicit substances, not including alcohol at the moment.

I am pursuing this issue at the moment because driving associated with drug use is one of the overlooked harms associated with drug use in terms of a harm minimisation approach. Historically, it sits within the realms of the transport department. However, the expertise and knowledge about drug use sits within the realms of the health department. That has led to, I suppose, an issue in terms of examining it in that drug driving has always been seen as a subset of driving behaviours as opposed to drug driving as a subset of drug use behaviours. When you work with people who use drugs and who drive, driving is subsumed under that greater drug use rubric.

Also, most of the research that has looked at the issue of drug driving has been based on toxicology analysis. There is some excellent work, for example, by Ollif Drummer in Victoria. However, the samples were taken pre 1995 and, due to the nature of toxicology, looking at post mortems. The data is pre 1995 and anyone who has had a longer history in substance use in Australia over the last 10 years, for example, knows that the major changes in substance use in Australia have occurred since 1995.

Much of the thinking about drug driving in this country is based on pre-1995 data and pre-1995 thinking and transport thinking. It has missed the major change in the heroin impurity rate from 10 per cent to 60 per cent, which occurred in 1995-96. It has missed the rise of ecstasy since 1995. It has missed the huge change in amphetamines in Queensland. It has missed the whole cultural change within drug use.

That is where I carry both sides. We have done small snapshot surveys of drug driving and we are looking at a university sample of drug driving in the past year. Fifteen per cent of the cohorts have drug driven in the past year. It goes up as high as 25 per cent when you are looking at cohorts of a certain age—so that is about a quarter of my university first year class.

We have then done qualitative work in terms of drug driving. We find that drug driving is routine behaviour. It is what you do if you do drugs, particularly as cars are a safe place in which to consume drugs. Some of the needle syringe exchange data programs suggest that over 40 per cent of the people who have used or injected drugs in the past month—particularly those who injected drugs—did so in a car. So it is a place for injection; it is a safe place for injection. With very successful policing campaigns we have pushed a lot of drug dealing to more suburban areas so people drive to get drugs.

To sum up, I dealt with a transport department official and I was talking about the issue of drug driving. They said that people drive to get their heroin. They might drive 20 or 30 kilometres to get their heroin and then they go home and use it. That shows a lack of knowledge of a person who is using heroin. If you are driving 20 or 30 kilometres to get your heroin, you shoot up straight away.

There are those sorts of issues. 'Driving while hanging out' is an extremely problematic issue when people are sick and cramping up. The problematic time is probably 9 o'clock in the morning. There are a whole lot of myths about driving such as, 'I drive better when I'm stoned' and driving while on the nod. There is also the issue of benzodiazepines.

Lastly, there is the knowledge that they cannot test for it. Almost all of our subjects had been pulled over at one stage whilst intoxicated by an illicit substance and not tested. They cannot test for it. That takes you back to the work done on drink driving: going back to, for example, Ross Homel's work in the 1980s. He found that what made the major shift towards prevention of drink driving was the perceived likelihood of being caught—not even the actuality of being caught but the perceived likelihood of being caught. This does not exist with drug driving.

CHAIR—Could we get a copy of that?

Mr Davey—Yes. I faxed a copy—I have been ill—but I think you were on the plane when it got through.

Mrs Entermann—There has been much media coverage and public discussion concerning the various illicit drugs, yet alcohol remains the number one killer of youth in Australia. In fact, Australia has the highest incidence of alcohol related brain damage in the world. If a dog that is known to be vicious is allowed to run free, or even if it is walked on a leash, the owner must assume responsibility if it attacks or injures anyone, particularly children. By licensing the manufacture and sale of alcoholic beverages, the government recognises the potential for harm to the individual, the family and society, but very little is done by way of warning impressionable youngsters who grow up believing it is a normal part of life and only bad if used in excess. Science is proving otherwise. While some would say that a little each day is good for the health, the same benefits can be obtained from fresh, unfermented grape juice without any of the dangers to health and safety that alcohol creates. Why risk permanent damage to brain cells, heart, liver and kidneys? Because of the euphoria it induces? A fictional state of mind? Reality is forgotten, along with responsibility, reason and reserve.

For over 100 years the Women's Christian Temperance Union has continued to raise its voice against the enemies of society and has endeavoured to teach children and youth of the dangers and foolishness of using alcohol and other addictive substances. Foetal alcohol syndrome is a very real condition, and so is the lifelong struggle to which some children are sentenced by their mothers who thought it was okay to drink while pregnant. Stronger warnings must be given if we are to avert this increasing crime against unborn babies. They have not only a right to life but also a right to a good quality of life—a sound mind in a sound body. May God give our legislators wisdom and courage, not only to get tough on drugs but also to include the number one curse of society. Make the manufacturers and sellers pay for the damage they cause, and stop sporting sponsorships. They want kids to think of them as good guys. Tell kids the truth—they want your money and they do not care if you end up in the gutter; that is your choice, they

hey want your money and they do not care if you end up in the gutter; that is your choice, they say.

As a child I was warned to never drink anything out of brown glass bottles—they contained poison. I think that advice would still be good today. Alcohol is an addictive intoxicant and should be labelled as such, along with the alcohol content. Warnings should be printed on each item; for example, ‘Alcohol causes accidents’, ‘Alcohol causes liver disease’, ‘Alcohol causes damage to unborn babies’, ‘Do not drink and drive’, ‘Do not drink if pregnant’ and ‘Alcohol causes brain damage’. I personally would like to see it labelled ‘For external use only’. Thank you.

CHAIR—Thank you.

[4.04 p.m.]

GRANTHAM, Mr Geoffrey Leonard (Private capacity)

KAVANAGH, Associate Professor David John, Associate Professor in Clinical Psychology, University of Queensland

NOSOVICH, Ms Jennifer Frances (Private capacity)

CHAIR—Welcome.

