COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Substance abuse in Australian communities

MONDAY, 21 MAY 2001

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STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Monday, 21 May 2001

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

Members in attendance: Mr Andrews, Ms Julie Bishop, Ms Ellis, Mrs Gash, Ms Hall, Mrs Irwin, Mr Lawler, Mr Quick, Mr Schultz, Mr Wakelin and Dr Washer

Terms of reference for the inquiry:

To report and recommend on:

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

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

WITNESSES

Committee met at 8.15 a.m.

CHAIR—Welcome, ladies and gentlemen. Thank you for being with us for this eighth public hearing of our inquiry into substance abuse in Australian communities. The Minister for Health and Aged Care, Dr Michael Wooldridge MP, referred this reference to the committee in March last year. Our task is to report and recommend on the social and economic costs of substance abuse, with particular regard to family relationships, crime, violence, including domestic violence, law enforcement, road trauma, workplace safety and productivity, and health care costs. We asked for submissions about a year ago and have since received over 200 submissions from individuals, governments and non-government agencies. Most of these submissions have been authorised for publication. If you would like to read copies of these, a list is available from the committee secretariat.

Last year we held a private briefing and a public briefing here at Parliament House, and it is great to have another public hearing here today. We have covered a lot of ground in the last year, but we realise we have a way to go before we are ready to write our final report that offers some helpful recommendations about how we as a community can more effectively minimise drug related harm.

This morning we are hearing from a number of agencies which have put in submissions to our inquiry. Later today we are going to be involved in a roundtable discussion, which will give a number of individuals a chance to have their views placed on the public record. What you have to say is important to us and will form part of what we call evidence, which we will be able to refer to when we write our final report. The committee does not swear in witnesses, but these proceedings warrant the same regard as the proceedings of the House of Representatives. Hansard will be transcribing this hearing, so people can read what has transpired this day.

[8.18 a.m.]

VUMBACA, Mr Gino, Executive Officer, Australian National Council on Drugs

WEBSTER, Professor Ian, Executive Member, Australian National Council on Drugs

CHAIR—I welcome the witnesses from the Australian National Council on Drugs. Thank you for being with us again. Would you like to make an opening statement?

Prof. Webster—Thank you very much for inviting the ANCD to make a further presentation to you. The chair of the ANCD, Major Brian Watters, is overseas at present and I am representing him at this meeting. Mr Gino Vumbaca is the Executive Officer of the ANCD. I have made a list of 10 points which I have asked to be distributed to you. I will not speak to them in depth because I know you have had a lot of material presented to you. I would just like to pick some of the key points out of this list.

You will know that the ANCD was established to provide direct advice to the federal government on a view reached through consensus processes about directions in the drug field. I would like to make a few comments about the ANCD. It prides itself on being able to reconcile competing and different views on drugs. In that group, there is agreement on the central and core issues in the area of drug policy. The ANCD strongly supports the Australian approach to drugs. I know that you would be familiar with that now, but essentially that is about including all drugs in the drug discussions, it is about cooperation between elements of the government and the non-government sector, and it is a multilayered approach. Another very important principle that the ANCD has adopted and agrees to is that policies and strategies adopted by governments should be based on evidence and measures of the effectiveness of programs and that policies in this field must be information driven, consistent with the best advice that can be obtained from expert advisory committees.

A very important characteristic of the interest of the Australian National Council on Drugs is that it wishes to learn more about the extent and the characteristics of the drug problem right across the geography of Australia. I know that in your visits you would have been exposed to different issues in different parts of the country. We are concerned that there are different groups in the community who experience drug problems in different ways, and as a group and as a policy making organisation we ought to try to understand those as well as we can. We do that through personal contact and experience, but very significantly the ANCD has commissioned a number of reviews and reports. Some of them have already become available, but in the near future they will be more available, and we can provide you with information about those.

The ANCD wishes very much to contribute to the breadth and depth of understanding of these problems in Australia, and it wishes to be involved in promoting the best and most appropriate response in the community to these problems being particularly mindful of the fact that local communities are different and that those solutions must be relevant to those communities. In that process, the ANCD deliberately acknowledges the viewpoints of drug users, includes those as an important element of its perspectives and attempts to balance those with broader community concerns.

The ANCD has a very privileged relationship with the government. We acknowledge that with relationships with senior political leaders and major government departments. We seek to influence the full spectrum of the government activity, not only those which might be identified solely with the drug area. So that leads us to be concerned about things like early intervention and prevention and the appropriate management in the community of people with difficult drug issue problems—for example, to do with housing, access to welfare and access to proper medical and health care.

In that context, the ANCD is especially concerned about the predicament of indigenous peoples in Australia. The council sees that the relationship of the whole of the Australian society with indigenous Australians is grossly unsatisfactory and problematic. The council considers that in terms of drug problems—and by that we include tobacco and alcohol—a major effort by, and a commitment of, all governments, non-government agencies and citizens is required to this issue as it applies to indigenous people. The council wishes to be part of a process whereby we take affirmative steps across these inequities to ensure that, in this generation, substantial and material positive changes will be made, and that these steps shall be taken in cooperation with the indigenous peoples themselves.

We are concerned also about the fact that drug using people or people with alcohol and other drug problems should not be stigmatised and discriminated against. We have a very powerful and committed interest in the issue of discrimination, because we believe that drug using people and, in turn, their affected families should have, as other citizens do, reasonable entitlement to the benefits of living in Australia. That includes, as I mentioned before, health care, health protection, antenatal care, dental care and so on. We acknowledge too that we are a multicultural society and that our policies need to develop appropriate responses to those characteristics.

Finally, the ANCD is concerned that drug policy should not develop in isolation from other social and health policies. As the committee would appreciate from the evidence it has received from a number of groups, there is good evidence that the aims of the programs in the drug specific area overlap to a very great extent with programs and policies in other areas. We are especially mindful of the early years of life and of youthful development. We are conscious that suicide prevention and crime prevention are also relevant to the way in which children and young people develop. A special concern of the ANCD is that issues of mental health and social wellbeing are related both directly and indirectly to the drug problem in Australia, and that mental health and alcohol and other drug issues must be dealt with in policy and action plans which complement each other in a range of ways. Thanks for the opportunity to make that opening statement.

CHAIR—Thank you very much, Ian. Gino, do you want to make a statement?

Mr Vumbaca—No. I am happy for Ian to make that statement and we will take questions at this point.

CHAIR—Ian, you mentioned in your submission the international context. You said that the Australian response is appropriate and that there is a degree of unity and consensus about how we are going forward with it. My question is: what is it about being Australian and the Australian context which is distinctive from the international context? We have many positives,

but there may be something about our culture which leads us into certain peculiarities. Is there anything about being Australian that is more noticeable than perhaps the international context?

Prof. Webster—I would like to make a number of comments. First of all, Australia in many areas was very progressive in social welfare reform back at the beginning of the 20th century. We were the first country to get the eight-hour day and women's suffrage; we were the second country to get an invalid pension and the second country to get the aged pension; and we got a minimum wage. So we have been a country which has been very progressive, and we have been very progressive in the health area. We have done better than most other countries with tuberculosis, coronary heart disease and the management of many public problems. Of recent times, the way we have managed HIV and AIDS has been outstanding, because we probably have the lowest rate anywhere in the world of that epidemic amongst intravenous drug users. So I think we have been a country that has been prepared to think for ourselves and move ahead of the field.

In the drug area we have been doing that. In 1985 we established the National Campaign Against Drugs. The key elements of that are well known to you, but they were that it was a cooperative effort—with police, law enforcement and education—and it was about the fundamental idea that we could join together in reducing harm. A very important characteristic of that program, which separated it from the way the drug issue was being looked at in many other countries, was that we said the drug problem was a problem of many drugs. It was not just heroin, which was the predominant discussion at the time, and certainly a number of state governments at that time were very strong in making that point. Finally, in relation to the Australian approach, we have really got people who do good research and who are prepared to research and evaluate what is done. Our research centres I think stand as high as any other research centres anywhere in the world.

So I think they are the benefits of the Australian approach. I think there are some downsides in Australia. We are a country which is very different in the north from the eastern seaboard. The general polices we might articulate nationally do not fit very well right across unless we allow for regional variation. I think our approach to alcohol has been problematic. We have had evidence in the last couple of days that our level of alcohol consumption amongst English speaking nations is the highest in the world. There are other nations with much higher rates than that—some of the European countries like Finland and Russia have absolutely massive doses of alcohol—but amongst the English speaking world, we certainly do not fare well with alcohol.

I would say the positive characteristic about Australia is that we have tended to run ahead of the field and not be supplicants to the way other people think about the problems. Essentially we have adopted a cooperative effort, which seemed to be working until the last decade, when the heroin epidemic became a problem, and the consensus we had achieved somehow or other got lost. There has been an unhelpful dialectic in the public sphere which has been extraordinarily polarised and unhelpful.

CHAIR—When we started this task back in June we had a group of people in, some of whom were experts in their field. They made the point to us that those things which they agreed about were much more to the fore than those they might have disagreed about. At that time the role of the media and the general public debate came under some scrutiny for contributing to this polarisation. In a democracy you are always going to have debate. The media will plead that

we want that to be as open and as free as we can have it. But sometimes it makes the debate, particularly for professionals, very difficult to respond to in a balanced way when you get caught up in this stuff. Could you make a comment about that, and the difficulty of dealing with the issue?

Prof. Webster—I think you are quite right. It is very difficult for professional people to publicly discuss things appropriately because there are certain rules regarding the way professional people discuss things and the paradigms they use. But I absolutely agree with you that the drug policy is probably one of the most interesting tests of the way communities reconcile competing views. Those competing views are often strongly held; they often come from religious constructs of the nature of the problem. The task of this committee that you chair, and of politicians in general, is to try to get the best balance there.

I mentioned that in 1985, when Mr Hawke called the premiers together for a drug summit, the national campaign against drugs started. That was a period when there was a huge amount of public debate. The political process, and those of us involved in supporting that, thought we had got a recipe for consensus—and that was harm reduction and the idea that everybody should be involved. In fact, the first line in that document is that the objective of the national campaign against drugs should be the 'reduction of harm' in Australia. At that time people who had very strident and different positions actually could work together; they could accept funds from government. Although they might have been abstinence based, they were happy to be brought into the fold to try to conform with best practice guidelines and make their submissions for funding which could be tested.

As I mentioned before, for reasons which would probably take all day to discuss but without finding the answer, that got undone. The epidemic was a major contribution to that. But I think the new ground for reconciliation, in a sense, is the idea that policies should be information driven and that programs should be based on whether they are being effective in the broad public sense, and that they ought to be held up to scrutiny and public discussion. There are no private concepts or answers to this solution; it is essentially a public process. As you said, it requires reconciliation between competing interests. As for the grounds on which that can be done, we are all trying to reduce the damage and we want to do that in a way which stands up to scrutiny.

CHAIR—You talked about research, 'research based' and 'evaluation based'. The nature of addiction interests me. What work do you know of around the nature of addiction? Are we coming to grips with the nature of it? How well do we understand it? Dual diagnosis, mental health—what do we know about it, in your view, or in the view of people in this country and internationally who deal with addiction?

Prof. Webster—The difficulty with mental health problems that you mentioned is that they are generally defined by their behaviour patterns, things which are hard to define the boundaries for—when is a behaviour abnormal and when is it acceptable? The definitions of these conditions usually require putting together a number of characteristics, and then you say, 'This person has a dependency.' But they are not clearly defined end points. On the other hand, if you look at the way medicine and medical science is moving, it tries to define problems much more precisely, although many of them have behavioural characteristics, and the definition of a condition is easier. With inorganic diseases you can say when you examine the pathology, 'This

is what you see, this is what the problem is, this is what it affects', but in this other area where we are defining it in relation to behaviour the definitions—although agreed—do get applied differently. So there is a lack of clarity there.

CHAIR—I was reading something this morning—this will be too simplistic but I think it will make the point—which reminded me that back at the time we knew that citrus would deal with scurvy it took decades and decades to apply that simple fact. We have all these tests—ether, amputation without anaesthetic—but the link between what we understand and how we might apply seems to be significant.

Prof. Webster—Going back to dependence for a moment, there are research centres which are studying it, defining it more precisely and helping us understand the differences and also the overlaps between mental problems and addiction problems, for example. The other development in which I have no expertise at all is in the neurotransmitter area, where people are studying the biology of the brain. It turns out that often the drugs which are helpful in treating a mental illness may also have a beneficial effect on an addictive state. I think there will be a lot of exploration in that area. I do not think it will mean in the end it is a brain disease we are dealing with, necessarily, but it will help us manage and treat those things.

The other idea that you mentioned is true. It takes decades to have a finding introduced into common practice, particularly in scientific medical practice. You described citrus juices for scurvy, but we could apply that even to things that are happening in contemporary situations in a hospital. Even the management of addiction is well behind what it might be. There are practices going on in our hospitals now when we know the evidence is that they ought be done differently, but it is very difficult to change the way staff do things. So the rate of change is a fundamental problem. Changes in knowledge run well ahead of the pick-up of change and our task is to try to get things implemented more quickly and more effectively from the time of discovery.

CHAIR—Thank you for that.

Ms ELLIS—Good morning. It is good to see you again. Can I take you back to the comments you were just making about the progressiveness that Australia has displayed in the past. I want to reflect on that for a moment. If we think about it, we owe an enormous debt to those who had the nerve to be progressive in relation to HIV-AIDS back in the early 1980s. I remember very clearly the controversies around those programs. When we think about that, and when we think about what you call the polarisation of the debate, and when you put into that equation as well your statement that programs need to be publicly tested and held up for scrutiny, the enormous difficulty that I see for us is getting the community at large—or the sectors of it that do not like it—to get into that progressive mode.

There are still strident objections on moral or religious or personal experience grounds that are making it impossible at the moment for certain progressive approaches to be tested. My major concern is how on earth do we get over that. My view is that we need to be game enough to try almost anything and not be critical if they do not work. That is an enormous ask. I saw a very small portion of what might be termed a fairly sensational panel last night on an hour-long TV show—I am looking forward to seeing it all just to make sure my critique is correct—but

very strong views are held. What is the council's view on just how hard and how effectively we can push this? I think it is integral to what we are talking about.

Prof. Webster—I think I touched upon this idea to some extent when I talked about the fact that the people who actually experience the issues, the drug using people and their relatives and friends, have to be brought into the equation. One of the reasons the HIV-AIDS epidemic worked is that we had very strong advocates of the people affected and they became peer educators, one for the other. When you look at community change and community development it takes far more than a committee saying, 'This is what ought to happen.' It is about getting ownership and commitment of people at a community level. There are communities now doing that in Australia and there are some communities where it is going to be very difficult. Some of you are in electorates where it is going to be very difficult for you to provide that leadership. But it is very important to be honest with people. Don't let us pretend that we have the answers. Let us say, 'These are the problems. This is what we know about it. These are the sorts of things that have worked in other places or that are worth trying. Let us try to do that together.' So I think the key approach is a community development approach, rather than a top down approach.

Mr Vumbaca—Based on what you saw last night it is also worth noting that the portrayal of harm reduction as being separate to abstinence, or there being zero tolerance and harm reduction, is not helpful at all because harm reduction has always included abstinence as part of the continuum of dealing with drug use. I think there is a polarisation going on that you are either with this camp or you are with that one—so if you support this therefore you must be opposed to that. That does not help any community understand the breadth of the drug problem or the fact that some of the programs are being targeted at specific groups and small groups within a drug using culture and not for the general community.

Ms ELLIS—Just one other question, on a slightly different tack. I am going to ask the Institute of Criminology this question later today, if I can. There was an editorial in the Sunday edition of the *Canberra Times* yesterday which you may not, obviously, have seen. But it gives a fairly positive view of the effect of policing in terms of the heroin supply. It talks in fairly glowing terms about what has been achieved so far and that one major seizure last year has led to the whole supply of heroin dropping down. If that is true, and not overly optimistic, then I would be the first to applaud it. But I am a little concerned about reality versus what we would like to see happening. I know that in our recent visits around the country and on the most recent trips we have been doing workers in the field have been saying that there has been a dry-up of heroin but that it has been creating, as a result, enormous problems in safety, in the personal health of users and so on. Do you have a view about the seizure rate versus the dry-up rate versus the manipulation of the market and the reality of it all?

Prof. Webster—I do not think the council has a view. I might ask Gina to make a comment in a moment. I just want to say a couple of things. I think we undersell the role of police. I think police can be very much engaged in preventative, supportive and referral activities and there is insufficient publicity given to that role. I think there is insufficient publicity given to the strategic approaches that police take at local levels, where they can be enormously effective. After all, it is often the policeman on the beat that first identifies a problem. We are in the position, I hope, of assisting those police to get people into treatment and rehabilitation and also to being agents of prevention at a community level.

The ANCD does get reports periodically of the programs which the government has introduced. Again, thinking about the last meeting of the ANCD where these were presented, it is disappointing that much of what is going on in that area does not get fully informed. There are many things that the police are doing which nobody knows about—nobody seems to write about it or talk about it—which all seem to be entirely reasonable and appropriate. As to the relationship between seizures and the availability, I do not feel I am able to comment.

Mr Vumbaca—There has obviously been an effect. The reports that the council is getting from various jurisdictions would suggest that there has been a substantial decrease in the availability of heroin in particular in many areas. You also have to be careful with supply and reduction about the impact it has. My experience prior to this position was within prisons. Generally, a prison has very restrictive supply conditions attached to it. As you reduce supply of one drug, you cannot reduce supply of all drugs and that is often displaced into drug use of another kind. If heroin dries up you find that people will move to other forms of drug use. As in prison, if particular drugs are not available, people move to other ones that are available, even if it is not their drug of choice per se. Sometimes in the media it is portrayed as being a fairly simple equation: you stop what is coming in and, therefore, you stop drug use. There are other tangents that come off that simple equation. We probably need to be a bit more mindful of what impact that has. There is no doubt that within Australia—Ian was talking earlier about the Australian approach—that has involved a whole range of strategies, including supply reduction. It does not mean that you just do not worry about any sort of importation or production of drug use. It has to be integrated within the whole range of strategies available, including treatment and education.

Ms ELLIS—I agree with you, Ian, but I fear that if we put too much emphasis on community consumption—on the success of seizure and the stopping of flow—we are leading the community down a false path because the people that we spoke to on the visits to which I referred were saying that, as a result, users were using anything they could get their hands on and that aggravation was growing, violence was growing—so it does not finish the problem. It is terrific to read an editorial that says, 'Isn't this great? Heroin flow has trickled,' but as a result it is not saying what the reality is of the flow-on problem.

Mr Vumbaca—But it is easy to present that. It is easy to show a photo of 40 kilos of this or 20 kilos of that.

Ms ELLIS—Exactly; that is the very point.

Prof. Webster—I might make one personal anecdote about this, and this is not the council's view. I was discussing Cabramatta issues recently. I work out in the south-west of Sydney. We anticipated what was going to happen to Cabramatta a long time ago. It was not until it became a crisis that people started to do things about it. Then it was too late. People should have been more attentive. I can remember talking about it being a hotspot well before it was recognised as a hotspot. In the group I was discussing this with there happened to be people who were general managers of health services in other parts of Sydney—Campbelltown and beyond. They were saying, 'What you are saying has significance for us because we can see the early signs developing here and we want to deal with this before it becomes the intense focal point of another place.' The police activity can contain it but, as Gino mentioned, other drug use might

take over and it might also be pushed into other areas. You have to think about what can be done at an early level to prevent that huge problem developing.

Ms ELLIS—That is fair comment; thank you.

Mr QUICK—There is a quote in the submission from the next group of witnesses, the National Centre for Education and Training in the Addictions, which states:

> The alcohol and drug field is especially affected by the siloed structures of our systems and services, as this field is characterised by its multidisciplinary nature. Alcohol and drug problems are complex, and require comprehensive, multi-sectoral responses.

Your statement was that we have had an Australian approach to drugs. I think we have, but it is a very minimal approach. To my mind it is an American approach. There is a real lack of political will. You mentioned HIV-AIDS, which is always held up as an example. Four years ago Martin Bryant went berserk at Port Arthur, the whole world stopped and legislation flowed instantly. My evidence over the last 12 months is that we jail them, we give more power to the police, we perhaps provide some more services, and then early intervention is spoken about in glowing terms but nothing is ever done. What is your reaction to that quote about the siloed structures, in view of South Australia and the ACT with their marijuana, and the sort of message that is sending to the young people living in those states, where you have different rules?

Prof. Webster—The concern about siloed structures is absolutely right. It is a problem for all government activities, isn't it? In the health system, there is a problem with the way hospitals relate to community health services and with the way the health services relate to the community sector; and also with the way education relates to these other departments. There is a generic problem in the management of government activities in that we manage in a straight line from the top down but we do not manage very well regionally or across departments.

In my earlier comments I said that the real preventative factors are to do with early childhood development, education, and how families are supported—much more fundamental ideas which go across the government departments—but we do that very poorly. Within the health system there is a problem of specialisation between the drug and alcohol specialists and the mental health specialists. Those areas of specialisation need to be diluted. The major task must be to apply better primary health care responses, where people can pick up and interact with the problems in a generic way.

I absolutely agree with you that we are putting too many people in jail. The fact that we are building jails at such a rate is amazing. I had hoped, and I still hope, that the fact that the Commonwealth government and other governments are looking at issues of diversion may alter that; but it is going to require a greater effort and it will require more resources in the education, treatment and rehabilitation sector. So I am agreeing with you but I am also pointing to the fact that, in comparison with many other places, we have a much more integrated response to this problem than do many other countries.

Mr QUICK—One follow-up question: for the workers we have seen in the field, in the Woolshed and Logan House rehab and detox units, their pay structure compared with that of other professionals and experts is not commensurate with the hard work and dedication that they show in diverting and setting up other structures to enable these people, when they decide

that the time is right, to change their lives. We went to Goulburn jail and saw the new section, worth tens of millions of dollars. Sixty or 70 or 80 per cent of the people there are in there for drug related crimes, yet provision of detox and rehab around Australia has a waiting list going into months. Who decides? With gun laws the Commonwealth clicked their fingers and the states jumped and said, 'Yes, sir; three bags full, sir.' How do we change it?

Prof. Webster—I agree with the difficulty of the proposition. The ANCD has been very concerned about frontline workers and their standing. I will ask Gino to respond.

Mr Vumbaca—The council has written a number of times to the Prime Minister and to various premiers about the funding available for treatment services. But it comes back to a fundamental problem. When you ask who is steering it or who is in control, if you look at drug policy in Australia, it is spread across a number of government departments. If you are talking about changing the amount of money being directed into treatment as opposed to supply reduction or research or whatever it may be, no-one actually has control of that to be able to say, 'Here is the total drug budget of $X million, and we might shift five per cent this way or that way.' You have to get the ministers together to agree; or the Prime Minister, or one of the premiers on the state level, has to intervene personally and say, 'We will do this, this and this,'—otherwise you will not get those sorts of decisions. The money going into treatment and rehab currently stands at something like six per cent of the total budget that is spent on drugs. That obviously has an impact on people who are working in centres. The amount of money available for their pay and conditions is obviously fairly low.

Prof. Webster—I think you are meeting some other people after us, of whom the question might well be asked, too, in the area of education and training; but I agree with your sentiments about that.

Mrs IRWIN—I would like to ask a question of Ian and I welcome you again to today's public hearing. You were talking about community development, and I get really peeved off with the journalism that I read in the paper. Nine or 12 months ago, we saw on the front page of the *Daily Telegraph* a young boy with a syringe in his arm. It is a pity that the journalist who wrote that article had not looked at the background of that child and why that child was injecting himself. He or she might have found out that he was injecting to take the pain away and was most probably sexually abused. How would you recommend we encourage more responsible journalism?

Prof. Webster—This is one of the most important questions that we should be dealing with. In the mental health area, it was recognised that the problems of mental illness and mental health related very much to the public perception. The mental health associations across Australia have each year had national campaigns to alert people to the fact that people with mental illness were you and I in a different state from time to time. You may recall that one of those campaigns was called 'The Issue is Attitude'. There have been major campaigns to alter the perception of mental health and mental illness. That has required good, leading journalists, such as Anne Deveson, to present very thoughtful programs about the nature of schizophrenia and how mental illness affects families, and to provide some leadership in the media area.

The other area is suicide prevention, where there is a lot of evidence that press publicity of an inappropriate kind creates very direct harm. There is evidence that a lot of the reporting of

homicide and other violent events creates direct harm in the sense that it prolongs or aggravates the suffering of those who have already suffered and does lead in some instances to replication of the events. In the mental health area, we have had the Press Council and people interested in the media meeting together. About 12 months ago the government launched—in conjunction with a non-government organisation, Suicide Prevention Australia—a set of guides called 'A Balanced Approach' which were guidelines to people in the media about how they should report the sorts of events I have been speaking about. For example, describing someone as a 'schizophrenic' or as a 'geriatric' implies that that is what they are; whereas what they are is a person suffering from, or at that particular time having, that condition. So even the language used in journalism is important.

Now there are programs of education in the journalism courses at a tertiary level to deal with these things. There is an acknowledgment that these things must change, and there is evidence that things are changing. The press generally is reporting mental health problems better. It is reporting suicide more appropriately and, rather than putting it on the front page, it tends to put it further back in the newspaper. At present, we have some university groups supported by the Commonwealth government studying what is happening in the media. The unfortunate thing about that is that none of it is being applied to the drugs area, when exactly the same issues of discrimination and inappropriate representation take place. It is an obscenity that there are reporters camped outside an injecting centre in Sydney wanting to take photographs of people. Why don't they camp outside the Accident and Emergency department of Liverpool Hospital and take photographs of people there—

Mrs IRWIN—That's right.

Prof. Webster—Or of people going into other situations where their privacy deserves to be respected. I think we have a lot to do. We have to bring people who write for the media into the tent and say to them, 'You are part of the way we deal with this. It is about how you write it, how you understand it.' The same principles that are being applied to discrimination against other people—mentally ill people and their families, and other groups—ought to be applied to people affected by drugs and, particularly, their families.

Mrs IRWIN—I have a number of questions but I will make this my last. Do you feel that the Prime Minister's Tough on Drugs policy is working? Do you feel that the money is going to the right areas? I think you understand why I am asking you this question. For the public record, out of $50 million so far, Cabramatta, which is in my electorate, has received only $76,000. Do you feel the money is going in the right direction?

Prof. Webster—The Tough on Drugs policy, despite its name, which I have problems with, actually did very important things. It directed money to what were called community partnerships—community treatment. It was really the first time that that group got access to funds at a national level in that way. The process by which these grants were awarded and distributed is a very important process. It involved representative non-government organisations in the states meeting with state and Commonwealth officers to make recommendations. It was an attempt to try to achieve some balance across the country. The areas of funding and the diversion program have been important and positive. The processes which have been engaged in have been new and very worthwhile and I would like to see them expanded and things done

more along those lines. In the suicide area, where I have some involvement, we are trying to do that too.

But, I absolutely agree with you—my heart sank when I saw that some of the real problem areas hardly got a guernsey. That is the problem of submission based funding. We have to somehow move beyond that. I suggest that one way to do that, which we are thinking about in South Australia at present, is to go to communities, such as up around the top end of Spencer Gulf, and say, 'This community has a particular social structure, and mental health or suicide rates are important issues here. If you, as a community, can put a package together that the government can work on with you and look at and fund—if it is appropriate and meets the general guidelines and is based on good evidence and good policy—we can do something.' That would get over it. I think that, for the south-west of Sydney, someone should have said, 'This is a particular area and there ought to be proposals coming forward, and we should be helping.'

Mrs IRWIN—I have had a lot of consultation within Cabramatta, and what frustrates the people of my area is that if you want a methadone clinic you have to travel a long way. We have a safe injection room at Kings Cross. People have to wait six or seven weeks to get into rehab if they want to get off drugs. The talk now within the community is about a one-stop shop where they can go for their methadone, their counselling, or even detox, et cetera. What are your feelings on that?

CHAIR—Just a quick response, please.

Prof. Webster—It is an excellent idea.

Ms HALL—Thank you for an excellent presentation. There is food for thought, there. My first question relates to alcohol. Alcohol causes great problems within the community and is probably the drug that is most abused. What strategies do we, as a community, need to put in place to deal with that problem?

Prof. Webster—That is a big question. Firstly, it is a question of public health: how do you generally discourage general consumption of alcohol in the community? We do that through such things as public education and by teaching people about the risk levels of alcohol use. The National Health and Medical Research Council in Australia has done some remarkable work—again, some of the best in the world—on defining safe levels of alcohol consumption so that every doctor, every medical student and every clinic is able to tell people at what level of alcohol consumption they are starting to harm their health. The work the police did in random breath testing and the introduction of seat belts has been absolutely dramatic. There are those public health questions which are about information and strategies.

In terms of managing the problems of alcohol, alcohol problems are ubiquitous—25 per cent of admissions to public hospitals are probably alcohol related. If you go to the emergency department, you will see that. If you go to the intensive care unit, you will see that. If you go to the coronary care unit, you will see some of the effects of alcohol on coronary heart disease, although perhaps not as much. If you look at the major disease problems that doctors deal with, cancers of the throat and gut, you will see that alcohol is a major component of those. If you look at mental health problems you will see that. Many suicides take place after alcohol consumption. Alcohol is responsible for 50 per cent of drownings. Alcohol is a major contributor to

many of our major health problems, and a major component of the work done in the health system. So our specialist drug and alcohol person cannot fix it.

Just as I said that those public health things are important, the mainstream health system has to be prepared to deal with alcohol. GPs have to be taught, and supported, to recognise alcohol problems early. The image in our community is one of deteriorated alcoholic people, but it is young people in their early 20s who most commonly have a substance abuse alcohol problem. In many ways doctors do not realise that even now. The evidence is there but they hardly ever think of that. They would think about it in relation to a person aged 45. It is about getting knowledge, action and early intervention into the front line health services.

Ms HALL—Do you think that model would work for the treatment of all drug abuse? Does that generalise out to cover all the other drugs as well?

Prof. Webster—Yes, in general principles it does.

Ms HALL—I believe that one of the biggest problems we have in dealing with the issue of elicit drugs relates to the fact that there are many other things involved—moral, religious, and a number of other issues. That often comes across in the allocation of dollars as well. Do you see any way these issues can be separated to allow us as a community to concentrate on the real issues?

Prof. Webster—I tried to make the point at the start: the way you can do that is by dealing with the actual evidence. Obviously, we will all have moral positions about different issues and problems. For example, if you take medicine as a discipline, there are going to be some doctors who feel morally compromised by certain actions that have to go on in medicine. But, in the end, the practice of medicine is about making ethical choices in the interests of the patient, not in your own interests, so your own moral judgments should be suspended in those circumstances. You are trying to weigh up the best outcomes by making a choice between the complex harms that might follow. It is actually harm reduction—every medical decision is a harm reduction decision. It is about trying to balance one disadvantage, one harm, against another. I think it is possible, and we do it successfully in most areas.

Ms HALL—I agree 100 per cent, but in reality it is difficult.

Mr LAWLER—The public has generally accepted that all these things we are talking about—diversion, different types of treatment, et cetera—are only the first part and that it comes down to the social problems that often cause the drug use in the first place. Given that, your submission does talk about treatment facilities and appropriate geographical locations. As Julie said, you have to wait six weeks in Cabramatta. In many parts of my electorate you have to wait forever—there just isn't anything. Clearly you cannot have a detox unit in every village over 50 people. Have you got a position on how they should be distributed throughout the country and in regional centres? Have you done any work on that?

Prof. Webster—I am also interested in health services generally: how they get distributed and how you give some guarantee to individuals living in a country town that they will have access to a proper level of health care. The fundamental idea, I think, is networking, but I am going to hand over to Gino because we are actually doing some work on this.

Mr Vumbaca—The council has held a number of regional forums in various communities around Australia and that is the issue that comes up. Most people in the towns you go to say that they want a detox centre and a rehab centre and they want it there. It is just not feasible to do that and a lot of it comes back to relying on GPs and community networks and organisations that can provide that. Another issue is that some of the people actually affected by drug and alcohol problems in the region do not want to seek treatment in their own area because of confidentiality reasons, so it often comes down to transport issues—about being able to get people to appropriate services. They are quite happy to move out of their area to receive treatment. It is the cost factor—and housing and family issues obviously impact on that.

One of the issues is knowing exactly what exists where in Australia, knowing where all the services are and where you can receive particular treatment. For instance, if you are a single mother with children, you need to know where you can access a rehabilitation centre which allows you to take your children. For indigenous people it may be where the nearest indigenous centre is. The council is commissioning some work, in the near future, to try to get a map of what drug and alcohol services exist, where they are located, whom they service and how many beds are available. It is difficult to make decisions when you do not have a complete map of what exists here and now.

CHAIR—I thank the council and its representatives. It has been very valuable. That web site is very appreciated. It is part of our agenda wherever we go now.

Prof. Webster—Thank you. It has been an honour to meet with you. Best wishes with your deliberations.

[9.12 a.m.]

ROCHE, Professor Ann Marie, Director, National Centre for Education and Training on Addiction, Flinders University

CHAIR—Welcome. Would you like to make an opening statement?

Prof. Roche—Yes, I would be pleased to. I have jotted down a few notes. I am aware that, in terms of giving a global overview, you have probably been subjected to these kinds of comments repeatedly but I want to reiterate them. To put things into context, Australia is experiencing a difficult time because of an increase in illicit drug use and an increase in licit drug use, particularly tobacco and alcohol, by certain segments of the community. So we are increasingly confronted with more drugs, with more varieties of different types of substances, and with more complex problems, sometimes brought about by polydrug use. There is a difficulty in maintaining balance in the debate in this area—and there have been references made to the role of the media. So I do not wish to overamplify the situation but simply wish to highlight that, over the last decade, we have seen a substantial increase in the use, and the associated problems, of a variety of substances.

Having said that, Australia is characterised internationally by its approach to looking at drug use—that is, in terms of its flexibility. Australia is definitely recognised internationally as being quite flexible, as opposed to some other countries that would be seen as being quite inflexible in their approach to drugs. We are seen as being quite innovative. Australia has taken on a number of very innovative and quite challenging programs. We are also seen as being quite pragmatic—that is, Australians are very much seen as people who say, 'We've tried that; that seems not to work. Let's try this,' or, 'The evidence for this approach is perhaps unclear but is good enough to give this a go.' So Australians would be seen to give an approach a go and then to stop and reassess it. I think that stands Australia in good stead in the way we go about approaching the drug problem in this country.

Over the last 10 years or so, we have focused primarily, essentially, on the area of treatment and, to some extent, policy. The research undertaken in Australia has fairly much underpinned our treatment and policy orientation. So my focus of attention in this presentation is about the area that we have not been so good at—that is, in relation to what we do in the work force. In our submission I made reference to the 1997 evaluation of the National Drug Strategy by Eric Single and Timothy Rohl. They highlighted many areas of strength in Australia's approach to this area but also a number of areas of deficit. One of the principal areas of deficit is education and training, or what we would now like to reframe as 'work force development'. So, while Australia has been quite progressive in trying to tackle this very complex and quite difficult area, I would argue that in many areas we have been quite neglectful in terms of where we have put resources and how we have even thought about or conceptualised the role of the work force.

There are numerous reasons for this, but one of them was tapped into in some of the earlier questions—that is, what is the nature of addiction? Certainly not all drug problems are due to addiction—many are, but not all are. What is the nature of drug use and the problems that we are dealing with? The answer is that it is multifaceted; it is extremely complex. And the people

who respond to those problems come from an enormously broad array of different disciplines. 'Everybody, from politicians to prostitutes' is one of the expressions that is used—and everybody in between. So, from a work force development perspective, you are looking at a complex problem with a complex set of solutions that bring in a range of different disciplines. So it makes it quite difficult to manage in that sense.

However, up until very recently, Australia has not been particularly focused or targeted in terms of how it was conceiving its response from a work force development perspective. This has improved a little over the last two to three years. There are more resources—not a lot, but somewhat more—that have gone into the area. But I would put to you a position that says that, if we are serious about trying to systematically and comprehensively tackle the drug problem, firstly, we have to address who are the people out there who are actually going to tackle the problem; secondly, what types of skills do they need to make that possible; thirdly, and more importantly, what are the kinds of structures within which they need to operate to allow that to happen?

Up until now, our approach has been very ad hoc. One of the challenges for this field is that the tradition within the alcohol and drug field has not stemmed from a scientific tradition; it has stemmed very much from charitable organisations and from people who have experienced personal problems in the area and who have then done enormously good work. Over the last 10 to 20 years, we have seen a merging of the scientific tradition and the experiential tradition. These do not necessarily sit comfortably together, by any stretch of the imagination. We need to work very hard to try to meld these two almost philosophical perspectives to fit together to develop a much better response.

Up until now I think we have been reasonably neglectful, which is probably not an overstatement. As I say, we have approached the problem in this very ad hoc manner. Over the last 10 years various training institutions around Australia, where they could get a bit of a toehold within universities or TAFE, developed some programs here and there. People would run a lot of short courses. We would run weekend methadone training programs for general practitioners, and those sorts of things. So it is only very recently that people have started to stop and say, 'This is probably not good enough. We can do better, and we need to do better. We need to stand back. We need to have a national approach,' which we do not have the moment. As I say, we need to have a systematic and comprehensive approach to looking at education and training. I would like to echo some comments that Ian Webster made that we are trying to balance information and the efficacy of that information. We need to have a culture within the field that looks at best practice, but we also need to have an evidence based approach and, again, that is something that does not sit philosophically comfortably with many people. I will stop there. I am happy to answer further questions that might like to probe some of those issues.

CHAIR—Thank you, Ann. I am endeavouring to understand your statement: 'Addiction and substance abuse—not necessarily the same thing.'

Prof. Roche—Absolutely.

CHAIR—Can we go through that and the purpose to which you apply your work. I personally am interested in trying to understand addiction and the characteristics of it. When we

say 'addiction', as a professional can you define for me the difference between substance abuse and addiction?

Prof. Roche—Illustration is probably the best way to do it. If you take alcohol, there is only a relatively small proportion of the population, using any criteria, who would be defined as being addicted or dependent—maybe four per cent to five per cent. There is real debate about 'once addicted, always addicted,' but we will not go down that path. There is an enormous proportion of the population who experience problems with their alcohol consumption. Our 15- to 25-year-olds, particularly males, experience problems and actually cause a lot of problems for other people in the community because of their alcohol use. The vast majority of those are not addicted and they are never going to become addicted. But the way in which they use that substance is extremely problematic.