Mr Grantham—Thank you. George Shultz said that the war against drugs, as currently waged, is doomed to fail. Was he right or wrong? The fact is we do not know because there has been too little research and modelling of our current primarily punishment based policies. Drug use is widespread and costly and cannot be addressed as a wholly moral issue. We have to have a cost-effective approach. Is punishment, particularly prison, the most cost-effective choice? I ask the committee to seek proper modelling of our current approach and ask: is it possible that, as a society, we are too wedded to the notion that punishment, and in particular prison, must follow wrongdoing?

With respect to modelling, let me assume there are 125,000 people seriously involved in drug use and supply in Australia. If someone were to discover an effective way of identifying these individuals we would immediately face a major crisis in our criminal justice system. Locking up half for 12 months would cost $2,500 million. Giving three-quarters of them two-year sentences would cost $7,500 million. Is it possible that the potential cost of a successful law and order strategy, if it exists at all, is beyond our reach?

On the question of the emphasis we place on punishment, I would like to refer to a woman I spent three hours interviewing in prison this morning for the purpose of writing a pre-sentence report. She is charged with property offences committed to fund heroin addiction. I spoke to her solicitor shortly before coming here. He anticipates she will receive about six months in custody at a cost of around $25,000. It may be that those she stole from believe this money will be well spent. But would they hold to that view if they knew her father died when she was a baby; her mother was abused as a child and was not an adequate parent; her uncle, who brought her up to the age of 11, was murdered at that time; criminals and drug users were regular visitors to her house; she spent a few unpleasant months in a home; she has never stepped inside the gate of a high school; she was seriously assaulted by her mother; she lost her brother when he hung himself; she left home aged 14 and lived on the streets for three years; and she began using heroin at 17, a drug of which she said, ‘It makes you forget, it takes all the pain away.’ That is not an unusual story. As a society we spent little money on her family when it disintegrated after her uncle’s death. Although she has been on methadone at different times, she has never received help to deal with the emotional pain of her childhood.

I would like to see the committee request proper modelling of our current policies to answer the following questions: how many must be imprisoned, for how long and at what cost to achieve a level of change in drug related behaviour for our current policies to be effective? Can

we afford that amount? If not, then are we able to adhere to a law and order approach only because it is unsuccessful? This appears ill founded. Secondly, I ask that we properly model the cost effectiveness of alternatives. More and more we are turning to evidence based practice in health care and I am urging the committee only to act similarly where this issue is concerned.

We could all ask ourselves: if my son or daughter were convicted of drug related crimes, and I was given $50,000 to spend on minimising the risk of them re-offending, would I invest it in sending them to prison for a year? I believe the answer could be yes, but only if we can show that doing so would be morally and economically the most sensible course of action. To show ‘yes’ is the correct answer we must first undertake thorough research of the cost and effectiveness of options such as rehabilitation, treatment, family support, et cetera.

CHAIR—Thank you.

Prof. Kavanagh—I want to make a plea for a subgroup of people. Substance abuse is much more common in people with mental disorders than in the rest of the population. A study published in 1990 in the United States showed that people with mental disorders had almost 2½ times the risk of alcohol misuse and 4½ times the risk of misuse of other drugs. In a study that was published last year based on 1998 data it was found that people with mental disorders comprised 44 per cent of the US market for tobacco. I think that is an extraordinary figure, and suggests that some exploitation of these people is going on. There is a very high cost with associated higher medical services, and the cost is perhaps highest overall in the most common disorders, anxiety and depression, and in the most commonly misused drugs, alcohol in particular and tobacco. Tobacco use in particular is probably one of the key reasons for the higher risk of mortality in serious mental disorders such as schizophrenia. It comes next after suicide. The greatest individual risk with co-morbidity is actually with people with psychoses or antisocial personality disorder—psychoses such as schizophrenia and bipolar or manic depressive disorder. In Australia, in a population study that was undertaken in 1998, 42 per cent of these people had a substance misuse disorder, as well.

In a study we did in Brisbane of young people in in-patient units, 70 per cent had a substance misuse disorder as well. It is important for your purposes because of the high cost of treating people with serious mental disorders, anyway. For example, schizophrenia costs about six times as much as a heart attack to treat in Australia because it is such a long lived disease. A study last year showed that bipolar disorders cost about 70 per cent of the cost of schizophrenia—almost the same. People with co-morbidity appear to cost much more than people without co-morbidity—with just the mental disorder. But we are not sure just how much in Australia because nobody has done the proper studies. There is also a substantial impact on themselves as individuals—their functional status—and a substantial burden on others.

There are two things I want to leave with you. Firstly, the problems that occur in serious mental disorder occur at very low levels of use. We are not talking about skid row here; we are talking about very small amounts of intake of substances that are enough to cause a difference. Secondly, our services at the moment are not really well set up to cope with this kind of co-morbidity. We have separate drug and alcohol services and mental health services. They have different priorities. It is very difficult to actually get cooperation at times between individuals treating these problems. The Commonwealth is looking at this issue. Last year they held a workshop in Canberra, which I attended, and they have put out tenders for scoping exercises to

look at exactly what treatment services are available. But it is not enough. In particular, we need to have research on what does work. We have not done the basic hard work to find out what are the effective treatment strategies. In the recommendations I sent you, I suggested that there be such research—that there be work on training across these practice areas, these separate services; that the problems of information transfer and collaboration between the services be addressed; and that consideration be given to the existing split between mental health and alcohol and drugs.

CHAIR—Thank you.

Ms Nosovich—I answered the notice to present a submission to your inquiry into drug abuse because I felt there was nothing else I could do for my friend who has a son who has not only a serious drug problem but also schizophrenia. She was to join me today along with another mother who has a son with a big drug problem, but they have both had enough—given up—and they could not make it. My eyes have certainly been opened since having a lot more to do with this friend. I have even become blasé when I visit, hear or see what he has been up to. I have seen a family of six—two adults and four children—completely transformed in all manner of ways. The most serious of which, I would say, is the effect on the different members of the family. The dog gets ill-treated continuously but they will not send him away because it is about the only thing they feel they can really love and show that love to at the moment. I understand that. My friend is a prisoner in her own home and at times when she feels she can hardly go on she admits life has been a nightmare over the past few years. However, she still seems to be positive. Whenever I leave her house, which is often, she is smiling and she tries to be positive and very strong, which she is a lot of the time.

What would help? Access to drugs, and doctor shopping, should be made much more difficult; adequately funded support agencies for families should be provided to enable carers to have some much needed relief; proper respite care centres—government or privately funded—that are sufficiently resourced by qualified carers and genuine volunteers should be established; more experienced volunteer carers who could spend some time at home talking to the user should be provided so that the parents can do their own thing just for a couple of hours even; education at schools and home on the effects of drugs and the like, with good case studies given, should be provided; healthy, stimulating activities for children and teenagers for out-of-school hours and on leaving school should be provided to stop the boredom and the other reasons that may be causing this; and dealers should be investigated far more thoroughly and given harsher convictions. Thank you.

CHAIR—Thank you.

[4.16 p.m.]

ROSEVEAR, Dr Wendell John, Director, Stonewall Medical Centre

SANDS, Mrs Debra (Private capacity)

SANDS, Mr Gary (Private capacity)

CHAIR—Welcome. Dr Rosevear, would you like to make an opening statement?

Dr Rosevear—Yes. Thank you for inviting me. I assume that you have my paper that I gave you, *Drugs in perspective: 'Get real'*. I work in drugs, sexual abuse, HIV and AIDS and prisons. I am currently a volunteer doctor in two prisons, having started in 1975. I am anti drugs, I am pro the value of life and I am pro respect for individual choice. In the last year, 11 of my patients died from drug overdoses: one in a maximum security prison where all the windows were sealed by steel mesh so that drugs could not get into the unit; another died in hospital; and three died recently after having left prison. Most of the people had actually stopped using drugs and lost their tolerance and then died.

The situation is that we have people taking unknown doses of unknown drugs from unknown sources. While ever the doses are unknown, people will always die. Until we legalise drugs and people can take known doses of drugs, we will never end the increasing rate of death from drugs in Australia. I see these deaths as predictable and preventable. My basic premise is the value of life and that we could save these people's lives. Currently, we have a situation where the user uses, the dealer profits and society and the user pays. I believe in the user use model and the user pay model. Until we remove the large profits that come from drugs being illegal, we will never address the issue of supply or the issue of crime. While ever there is a large profit, we can guarantee supply. We have the best network marketing system in the world.

The dominant message that our society sends is that you are weak, bad, sick or stupid. That leads to rejection, isolation, stigma and individuals trying and failing to the point of desperation. In the last nine years, 25 of my patients have died by suicide and 18 of them died specifically by suicide after trying and failing repeatedly to stop using drugs. I propose that we currently have a bad model: if you use drugs you are bad. Some people want to use a sick model, so we move the control person from the prison guard to the doctor. I would actually like to move to a new model: the 'you are a valuable person' model. I do not think that moving from a bad to a sick model is going to solve the problem. My basic premise is that we need to move to a 'you are a valuable person' model. The 'bad' and 'sick' models are both flawed because they are focused on external control; the 'valuable' model is that you are a valuable person and we will nurture you being honest and making your own choices. My work in rape tells me that unless you have a choice you do not feel valuable. We need to relate the value of a person to the right to make choices and learn.

When more than 500 of our young people were dying in Vietnam, we valued their lives enough to be honest and say, 'It is not working. We need to change what we are doing.' When we have got up to 1,000 people a year dying in Australia, we need to stop and say, 'Let's be

honest. The get-tough policy just does not work. It actually makes the problems worse.' Recently I asked Mr Howard to say sorry for the National Drug Strategy, because of the deaths of 11 of my patients last year. He said to me that most of the parents he talked to did not want their children to experiment with drugs, and I said, 'The parents I talk to want their children to experiment and learn, not experiment and die.'

We now have a situation of basic denial. My experience is that denial plus dependency always go together to create addiction. I respect your respect for the denial link to drug use in Australia. My recommendations are: (1) we value people; (2) we nurture honesty; (3) we legalise all drugs; (4) we regulate so we can control dose and price; (5) we tax all drugs and we use all taxes from all substances to address the problems that substances cause. Alcohol and tobacco taxes are $6.1 billion a year. I suggest that we educate at point of sale. I suggest that we use the money to help people who would like to stop rather than trying to stop the people who do not want to stop.

I suggest that we foster communication so that parents can nurture honesty. If we send the message that your kids are criminals, then we kill the communication because, unless the communication is safe and there can be confidentiality and respect, we cannot expect honesty. My work in prisons tells me that. You have heard that repeatedly today. I suggest we move from the bad to the valuable model. I would like to say that people who use drugs are seeking relief. When they find that relief they can perhaps let drugs go, and the relief can come from us valuing those people.

Mrs Sands—I would like to thank the committee for inviting me to speak here today. I am the wife of Tony. We have been together since we were 15. We also have three teenage children. Tony is opiate dependent. After being together for almost 20 years, in 1996 I almost lost Tony several times to bacteria endocarditis, which is a serious heart infection, which also affected all his other major organs. My children and I watched Tony fight for his life in hospital for almost five months. When he came home and his health struggles continued I started seeking answers. We have been through so much together I still find it difficult to comprehend that someone so close to me was facing such a life-threatening illness and I did not know anything about it. From those two decades, I also knew very little about the illness known as heroin dependency. In Tony's defence, I would always say that he was sick and that this was an illness, but I had nothing to back me up.