The same is true for a number of other substances: cannabis, for instance. It is only in the last few years that we have even identified a thing called a 'dependence syndrome', and we would speculate that maybe 10 per cent of cannabis users would exhibit a dependence syndrome. It is a very low level of dependence, so it is not addiction. It is not a particularly addictive substance in that sense. Amphetamines are controversial, and we have a very large and increasing number of amphetamine users in Australia. As to how many of those are classically addicted, the number is probably less than we would think.

Turning to heroin, the classic and stereotypical notion of heroin use is: one use, one shot, and you are an addict straightaway, and always an addict. That is probably not necessarily the case. It is very difficult for us to get a handle on how many what you might describe as social heroin users there are in the community. It is very difficult, too, because the way we know for sure about people who have heroin dependence is because they are in treatment. They are in treatment because they are dependent. But there are usually several years of progression before you reach that point. Again, it is an area of some controversy as to how many people use it socially, for what period of time and whether they inevitably become dependent on heroin, and can you use it socially? Some people do not even want to have that discussion because it is quite politically contentious. Hence, there is this large grey area. There is a range of use that does not fall—as I say, against any criteria—into dependence but can be extremely problematic. Some might also argue that you can be dependent on a substance but not necessarily be experiencing great problems with it.

CHAIR—It just highlights the complexity about it.

Prof. Roche—It does.

CHAIR—You have defined a large group of people who are making conscious decisions to abuse and are creating problems for society in general from time to time and then another group who have to have it. That is the rough criteria. I suppose the next part of it for me is: what is the evidence to say that those who just do it socially go on to become addicts? What work are we doing to understand that general nature of addiction? With addiction, where should the biggest resource focus be? One would think it would be with the addicts. That is where the more critical nature of the issue is. Would you agree with that? I suppose it is difficult for an educator. Where do you start?

Prof. Roche—That is one of the issues about education. Because the area is so complex, the approach I have always taken is to say, 'This is the best information we have available. It is important that you critique that information and make the most sense of it.' Some very useful tables have been developed. There are probably two or three dozen models of addiction. I used this late last year with some Asian colleagues, and they found it extremely helpful. Your perception of the nature of addiction will determine for you the nature of the intervention that you want to provide. If you see addiction—as certainly many Maoris and some indigenous Australians would see it—as coming about because of a spiritual deficit, the kind of solution you would provide would be to in some way supplement your spiritual wellbeing. Addiction is defined in America as being a brain disease with a behavioural manifestation. The rest of the world tends not to agree with that. If you see it as being primarily a biological thing, then you seek a biological solution to it—often a pharmacological solution. So the answer is: there is no one answer; it is a very complex phenomenon.

I would like to go back to the comment that was made earlier that many of the people who are in treatment for an addiction may well have been sexually abused as young people. While that is true, there are probably two main reasons that people get seriously into different sorts of drug use. One is to forget—for example, if there have been painful earlier experiences or some major problem in their life. Alcohol is very helpful in helping people to forget and so is heroin. But, primarily, young people get into using drugs for fun, not to forget, and the people for whom there is often an underlying level of pain in their life are very vulnerable and it becomes difficult for them. That is a very different way of seeing it. People often get into drug use because it is extremely pleasurable.

Mrs IRWIN—What are the statistics on the young ones who have become addicted to drugs because it is fun?

Prof. Roche—There is a large body of literature of surveys which ask young people what the reasons were. I have a very good set of data that asks young people what the main reasons were for them starting to use. In this instance we did not show what the drug was. When I have taught these classes I have asked people, 'Which drug do you think they are talking about?' People would suggest alcohol or maybe even coffee, but it was heroin. If you look at a lot of surveys that ask, 'Why did you start using drugs,' you find that the answers are, 'It was what my social circle did.' 'It was pleasurable.' 'It was fun.' 'It was part of socialising.' But people for whom there is often an underlying pathology of some sort—psychopathology—are very vulnerable individuals and it gets very difficult for them to stop using something that gives you immediate pleasure and relief from any kind of pain. It is actually very well documented.

CHAIR—In priority, where would you focus the resources?

Prof. Roche—I like to think in terms of hierarchies of harm. It is sometimes a helpful way to look at complex problems like this in the community. Keeping people alive is extraordinarily important. We know that we have had this escalating level of overdose death rates from heroin—heroin in conjunction, usually, with another central nervous system depressant, often alcohol, sometimes benzodiazepines, that sort of thing. Keeping people alive is extraordinarily important: we know that if we can get people into treatment we can reduce the death rate phenomenally. The death rate absolutely plummets. That usually means getting people onto a methadone program if they are heroin dependent: getting people into treatment and keeping

them alive, keeping them out of jail and keeping their social life intact, keeping them functioning in the community as healthy individuals.

CHAIR—Have you done work in jails?

Prof. Roche—Not me directly, but many of my colleagues have.

CHAIR—Do we have much evidence from within the jail system? Are there any models within Australia within the jails that you know of?

Prof. Roche—There are a number of people that it would be worth while speaking to, if this committee has not contacted them.

CHAIR—So it is not within experience?

Prof. Roche—No.

CHAIR—Where do the alcohol and drug professional workers fit in the hierarchy of the medical system, in your view, and how does that impact on the way they are addressed, the way they are treated and the way they are resourced in the Australian system?

Prof. Roche—Many of the people who work in the field do not operate within the medical or even the health system, so that makes it quite complex. Many of the people who work in the areas where you went to—The Woolshed and Logan House, et cetera—are probably operating on the lowest professional rung of any workers in Australia and they are trapped at that level there. Those services are often extremely limited in terms of whom they can recruit because their budgets are very limited as well. So it is something of a vicious cycle for them. You need to up the ante in terms of the quality and the level of the people that you get, but also retain them. Often you bring in somebody that does not have a wealth of experience but you train them up; you have this gem working in your system but they have nowhere to progress, so they leave that system. That is a major problem.

Within the medical system, Australia has been quite interesting over the last 10 years or so in that we have seen something of an elevation of an area that has been extremely stigmatised. People in the medical profession, and health professionals generally, who worked in the alcohol and drug field were pretty much seen as 'working in that area because obviously they could not get a job anywhere else'. In some work I did last year with medical practitioners, somebody said, 'I think any doctor that gets into this area needs counselling as well. There must be something wrong with him, to be working in the area.' It often has been seen as a low status area, although it is changing.

CHAIR—So it is a serious matter, about dealing with best practice.

Prof. Roche—Very much so. To bring about change in the work force you have to be able to elevate the status of it and say, 'This is an important and legitimate area of work,' and you need champions in the field to do that.

CHAIR—For a whole range of reasons it is important work.

Prof. Roche—Absolutely.

Mrs IRWIN—In your submission on page 17 you speak about professional mix. You state:

An essential aspect of improving health outcomes is planning to ensure a suitably qualified workforce is available to deliver quality services and interventions. This entails making clear judgements about the professional mix required for delivering the best services.

What is your opinion about the current state of the professional mix of alcohol and drug workers in Australia?

Prof. Roche—I think Australia suffers greatly from not having been able to provide, over the last 10 years or so, better quality education and training to our mainstream health professionals. The police have actually been very proactive in this, training up their work force in the last five years, but we lag behind tremendously. Most of our social workers, our psychologists, our doctors and our nurses would have received very little, if any, training in this area. Because you are dealing with a complex problem that has many dimensions to it, the work force has to respond on many fronts. This raft of different workers all need to have some degree of a common understanding of this complex thing. That is why the mix is particularly important.

Mr QUICK—How do you change the mindset of, for example, the screws inside Goulburn Jail? I have done 4½ months in jail as an education officer, so I know what I am talking about. They have a mindset you could not move in a million years: it is just punishment and retribution.

Prof. Roche—It often is punishment. However, they also like passive prisoners, prisoners that are not going to be extremely difficult to manage. If giving people some kind of assistance in managing their drug problem will make them more easy to manage within the prison system, sometimes that has appeal. I am not suggesting that as the beginning and the end of it, but it might provide a lever to say, 'There are benefits for you in regard to this as well.' We use the same argument with police. A huge amount of the police workload is around alcohol. We say, 'You want to reduce your work load, don't you?' They say, 'Yes.' Then we say, 'Well, let's see what we can do about managing alcohol on the street.' It is a similar kind of argument.

Mr SCHULTZ—I was interested in your comments about keeping people alive. I do not think there would be a person in this room that would not agree with that objective. But I am concerned about how that is done. Is your organisation in favour of keeping people on their habit in the way in which we have gone with methadone? Is your organisation in support of injecting rooms, which just allow people to stay on their habit? Or is it seriously going to contribute to some positive outcome to get people who have a real health problem with drugs off their drugs through education and rehab programs?

Prof. Roche—Let me deal with methadone first. We have talked a little bit about best practice and evidence based practice so I will speak from an evidence based perspective, dealing with this purely as a health problem, in terms of looking for a treatment. We have close to 40 years of excellent research around the efficacy of methadone for managing heroin dependence. The research is actually stunningly good—and you cannot say this across this field,

in particular. But around methadone you actually can say that unequivocally. The gold standard for best practice for heroin dependence is methadone. It is not the only option that is available but it is the biggest and best arrow in our bow. It is extremely successful.

What you have tapped into is one of our fundamental dilemmas in this country: in terms of solving or dealing with the drug problem, do we want to achieve abstinence? That means a drug-free lifestyle. I am not quite sure what that actually means, because most people use some kind of pharmacological agents or psychostimulants, ranging from aspirin to caffeine. So I am not sure how helpful that is.

Having said that about methadone is not to say it does not have some limitations—because it clearly does. I will give you a very good example of this. I recently moved to South Australia from Brisbane. The Lord Mayor in Brisbane, as many of the lord mayors around Australia, has been holding public debates. We had one about 12 to 18 months ago. I was on the panel with the Lord Mayor, and I got booed and hissed vigorously about the methadone issue.

CHAIR—And you still remember it.

Prof. Roche—I remember it very clearly.

Mrs IRWIN—Join the club!

Prof. Roche—The reason I remember it so vividly was that there were two groups. On the one hand, there was a group in the audience who were antimethadone who were heroin users who did not want methadone because methadone is essentially not a very interesting drug. It is a dull drug. They wanted heroin. They did not want this not so interesting substitute. The other group was abstinence oriented. They did not want to have people on methadone at all because it was simply drug substitution. You have this enormous ferment of activity and opposition around methadone. In the field, where we struggle to help people maintain their health, maintain their wellbeing, maintain their contribution to society, reduce their criminality, we have a very good aid at the moment and that is methadone. But it receives an enormous amount of bad press.

Mr SCHULTZ—That is all good motherhood stuff. But let me take you into history. In the late 1960s we introduced methadone as a means of weaning people off an addiction. There were something like 6,000 people in Australia who were addicted to heroin in that program at that time. Now we have 30 times the number of people addicted to methadone. And we do not just give them a small dose and reduce the dose as was originally intended; we give them a small dose and then we increase the dosage to the point where they are totally addicted to methadone. All I have seen, in the 14 years that I have been involved and had an interest in the drug issue, is an industry building itself up around poor unfortunates who want to get off their habit and who are encouraged by those industries to stay on it. I could go on and on with the needle syringe exchange program and all of that nonsense, and with the HIV-AIDS program. All we have seen is massive medical industry building on that.

CHAIR—Can we have a question, please, and then a response to the question?

Mr SCHULTZ—My question is: can you see why people like me are concerned about the direction that is continually taken by groups of people, organisations, who come up with this

motherhood stuff to make it sound like there is no great problem out there but we have a massive problem, and the problem is people?

Prof. Roche—Let me speak to you as a scientist and not giving motherhood statements. I do not have a personal view about methadone one way or the other. However, having worked at Royal Prince Alfred Hospital in Sydney for seven years where there was a methadone clinic and having watched first-hand people's struggle to maintain themselves on the methadone program, if I had to turn up somewhere every morning of my life for a long period to take a substance that meant that I would cope, I would find it extremely difficult. Those people do remarkably well. For them it is a very challenging and demanding program to go through. I am not diminishing the burden that can be associated with methadone.

However, if I speak to you as a scientist and say, 'If not methadone, what are the other options that are available to us?', what does the evidence tell us about how well those other options work? One option is methadone versus no treatment and the death rate is phenomenal. That is one choice we have: let them die. When we put them on methadone, the death rate plummets. We know that their health status returns incredibly well. I go back to my comment about my GP who said, 'People who work in this treatment area must need counselling; it must be very depressing.' People who work in the methadone area say, 'It's so encouraging because you see someone who is often very sick and unwell and their life is in tatters and within three to six months you see them operating socially. Their life comes back together and they often get their employment status back. They still may have to deal with some criminality issues, but their health status is returning where it has often been undermined substantially.' You can often see this radical turnaround.

If I then compare methadone with a non-pharmacological intervention, the evidence tells us that for some people that works quite well but overall it does not work as well. What we are seeing now is some people saying, from the therapeutic community's perspective, 'Perhaps we can combine some of these things. Perhaps it is not all this or none of that. Perhaps it is different things for different people.' As we say, this field is so complex, and people are being more flexible about that. That has much to commend it.

Mr SCHULTZ—Would it not be better for people if they were off their addiction? Would their health not be better if they were off their addiction?

Prof. Roche—That is a very important point that I want to come back to. As researchers, I think we have been neglectful, until relatively recently, in saying, 'What do we do after we've got someone on methadone?' Clearly, we as a state do not want to see people maintained in that way in perpetuity. The more recent research around alternative pharmacotherapies, around buprenorphine and naltrexone, gives us some way of actually managing the transition—moving somebody from being dependent, which they do become on methadone, to a non-dependent state. We have been doing that successfully over the last two to three years. You are right to raise it. We had been neglectful for not focusing on it. Throwing the baby out with the bath water would be a huge mistake in this area.

Ms ELLIS—I would like to deal very briefly with the work force training angle, and I have two quick questions. I think that one of the most important groups of people who need to be trained up—for want of a better term—would be our teachers and our teacher counsellors within

our education system, given their integral role with young people in a range of ages. How do you think we are progressing in that area? It dismays me a little when I go into schools in my electorate and other parts of the country. They are trying very hard, and a lot of them have some training to some degree. I see this as an integral early intervention point of identification of possible problems with addictive behaviour of one sort or another. Do you have a view on how we are progressing in that area? I do not want to isolate them, but they are important.

Prof. Roche—I wonder sometimes whether we overstate the importance of the role of teachers.

Ms ELLIS—Okay; tell me what you think.

Prof. Roche—The reason I make that bold statement is that our evidence in terms of the efficacy of intervention by teachers in the school setting is not that great. Teachers themselves in Australia have become increasingly clearer about saying, 'Our role is to educate. Our endpoint, the outcome we are seeking, is not necessarily behavioural change.' In the alcohol and drug field, behaviour really counts, and it is what we are interested in. So teachers themselves have been saying, 'This is a mighty big ask if you are trying to put the resolution of drug problems onto teachers.' We do not have the evidence to suggest that intervention by teachers is effective. It is not to say that there may not be some ways of actually doing it. There has been some recent work in Western Australia around alcohol that has been demonstrated to be quite successful. The Commonwealth initiative looking at preventive strategies will provide, I think, some illumination in terms of where we can place most of our preventive effort most successfully, but the role for teachers is probably less prominent than we would like to think. I think we cling to that.

Ms ELLIS—I do not mean for them to do the work, I mean for them to be trained to identify the problems and to maybe do the referral stuff. I would not wish for a moment for a teacher to become the drug counsellor/solver for the world, but I think it would be more identifying—if they can—what behaviour is in the front of and where they need to pull in or refer. That is really what I am talking about.

Prof. Roche—Absolutely. I think Ian commented earlier that drugs and alcohol, problematic use, do not exist in isolation. They usually occur as part of a constellation of other things, and what we are looking at now are called pathways to the development of problematic patterns. You may exhibit yourself with alcohol and drugs or other things, so we are looking at early developmental patterns of behaviour and factors that might contribute to that. Certainly raising the level of awareness of teachers around those things, say, may identify children in these kinds of circumstances that may be more vulnerable to developing problems around a range of areas. I think that is an extremely constructive way to go.

Ms ELLIS—I have one more quick question. I think we all agree that training generally of professionals is necessary and that we should be putting more emphasis on it. Do you have a view about the climate in which that is welcomed by the institutions or facilities in which they work? I think this is a very important point. It is no good wanting to have names—that is, nurses or, to pick on the health profession for a minute for a purpose, other health workers—trained up to an incredible level if the facility or institution in which they work does not have an approach to it. It is not that long ago that I can recall here in my own home town an accident

and emergency area would not take in someone if they were inebriated with alcohol and behaving in an unacceptable way, even though they may have been intellectually or mentally ill at the same time. So the picture on the drawing is quite evident. Tell me your views on what sort of work has been or should be done to bring all of those people on board so that the workers within those areas can actually do what you want them to do.

Prof. Roche—It is an extremely important point. I have a study still going on the Gold Coast at a hospital in the accident and emergency area where they refer to WOMBATs—patients that arrive that are a waste of money, beds and time. Often alcohol and drug patients fall into that category.

Ms ELLIS—Especially dual diagnosis people.

Prof. Roche—Very much so. I think you have really hit the nail on the head. I think our current emphasis in Australia has been very much on running courses and developing training packages, and we focus on the individual who has got the problems, but the individual exists within society if something happens at a broader level. The same with the worker. There is not much point in just training up a worker if they return to an organisation, agency or institution which may not be interested and may be positively antagonistic toward dealing with that. Increasingly, NCETA is saying that we need to look at work force development, we need to look at the organisations and the structures within which the worker operates. Unless you get that kind of top-down support for the bottom-up activity that we want to occur, then it cannot be sustainable. Up until now we have had difficulty even changing the rhetoric in the discussion. People say, 'Oh, it is about running education and training programs.' We say that in small part it is, but the bigger picture is that, unless you get organisational and institutional support, it is not going to make a huge amount of difference. Increasingly we are saying it is the bigger picture that we want to focus on, getting that top-down support.

Ms ELLIS—Are we making progress in that area? Is the emphasis now starting to shift?

Prof. Roche—I would hope the emphasis is. We are putting the issue on the table, I think. That is a little bit of progress, but that is about as far as it goes.

Ms HALL—My question goes to the training of workers. Most training of workers in this field I know about comes from within either a particular work force—you mentioned the police and a couple of other areas—or, alternatively, postgraduate or a component of a course. Do you believe that having specialised courses and faculties within universities—and even TAFE colleges—that deal with alcohol and drug issues and training for workers would raise the status of it as an issue within society and therefore make it easier to deal with the problem? Because it would be mainstreaming it, rather than putting it as an issue that you deal with after everything else.

Prof. Roche—We in our field have long discussions about that. Most people would agree with us, I think, that there is not a discipline of addiction studies. In America there is a thing called the American Society for Addiction Medicine, but there is not a discipline as such. It has been described as you should get your main training, whether you are a social worker or a psychologist, a doctor or whatever, and that learning about alcohol and drugs is something that you add on, that you bolt on. You see it within that kind of context and it makes most sense in that

way. Again, because alcohol and drug problems do not occur in isolation—they occur as part of this constellation of other patterns of things that occur in people's lives—it is important not to segregate them off in that way. However, having said that, and having now taught in four or five tertiary institutions around Australia, it leaves the development and running of those kinds of single courses, or a semester on this or a topic on that, very vulnerable because universities are quite cash-strapped in Australia these days.