During the difficult times, when money was tight and it was a struggle to put milk, bread and heroin on the table, I was often forced to abandon my sense of what was right and what was wrong and would often turn on Tony and blame him and his drug use for all our problems. I lived in silence and shame, alienated from the community. I tried to deal with his problem by getting on with my life, raising the children as if the problem did not exist, and hoping that one day I would wake up and his drug problem would be gone.

I was living in hope of the day when Tony would get over it or grow out of it. There are my other times of shame when I wished he would go elsewhere to be sick or just die and get it over and done with. No-one involved in his treatment over 20 years of rehab, detox or methadone ever informed me he had an illness or gave me any information that would help. I was often told that he had a self-control problem and was weak willed or a bad seed. When he was on methadone and unable to get off the drug, I was told he would never get off it because of this

weak will. I had no idea that so much had been written up in the medical literature and that health laws defined heroin dependency as an illness.

I had no idea that there were provisions under our health laws for Tony to receive treatment tailored to meet his individual needs without discrimination. To everyone, including treatment providers, he was an addict, a junkie. The attitude was: throw him out, do not give him any money, let him hit rock bottom and then he will stop using drugs. I also knew nothing about methadone, a drug that he took every day for 10 years, and which caused the most insidious side effects. It is a drug which works well for some, but I have since found out that Tony should never have been on the drug. I did not know that heroin was made from morphine and changed back to morphine once it crossed into the brain, or that it was available for Tony all this time as an alternative to methadone and would have afforded him a better quality of life for all those years that he struggled. And I certainly did not know that morphine was relatively cheap and costs about 30c an ampoule—a lot cheaper than bread, milk or heroin.

Through the help of compassionate and caring doctors and nurses and my own research, I came to understand this illness for what it is. It was reported in the early sixties, about the time that we were born, that heroin use causes a metabolic deficiency in the brain and an associated disease which requires repetitive dosing of the drug to correct the deficiency. Put simply, Tony's brain does not produce chemicals called endorphins, which are the brain's own natural pain-killers, and these endorphins are almost identical to morphine. When Tony was placed on morphine in hospital, the drug was used to treat chronic pain, but at the same time I saw that the deficiency was also corrected, and Tony was able to function normally for the first time in almost 20 years. From what I saw, the drug put life back into him, and I expect that he will need morphine until he dies.

Tony now receives a known dose of injectable morphine that he is able to tolerate without the serious side effects he suffered on methadone. I am comfortable knowing that I am not going to come home and find him dead from an overdose. I also know that it is clean and sterile, so he is not at risk of an insidious infection like endocarditis. I am grateful that the government does have this treatment option available, and I feel that it should do more to promote it as a harm prevention measure to injecting opiate-dependent people who have had problems with oral drugs such as methadone.

We accept that we cannot change the past, and we are still trying to pick up the pieces and deal with issues like other families have to and move on, but we are not going to be victims any longer; we are survivors. To the children and me, Tony is much more than someone who uses drugs; he is a human being, my husband and the father of our children.

I also found out through my research that no amount of unconditional love and support was ever going to correct this deficiency. Sending him to prison was not going to cure him, and being on a drug like methadone, in which his brain was not deficient, was never going to help. No amount of counselling was ever going to help him learn to overcome this illness. He had been receiving inappropriate care for 20 years. I found laws that provide for quality health care for people like Tony who are dependent on opiates. There are provisions under Commonwealth and state health disability services and disability discrimination legislation and provisions within consumer protection laws that fall under the Trade Practices Act and common law rights.

We have been disappointed that, despite raising these serious matters, health officials have made no changes to improve health care standards for dependent users like Tony.

Our story was recently aired on the ABC's *Australian Story*. We wanted to tell our story because we felt it may offer some hope to those who are still struggling with similar problems, and I have been overwhelmed by the number of people who are experiencing problems with their drug treatment. I also hear from people who require opiates for chronic pain caused by cancer, migraine, arthritis and other illnesses, and they have never even used illegal drugs; however, they too find themselves caught up in this absurd situation where health departments interfere with the manner in which their doctors treat them. Many have found themselves taken off morphine and put on methadone and left suffering side effects and ignored when they complained. We are helping other people out of a life of misery and despair by helping to empower them with the knowledge we did not have—knowledge that the health department has not provided them. They are now taking on the health department and seeking a better quality of life for themselves.

Mr Sands—I would like to thank the committee and staff for inviting me to speak today. I am a person who is drug dependent and who started using heroin in 1977, when I was aged about 15, and I have been opiate dependent for the most part ever since. At present, I am being treated with morphine injections. One of my cardiac specialists started me on the morphine injections five years ago to treat chronic and acute pain whilst I was in hospital battling serious complications from bacterial endocarditis, a life threatening illness faced by many injecting drug users—complications that have resulted in damage to every major organ in my body.

After my discharge from hospital, I attended my family doctor or the hospital to receive the morphine injections. Then nurses were organised to come to my home twice a day for a period of 12 months. Almost 18 months ago, Queensland Health gave permission for me to inject myself. This treatment has enabled me to live with dignity and respect—something that I feel I was not afforded when using heroin, attempting numerous detoxifications, spending time in prison on methadone, or whilst receiving other inappropriate care. Despite being left with multiple health problems that need constant monitoring, I now have a quality of life.

Methadone, on the other hand, was cheap and affordable. When I started on the methadone program after 10 years of heroin use, I was told that I would be off methadone in six months and would never use heroin again. However, I suffered serious side effects that made work almost impossible, and, despite dozens of attempts at withdrawal from this drug, I remained on methadone for 10 years.