There is an enormous level of enthusiasm, shall we say, for people to get their grab at the curriculum. So it is a cut and thrust business in terms of what you can get on to the curriculum. You do not want to go away for a month or two at a time when they are revising the curriculum because you will lose your courses, and that happens quickly. So that is the downside of it. But on the other hand, you do not want to marginalise it and isolate it, even though there may be some real advantage in terms of being able to see it as an important readily identifiable area that might attract resources. So it is betwixt and between to some extent. Australia has never come close to doing that, anyway. The best we have been able to offer is these graduate level courses at certificate, diploma and masters level in addiction studies, and there are now good courses around Australia. That is probably adequate, but people struggle to even maintain those.

Mr QUICK—On page 11 of our briefing papers are 56 acronyms of organisations. I want to make that point with your silos and silence and the quote that I asked Ian Webster about—the 'siloed' structures of our systems and services. I will cite some of the 56 organisations: the Alcohol and Other Drugs Council of Australia, the Alcohol and Drug Information Service, the Australian Intravenous League, the Australian National Council on Drugs, the Australian Pharmaceutical Advisory Council, the Centre for Education and Information on Drugs and Alcohol, the Drug and Alcohol Services Council, the Pharmaceutical Benefits Advisory Committee, the National School Drug Education Strategy, the National Organisation of Fetal Alcohol Syndrome and Related Disorders, the National Drug Research Institute, the National Drug and Alcohol Research Centre, the National Centre for Education and Training in the Addictions, the National Centre for Epidemiology and Population Health, the National Advisory Committee on School Drug Education, the Ministerial Council on Drug Strategy and the Intergovernmental Committee on Drugs—ad nauseam.

I know a 20-year-old who today is on his way to a rehab and detox for a 12-month course, and hopefully his life will change. What the hell does all that mean to not only Jason, who today is at the fork of the road, but his mother and his two siblings? We can train all the workers under the sun but if addicts do not have access to rehab and detox when they want it, right here and now, it does not mean anything, not all of the money that we pour into those organisations. I just mentioned a few of the 56. They are doing fantastic work—I do not knock any of them—but how the hell do we coordinate them? Today Jason is probably half an hour away from walking into something that I liken to when I first walked into boarding school. He is part of a young group of people who have suddenly decided to say, 'Today is the day, make or break'—not only for him but for his family and his siblings.

Prof. Roche—Yesterday I spent the day at the Royal Prince Alfred Hospital with my 18-year-old niece, who is in the cardiac intensive care unit. She has previously had open-heart surgery and will be in intensive care for the next month. I have thought quite a lot about this. I could list off a similar raft of acronyms around the medical profession, but my reaction to that is this: 'Thank God I know that she is actually being treated by the Professor of Medicine at the

University of Sydney, and thank God that the raft of specialists who keep coming out and taking litres of blood from her and doing all sorts of things to her have been extremely well trained, and that I know that she is getting the best treatment in Australia.' Coming here today I was thinking, 'Isn't it dreadful that if my 18-year-old niece was in exactly that set of circumstances, I could not necessarily say that about the level of training, qualifications and evidence based practice from the people would be operating?'—and I think that is a real condemnation of our system.

Mr QUICK—If you look at the budgets of state and Commonwealth departments, hundreds of millions of dollars are being poured into alcohol and drug related systems, yet we still have drayloads—we have been wandering around Australia and seeing the kids, and they are crying out—and hospitals are sucking the money in as fast as you can print it. How do we get these silos down, right here and now, and say to Juvenile Justice, Housing, Education, and Sport and Recreation, 'For God's sake, develop a community program'—whether it is in Tony's area or my area or Cabramatta—'because these kids are crying out for something.' They do not give a toss whether the education department has got a drug policy on exclusion and that the police are saying, 'It is not our problem that they are wandering the streets. We do not have enough SAP funding to provide homes for these homeless kids.' How the hell do we break the silos down and say to community X, 'You've got what you want: we are saving these kids' lives'?

Prof. Roche—You are absolutely right.

Mr QUICK—How do we do it? You are training the people. How do we convince them to think outside the square, for God's sake, so that, when they get to be the First Assistant Secretary to the Commonwealth Department of Health, they know to say to Dr Wooldridge or Jenny Macklin, when they are ministers, 'Do it. Here's the way to do it'? We need an Australian approach, not an American, British, Swedish or Dutch approach. Our kids are dying. We need to have someone with some vision, for God's sake. We did it with gun laws and with HIV, so why aren't we doing it with drugs and alcohol? Thousands of people are dying every year.

CHAIR—Do you wish to respond?

Prof. Roche—Only to say that I think you are absolutely right. We have in Australia made some progress. It is really encouraging to see how much more closely the police and correctional sectors work with the health sector, for instance. Five years ago, it was not like that. There is much closer collaboration now. We speak a much more common language and have a greater understanding of the common issues. On the issue of sharing the same kind of information base and understanding what this complex and bizarre thing is that we are dealing with, I think we have made a lot of progress in that regard. But, when it comes down to political issues about where the resources go, that is actually in your ballpark.

CHAIR—Actually, it is in your submission, too, isn't it? You say, under the heading 'Monitoring the AOD Workforce':

> There has been no analysis of whether this distribution of resources reflects the values and priorities of Australia's drug policy, a public health understanding of drugs, the mix of skills required for implementing the most effective responses to drug issues, the numbers or influence of the professions currently responding to drug problems ...

et cetera: you have written that in your own submission.

Prof. Roche—That is exactly right. At this stage in Australia we actually do not know how many people work in the alcohol and drug field and we do not know how qualified, unqualified or experienced they are, or what the standards of those people who work in the field are.

CHAIR—To pick up Harry Quick's question: isn't it an indictment on your industry as well, in terms of the leadership within that industry?

Prof. Roche—Yes; perhaps you right: it is something that we have not lobbied hard enough on or said was something that we should focus on.

Mr QUICK—We have to accept our responsibility politically and we must; but we do rely very much on the professional support.

Prof. Roche—Yes, I think you are right. As I was saying, the Single and Rohl report in 1997 was quite useful in terms of saying, 'That has been good progress, but this is one major area you have missed out on.' In the last two to three years people have been saying, 'You are absolutely right.' Until we can up the ante in terms of the work force, knowing at least who the work force are—teachers can do it, doctors and nurses can do it, but we cannot do it across our complex and broad field—it is very difficult to even monitor whether we are making progress or falling backwards.

CHAIR—A lot of that is going to come from within the health industry itself.

Prof. Roche—Absolutely, yes.

CHAIR—If we were to make a recommendation, this would be absolutely essential to know. At least we might have something there to guide the industry if it cannot self-educate, self-develop.

Mr SCHULTZ—Harry's frustration is something that I also agree with because there appears to be, as I said earlier, an enormous focus on building an industry with no positive outcome in terms of the end result. In my brief time involved in being concerned about drugs over a 14-year period, I have seen nothing come out of it that is helping young people get off their habit and maintain a healthy lifestyle for them and their families. It is just a frustration that is there and we have to get some method of coordinating the knowledge we have to the extent that the hundreds of millions of dollars that are being wasted are not wasted and go into providing facilities that will allow these young people to maintain a healthy lifestyle for as long as we live.

Mr LAWLER—Coming back to regional areas—I apologise if I am harping on it, but I suppose that is what I am paid for—in some of these areas, as we said before, there is no detox or rehab, those sorts of things. A lot of people think of buildings and structures. With detox you do not really need buildings so much, but maybe a couple of hospital beds and knowledgeable people to determine and balance the methadone, naltrexone, whatever. In our areas, all the health professionals—doctors especially, and nurses—are flat out doing all the other stuff. I know a couple of them who have done training to be accredited for methadone prescribing. They have done it for a little while and then got so busy doing other stuff. In an education sense, is there any ability for lesser trained people to be trained to some degree and contribute to the

rehabilitation? We talked about teachers; I think teachers have that much on their plates as well. I am concerned about parents not having the tools to recognise problems that are arising. Is there some sort of training for caring members of the community who wish to get involved to assist people? Are they a resource that we can use, given some training? It would be great to have another couple of dozen doctors and nurses who had some add-on to their training so that they become experts in drug treatment. Given that we cannot even satisfactorily treat people for heart conditions and diabetes with the resources we have, is there another resource we can use with appropriate training?

Prof. Roche—There are and there are some very good examples from a number of places around Australia where people have trained up volunteers—I will mention that in a moment. One of the things I get very concerned about in the debate around drugs in Australia is that people talk about alcohol, they will talk about cannabis and then it is often heroin. Again, the media is largely responsible for this. Certainly the death rate from heroin overdose is an extraordinarily important thing and not to be underestimated at all. Just to try to keep things in balance, there are a number of other drugs that wreak considerable havoc on a community, including amphetamines, and they rarely get a mention. We do not have as good and formalised treatment programs for amphetamines, but for younger teenagers—I am talking about 14- and 15-year-olds—the problem is more likely to be around amphetamine use and the injection of amphetamine than around heroin. Traditionally for the last 10 to 15 years, heroin has been something that older teenagers or younger adults would get into, but amphetamines are particularly important. There is no detox procedure around amphetamines and no treatment. I put that on the table for consideration. The drugs we are dealing with are broader and more complex than the impression you sometimes get from the media. That is one thing.

The other thing is that people often talk about detox as though it is the beginning and the end of a process, the total event, when in fact it is not. If you are looking at somebody who is heroin dependent, you are looking at a very long-term, chronic, relapsing disorder for which detox will provide some temporary relief whilst they then go on and get treatment. So it is an opening of the door, and that is about it. People often underestimate the significance of that.

CHAIR—That is really where I am leading you.

Prof. Roche—You started off by talking about whether it was possible to have volunteers involved with things like methadone. One of the areas where Australia has made a lot of progress is in terms of how strict we are with the way methadone is managed. We had a substantial death rate around methadone in the early 1990s and, through very rigorous policies and procedures and good training, we have put a cap on that. It is quite low, but there is still a small risk. So that is not an area that you would want volunteers to be involved with at all. It is an important clinical area, and the highest and most rigorous clinical standards should be maintained around that.

However, beyond that, there are increasing areas of scope for volunteers to be involved. Over the last decade in Western Australia they developed an excellent volunteer training program, which the Commonwealth had then supported, which has been disseminated to a number of states. When I was still in Queensland, we adopted that program. We put one advertisement in the Saturday *Courier-Mail* and I think we got something like 360 responses from members of the community. There was just a very strong response saying, ‘We’re very concerned, we’re very interested and we would love to help in some way.’ I think there probably is an

undertapped resource in the community regarding carefully selecting out people who have the right kind of attributes—they are warm, empathic, non-judgmental and caring people who have good interpersonal skills—to give people the support they need through a treatment and rehabilitation process. So I think you are absolutely right: there is a lot of scope there for that.

CHAIR—With the dosage rates, are you satisfied that we have reached best practice yet?

Prof. Roche—Absolutely. I think the guidelines around best practice for methadone are very—

CHAIR—Have they been implemented?

Prof. Roche—That is a very interesting question. There is some degree of variation.

CHAIR—Within my observation, there is still a huge variation.

Prof. Roche—My view about that is that the evidence suggests to you that the higher doses are probably the better doses. Basically, you want to hold people so that it reduces craving and the propensity for people to go and use other drugs. So this notion that 'more of the drug must be bad' is not a logical notion. Alby raised the question about how you then stabilise someone—and that may take a year or two or three—and how you then help someone get off methadone being extremely important. He is absolutely right in raising that.

CHAIR—Statistics on those coming off methadone?

Prof. Roche—I do not have good statistics on it. Could I go back to that point? What are you dealing with with heroin addiction is a chronic relapsing disorder. People will pull themselves out of the program—

CHAIR—I understand that.

Prof. Roche—they will go back to using and then they will come back onto the program maybe a year or two later. So this notion of a quick fix, that it is going to be all over in a fortnight or a month—

CHAIR—No, my specific question was about those coming off methadone.

Prof. Roche—But that is my point. People come off methadone, often go back to using heroin and then go back to methadone—and they might do that a number of times.

CHAIR—That is the part that really interests me in terms of those stats. You have been excellent, and our interaction obviously has shown how much we have appreciated your contribution. Good luck and thank you.

Prof. Roche—Thank you, and good luck to your panel too.

[10.09 a.m.]

DALEY, Ms Lee-anne, Deputy Chief Executive Officer, National Aboriginal Community Controlled Health Organisation

KEHOE, Ms Helen, Policy Officer, National Aboriginal Community Controlled Health Organisation

RITCHIE, Mr Craig, Chief Executive Officer, National Aboriginal Community Controlled Health Organisation

TONGS, Ms Julie, Director, National Aboriginal Community Controlled Health Organisation; and CEO, Winnunga Nimmityjah Aboriginal Health Service, Australian Capital Territory

CHAIR—Welcome. Do you wish to make a short opening statement?

Mr Ritchie—Before moving to a short opening statement, I would just inform the committee that Helen Kehoe, in her role as a policy officer working within NACCHO, has had general responsibility for substance misuse policy areas. Also, Le-anne Daley was formally the Chief Executive Officer of the Wellington Aboriginal Medical Service in Wellington, New South Wales.

Thank you for the opportunity to give evidence today. It is pleasing to be able to speak to this committee. I appreciate that, as a committee, you have a fairly high degree of familiarity with issues around Aboriginal health, being responsible for *Health is life*. In that context, section 6.61 of that report deals with the area of substance misuse and the role particularly of Aboriginal community controlled health services. I must say that we are pleased that that issue was taken up. We would be even more pleased if the government had been able to respond to the report at this late stage; nevertheless we look forward to a response coming soon. As the national peak body in Aboriginal health, we certainly are of the view that one of the things that Aboriginal communities suffer under is the weight of unimplemented reports. So we hope that that report is not just going to be another one sitting on a shelf.

These are the main points that we would draw to the attention of the committee this morning. First, there is the particularly vital role of Aboriginal community controlled health services or Aboriginal medical services, AMSs, in the delivery of effective substance misuse services to Aboriginal communities. Earlier in the morning I was particularly pleased to hear Mr Quick's plea for community based and community oriented solutions to substance misuse problems. The committee would be aware that Aboriginal community controlled health services are in their 30th year in this country; the first of those began in Redfern 30 years ago. Those services, 100-odd medical services around the country, provide that very thing: Aboriginal community controlled holistic primary health care services that do deliver a significant range of substance misuse services to the communities that they serve and also represent.

We would also like to talk about the role that NACCHO could play. NACCHO, as a national peak body, could play a role in increasing the effectiveness of substance misuse services that are delivered to Aboriginal communities—in partnership, of course, with our state and territory affiliates and the services on the ground that are already doing the work. Also, we would talk of the importance, in our view, of having an ongoing funding framework, which currently does not exist, to enable that work to continue.

It is important to understand that, in the context of Aboriginal health, the National Aboriginal Health Strategy 1989 articulated a view—a particularly culturally derived view—that health services provided to Aboriginal communities needed to be holistic in nature. So, rather than pursuing a course of action that is defined by vertical programs and what our chairperson, Puggy, calls 'body parts'—a phrase that I am sure you have all heard—services are delivered in a holistic context that takes into account the whole of life of the individual and the whole of life of the community. It is an approach that focuses not just on the individual in isolation but on the individual in context. Certainly in the area of substance misuse, that context cannot be underestimated and takes into account issues such as the removal of children and the ongoing effects of that on the people who were removed and their families—now second and third generations of families. That is particularly important. So a holistic approach, in our view, is the way to go. The third recommendation in our submission to this inquiry deals with that particularly.

About the role that NACCHO and its state affiliates can play in undertaking a more coordinated approach to substance misuse activities, I refer the committee to recommendation No. 7 in our submission. We have developed a proposal that we submitted to the department of health through the Office of Aboriginal and Torres Strait Islander Health Services on 12 October last year. To date, there has been no response to that proposal. That proposal was particularly focused on coordinating effort. This is one of the banes, if you like, of Aboriginal health, particularly working at a national level—in fact, in any area of health. One of my dreams, coming from the great City of Newcastle, is to have somebody take a piece of paper and draw a simple version of the Australian health care system for me. As yet I have not been able to find anybody to do that. One of the big problems is that often there is not a lack of activity but a lack of coordination of activity, particularly in the area of Aboriginal health. I think most people are agreed that the health status of Aboriginal people is appallingly bad, even in the year 2001. We need to do something about that, but effort needs to be coordinated and concerted. So, as I have said, we have put in a submission to the department of health, but we have had no response in relation to that. Our estimation of the cost of delivering that coordinated approach, in concert with our state and territory affiliates and local services, is around $1.6 million. I do not think it is going to break the bank, but there has been only some slow activity or no activity in that regard. Lee-anne may be able to share with the committee a model that was talked about or has been achieved in the work force area on an issues network involving state and territory affiliates that we have modelled this approach to substance misuse on, if that would be helpful.

Last May NACCHO launched a strategic plan in the area of substance misuse, and the work there has been slow. The submission that we put in to the department of health is the first step towards implementing and progressing that strategic plan. Important priorities in that strategic plan are to provide support to front-line service providers. At the end of the day, the work is done by real people in real communities on the ground. Often those people are Aboriginal health workers or perhaps even specifically oriented substance misuse workers in Aboriginal

medical services who often feel isolated and overwhelmed by the problem. One of the things that people need to be aware of is that Aboriginal people, when they are involved in delivering health services to their communities, are part of the communities that they are delivering the health services to; they are not something other than that community. So we have a focus on providing support to those workers.

We also have a focus on sharing information with them. It is our view that sometimes good research and resources, where they exist, do not reach the people that could make the best use of them. Then there is the building of a database of what is out there and what is needed. A particular example of that is that the Commonwealth has funded NACCHO to undertake a research project in the area of tobacco control. Certainly we are engaged at the moment in looking at the area of tobacco control: what is working and what is not; if it is not working, why it is not working; if it is working, we are asking the question why it is working—all around building our knowledge of effective service delivery mechanisms. There is also helping to build stronger links with other service providers in order to get the best outcome. At the end of the day, 100 Aboriginal medical services cannot do it by themselves—certainly not operating on the shoestring budgets that they operate on at the moment, by and large. So there is a need for effective partnerships with other organisations in order to get the best outcome for our communities.

Finally, in the context of an ongoing funding framework, I refer to recommendations Nos 5, 6 and 9 in our submission. There is currently no mechanism for people on the ground to get funding for substance misuse issues, and that is particularly difficult. Grants, where they do exist, are generally small and they are available under the National Illicit Drug Strategy—but that has now ceased. That is one of the problems with vertically funded programs: they have a life and that life runs out. Our view is that you effectively resource services in terms of their core global budgets so that they can deliver sustainable services. Vertically structured programs, as I have said, are generally finite. Often, there are lots of strings attached to them and they are too small to be effective. So we need to build resources through adequate global funding to AMSs so that they are able to achieve the goal of being properly resourced primary health care facilities that are able to respond to community needs.

In the context of specific recommendations from today, we would advocate that new money available through the newly established alcohol foundation should be directed to priorities identified by the community controlled health sector in the context of Aboriginal health; affiliate based positions, as we have outlined in our submission to the department of health, would be one way to go. In terms of more specific context, if the committee has questions in relation to the urban context, Julie as the CEO of an urban AMS is in the position of being able to respond; coming from Newcastle, I am possibly as well; and Lee-anne has a long background in delivering health services to Aboriginal communities in rural and regional settings, so she may be able to respond in that context.

CHAIR—Thank you very much. Does anyone want to add to Craig's presentation?

Ms Daley—I know that some people on this committee have been out to Wellington and seen some of the issues that we have out there. I suppose some stuff that has come to light since that is that we have a community of about 10,000 people around the township of Wellington. Ten per cent of that population is Aboriginal, 56 per cent of which is under the age of 20. We have a real problem with substance misuse in Wellington. That was highlighted through a survey done

through the Sydney University with Gavin Mooney, in which we surveyed the community and asked what their health issues were. The response that came back from that really shocked us. We knew it was a major issue for us in our community. But the result from that survey was that 81 per cent of those surveyed felt that substance misuse was the No. 1 major health problem in our community. We had always known that it was a big problem, but finding out how much of a problem it was just blew us away.

The issues that Julie will speak about will be those in an urban setting. I do not think they are too different from those in a rural community; it is only that we would have problems with accessing services. Our services are often in regional settings. With drug and alcohol services and mental health services, we are still waiting for people to come out—and waiting for people to come out is very distressing.

The role that we played as an AMS in Wellington and that we continue to play today is vast. We did not just work with a methadone program; we did not just work with somebody who was affected by substance misuse. We worked at the prevention stage. We looked at young people to see how we could prevent them becoming victims of substance misuse. We tried to work within the school system; we tried to see how we could help within that school structure. We looked at treatment with young people as well. Young people were a particular focus of ours. It is devastating to see 16- and 17-year-olds with these sorts of problems. I remember one young person who at 17 basically had been told that she was a palliative care case, due to a heart condition that she had contracted from using illicit substances. We also looked after young mothers, trying to encourage them with positive parenting and those kinds of issues. We also went with clients who were heavily addicted to substances when trying to get them access to treatment—especially with hep C, which was a real concern of ours—giving them those backup supports so that they knew basically what they were experiencing and how they could improve their health.

I think too that some people have spoken about this this morning: it is not just about people going into rehab; we also transported people to rehab and had networks with rehabilitation services that were appropriate. We tried to direct our clients to the most appropriate service that fitted their need, whether they be a family, a male or a female. But it was our trying to get something in place so that, when you come out of a rehab service, you were not just dumped back in your community; there was some support mechanism there for you at that time.

A lot of our frustration was that we just did not have the money to do these things. Particularly with our youth programs, it was voluntary work. A lot of the community people were involved in that. We also tried to bring all our Aboriginal organisations together, because we were all finding that we were trying to do something in the same direction. It was a matter of coming together as a group of people and trying to get some common direction so that we were all working together. But the lack of funding is so frustrating out there that it just blows you away. As Craig has alluded to, you do not just stop when you finish work; we go home to it every night of the week. We are affected by it and so are our families, so it is a major issue for us.

CHAIR—I accept that the issue of substance misuse or abuse must be addressed from the mainstream in many cases, but where are the similarities across mainstream, to use that phrase, and indigenous communities? What do you think the similarities are in substance misuse in

terms of how we might, where possible, use mainstream services? I suppose that is the context of my question. Then I will go to the clear differences. What areas are similar? Craig, do you wish to lead off?

Mr Ritchie—Are you asking about patterns of use?

CHAIR—It seems to me that substance abuse is a national issue. Certainly, indigenous communities have particular issues and there are a whole range of reasons, which are fairly well documented. What I am trying to understand is where the similarities are, as well as how we might understand how we might work together in mainstream services.

Ms Tongs—I could probably give you an example. In the ACT we have a lot of mainstream services, but getting access to those services is an issue, particularly detox. I know that—

CHAIR—You have exactly the same problem as everybody else.

Ms Tongs—Yes, as non-Aboriginal people accessing those services. At our service we don't discriminate. We see young non-Aboriginal users. The thing about our service is that it is an Aboriginal community controlled health service and it gives ownership to our community, but we do not discriminate. We see a lot of young, homeless, non-Aboriginal people that feel more comfortable accessing our service and that is the difference. We have problems with detox. At the moment, because there are limited detox beds, they refer them back to their GPs for home detox. You have to have a home to be home detoxed. You have to have stability. You have to have a responsible person giving those drugs because if these people go and shoot up, they are dead. There is a lot of responsibility. You need to be able to support them.

The magistrates refer clients to Winnunga for drug and alcohol counselling and we do not have a dedicated drug and alcohol counsellor. My staff support that person to go for mainstream counselling. There are things that work, but there are things that do not work. We need to be properly resourced. I really believe that we can make a difference if we are properly resourced. This is something that has not just happened for us overnight. This has been happening for a long time. Our doctors in Aboriginal medical services have got a better grasp on what is happening and how to treat people than the mainstream GPs. They are actually coming to us for advice on how to work with people with drug problems.

CHAIR—That is excellent. Thank you very much for that. I have another question which anyone can answer and it relates to inhalant misuse. It seems a particular issue. Can you give me a little insight into why you think it is a particular issue—maybe it is not?

Ms Kehoe—To my knowledge, I think the main point that is being emphasised in the part of the submission that deals with inhalant misuse is in relation to a particular recommendation that came from our central Australian members and affiliates. The point that was being emphasised was that inhalant misuse should not be seen as something different or separate. In fact, one of the difficulties with programs dealing particularly with petrol sniffing and youth was that it did target the young people currently having problems. They were seen as abnormal or different and requiring of special treatment. In many cases they do need that. The important point to emphasise is that with inhalant misuse there is an expression of a community-wide crisis—I guess that is the best way of saying it—and that is expressed and manifested in different ways

as parents are depressed, out of work, leading an itinerant lifestyle and having alcohol problems. We see children petrol sniffing out of school, et cetera. It is a community-wide issue.

I think the point that is being emphasised in that recommendation is that we need to go a step back before treatment and look at it as a community issue. I think that really ties in with the point that Craig was making earlier, that Aboriginal medical services are taking a holistic, whole of family, whole of community approach to the issue of substance misuse. It is not just the child with the petrol tin round the neck that is having the problem; it is that school, it is that community, it is that family, those parents, the grandparents, et cetera—a much broader approach than, 'Gee, we must get that particular kid or that particular group of kids off petrol.' If they are off petrol they will be onto something else if those conditions of life do not change.

CHAIR—That is my point. In many of the communities, as you would know, there is a prohibition on alcohol and other substances. That is easier said than done. Petrol and other substances, and inhalation, as I understand it, are not illegal. I raise it as a fact that here we have a clear policy of prohibition in all other substances but, as I see it—and I see it in my own electorate—petrol is a particular issue. I am seeking your collective advice. I will leave it there and if people want to add to it later that is fine.

Ms ELLIS—Thank you for being here. It is good to see you all here today. I notice, Craig, in your opening statement you made a very quick reference to the *Health is life* report. I want to refer to that very briefly. I want to talk about alcohol particularly. The comment that we as a committee made in the *Health is life* report in relation to substance use, particularly alcohol, was that we observed things such as the restriction of sale, that some communities had declared themselves dry and were operating that way with restricted hours of trading—there were some successful trials in Tennant Creek of that—and the introduction of night patrols. All those sorts of things we observed as core business in many communities to try and address the problem. We made a recommendation, I think recommendation 24, which talked about the need to address intervention programs, diversionary and sobering up shelters, detox programs, rehab programs and all those things. I want to explain this. Following that recommendation, we then made a comment that the program should be coordinated at the national level and funded separately. It must form part of the overall Commonwealth-state agreements on health with appropriate mechanisms for quality control, monitoring, developing standards and so on.

The reason I have gone to that length is that, when we were in the Northern Territory recently, we had a very interesting 2½-3 day visit to Darwin and Katherine. My colleagues with me on that trip will correct me if I have got this wrong, but we heard evidence that there was some 'emphasis' by the Northern Territory government, or 'encouragement'—and I am using those words in inverted commas; I do not want to misrepresent it—but that it was worse for communities to have wet canteens because there was a financial gain for them, that they could make money out of a wet canteen and put that money back into their communities. It seems to me a really weird way for any government to responsibly look for encouragement to develop some of the needs in those communities, and I was dismayed to hear that sort of evidence—I was appalled. That is my view. What is yours? And what is your knowledge of that development? It seemed a more recent thing. If you have not got that information you can get it for me and come back with it, if you will. There was definite emphasis to us that there was encouragement from a financial point of view for those communities to have a wet canteen.

CHAIR—There was an incentive.

Ms ELLIS—Incentive. At the very least an incentive.

Ms HALL—It was looked upon as that it could have some positive effect on road accidents.

Ms ELLIS—Yes. They will not have to travel so far to get drunk and drive home and run into a tree. This is seriously what was said to us up there by the Northern Territory government. To me, it seems to fly in the face totally of not only responsible government but also absolutely all of the efforts made by indigenous communities in the most genuine way to approach this issue. Does anybody have any comments, or do you want to take it on notice and find out a bit more about it if you are not aware?

Mr Ritchie—I will respond. Helen may have some comments to make. Certainly we are not aware of that rather creative approach to public policy, so I will take that on notice and find out some more about it and perhaps get back to the committee. On the surface of it, I agree with you: it would seem to fly in the face of commonsense, if not policy.

I think, particularly looking at recommendation 24 of *Health is life*, there are a couple of important things to say. Firstly, the nature of the intervention, the nature of the program needs to be reflected in community priorities and ideals. They need to arise from the community rather than be engineered or suggested elsewhere. The other thing is section 6.67 where you talk about appropriate mechanisms for quality control, monitoring, development of national standards and so forth. I am not sure that they currently exist. Well, I am sure they exist—you have the performance indicators in Aboriginal health that the states, the territories and the Commonwealth all sign off on, but NACCHO has some serious reservations about how well that sort of thing is monitored between governments anyway. It really goes to the broader issue of the constitutional problems that we have in delivering good health services to Aboriginal communities because we tend to get caught up in the interplay between 'This is a state responsibility; this is a Commonwealth responsibility.' It is not the brief of this committee but you will have heard about the issues in relation to—

Ms ELLIS—It was in relation to our previous report.

Mr Ritchie—You will have heard in relation to dental health, for example. But that is a broader systemic and contextual problem. I am not sure, short of getting a new Constitution, how one might solve that—in the short term, anyway. Helen, you may have some comments in relation to the other issue.

Ms Kehoe—I am not aware of the specific inference that you were talking about in the Northern Territory. Unfortunately, I would not be surprised if that were true because certainly anecdotally I have heard from various communities and members that sometimes the issue of substance misuse is seen not as a problem that impacts on Aboriginal people's health but as a problem that impacts on tourism or as a problem that impacts on white people's amenity in walking down the street, and that the problem needs to be solved by moving it away, out of sight, where people will not be brothered by it. So getting alcohol outlets in communities is seen, at least in some quarters I believe, as, 'Well, we have solved the alcohol problem because we do not have to worry any more about seeing drunk Aboriginal people in the street as that

certainly puts off our tourists.' So, unfortunately, there is quite a chance that what you are saying is correct. Again, anecdotally, I have been told that when wet canteens were first being discussed in Queensland it was against community wishes that those licences were granted, and that that was something pushed through by the then Queensland state government—very much against people's wishes.

Something else I wanted to touch on relates to something that Craig talked about earlier in his opening statement—communication and coordination. I know of several recent studies that have talked about this particular issue from a number of angles. One of the points in recommendation 21 was about early and opportunistic intervention programs, and you have also touched on the issue of alcohol licensing. A number of reports have been produced—Maggie Brady's *The Grog Book*, Denis Gray's work in licence regulation and the effect on communities, and a number of others—and I guess the challenge for us, obviously, sometimes is, 'Well, how do we make use of these important documents? How do we provide this information in ways that will be helpful for our communities to implement?' This is the difficulty. For a person such as myself sitting in a substance misuse job in Canberra when our communities are scattered around Australia, how do we help get that information out there and support people to use it? There is no structure in place, there is no communication network in place so that we can try to share the information around—'Look, this is the kind of thing community A use; these are some of the options you might want to consider for community B.' How do we put that information in front of people and help them use it? That is certainly one of the aims in our proposal that went to the department of health, to try to get that kind of network and structure in place so that we can actually share resources around the countryside and not make the same mistakes everywhere.

Ms ELLIS—Or continue to reinvent the wheel.

Ms Kehoe—Absolutely.

Ms ELLIS—From my knowledge of Julie and the work that is done at her centre, one of the biggest concerns of substance abuse in this region is the heroin impact that we have been having in the past, and probably still. However, overall, would you agree that the most invasive substance abuse for our indigenous communities is, from my observation, generally alcohol? If you do, how inept are we at supplying the resources to the communities—I have just given a terrible example, Northern Territory—to begin to address it? For example, take night patrols: we hear they have run out of funding and the only way they can continue is on a voluntary basis. It is really heartbreaking to see the initiatives and then see the lack of resources to actually carry them out. Am I right or wrong in suggesting that alcohol is the enormity that it is, in all sorts of senses of misuse?

Ms Daley—It depends on the community. For the services Julie and I are involved in—one is rural and one is urban—heroin is a major problem that is undermining our families.

Ms ELLIS—Yes, I do not wish to ignore that, either.

Ms Daley—It depends on the community. Petrol sniffing is a problem for some communities; alcohol is a major problem for others. We have alcohol problems in our community as well, there is no doubt about that. It comes back to having the resources at the local level so people can identify the issues and the way to address those issues appropriately in their communities.

Mr Ritchie—Statistically speaking, at a national level, on percentage terms, fewer Aboriginal people drink than non-Aboriginal people.

Ms ELLIS—Yes.

Mr Ritchie—In terms of the broader context, those Aboriginal people who do drink do a pretty good job of it.

Ms ELLIS—The impact is dramatically worse.

Mr Ritchie—In broad percentage terms that is the reality, but often it is more obvious amongst the Aboriginal people. I would agree with my colleagues that it really is a community by community issue.

CHAIR—A very appropriate reminder.

Mrs IRWIN—I want to talk about the sentences. You cover that on page 16 of your submission, where you talk about diversion from custodial sentences. I thought recommendation 11 was an excellent recommendation:

> Aboriginal people must be diverted from custodial sentences where ever possible, and likelihood of incarceration must be reduced ...

And you give the example of repealing mandatory sentencing. What do you feel are the main reasons why Aboriginal incarceration rates are as high as they are?

Ms Tongs—I think it is because of the burgeoning drug problem. A lot of our young people are dropping out of the education system and school at an earlier age—10 and 11 years old. They are getting into drugs and getting caught up in the welfare and juvenile justice systems—and then they just keep going. They go from the juvenile justice system to the remand centres and then into jail. A lot of it is historical. A lot of it is about poverty and low self-esteem, or poor housing—10 people living in a house. You might have six kids and four adults and there might be drug and alcohol abuse. That impacts on the kids. If that is the sort of life you see every day then that is the sort of life you are going to have. It takes strength and a lot of support to get the kids out of that.

Mrs IRWIN—Craig was saying earlier that it is the lack of resources and funding—if you had the money you are waiting for there is probably a lot more you could do.

Ms Daley—I see a lot of young people, particularly those that get into trouble, committing the most ridiculous crimes. They are never going to get away with it—it is more a self-harm mechanism. They are crying out for help. I have also witnessed a young person being recommended by an officer to return to the correction system because the mental health services there were better than what was on the outside.

Mrs IRWIN—What really touched me—and this is why I wanted to ask the question on custodial sentences—was a section in your submission. You are telling the story of a young Aboriginal girl, and it says:

This young Aboriginal girl was detoxed in custody, but as part of her bail conditions, she could only be released into the care of a rehabilitation centre. Even though we searched high & low it took us 3 weeks—

Appalling—

to find her a rehab bed, so she had to wait in custody for that much longer.

And that is what it all boils down to—facilities.

Ms Daley—Yes, and often you have to find the detox bed before you can get the rehab service, and finding a detox bed is very difficult. And these are services for kids under 18.

Ms Tongs—A lot of it is a symptom of other problems—there are a lot of social and emotional wellbeing issues. When people turn up to the hospital they will not accept them in the mental health ward because they have a drug problem, and they will not accept them into detox because they have a mental health problem. We talk about holistic health—we do not separate things.

CHAIR—Thank you. We have to keep moving.

Mr QUICK—I would like to place on record my disappointment that the *Health is life* report has not been responded to by this government. I think it is an indictment and an illustration of a lack of real concern. Given that the Wakelin report received unanimous support from all members of this committee and had lots of wonderful things in it, it is appalling. Following on from Julia's comments about justice: how do you see yourself, as a peak body, in having a role in prison reform—not only in relation to incarceration rates but also in changing or putting in place programs in jail that deal with pre-release, the problems of drugs while they are in jail, and housing options and support once they are released, so that we do not have this cycle of recidivism? Are any exciting things happening in any states or territories of Australia, or is it still like this: you are punished while you are there, you are let out at 6 o'clock in the morning with a handful of money, and you are on your own—if you come back in, the same thing will happen.

Mr Ritchie—My colleagues may comment further, but I think that is still, by and large, the case. In my experience in New South Wales prior to moving to the ACT, there were the beginning phases of some level of collaboration between corrections health in that state and the community controlled health sector, but that was more around the delivery of services to Aboriginal people who were in custody, not so much around the issue of prison reform and those broader structural issues. I am aware of some work like that happening. I know that the Winnunga service provides regular health services to Goulburn, which Julie can probably talk about. That is an incredibly difficult and highly stressful mode of service delivery. The problem arises—and this is a problem our chair, Dr Puggy Hunter, has highlighted again and again, and continues to highlight—that there is very little coordination between the various parts of government. Just take the one you referred to: housing. Where do people go once they are released from prison? What involvement does that arm of government have with the others? It seems like everybody is doing everything but one person is over here and another is doing something over there and they just do not talk.

Mr QUICK—People would argue that ATSIC has the capacity to develop a holistic approach. One would think that you would be the first people to develop a holistic ATSIC approach to health issues, and part of that holistic approach would be to say, 'We need to have X number of beds because we have a huge incarceration rate. That should be one of our priorities so that no-one falls outside.' If you are released from Goulburn then in the Goulburn municipality there must be some indigenous health beds and housing options as part of the holistic approach. Is that happening within ATSIC? Are you happy about that? I am putting you on the spot here.

Mr Ritchie—You are.

Mr QUICK—It is okay to say that mainstream are hopeless, but one would like to think that ATSIC has a more holistic approach to this issue, because you people understand it better than anybody else. Are there still silos within ATSIC?

Mr Ritchie—ATSIC can speak for itself but, from our perspective, ATSIC is hamstrung in lots of ways by mechanisms and arrangements within government. One would think that, in our particular area, we would be able to move towards getting it right. I guess we are moving towards getting it right. The National Aboriginal Health Strategy in 1989 talked in broad terms about intersectoral collaboration, and that strategy is in the process of revision as we speak.

Mr QUICK—That was 12 years ago.

Mr Ritchie—It was 12 years ago, but we are revising the strategy now. One of our major concerns about the current revision—it is in draft form—is that it does not, in our view, sufficiently tie in the significant other players outside the health portfolio because portfolios still exist. For example, the approach that the South Australian government is now taking is that a lot of those portfolio areas are rolled up into one portfolio in terms of health and human services. I think they are doing a similar thing in the ACT: they are putting housing and all those areas together administratively, which has the potential, at least—it remains to be seen—to move to a much more holistic and coordinated approach to a lot of these things. I am not sure I am answering your question. I do not have a great deal of familiarity with the internal workings of ATSIC. From NACCHO's perspective, we think a lot more could be done in that area.