I also remained on methadone as I did not want to go back to living like a criminal or watching my family carry the financial burden of heroin. Changes to the drug after eight years caused further side effects which left me fighting for my life in intensive care. People who are opiate dependent, like myself, pay not only in health terms; we usually end up with this illness for life. We also face ignorance and prejudice from many in the community. Our families also live in shame.

There has been a lot of opposition to the morphine injections and I know that many have been waiting for me to fail. This opposition has come from senior bureaucrats within the health department and a few doctors who were treating me during my time in hospital. These are

people whom one would think would put a person's health and welfare first. An example of opposition is where a professor at Royal Brisbane Hospital stopped the treatment and insisted that I go back on methadone. Despite being seriously ill, rather than return to methadone, I left the hospital. Thankfully, I went back to the Gold Coast Hospital and was placed back on morphine.

After open-heart surgery and my discharge from hospital, my family doctor also came under immense pressure. My doctor saw the health benefits for me. However, the problem lay with the health department sending letters and making phone calls stating it was unlawful to treat me because I had been on methadone. This was a health department entrenched in policy and practices which had little regard for my health. My wife had found laws in support of my health needs and took on the department on my behalf and after several years of advocating, my treatment is now appropriate.

We were told that the reasons for the opposition to the injections and the use of morphine were the closeness of morphine to heroin, whose real name is diacetylmorphine; the use of syringes and that morphine is seen to be a feel good drug like heroin because of its pain killing properties. I can attest that it is not about feeling good as much as it is about sick people being able to function in a normal manner and participate in society as others do. It is about quality of life.

Another argument was that we are sending a message to young people that drug use is acceptable, but surely the message that would be sent is that heroin use causes a serious health problem and there is a real possibility it could result in life-long disability, or death. The fact that my family struggles to find a solution to our problems demonstrates how much families are still on their own with this health issue. If health departments were to permit doctors to treat heroin dependency as a health issue with all treatment options available, including morphine injections, then simple solutions such as ours could not only help to keep our families together, but also save the community from annual jail costs of $50,000 per inmate, reduce health care costs and, of course, lead to a reduction in crime. If the government were to expand this treatment, then the only losers would be the drug traffickers. Thankfully, my wife and children have supported me throughout this. Their love and support have been unconditional and I know I would not have made it without them.

Mrs IRWIN—Mr Chair, I would like to thank Gary and Debra—mainly for her courage, love and dedication to her husband and family. I would like it noted that when we are in Canberra next, for those members of the committee who have not seen the episode of *Australian Story*, we might be able to view it. Thank you very much for sharing that.

Mr Sands—Thank you.

CHAIR—Thank you and all the best to you.

[4.33 p.m.]

REECE, Dr Albert Souare, Consultant, Drug Free Alliance

SAUNDERS, Professor John Barrington, Professor of Alcohol and Drug Studies, Department of Psychiatry, University of Queensland

WHIELDON, Mrs Pauline Anne (Private capacity)

CHAIR—Welcome. Professor Saunders, would you like to lead off?

Prof. Saunders—I speak from the perspective of somebody who has been a clinician, an academic and a researcher in the field of substance abuse for the past 25 years. I would like to offer a number of comments to the committee for their consideration and I have prepared a brief document here which I believe has been circulated.

I would like to stress the importance of identifying long-term goals for the community in terms of the use and misuse of drugs and alcohol and, in particular, to try to establish consensus on the legal status of certain psycho-active substances. My feeling is that, unless we achieve a broad societal consensus on the legal status of various substances, formulating coherent goals and policy will remain difficult.

Also, we need to have a pragmatic acceptance of strategies for harm minimisation when substance use cannot realistically be eliminated. This has been a strategy which has been endorsed by Australia’s National Drug Strategy for a number of years. It is not accepted by a significant proportion of the community. Therefore, wide public debate and the attempt to achieve a consensus on both short-term goals and long-term goals are very important.

Thirdly, I would like to draw the committee’s attention to very major developments in the neuroscience of psychoactive substance use, misuse and dependence. There has been a tremendous investment over the last 15 years into research into the biological basis of dependence. We are now seeing new treatments coming on-stream, which derive directly from this research. I would like to see support from the committee for the further development and trialing of these innovative new treatments, specifically some of the pharmacotherapies. I also note that vaccines are being developed directly against drug abuse, and I would like to see support for the integration of these innovative treatments with psychological therapies in overall client management.

I would also like to continue to emphasise the need for greater efforts to promote cooperation and collaboration between the different service providers. This field is characterised by a large number of different service providers being involved. I see encouraging developments of collaboration between government and non-government sectors; and support from the committee for this would be appreciated. That is all I would like to say.

CHAIR—Thank you very much.

Mrs Whieldon—I really appreciate the opportunity to be here today. I am absolutely rapt that somebody is listening. It has not been my experience in many years that anyone has really listened to me. I live in a little country town a few hours away from here. I have been married to my husband for almost 31 years, mostly happily. We have three daughters and, between them, they have four daughters. Our youngest daughter is 19 years old. She has been using a variety of drugs since age 12 and has a 4½-year-old child who is now in the full-time, and probably permanent, care of my husband and me. We began proceedings in the Family Law Court in March last year in order to obtain residence for young Emma, after she was found abandoned by her mum in a park here in Brisbane.

Over the last seven years we have often sought help or advice from Family Services—to no avail whatsoever. While going through the Family Court process, we learned further that Family Services has no credibility within that system. When reports are submitted to court by Family Services officers, they are not taken into account, as it is felt that they are seldom in the interest of the children involved and they are written by people who really do not have much idea of what they are talking about in relation to the wellbeing of those children.