Ms HALL—First of all, I would like to endorse the comments that Harry just made about the *Health is life* report. I am very disappointed, as are all of the members of the committee, that there has been no government response. How much consultation has there been with NACCHO at a government level on the development and implementation of policies in the area of drug abuse within the community? Secondly, how much money has NACCHO or any particular AMS received from the Tough on Drugs policy money?

Ms Kehoe—To answer the first question, in terms of formal communications regarding the national drug strategy and the specific plans which underpin that, NACCHO has been consulted to a degree about those, and has put in submissions on both illicit drugs and the alcohol national plan, which I understand is still in draft form. It is important to note too that there has been a recognition that Aboriginal issues should be dealt with separately by the Commonwealth in terms of its advisory structures regarding substance misuse. As committee members are probably aware, the national drug strategy Aboriginal and Torres Strait Islander reference group

has been established and there is an agreement that a separate and complementary strategy for Aboriginal substance misuse will be developed to sit across the separate ones. It is unfortunate that the reference group was set up over 12 months after every other of the expert advisory committee groups were set up, so it is very difficult to influence plans that have had 12 months to two years head start on where we are coming from. There is a bit of a positive move there but it is a little hampered in terms of its timing.

It is great for people to come and consult with NACCHO—that is obviously what we want—but the difficulty for me, because it comes to my desk, in getting input and struggling, for example, to put in a submission to this inquiry, is working out how we tap into what our services need and want to say. What is the consultation mechanism? We are a grassroots organisation, but without coordination and positions in states and territories it is very difficult to get that data and that communication flow. That is what the NACCHO strategic plan was about, and that is really our proposal that is being held up in the health department. Obviously, having that sort of structure in place will mean that, when we get consulted, we really can properly pass on the views of our members. For example, it is great having Julie here—but she is here because she is in Canberra. We get one service's input, but we need to be able to tap into so much more.

Ms HALL—What about the Tough on Drugs money?

Ms Kehoe—I do not think I have those statistics immediately to hand, if they are not in the submission. We did get some funding under the NIDS funding round for both the community partnerships and the other one. Whilst we did get funding—'we' meaning our services within NACCHO—to a degree under that funding round, I need to ask Lee-anne to comment on her particular experiences in the service where she did get some money under NIDS and on the reaction from the Commonwealth, because it is not always as a rosy a story as it sounds.

Ms HALL—Maybe you could submit something formally, but I am interested to hear what Lee-anne has to say too.

Ms Daley—We applied for some money under NIDS to establish an Aboriginal youth treatment centre to target Aboriginal youths with substance misuse. It was a major need out there. Our closest centre for under-18s was Sydney—which is also in the submission. We did get $150,000 for a feasibility study. There was a very strong emphasis from the government that this was one-off funding, that once we got this we were going to have to go somewhere else to find dollars to get it up and running. I had left that service then, but the feedback I have got was that, when they tried to establish some dollars with the area health service and the state health service, they were told that it was Commonwealth dollars and that they could not come back to them for the other stuff. As I understand it, that money put up to Wellington has now been used to employ a drug and alcohol worker to look at some other programs around Aboriginal youth. So it has fallen far short of what we intended it to achieve.

Mr SCHULTZ—Throughout this inquiry, the committee has repeatedly heard about the difficulties of organisations getting sufficient funding. It is true to say that the committee has also noticed that a significant amount of money has been allocated for various programs through Aboriginal health and other organisations. I think I can speak for the committee in saying that part of the problem we have is that, firstly, the accounting process is not as efficient or as pro-

fessional as it should be. Secondly, there is an enormous amount of money filtering down through the organisations handling it to the extent that a lot of that money is absorbed and you get very little—40 to 60 per cent—of the total package allocated. In your opinion, if the Aboriginal community received the money directly, is there a problem with highlighting the extent of administrative process that is absorbing money that should be coming to you? I know that most of my parliamentary colleagues on this committee agree that you should get your funding directly, because we have concerns along the lines that I have briefly outlined.

Mr Ritchie—On the issue of the community's accountability, in my view there is not a more highly accountable group of people in the country than those from Aboriginal organisations, particularly the health services. That is acknowledged by the Commonwealth department of health as well. We do have some concerns about how much money gets lost in administration, particularly within government, and many of our services receive their money directly from government. At the end of the day, a significant increase in resources—and Professor Deeble made some estimates on the additional dollars required in a paper commissioned by the AMA in the last 12 months—needs to go directly to communities. Obviously, there have to be organisations in order to receive that money. You cannot just give public money into the air. To me it is about resourcing communities. At the end of the day, you have a view that people need to pull themselves up by their bootstraps. If you had any bootstraps to begin with, it would be a good thing. This is what it is about. It is empowering Aboriginal communities to take responsibility and to deliver the services that they need, and it needs to go directly—absolutely. NACCHO and our affiliates are not funding distribution agencies anyway. I think I should make that clear.

Mr LAWLER—Several of the AMSs in my area have expressed concern about a push towards regional based funding, which they believe is supported by the organisation. What is NACCHO's position on regional based funding rather than direct funding for AMSs?

Mr Ritchie—NACCHO has long been an advocate, and continues to be an advocate, for local Aboriginal community control of health. Our concern about regionalisation of funding is that it may militate against that level of being able to tailor and deliver services to local communities. I am aware that in New South Wales there is concern about regionalisation processes. I should say that, as far back as the last two federal budgets, NACCHO and its member services have been involved in a process of regional planning and have been looking at developing local Aboriginal health plans. I know that in New South Wales there are very specific local Aboriginal health plans for each Aboriginal community. NACCHO is advocating that they be resourced. It is one thing to fund against a regional plan and to fund organisations in the context of a regional plan, but it is another thing to fund through a regional authority. I think that is the concern of people, particularly those who are tied to the regionalisation process that ATSIC has been going through over the last couple of years in devolving a lot of their administration to regions. We have some concerns about regional authorities subverting the role of local communities and determining priorities.

CHAIR—I thank NACCHO for a very comprehensive and thorough presentation.

Mr Ritchie—We have some copies of our strategic planning which we are happy to leave for the committee.

CHAIR—Thank you very much.

[11.02 a.m.]

BATH, Ms Nicky, Policy Officer, Australian Intravenous League

BYRNE, Ms Jude, Education Program Manager, Australian Intravenous League

MADDEN, Ms Annie, Executive Officer, Australian Intravenous League

CHAIR—I welcome representatives of the Australian Intravenous League and invite you to make a brief presentation.

Ms Madden—The Australian Intravenous League is the national drug users organisation. I thought it was important, based on some of the discussion earlier, to say that I am an injecting drug user and have been for the past 15 years. I am also on methadone and have been for the last eight years. I think it is important to say to you also that I feel very strongly that without methadone it is very likely that I would not be sitting before you here today. I think it is important for you to have the chance to speak to people who have directly experienced methadone, and for me to speak about how that has improved my life and the lives of a lot of other people. I understand the concerns about methadone. This is a good chance for you to ask some questions directly in that regard.

Ms Byrne—Like Annie, I have been part of the injecting drug using community for 25 years and I have been on methadone for the last 11. I have three children, a husband, and I think quite a happy and successful life.

Ms Madden—I would like to thank the committee for inviting us to present to you today. As you are aware, we made a submission to the inquiry about 11 months ago. Given that we have only a few minutes, rather than going over any of the issues in the submission we will raise a few issues that we believe have emerged since we put in that submission, as they relate to your terms of reference. The only thing that we do wish to say about our original submission is that we obviously stand by all the issues we raised in it and to state that, for the record, we are disappointed to have to say that, unfortunately, in our opinion the problems and issues identified in the AIVL submission are still problems and issues today, almost 12 months later.

Turning to new or emerging issues in relation to the first term of reference for the committee—that is, the overview of the social and economic impact of current approaches to the use of licit and illicit drugs in Australia—one of the issues we want to raise involves emerging issues and is about level of complacency in Australia in relation to HIV-AIDS and injecting drug users. Although we have a world-leading national strategy for HIV, the very low levels of HIV among IDU have meant that the past few years have seen an increasing complacency and a sense that Australia has dealt with this issue and that the job is finished. While AIVL genuinely wish that this is the case, we know it is likely that the job may never truly be done when it comes to this issue and that the best we can do is to work constantly and strenuously to prevent the number of infections rising.

The fact Australia must face is that we have a large and growing HIV epidemic in almost all of the countries in our region. In Asia it is the injecting drug users, not gay men, who are the main affected community when it comes to HIV. People are travelling between countries in the region more than ever before, and I know that I do not need to talk to this committee about the fluid nature of the illicit drugs trade in our region. In Australia, too, there have recently been a number of situations that are cause for concern, including an HIV scare in one of Australia's largest prisons, where a known HIV-positive inmate was found to have shared his syringe with many other inmates in the prison. With short sentences, the high mobility of prisoners within the system and no NSP in prisons it is not difficult to see how this situation could quite easily lead to a dramatic escalation in the number of HIV cases among injecting drug users.

As well as this, the year 2000 HIV-AIDS statistics for Victoria show a doubling, a 100 per cent increase, in the number of HIV diagnoses among one section of the IDU community. While it is important to stress that these numbers are still very low because of the low levels of infection we are beginning with, AIVL believes it is very dangerous to ignore this situation at this point in time. Overseas examples have shown that HIV infection rates among IDU can increase from less than five per cent to almost 30 per cent in 12 to 18 months. Such an increase would be a disaster for the Australian community, and we believe we must renew and redouble our efforts in this area.

The second issue we want to raise under your first term of reference and which has already been talked about today is the so-called heroin drought. Basically, we want to raise the health and social impacts that this brief reduction in the availability of heroin has had across Australia. As you know, there are many debates about what actually caused the drought, but perhaps more important is the negative impact that this temporary drought had while it was happening and is still having now that it is over. A simple analysis may see a heroin drought as an inherently good thing; however, the recent drought in Australia has simply led to desperation, increased violence and crime, suffering and, now, increased levels of heroin overdose. AIVL believe that the desperation and suffering were caused by an inadequate drug treatment system that was left unable to cope with the increased demand, which meant that people who wanted to get into treatment ended up simply using a larger variety of substances in a more dangerous manner.

In particular it showed that, while relatively large amounts of funding have been poured into the drug treatment area in the last few years, it is not making it to the types of treatments that are in demand—that is, methadone programs. Too often the money is going to 12-step abstinence based programs which, although they have their place, are not where the treatment demand lies. Increased crime and violence associated with the heroin drought came from the increased price that people had to pay for heroin so, rather than the drought decreasing the demand for heroin, it simply pushed the stakes higher in terms of what people had to do to get it. We are concerned that the heroin drought caused a lot more problems than it solved, as has been said earlier today. We are also concerned about the idea that the drought is still going, because our information from our peer based groups tells us that heroin is now available pretty much to pre-drought levels in most areas.

We also want to raise issues in relation to family and relationships, which are primarily about Naltrexone. We are concerned about the impact that Naltrexone treatment is having on some drug users and their families. There are two issues: a recent study in WA showed that, of over 3,500 heroin users, people using heroin on the street are less likely to die than people who are

on the Naltrexone program. The statistics are: one in 100 people for people using on the street; one in 61 for people who are on the Naltrexone program; and one in 458 for people who are on methadone.

We are also concerned about the unregulated nature of some of the private clinics who are doing naltrexone. They are charging large amounts of money. Some people are mortgaging their houses to put their children into these treatments and they are not being given realistic expectations of the likely success of those programs.

Finally, although we are aware of the politically sensitive nature of such trials, we would like to call on the committee to support the current trial of the medically supervised injecting facility in New South Wales. We believe there is a growing body of evidence to support such a trial, particularly in reducing morbidity and mortality. We would also like to call on the committee to support a future trial of heroin prescription programs based on the same overseas evidence that shows that such programs not only significantly improve health and social outcomes for participants but also directly break the link between crime and illicit drug use.

CHAIR—Do you know of any statistic or anyone that has been able to make the move from heroin to methadone and off?

Ms Madden—There are quite a few people who do that. I suppose we do not hear from them because they get on with their lives. They come off the program and they are not people who are obvious to the public. I can certainly get back to you with a concrete reference on this. For treatment programs in general, the general statistics are around 50 per cent of people who go into drug treatment broadly have a successful outcome. One of the things we do need to be careful with is our definition of success. I, clearly, and Jude as well, are examples of people who are continuing on the methadone program but for all intents and purposes are success stories for that program. We work full-time. We have families. We are not using. I stay on methadone because it provides me with the stability to keep that lifestyle there. I would rather stay on methadone for the rest of my life than risk going back to a problematic lifestyle just because I felt the pressure to come off methadone. I think there are a lot of people in that situation.

CHAIR—Do you have a view on dosage rates?

Ms Madden—To suppose what the previous speaker said, I think one of the reasons we see such a fluctuation in dosage rates is because it is such an individual thing. You are talking about a drug where people develop a physical tolerance, so some people need more to prevent withdrawal than others. Personally, I am on a low dose and moving downwards, but I know people who are on higher doses and that is right for them. They need to be there because otherwise they may go back to using.

Mr QUICK—We have some information in the AMA submission that there were 112,600 recent heroin users in 1998, of which 15,500 were teenagers. Do you have any actual figures as to the number of heroin users in Australia? Is that a fair dinkum figure?

Ms Madden—I would suggest that is quite low, but I understand it is talking about a specific group of heroin users—young people.

Mr QUICK—No; it says 112,600 recent heroin users in one year, of which 15,500 were teenagers. Who knows, if you guys don't?

Ms Madden—It is a very difficult thing to estimate. Because it is an illicit behaviour, a lot of people are forced underground by that behaviour and do not necessarily come forward for census or for surveys, so it is very difficult to estimate. There is one group who has worked out a formula called the Delphi formula. It was done in conjunction with the national hepatitis C strategy. It is a report called *Hepatitis C projections report*. It was authored by the National Centre in HIV Epidemiology and Clinical Research. It estimates through that formula that there are probably over 200,000 regular heroin users.

Mr QUICK—So it is about two per cent of the Australian population?

Ms Madden—Yes. And that is consistent with what the household survey has shown as well.

Mr QUICK—The AMA submission also says that 80 per cent of deaths are tobacco related, 16 per cent are alcohol related and four per cent are related to illicit drugs. Is there a media hype about it? The number of deaths is four per cent, and it is the same with hospitalisation—four per cent. You would read the newspapers, you would have watched *A Current Affair* last night, and you would think, 'Holy hell! The whole world is coming apart.' But we are only talking about four per cent of deaths and hospitalisations, of just over two per cent of the total Australian population, and yet money is being printed and thrown away like a person with no arms! Have we got it all wrong? Is this just an issue because you see the ambulance race around and a body in Victoria Street in Melbourne or in Cabramatta or Kings Cross is so evident, when 96 per cent of people in hospitals that are dying have nothing to do with illicit drugs—they are legal?

Ms Madden—To an extent you are right. I think that to an extent there is a media focus on these issues. It is a very emotional and politically sensitive issue so it is quite easy to 'beat it up'. But also it is important to understand that it is the smallest percentage. There are a lot of illicit drug users and a lot of those people are using drugs in a very 'functional' way. They do not come to the attention of health services. They do not come to the attention of ambulance services. They do not need those services. But there is a small percentage of people who do actually use the bulk of illicit drugs and so there is a large amount of harm occurring in that small percentage. Often those people are young people, and that is why the community is very concerned about this issue. Everyone has the right to live and so we want to save those lives if we can, and it is important to have services that ensure that. But you are right: there is a lot of emotional beat-up about this issue as well.

Mr QUICK—This question is probably way out of left field, but I think we need to think way outside the square: legalisation of marijuana. Do we say to those 200,000 Australians, 'We will prescribe it. The crime rate will go down. Our house insurance rates will go down'? Do you have an opinion on that?

Ms Madden—An organisation like ours does support strategies to look at better ways to manage illicit drugs than the current system. We are not predicting that legalisation is the best way to go—because we do not know that—but we do feel that we should be trialling whatever we think we can, based particularly on experience overseas. There are a lot of examples overseas where such programs have been trialled or are in place where there are really good

outcomes. There is an onus on us to look at such programs and assess whether we think on balance of probability it is worth trialling ourselves. But there are a range of issues that we could say the same thing about in that regard. I think it is a question for the whole community, not just organisations like ours.

Mr QUICK—Why do we need a trial? Why can't we just do it? There have been trials and trials and trials all over the place. Why can't we just say, 'We are going to have safe injecting rooms in every capital city and every city over 250,000. Let's go and do it'?

Ms Madden—I would be more than happy for you to make that decision, but I am saying that it is a decision for the entire community, and the entire community has to feel safe and happy with that decision, not just a small proportion of it. On that basis, the majority of the community, it is my understanding, would like to trial it.

Mr SCHULTZ—I am interested in the fact that your organisation say they are concerned about the use of illicit drugs in the community yet they encourage the continuation and indeed the expansion of the needle-syringe exchange program. How can you justify that in an environment where, since the needle-syringe program, the use of heroin, the deaths resulting from heroin and the increase in hepatitis C is getting to the point where it is becoming uncontrollable? I would have thought that any responsible member of the community, whether they be former users of illicit drugs or not, would have been looking at the health outcomes for people. Can I finish off by asking you the question: how many milligrams of methadone are you on daily?

Ms Madden—To take the last one first, I am not sure it is relevant to the committee to tell you how much methadone I am on. I am happy to share with you that I am on methadone and my experience of the methadone program and the issues for people on methadone but I am not sure that it is relevant for me to say how much I am on.

Mr SCHULTZ—I will put it another way to save you that embarrassment.

Ms Madden—What embarrassment?

Mr SCHULTZ—I have just read a journal of the Health Care Complaints Commission and some of the case studies in that are really horrifying in terms of the amount of methadone that people are being subjected to by their GPs. As an example, 30 grams was prescribed to one individual because of the type of person he was—he was getting 85 grams. Does that sort of thing disturb you? That does not indicate to me that that program is helping people stay away from their addiction to heroin, for example. It is in fact creating another massive problem for them, turning their addiction to methadone in an environment where, I would have thought, that the best medical outcome for those people was to put them on the methadone program and slowly get them off their addiction over a period of time.

CHAIR—I am acutely aware of your time lines, so you might like to make a brief response and then go.

Ms Madden—I am not a medical practitioner; the dose and what level a person is on is an issue for that person and their medical practitioner. I very much support that people need to indi-

vidually negotiate that—like any other health issue, like any other medication. I am sure there are good reasons why the medical practitioner has that person on whatever dose they are on. If the person is not happy on that dose, then they need to negotiate that with their medical practitioner. On the issue of needle exchange, there are a lot of issues that you have put together there. I think it is very important to be clear that the needle and syringe program was commenced in this country for one objective and one objective only—that was to reduce the level of HIV-AIDS transmission in this country.

Mr SCHULTZ—It has not done that.

Mrs IRWIN—It has; look at the statistics.

Ms Madden—That is something that in our opinion is not disputable. We have one of the lowest rates of HIV-AIDS of any country in the world. It is less than five per cent and it has consistently stayed at that level for over 10 years.

Mr SCHULTZ—Because of the use of condoms.

Ms Madden—No, through injecting drug use. I am specifically talking about the transmission of HIV through injecting drug use, not through unprotected sex.

CHAIR—Annie, I think you have made your point. If you want to add anything, by all means do so, but I know you have a time line; you must rush.

Ms Madden—Thank you for your time.

Mr LAWLER—I was not sure about the comment that Annie was making about the death rate of people on naltrexone. Clearly, if someone is on naltrexone treatment and they are using, they are more likely to overdose than someone who is not on naltrexone. As a group, are you not in favour of naltrexone being a part of the treatment regime? If you wanted to make a true analysis of the use of naltrexone, then you probably should look at the death rate of people who have been treated on naltrexone and are off and include all of those people in the statistics, and I would imagine that the percentage would then be dramatically lower.

Ms Byrne—No, it is actually higher.

Mr LAWLER—But what if you included the people who had been successfully treated with naltrexone and had kicked the habit and were not using?

Ms Byrne—There is some evidence to suggest that, when people come off naltrexone, that is when they are overdosing because their tolerance has dropped so much with the use of the drug, and that they then go back to drug use. What we are saying about naltrexone is that it has not been tested properly. Doctors out there are giving naltrexone and they do not actually know what they are doing. They are not giving it to the people that best practice says there is a certain clientele that naltrexone will work for. These doctors are giving it to anybody who walks into the office; they are not offering them support and all the other attendant things that need to go with any sort of drug rehab or detox. It is like cowboy country, and doctors are treating it like a free-for-all to make money—that is what we are complaining about. We think any drug that will

help somebody overcome their problems with drugs needs to be looked at, but it needs to be looked at in a scientific and best practice manner.

Mr LAWLER—I am sure the guys who are treating out of Westmead Hospital are doing it well, but you are probably right, there are probably some who are not.

Ms Byrne—Some are, but there is a doctor in Perth and another one in Queensland that everyone is very concerned about. They are doing absolutely appalling treatments on people.

Dr WASHER—Could you elaborate for the committee just what it means to be on a methadone program, what supervision is prescribed, what the costs are, what the access to methadone is, et cetera?

Ms Byrne—As I said, I have been on methadone for 10 years. I am still getting the same methadone treatment as an 18-year-old chaotic drug user. I can get three takeaways a week; I have to go to the chemist four or five days a week; I am still doing urines. I am 44 years old; I am quite in control of my life. I actually think the way they are doing methadone treatment at the moment is entirely inappropriate. We have lots of people who want methadone and we are keeping people like me in this quarantine sort of situation. I do not need that sort of treatment. They could give me takeaways and free up my spot for somebody else who would actually benefit from it.

The methadone program is a very invasive and difficult program, but it is a choice you make on quality of life. If I have to turn up to the chemist every day, wait for 20 minutes while they serve everybody else and do a urinal in front of somebody I do not know, I will do it. But it is not something that you do easily, and it is not something that you do without thinking very hard about it. I think there is lots of room for improvement in our methadone program.

Dr WASHER—The other point that was mentioned, I think by Annie, is the need for possible heroin injection trials. Can you tell the committee why that would be, Jude?

Ms Byrne—Methadone and other drug treatments do not work for lots of users. We have had lots of people up here today, but nobody understands addiction and nobody understands why some people become problematic users, which some of them do. Why then do we just let them lead these terrible chaotic lives when we know that, if we gave them heroin in a controlled setting, in many ways they could take their lives back? This is about human beings; this is not about animals in a laboratory. If we know something is going to work, why don't we do it? It clearly does work for so many people. It just seems to be something that people cannot get their heads around because of the emotion and the illicit nature of the drug. But absolutely I think heroin trials should be tried. I think we should have amphetamine trials; I think we should have cocaine trials; I think we should have trials for everything. That should be the case for any drug that anybody ruins their life over—I do not think it is necessary and I do not think it has to be like that.

Mr QUICK—So, Jude, how do we change the public perception about this whole thing? It is like cancer and AIDS and a whole lot of other things: you do not want to know unless it hits your family, and then it is too late.

Ms Byrne—That is it. I said to my sister 10 years ago that we will get no change until every politician in the country either has lost a child or has had some sort of trouble with illicit drugs. The only people who seem to be reasonable and rational in this debate are people who have had some sort of personal impact. It is their child that they love; it is not some filthy drug addict lying in the street. I think that is what is going to turn this debate around.

Mr QUICK—But every federal politician, member and senator will tell you that we know about stacks of families that are falling apart or are trying to cope. So it is not that we do not know about it. We can change all the laws under the sun, but out there in our neck of the woods there are heaps of our constituents who are scared witless that if you legalise marijuana—which is a $5 billion industry that is not being taxed—suddenly every second kid will be an addict. There is this sequential belief, yet those people who have these crazy beliefs go down and get themselves—

Ms Byrne—On television.

Mr QUICK—Well, on TV, but they also go down to the pub, get a couple of slabs and say to their kids, 'You can go and get drunk on Saturday afternoon.' We have schoolies parties in northern NSW and southern Queensland, and that seems to be a norm. It is an Australian psyche: you can smoke yourself to death, you can drink yourself to death, but stick something in your arm and you are the worst bloody fiend imaginable.

Ms Byrne—I think, as Julia mentioned before, the media has a hell of a big part to play in this. The media seems to breed on misinformation and lies. If people were actually given some of the facts around illicit drug use, I do not think we would have the hysteria that we have, but we do not seem to be able to get a reasonable debate about it. Any time we come close to it, one of the newspapers tends to beat up this story about something which is entirely untrue, and people take it as gospel. I really do not know; I wish I did, but I have no idea.

Mr QUICK—No-one else around the world has done it either, have they?

Ms Byrne—No. I think the Dutch have come as close as anybody else has, by having reasonable debate and making it a public health issue rather than a criminal issue. They do not try to demonise and beat up drug users and treat them as people who have come down from another planet.

Ms ELLIS—I want to throw in a couple of thoughts following that discussion. I gently disagree with what you just said, because I think we are the last people, in fact, who need to experience it to understand it. The reason I am saying this is that in our travels around the country—and this is the frustration for us, for you and for everybody else working on this—we have had people come in front of us who have lost children, and they have different views on how to approach it. We have spoken to people who have been addicted who are now not, and they have different views on how to approach it. I think what all of us have to do is somehow keep leading the debate—that is, the politicians who want to, the people in the community who want to, people like you who want to—to try to stop the polarisation of the arguments and the moralising of the arguments.

I am sure that if we did a straw poll now—which I have no intention of doing—we would find people in this room who would be in favour of or absolutely, to the extreme corner of the room, against different ways of approaching the issue, even though we are all here with the same motive. That is our frustration and the hardest thing and that is why we are having the inquiry. We somehow need to break through that. I just frankly think the issue needs leadership. I am not talking about leadership politically but leadership right through every level and stratum of the community.

I am talking about those who have the views leading through, despite all of those polarised views, and somehow getting to the point where we can actually start to have the intestinal fortitude as a community to approach it with the most honest motives, regardless of our agendas or difficulties. I have some difficulties with some things, but I do not have the ability to say no to them because I might be condemning someone to something. I just think that we need to deal with it at that level, because the hardest thing for me is to have two parents sitting in front of me, both of whom have been touched so deeply and both of whom have completely different suggestions to us as to what to do.

Now how do we as human beings—for that is all we are—deal with that? We can only deal with that if the community is willing to deal with it with us. It is a whole of community issue and I think that we need to see more people like you and Annie and your community—people like you who are demonised by many in our community—in a forum like this where you can be exposed and seen for what you are, what you are doing and what you are achieving, rather than having people knocking you on the head.

Ms Byrne—One of the problems is that most functional users, unlike Annie and me who are actually working in the drug field—it is okay to be an injecting drug user working where we work; that is why we have our jobs—do not dare to come out, because they will lose their jobs.

Ms ELLIS—Exactly.

Ms Byrne—So the community—

Ms ELLIS—That is exactly the point.

Ms Byrne—never actually sees those with a level of functional drug use or sees that it does not have to be this complete disaster that is always portrayed. But until there is less demonisation we are not going to get those public figures standing up and saying, 'Look, I have done it for years and I am okay with it.' They are not prepared to put their necks on the block at the moment because it is just too damaging.

Ms ELLIS—I think we all understand the severity of the difficulties.

Ms Byrne—Yes, we often plead with people, 'Please, we need some advocates on this—

Ms ELLIS—Exactly.

Ms Byrne—but we just cannot get them at the moment.'

Ms ELLIS—I could not agree more.

Mrs IRWIN—Following on from that, Chair, I think it is correct what you were saying earlier, that the media has a lot to answer for.

Ms Byrne—Absolutely.

Mrs IRWIN—I would like to find a journalist who is prepared to come out and actually tell the truth as it is. I think that as a community we have to work in partnership; we have to have local government, state and federal governments that have the guts—and excuse me for saying this, Chair, the balls—to do something about it, whether it is safe injection rooms or heroin on prescription. What it boils down to is that it is a life—

Ms Byrne—That is exactly right.

Mrs IRWIN—and the most important thing that we have to do is to save that life. I just want that on the record, Chair.

CHAIR—Thank you. Jude would like to respond.

Ms Byrne—Drug users often say that the *Telegraph* single-handedly stymied the heroin trial, because they did this amazing beat-up, relentlessly, week after week, about that trial. Many of us will not buy it on principle now, because we think—

Ms ELLIS—When we were in Melbourne for a committee hearing we went to the Melbourne City Council. The day we were there we got a very good, useful briefing on what the Melbourne City Council were attempting to do in identifying and recognising the issue within the business district and so on. On the very same day we were there, the *Herald Sun* were running double- and four-page feature articles with derogatory photos and saying, 'Move them on, move them on.' Remember? They were the headlines. The very day we were sitting reading this paper the Melbourne City Council workers were telling us how they were attempting to deal with it, not by moving them on but by dealing with it. I will never forget that, because the newspaper articles were appalling. All they wanted to do was treat these people as a bit of garbage, cluttering up the laneways, that they needed to somehow dispose of. That is what we are talking about when we talk about bad media.

CHAIR—Okay.

Ms ELLIS—Sorry.

CHAIR—That is fine. Thank you. Nicky, did you want to add anything?

Ms Bath—Just to reinforce what has been said. I think the media issue is a really sensitive one. I see it as part of my job each day to look at the media clippings and I am appalled by the language that is used to describe drug users in Australia. Language described by the communities would be held up in court, I think. The issues are contentious and sensitive and bring a lot of emotion. The chance for us to be able to be here today to address you in this way

has been fantastic for AIVL and for illicit drug users across Australia. And I want to back up what has been said, that it is really important that the role of drug users be taken into consideration at all levels within government and within the community and that they address the issue of drug use. Thank you.

CHAIR—Thank you very much, Jude and Nicky, and Annie in her absence.

[11.38 a.m.]

MARTIN, Dr Carmel, Director, Health Services Department, Australian Medical Association

MURRAY, Ms Joanne, Youth Health Advocate, Australian Medical Association

PRING, Dr Bill, Chair, Public Health and Aged Care Committee, Australian Medical Association

STOCKHAUSEN, Dr Kate, Senior Research Officer, Australian Medical Association

CHAIR—I welcome the representatives of the AMA. Bill, you might like to make a short opening statement and others may wish to add to it.

Dr Pring—I thank the committee very much for the opportunity to update you on some extra information beyond our submission, and perhaps I will just emphasise a couple of points. I was actually very encouraged by the comments I heard before of the parliamentarians wanting to form partnerships with the community because I think that is what it is all about. It is community awareness raising, and I think that it is very important that that continues.

The AMA is trying to do its part by forming partnerships with other drug control agencies and organisations in the community. On 22 March this year we were able to host a national drugs roundtable where we brought all those organisations together and looked at the evidence base for treatments, rehabilitation, prevention, research, and strategies across the board in all the areas of tobacco, alcohol and illicit drug control strategies. It was a very exciting meeting. We were able to have a joint communique signed—and I think you may have been provided with copies of that—with 17 signatories. The essence of it is a call to the community really and to the parliamentarians for this community initiative of partnership.

We have asked for a multiparty strategy on substance abuse control. We feel that is very important. We have asked for increased funding. One of the things that we noticed over and over again is that drug control organisations are low funded compared to an industry which, in each case really, is worth billions of dollars and uses those billions of dollars to make sure that people want to keep consuming tobacco—and a large industry, alcohol. In fact, the illicit drug industry is probably a well-subsidised industry, it is just not in the general domain. We want to prevent drug deaths and morbidity associated with substance abuse. We suggested for the May 2001 budget that there be an additional $186 million per year funding for drug control strategies over four years, but balanced by a net new revenue of $118.8 million a year; therefore, a net cost of around $68 million per year over the next four years. It is actually not big money compared to the huge industries that we are working against in a sense.

The roundtable also endorsed specific strategies with an emphasis on decreasing drug and alcohol harm. Those strategies were to increase taxes on alcohol and tobacco. We have pushed for a volumetric alcohol beverage tax. We have suggested that the excise on low alcohol products be reduced, and that money be put into research on why children and young people

take up drug use and drug abuse. Briefly, the details are that for tobacco we have suggested that $100 million a year extra be spent—this would be balanced by increase in excise tax revenue—and that spending for alcohol control strategies be increased by $18.8 million per year, again balanced, therefore a cost neutral exercise by tax revenue. We have asked that illicit drug spending be increased by $165 million over four years; that the national indigenous substance misuse strategy be increased in funding by $55 million over four years; and that specific strategies directed to children, young people and families be increased by $50 million over the four years.

In addition, we have asked for clearly delineated and visible funding of drug control initiatives through Medicare and the Medicare agreements so that we see that money being spent on those strategies and not going into other areas. We have also asked that all levels of government seek to show accountability for the funding that is going into drug control strategies so we can see what funds are actually being used, what they are being used for, and the outcomes of that spending—an evidence base. We are encouraging an evidence based policy, in a sense, and we would look at what spending is occurring and what the outcomes are. I think there are abundant reasons to be increasing our funding for drug control.

Mr QUICK—What do you mean by drug control?

Dr Pring—Drug control strategies include the broad range of prevention, treatment, rehabilitation, education and research. All of those. There are multiple strategies in that area.

Mr QUICK—Is 'control' the right word? One of the things about this debate is that there are phrases and words which mean different things to different groups, whether they are publicised in the media or not. 'Harm minimisation' is a glib phrase but it means different things to different people.

Dr Pring—Yes.

Mr QUICK—And 'prohibition' and 'control': you talk about gun control and drug control. We need to elaborate.

Dr Pring—Unfortunately a lot of these terms, as you are indicating, tend to polarise people too. Is it use minimisation or harm minimisation? People seem to polarise whereas truly evidence based strategies often cross those things. No-one is saying that one does not want to try to achieve decreased usage but we have also got to try to decrease the harm associated with drug use. I think that often, for people with drug use problems, there are multiple problems. I was going to draw attention to the fact that a number of people with drug use problems have mental health problems as well. As one of my colleagues has said, we have to cherish the strides we can make; we have to cherish the achievements that we can manage to make in this area. The problems are so large.

Mr QUICK—I would rather have 'staying alive' than 'harm minimisation'. Staying alive has this holistic meaning but that is just my opinion.

Dr Pring—This is where I feel these terms tend to polarise, but unnecessarily so. Staying alive is very much a part of harm minimisation. We want people not to die; we want them to

live longer. Ideally they would stop misusing drugs but if we cannot totally achieve that then it is worth achieving increased years of life lived et cetera.

Mr QUICK—So why is the smallest amount of money for children, young people and families when all the international and national evidence says the cost benefit of early intervention is proven?

CHAIR—Harry, we need to finish the presentation and then we will come to questions. I allowed one or two questions but we need to focus a bit.

Mr QUICK—Yes.

Dr Pring—I would like to finish off a few more comments. The reason that we are concerned is because of the $19 billion it is estimated that drug abuse costs the Australian community. There has been a report by the Australian Institute of Health and Welfare for 1998 published just recently which shows that there is approximately a $19 billion cost mainly in terms of health care costs, property crime, increased law enforcement costs, decreased workplace productivity. What is not easily costed is the breakdown in families and relationships and the suffering of the individuals. Against that, $4 billion has been received in the 1997-98 financial year in alcohol and tobacco taxes. Of that, $36 million was spent on drug treatment and rehabilitation programs—about 0.9 per cent. Tobacco control funding has done particularly poorly out of the revenue from excise. The morbidity and mortality data in the Australian Institute of Health and Welfare statistics shows that some 23,000 people die each year from drug abuse problems in Australia. It has been estimated that there is approximately 230,000 potential years of life lost.

CHAIR—Bill, how long did you want to go for in terms of your presentation here?

Dr Pring—I am coming to the end.

CHAIR—I have two people who have to go at midday and they would like to ask questions and we need to wind up by about 12.35—just to give you an idea of time lines.

Dr Pring—If I can just wind up by referring to some final points where, essentially, in summary, we are calling for partnerships. We are hoping that the politicians can join together in a multiparty strategy. We want to have evidence based strategies in place with clear delineation of the spending and good evidence based measurement of the outcomes. We would also call, as another issue, for a youth peak body. We are very concerned about youth and the youth peak body ceased a couple of years ago. We believe that might be a useful extra strategy.

CHAIR—Thank you. Does anybody want to quickly add anything else?

Mrs IRWIN—I would like to refer to your submission on page 12. I only have two questions, mainly to do with recommendations. Firstly, it is stated here that:

In order to reduce the risk of disease transmission via injecting drug use, the AMA recommends:

And there were a number of recommendations. One of the recommendations was:

The implementation of needle-exchange programs, particularly in prisons.

Are you aware of any successful programs in any of the jails within Australia?

Dr Pring—I do not know of programs within Australia, but I believe that there are programs overseas that have been successful. That is my understanding. It is mainly based on overseas research.

Mrs IRWIN—Could you give us a brief background on the overseas programs?

Dr Pring—No, not offhand.

Dr Martin—I think Edinburgh is where it is the most successful and the research has been done. Certainly, there have been successful programs.

Ms HALL—Could you send something to us in writing?

Dr Martin—Yes.

Mrs IRWIN—That would be great if you could take that on notice. The other question I would like to ask you—and I am going to quote again—concerns doctor shopping, which is of great concern to me and I am sure to a lot of members around the table here. You stated that:

The AMA is particularly concerned with 'doctor-shoppers', or more precisely, 'prescription-shoppers', that consult multiple medical practitioners—

And then it goes on. But your recommendation is that:

'Prescription shoppers', as defined by the HIC, should be counselled by the HIC as to their excessive use of medical services and pharmaceutical products.

What types of systems are in place to detect this abuse? I am just looking at the notes I have down here. What changes would you like to make, and has there been any discussion about a national database?

Dr Martin—We have a very good system. The Health Insurance Commission has been running this program, and they identify through the pharmacist, through the GP or through hotlines. They do have a database of people and they do give advice. It is an excellent program. They give advice to the prescriber and the dispenser, and they also offer counselling to the 'doctor shoppers' or 'prescription shoppers'. I think Australia has a leading system here.

Mrs IRWIN—You do not feel that it is being abused?

Dr Pring—In what way?