If I had three hours to talk to you today I could only begin to tell you of the inadequacies regularly displayed to us by these people. I am very much of the mind that a lot of the anguish that our family has experienced should have been avoided. Early intervention would have had such a different outcome. This leads me to ask: what purpose does Family Services serve? In our case, none—and at huge expense to the taxpayers. As for the direct issue of drugs, I feel that we as a society have tolerated enough. It is time for zero tolerance.

It is time for truth in sentencing. It is time to take back control of our society and give the kids a bit of a future that they can look forward to. Personally, I do not have a problem with firing squads for convicted drug manufacturers and big dealers of drugs. I am not talking about little Johnny or Susie on the street corner just peddling for their next fix. What they are looking for comes from further up. We need to annihilate the people further up. There is no place in this society for them. The cries of, ‘But that is not humane!’ fall on deaf ears on this head. Where is the humanity in seeing your model child of 11 turn feral almost overnight? Is the humanity in seeing that child give birth at just 14 years of age, knowing in your heart that she will probably never be able to be a successful mother to her child? Is the humanity in seeing her go on to deteriorate into a damaged teenage psychotic who can no longer focus on reality?

There is always the option for users to say no, but wouldn’t it be fantastic if they were never offered the life-destroying drugs in the first place, or did not have them so readily available? People who manufacture and supply drugs are murderers. They should be treated accordingly. While we have this scum destroying so many of our younger generation, we have a poor future ahead of us and they have a poor future ahead of them. It is imperative that the control they now have is taken back by those of us who will give hope to the future. The original question I sought to answer when I first put my submission in last year was, ‘What is the cost of illicit drug use to our society?’ One could also ask, ‘How long is a piece of string?’ or ‘How long is eternity in hell?’

Dr Reece—I would like to distribute some folders to you. In them you will find a copy of a letter to the *Courier-Mail* and a full version of the article which is in today’s paper detailing the very topical problem of the death rate on naltrexone and the safety issues. You will find an

article summarising a recent report on what, from all the reports I have heard, was a very successful meeting in London recently: the Sixth International Stapleford Conference on the Use of Antagonists in the Therapy of Addictions, which many of us attended. You will find a transcript of most of the slides I will use today and a graph at the end of that showing the very close correlation—significant at one in 10,000—between needles distributed in the nation and hepatitis C. If not otherwise specified, data is supplied by the federal Department of Health.

Slides were then shown—

Dr Reece—Moving to the slides now, I want to talk about naltrexone. I want to put it in context. This slide shows relative causes of death for young people aged 15 to 34 in Australia. You will see that in 1999, drug related death was the commonest cause of death in young people in the nation. Suicide has dropped and there has been a dramatic drop in car crashes, as you must be aware. In New South Wales the difference is even more significant and in Victoria there is a huge difference. The next slide lists the differences in Queensland. When we move to years of potential life lost in the whole nation—this is across all ages; the years of life wasted as these young kids die—you find that heroin is now coming second after suicide. That is the data for the last six years. We will move to the projections in a minute.

In the year 2000, it is likely that drug death will supersede even suicide as a cause of wasted years of life. Naltrexone will not cure heroin; that is the one thing that it does not do. But what does it do? It reduces physical craving, it blocks the shot if they have one and it increases the time to bust from 10 minutes in any major city in the nation to three days. It shortens and attenuates the detoxin syndrome in a way that is very useful in a clinic. It actually changes the way patients think about drugs. That is a huge issue, and one I would be happy to take questions on. It will not reduce the psychological craving.

The year 2000 data will not be released for six months, but on the projections of the trends you have just seen, drugs will overtake suicide as a cause of death. The mantra repeated by Australian governments, which is grossly untrue, is that there is no evidence for naltrexone. We have collected 94 series, including 26 controls, 180 data points, 11,000 patients and 2,000 controls. The overall success rate of patients who continue to take naltrexone tablets for six to 12 months is very low. But the opiate free success rate, which is the main event that society is interested in, is actually 52 per cent, as indicated in that graph.

Our experience is something over 1,200 procedures in 850 patients. For the London meeting, we reviewed half of our patient group—400 patients in three groups. In the last six months, we have been using naltrexone implants, which, as the committee is very well aware, are highly controversial. Nevertheless, they are the best pharmacology available in the world at present to prevent heroin use.

The problem with naltrexone pills is that the patients do not take them. But when you slip the pills under the skin, it is in there—game over. The standard ones available from the US work for four to six weeks. In Perth now there are some available which act for around 12 to 26 weeks. So there is a whole quantum shift. I am sure this is what the professor was referring to. This is one of the major quantum shifts which has occurred in an area where we urgently need studies.

To compare implants and tablets, our experience in the last six months has been with groups that were treated over 12 months ago. You can see in all three groups an overall dramatic improvement in work status—significant at 10 to the minus nine, which is one in 10,000 million. In case you do not understand that, it means that there is one chance in 10,000 million chances that improvement occurred not due to the drug.

With regard to urine positivity rates, our rates of use in our drug screens performed in the clinic are very low. You see the amphetamine use rate there is 15 per cent. Cannabis, of course, is high, as one would expect, but the heroin use positivity rate in the three groups is low.

With respect to crude opiate free success rates at six months and 12 months, as indicated, there is an 85 per cent implant group, 67 per cent in the tablet group, 50 per cent in the historic group—that is over 12 months. That is the overall group—the opiate free survivorship. One notes that at 52 weeks they are 60 per cent clean, which is a brilliant result. It is about 30 to 60 times better than the equivalent result achieved with methadone. If one compares tablets with implants, one finds that at 52 weeks about 84 per cent are clean on the implants and about 50 per cent clean on pills. By type of implant, the blue curve at the top is the world's best implant. That is from Perth, and the lower curve is the American implant.

Working after treatment makes a significant difference, and one notes again a statistically significant difference there as seen on the slide. Social support is a huge factor. Probably all speakers today have mentioned the importance of psychological and social support, usually by the family, the spouse or the parents. That is a very important thing and we have graded social support there as one, two and three—you can see the huge difference that makes.

Sport also helps in a statistically significant way, although the separation of the two curves is not as different. With regard to financial resources, I am sure the committee is aware that, in some cities, it is a very expensive treatment. And I am sure the committee has also heard a thousand times that, for the rich and for parolees, naltrexone is accepted as working because there are three or four papers that demonstrate that in the scientific literature. We believe those two factors are surrogate markers for the truth of character reformation and psychosocial support and personal transformation.

Spirituality is also important, as the committee would know—groups like AA, NA and traditional religions seem to have a huge role. And one will note there that that effect is significant at the one in 100,000 level. In fact, if one combines implants and spirituality, there are actually no failures in our early experience which go to six months—and they are the calculated success rates listed there.

Mrs IRWIN—Have there been any deaths with naltrexone treatment?

Dr Reece—We will come to the subject of deaths in a minute. You might like to ask me at the end when we have dealt with that in some detail. So we have a number of variables which have been charted through our clinic. This is multiple regression, this is all the tablet patients, and we find that the numbers of detox patients we have had, whether they work afterwards, have spiritual involvement, social support and cannabis use, are all statistically significant, with other variables not proving statistically significant.

When analysed across the whole group, the number of detoxes clearly is an important predictor of success, as is social support, spirituality, working afterwards, work before, and cannabis. Sport is borderline statistically significant in that regression. When we analyse the whole group, ignoring the number of detox, which is an obvious predictor of success, in fact spirituality turns out to be one of the prime successes.

Let us talk about death and safety issues—they are very important; they have certainly been very topical. Our experience of deaths—this was interesting—is that they did not occur randomly; they all occurred early in the second year of our clinic. We have been going about three years. There was a large cluster of deaths in the second year. I have divided the three years into six periods of six months, and that is the way they occurred. With respect to the annual cumulative mortality rate—that is, the mortality rate by date—in the Perth series—the big clinic in Perth that you heard of—and in our own clinic and in O'Neill's clinic, there is an interesting drop: from three to two, to 1.3 to one per cent in the four years of operation of the clinics. That is a very interesting drop. Our own clinic saw an almost identical progression and decline in the death rates. Both clinics found that there was a group of deaths early on, and one presumes that that is due to patients getting used to the clinics. Obviously, drug addicts are not little angels—they tend not to do what you tell them—and they pay a very high price for that in our naltrexone program. This is analogous to the huge number of deaths that occurred when methadone treatment was introduced.

I wanted to look with some exactitude at what the science says about death rates with these different treatments. In the scientific literature there are 49 studies of heroin and the death rate after heroin, involving some quarter of a million patients, was 10,000 deaths, and 600,000 patient years, with an average statistical death rate of 1.9 per cent. If we look at methadone treatment, the average death rate is 1.4 per cent in 21 studies involving roughly 100,000 patients. Some patients have been non-compliant with their methadone or have jumped off methadone, so they are not good patients—they are not angels—and there are 47 studies looking at that: 20,000 patients, 2,000 deaths, and 140,000 patient years, with an average death rate of 1.65 per cent. In Perth last year, their mortality rate was 1.35 per cent, which we note is lower than the other death rates that we have seen. This year, the Perth death rate has dropped to 1.11 per cent. In Brisbane, our death rate is 1.3 per cent and dropping quickly. From this, we can obviously calculate the lives saved, based on the 1.87 per cent death rate of using. In Perth, there were 50 lives saved and in Brisbane there were 10, for an overall saving of 60 lives. That rate is increasing as patients become more wary and take more seriously our warnings.

So what can we conclude? The first thing I would really like to stress to the committee, beyond all the points that we have heard today, is that this is now the commonest cause of wasted years of life in the nation. It needs to be prioritised. Obviously, it is topical—obviously, it is in the news—but it is not prioritised and it is not resourced in an appropriate fashion. Every speaker today has spoken about social and psychological supports. We see naltrexone as an aid and as a very important assistance to an abstinent lifestyle—like a plaster on a broken leg. It is not the whole story, but for many it is a very simple beginning to a life of freedom, and then the challenge is to the community to help these kids live. It needs to be prioritised and it needs to be funded appropriately. Whatever we need to do, we just need to do it.

Only naltrexone sets kids free. This comes back to the hugely important point that the professor made: as a nation, we need to think about drugs. The second last speaker spoke about this,

too. Do we want kids off opiates? If we do, there is only one drug in the whole pharmacopoeia that reliably takes them off, and that is naltrexone. That may not be clear to this committee—it may be confusing, with all the technology. We have shown the data here. The program must be free and kids must be able to get onto it. The huge financial barrier has to go. Naltrexone programs can dramatically save lives and end the scourge. Impressive opiate-free survival can be achieved with tablets at 52 per cent, which can be raised to 82 per cent in one year with implants. It confirms the abundance of literature results. Federal and state politicians who talk about an absence of literature are making it up. There are 4,700 published studies on naltrexone and 99 clinical series of which we are aware. All the variables who talk about help recover, and they obviously need to be combined to produce successful programs, and effective money is removed when appropriate statistical controls are introduced. Naltrexone is safe. Rapid detox under sedation is very safe.

Even detoxing without any drugs incurs this risk of death afterwards, because if they use heroin it will not be $5; it will be $50 or $100 that they used before. Are we going to capitulate to drugs as a culture and say, ‘If we can’t clean them up they might use and die’? This is a challenge we are going to have to face. We need to reject the suggestion of leaving them on drugs because detox is too risky. That is a ridiculous thought. There is no evidence whatsoever in any human studies that naltrexone elevates mortality. The implant news is very exciting. If there is one point I would like you to take back to Canberra it is this: they are easy to insert; implants is the way to give naltrexone. The best implants in the world are coming from Perth, which means we are leading the pack. There is no evidence of shooting over the top or significant safety concerns with the person implant, and we lead the world. This is an important biotechnology, which as a nation we can develop not only for heroin, but for cocaine, cannabis, amphetamines and nicotine as well, with significant export type opportunities.

We know why naltrexone blocks. The reason is this methylcyclopropyl radical. We have good reason to believe that it is in at least four or six other drugs and turns an agonist, a stimulant, into an antagonist or a blocker. We believe there is an urgent R&D to be prioritised at the highest level. This molecule, this radical, needs to be put on the addictive drugs until we can get the kinds of blockers that we need to use for these other problematic agents. Thank you for listening and for your generosity.

CHAIR—Thank you, Dr Reece. Do you have estimates of finance—ballpark figures of costings?

Dr Reece—We believe that to run patients on naltrexone would be roughly in about the same ballpark as methadone. My formal submission to the committee is about three or four inches thick and there is a detailed cost-benefit analysis there. However, with naltrexone—Professor Saunders might care to comment on this—the psychosocial supports are critical. These kids have to be taught to live again. They need lots of social support, help, intervention and counselling, people to be there, jobs, housing and accommodation. It is so tragic. We are getting these lives at the bottom of the pile and now we are working with nothing, trying to make bricks without straw, if you know what I mean. That has to be put in place.

CHAIR—Is it hundreds of millions or is it billions?

Dr Reece—Hundreds of millions. We understand the current methadone budget in the nation to be around the $100 million mark. There are 200,000 or 300,000 heroin users in Australia.

CHAIR—Do you know what the Californian figures are in terms of cost benefit? Have they done some work?

Dr Reece—In a straight cost-benefit analysis, which is the submission which I have already sent to Canberra, we think naltrexone is about 50 per cent more cost-effective, but the psychosocial supports are particularly critical if we are going to do this properly and safely.

CHAIR—The last point, the radical, what is the issue with NHMRC? Have submissions gone there?

Dr Reece—We feel pretty strongly that NHMRC are our ideological opponents.

CHAIR—But has anyone tried?

Dr Reece—Not that we are aware of, but we see this as a priority issue.

Mrs Whieldon—Do you mean put it on the PBS?

CHAIR—No, I am thinking about research into the radicals.

Dr Reece—We do not even have the molecules yet. To us this is urgent. We have the best delivery system in the world in the west, and if we can invent the modules—there is no reason why we cannot do it here as there are at least two laboratories that can do it—and put it in that delivery system, then we can really start to take the high ground with social services.

CHAIR—I have to finish as we are all out of time, but thank you very much. I am just interested if you can give us anything else on NHMRC and what are the issues around that, if you have got a minute or two.

Dr Reece—I am not an expert. I would have to speak with Prof.

Prof. Saunders—I would have to say that around the country there are a number of very influential people in the drug and alcohol field, including people who sit on the respective NHMRC committees, of which I am also one, who are, it seems to me, fairly either emotionally or ideologically opposed to naltrexone and other antagonist treatment. I think that is a tragedy because they do invest a considerable amount of energy and emotion in trying to detract from naltrexone treatment. It is a difficult treatment, but I am a strong supporter of doing proper, good, controlled trials against standard forms of treatment so that we will make progress in that regard.

CHAIR—The great luxury we have is that we are not caught up in those sorts of debates. We are really quite interested in the cutting edge issues and what works. To that point we are not entrapped.

Mrs IRWIN—You have got your private clinic here, Dr Reece. How much are you charging for treatment with naltrexone?

Dr Reece—Our medical fee is $200 plus GST, plus a stealing and breakage fee, which are found to be extensive, which is $100, so it is $324 all up. They also have to provide the cost of their own injectable drugs which we use to detox them, which is about $200. So the up-front fee to start on naltrexone is $500. The implants cost $500. So it is $1,000. That will hold them for three months. We are working at improving implants out to six and perhaps 12 months.

Mrs IRWIN—That sounds a lot cheaper than in other states. I think in New South Wales we had a clinic in Speed Street in Liverpool in my electorate where we have had more than one death, that have been on naltrexone. That has since closed down. They were paying quite a few thousand dollars. Even George O'Neill's clinic, which I visited over in Western Australia, are not looking at the sort of price that you are talking about. What is the difference between Queensland, New South Wales and Western Australia? I am not knocking naltrexone. I have actually spoken in the parliament to try to get it on the PBS because it has helped a lot of people. I know of kids who have been drug addicted for a number of years who have been clean now for two or three years with naltrexone. The problem that we are getting, and I am speaking to people, is that you can get that out of your system within 24 hours, but it is the ongoing cost. It is up here that you have got to assist as well. I find that some of the clinics are not giving that to their patients.

Dr Reece—That is the main engine. John Currie, the leader at Westmead, who talked about it, talks on and on about the quality of your maintenance program, the quality of your psychological and social programs. To me, this is a great challenge for the Australian community. We cannot let things go on like that. This is a charge that we have to rise to and it will amount to some resourcing. No matter what treatment you do, you are looking at about 1 to 1.5 per cent mortality. Are we going to take that on now when there are 200,000 users or are we going to wait until there are two million users in five or 10 years time?

CHAIR—Thank you very much. It was quite inspirational.

Resolved (on motion by **Mr Wakelin**, seconded by **Mrs Irwin**):

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 5.02 p.m.