Mrs IRWIN—The reason I am saying this is that I had a constituent who came to see me recently. It was actually the constituent's 16-year-old daughter who felt that she had no place to go. Mum was 'doctor shopping' mainly for valium. She was going to one doctor, and then she

would hop on the train and go to another suburb to get another prescription. She just felt that her hands were completely tied.

Dr Pring—The thing about the HIC program is that it has its limits because it is based on computerised detection, essentially, of people visiting multiple doctors in a certain length of time. They are very conscious of the privacy aspects of it as well, and of imposing by using the HIC database. On the other hand, they do try to counsel people and if people are interested in receiving help then they can refer them to appropriate sources of help in their area. It is an excellent program, but it has its limitations because it is based on the HIC computer database. It may be worth that daughter contacting the HIC. Her mother perhaps has not come up on the HIC computer yet, and yet I am sure the HIC officials would be helpful in helping to direct that person to agencies locally.

Mrs IRWIN—What is the AMA's views on heroin on prescription?

Dr Pring—As we have said, we are in favour of trials of a number of different drug control strategies and that is one where we would be quite happy to see a proper evaluative trial occur. We are in favour of scientific trials of such things in the first instance.

Ms ELLIS—When we were in the Northern Territory many folk told us that heroin was not the big problem, morphine was in terms of usage levels and that access was through prescriptions from doctors. It raises two issues for me, and they are quite converse to each other. One of them is doctor shopping but also the readiness of some versus the non-readiness of others to assist as they see it in the prescription of such a substance. On the other side of the coin is also the hypothesis we could draw, if we wished to, about the consideration of a prescription substance—I am using that word because I do not want to necessarily say 'heroin' because in this case it is morphine. Are you at all aware of that situation in the Top End? Whether or not you are, do you have a view on either side of that discussion?

Dr Pring—We are aware that there is sometimes a misuse of prescription drugs. We are the first to acknowledge that doctors need to lift their game too. One of the things I did not get to say was that we believe there needs to be adequate funding for training of doctors and remuneration for proper work in the area. We are not against further examination of our practices, and what is appropriate and what is not. I suggest that the indications would be that there are very few doctors who are cowboys and are deliberately or unconscionably doing this consciously. There probably are areas of less adequate practice, and it is partly related to the lack of appropriate funding for training and incorporation of strategies in the medical area.

It is a very exciting time for medical drug treatment and rehabilitation because there are a whole lot of new strategies, not just medications but including new medications, that doctors can use. There has been a tendency over the last few years for the medical side to drop out of the spectrum a little bit in substance use control strategies, but we are very keen to take a leadership role, not by ourselves but in partnership with the other drug control agencies, with proper training to work on the issues with evidence based treatments and with guidelines to be really effective and deliver value for money.

Ms ELLIS—In the Darwin experience, if the evidence to us is that substance abuse is being assisted somewhat by prescription of morphine, do you think if we are going to run all these de-

bates that we should have a proper look at what is happening to the health of those users, to the crime rates, to the family relationship stuff and to the whole thing? I am not wishing to sound one way or the other in favour of prescription drugs, but I am saying that if we have something happening then would we be foolish not to look at the outcome of that, whatever that outcome may be—good, bad or otherwise?

Dr Pring—I do not know the details of the information you are saying, and one of the first things I will do when I get back to the office is make some inquiries. This is the problem with a lack of adequate evidence in a lot of areas. With proper evidence the medical profession would be happy to act to try to correct any discrepancies or problems that may be occurring.

Ms ELLIS—I do not wish the questions I have asked to be in any way transmitted by osmosis to Darwin where we actually have more practitioners thinking that we are thinking this is a good idea. It is just that, if something is happening, we need to look at it from all angles.

Dr Pring—A collaborative approach.

Ms ELLIS—Absolutely.

Mr SCHULTZ—In the summary of your recommendations in relation to illicit drugs, in the second paragraph of that document you refer to a survey. The words are:

> This survey estimated that there were almost 110,000 injecting drug users in Australia, 12,000 of which were teenagers. The AMA notes (pg 11) that for first-time users, the source of illicit drugs is almost always friends and acquaintances, and users of some drugs subsequently progress to street dealers

I am assuming that the figures that you used were the figures that were quoted in the AIHW *1998 national drug strategy household survey*. If so, how are we, as parliamentarians—and, indeed, the community—able to ascertain which are the true figures and which are not? I have figures here from the Australian Institute of Health and Welfare—these are earlier figures than the ones quoted. They estimated that the number of heroin users in Australia had grown from 109,000 in 1986 to 172,000 by 1990. That is an accumulative growth rate of approximately 12.1 per cent per annum. It would indicate to me that if that growth rate of 12.1 per cent were true, we would be looking at somewhere in the vicinity of 480,000 heroin users in this country. The point that I am making is that there appears to be a collection of seriously underestimated figures of the severity of Australia's drug problem. How do you expect the public and parliamentarians like myself to take on board the figures that you have quoted in that scenario when the same body you quote from said something different a few years back?

Dr Pring—The most up-to-date figures are the ones that are most accurate, one presumes, because the methodology of collecting information tends to improve very significantly over years. It is true that it is often very difficult, especially in the illicit area, to get accurate figures. That is one of the reasons to update you today with the latest AIHW survey. I am sure you have access to that. They are the latest figures and they are likely to be the most accurate.

Mr SCHULTZ—Do you agree that a reduction of 60,000 users in Australia from the year 1990 to the current figures that were put out by the same body is an absolute disgrace and a misrepresentation, or an indication of the way in which surveys and figures are manipulated? The

point is: how do we expect the public to believe what we are saying if we cannot get that process right?

Dr Pring—Rather than the figures being manipulated in some underhand way, I suspect that the difference that you quote there—which I understand causes people in the community to be confused; I am not trying to back away from that—is because they have more accurate ways of measuring. At this particular time, it just happens that there seems to be a reduction based on the fact that earlier figures were not as accurate and were perhaps overestimated. I do not think anyone is trying to manipulate the figures adversely. I suspect it has to do with better methodologies sometimes coming up with paradoxical results. That is where statistics are okay by themselves but they have to be interpreted appropriately. No-one is denying though, surely, that we have a massive problem. As one of my colleagues said to me, 'Over the last 30 years, we have failed to make a difference, especially in the illicit drug area.' The AIHW figures show an increase in the number of regular users of illicit drugs from 17 per cent to 22 per cent of the population. In some ways, it is bigger than the HIH collapse—he compared it to that with me. For 30 years, we have not been able to make a difference there. It is about time that we had evidence based strategies that could make a difference to that.

Ms HALL—I notice in your submission and your recommendations, and I think it was mentioned earlier, that you recommend the extension of the needle exchange program to prisons. From that, I make the assumption that you support the needle exchange program. Can you share with the committee your reasons for your support of the needle exchange program?

Dr Pring—Yes. It is based on a harm minimisation approach. We want to prevent the extra harm that can occur, and to wake up to the fact that although we may wish prisons were free of illicit drugs, unfortunately they are present, and we do not want the spread of hepatitis C and HIV in such institutions. We need to look after the welfare of prisoners, including their medical welfare, and that is why we are supportive of the program.

Ms HALL—Could I ask for an extension of your answer? There is some division within the committee on the question of scientific support for the needle exchange program. I support a needle exchange program—

Mr SCHULTZ—Overseas scientific support.

Ms HALL—Could you just expand on your answer a little in that area. Thank you.

Dr Pring—Yes. In this sort of area, the evidence is not found in the test tube or in the lab, it is found by looking at what has happened in different countries, as Alby was referring to. I think that the evidence—as people have said—is that Australia has not done too badly. We may have minimised some harm through a combination of strategies. It is very hard often to delineate down to one particular mechanism of action. One can do that through studying different programs in different countries, which have pluses or minuses. But the evidence seems to be that the needle exchange types of programs, along with other strategies, in combination, have been successful in decreasing the spread of hepatitis C and HIV.

Ms HALL—So the AMA supports all needle exchange programs?

Dr Pring—Yes.

Ms HALL—My final question relates to prescription drugs. It is taking the question that Annette asked a little bit further. Linked in with that is the training of GPs and the costs associated with that training. I was speaking to a GP in the area I come from and she was doing some home detox and using naltrexone, and was talking about doing some training in the area of methadone. Along with that there were associated costs to both herself and the practice that she was involved in, and other issues came into play. Do you think that it should be mandatory that GPs have this training, so that they have the understanding and can react a little quicker if they have a patient who is presenting with some sort of alcohol or drug-related problems? Maybe there needs to be a little bit more emphasis placed at the initial level within the degree courses. Can you comment on that?

Dr Pring—I think you are indicating that training issues need to be addressed at a number of different levels. That includes upgrading training in the degree course and it will include postgraduate training as well. I doubt if making it mandatory will be particularly helpful. I am a psychiatrist and my interest is mental health particularly. Not all GPs are interested in mental health issues. There are varying levels of interest among GPs, psychiatrists and physicians in this area.

Certainly, there should be some upgrading of the postgraduate programs in general practice training and in other specialty training and then further upgrading training programs and possibly continuous retraining programs for people who are particularly interested in working in the area. They are the sorts of things which, unfortunately, cost money, but it is money well spent because it does upgrade the medical work force to work well and effectively with those groups. Of course, remuneration has to be adequate, too, for the doctors working in those areas.

Mrs GASH—I do not mind who answers this question. It is in relation to the education processes that we have in schools. Does the AMA have an opinion on those processes?

Ms Murray—There are some very good programs now being developed for schools. A lot of them are focusing on more protective factors rather than on risk factors. They are actually looking at things like self-esteem and a young person's ability to protect themselves against risks such as drugs and alcohol. I think they are heading in the right direction.

Mrs GASH—There is an image perceived by shooting galleries and there is an image perceived by the state of New South Wales allowing certain quantities of marijuana. Personally, I think that is in contrast to the education process. Does the AMA have an opinion on that?

Dr Pring—There is a tension at times in a number of different areas. The AMA is in favour of decriminalisation of holding small quantities of marijuana and has been for a few years now. I was one of the people who took part in that policy making. I emphasise that, if we do criminalise in jurisdictions, it is important that a significant amount of money is put into explaining why marijuana is quite noxious to health in a number of ways and is likely to produce quite significant harm. It is the next wave of severe harms medically, in my opinion, because one can guess that there are going to be significant respiratory, cancer and heart disease problems from the usage of it from a young age. It is a significant problem with harms. On the other hand, making criminals out of young people who have been caught with small quantities

of marijuana does not help their career prospects and their ability to progress successfully in life. So it is important to have those balances. Often they get left out of the equation because of the funding issues.

Mr SCHULTZ—They think it does not affect their mental capacity at all.

Dr Pring—I was not going to go into great detail, but being a psychiatrist, I am painfully aware of the adverse mental effects of chronic marijuana smoking in some people.

Mrs GASH—How then do you explain to 10- or 12-year-olds in school that there are good drugs and there are bad drugs? I asked that of one of my grandchildren. I said to my young grand-daughter, 'What is a good drug?' She said, quite innocently, 'Oh, when mummy takes a drug, she has a headache. She takes a drug to make it better.' I said, 'What's a bad drug?' She said, 'All drugs are good because they make you feel better.' She is a school child. It rather concerns me that this is the image which is coming across. You are telling me that you are not really doing much about it because you condone the fact that small quantities of marijuana should be legalised. I find what you are trying to say to school children a great contrast to what might happen later on in life.

Dr Pring—But do you understand the argument about the effect on young people of a criminal record?

Mrs GASH—I certainly do, but nobody is asking people to take marijuana. It is not legal at this point—it is legal in New South Wales. You can take a certain amount. Nobody makes me take things if I do not wish to. It is a very fine line. I understand where you are coming from, but please try to understand that, as a parliamentarian, with the education process in the schools, when I try to say one thing, you are coming out and saying something else. I will leave it at that, thank you.

CHAIR—Do you want to respond?

Dr Pring—I think your issues are very important issues, and they really actually move into the area of medications. With my patients I always talk in terms of medications rather than drugs to emphasise the difference. One of the problems is that we are a society that does use a lot of medication. A lot of that is appropriate but sometimes it is not totally appropriate. People do need to be educated—and I think that is something that can occur in schools—about the difference between medications and drugs, if you like, and the fact that the use of medications, based on evidence, is that they are highly refined and properly regulated in the way they are produced. But there are still problems with prescription and other drug abuse and drug use, but it is a complex issue to educate people about.

I would also say that the partnerships we have in the community are very important for getting the message across. We are only going to get across the complex issues, the differences between, if you like, good drugs and bad drugs, or medications and other drug use through a collaborative approach—working not just on children and young people but on the older members of the community too.

Ms HALL—You support the decriminalisation not the legalisation?

Dr Pring—That is right.

Ms HALL—Thank you.

Ms JULIE BISHOP—I want to raise the issue of alcohol consumption. At community meetings I have convened in my electorate one of the major concerns that parents have expressed about substance abuse by their children has been binge drinking—and thinking back to my uni days, perhaps it was ever thus. But is the incidence of binge drinking among young people on the increase? I refer to the *1998 National drug strategy household survey* which talks about 50 per cent of Australians between the ages of 20 and 59 being regular drinkers. Then it goes to teenagers: 70 per cent of teenagers are recent drinkers; 30 per cent being regular, 40 per cent being occasional. It does not seem to give statistics on binge drinking or the impact of that in the short term—road trauma, and the like, or suicide—and then whether binge drinking leads to later long-term dependency on alcohol. Perhaps you could comment.

Also, your position statement refers in paragraph 5 to producers and retailers having a responsibility to reduce the incidence and consequences of binge drinking. That seems to assume that underage drinkers are drinking in licensed premises where there can be such control, which clearly is not necessarily the case. Thirdly, could you comment on the $18.8 million per annum that you suggest should be provided for alcohol consumption and related problems? What proportion of that would be directed to this issue of the youth binge drinking and what specifically do you have in mind to counter that problem? Sorry, it is a long question.

Dr Stockhausen—I cannot remember if that particular study did address binge drinking, although I think it did, but I would have to get back to you on that.

Ms JULIE BISHOP—I have been looking for it for some time so, if it did, I have not found it.

Dr Stockhausen—With a lot of the evidence we put together, particularly for our roundtable, I know there have been stats in Australia on binge drinking. I think it is the Institute of Health and Welfare but I can just go back and have a look and then send that on.

Ms Murray—I have got some quick statistics here but it is not broken down to underage drinking—it is actually from 14 to 24. The Institute of Health and Welfare reported that 34 per cent of females reported having five or more drinks on any one day and that 60 per cent of males reported having five or more drinks on any one day. Five or six drinks for males is actually considered hazardous and more than three or four is considered hazardous for females.

Ms JULIE BISHOP—Which would then put them in the heavy drinker category. But that does not take into account the binge drinker which, I understand, is God knows how many drinks over a weekend and then perhaps not during the week. It is that binge drinking element that seems to be the great concern because it is at that time that the road accidents take place, the possible suicides, and all these sorts of issues occur, so I am actually trying to isolate the binge drinking occurrence.

Ms Murray—It depends what you term as binge drinking, too, because for a female—

Ms JULIE BISHOP—What does the AMA consider to be binge drinking?

Ms Murray—I do not think it is in our policy.

Dr Pring—We have not got a specific policy on the definition. We can get back to you, though, with the information that we do have from our national drugs roundtable; there was a speaker who did seem to have some information about that. But we are not trying to deny that it is a serious issue. We are very concerned about the beginnings of drug abuse patterns in young people, and that is why we are suggesting the research into children and young people and the reasons that they take up drug use and drug abuse. But I point out that there seems to be some evidence—in some areas, at least—of more responsible behaviour in young people with drinking. There are some young people that have a person who is not drinking for the night, because they are going to drive them home, and that sort of thing—once they are up to driving age. I have certainly come across that a lot. I think in some ways there may be some concerning patterns in relation to binge drinking, for example, and there might be other patterns that are encouraging.

Ms JULIE BISHOP—You do not know, then, whether binge drinking as an incidence is on the increase?

Dr Pring—I think there was some evidence that it was increasing, but again we will have to come back to you with the actual figures.

Ms JULIE BISHOP—The only other part of that question was: did you have anything specifically in mind out of the $18.8 million per annum that would address the issue of youth binge drinking or where that money was to be directed?

Dr Pring—I think that there was a significant proportion that was going to be spent on research into young people's alcohol patterns, but I cannot remember the exact proportion.

Ms JULIE BISHOP—So you cannot attribute an amount to that program or research?

Dr Pring—I cannot, offhand.

Dr Martin—Not specifically to binge drinking. We did not go down that fine.

CHAIR—Take it on notice, if you can.

Dr Pring—Yes.

CHAIR—Thank you very much.

Mr QUICK—You mention that funding for quit tobacco, alcohol and illicit drug programs is not enough, you mention that drug abuse costs Australians almost $19 billion annually and you quite rightly state that the less tangible costs of drug abuse include disruption to family relationships, school underachievement, youth suicide, increased unemployment rates and family fragmentation—all of which cost society God knows how much. In your submission you

continuously mention evidence based strategies with a view to having a national approach, when we have now got states with their own bags of money because of the GST. Previous submissions have mentioned the silo mentality within the states and also within the Commonwealth government.

How the hell are we going to get evidence based strategies when, as I highlighted earlier, we have got 58 acronyms? God knows how many more other players are there, each with its own vested interest. I have written it down here: we have now got a lead-up to the corporatisation of medical practices, we have got a lack of bulk-billing in regional areas and we have got people who are in crisis and who cannot access a whole range of services—whether it is their GP, detox, rehab, or some form of 'medical treatment'. How much longer are we going to have to look at evidence based material? When does it stop and when do we actually put things in place? As I mentioned earlier today, there is young Jason, day one. He has been waiting for seven years; he has finally come to the fork in the road. When do we stop putting money into research? I am a great believer in research, but there is $19 billion dollars that we can quantify. There probably is twice that in family fragmentation, youth suicide, school underachievement, unemployment and so on. Let us put some of it back. How do we do it? I have not mentioned gambling. That is another horrendous thing that is impacting on Australian society, along with illicit drugs. Kids cannot get fed because mum and dad are in the casino.

Dr Pring—The AMA has been struck by the disparate number of organisations and the lack of coordination. That is one of the reasons that we have been interested—as an independent organisation in many respects—in trying to coordinate a number of those key organisations. I would hope that one of the outcomes for politicians will be to look at how to bring in coordination, collaboration and partnerships so that it is possible for the various organisations to work more effectively together.

We are also prepared, if you would like, to provide more of the medical expertise in the treatment and rehabilitation areas, where the evidence is, and, through our partners, the evidence of research that has been most appropriate and helpful and of education and prevention strategies that have been successful. I think the only way we are going to resolve and really do something about the issue is with coordination and collaboration, between areas, getting it together, getting the information out on the table, finding where the funding is going, and seeing what the outcomes are as much as one can—collecting evidence and evaluating it. It is the only way to go.

Mr QUICK—But the young police constable in Cabramatta, confronted with someone lying in the gutter, does not want to know about the fact that this kid might have been in a bad relationship with his parent or might have only one parent or be homeless. He has a problem—he needs to remove that person and have an instant reaction. So that happens, and it ends. It is part of a continuum. He does not think, 'When he wakes up I will say "Who is your GP?" and get some sort of case history.' We then get into that hoary area of, 'It is private and we cannot do that.' Are social security going to be involved because he gets a young homeless allowance? Who is going to visit his mother, who is trying to keep the other siblings out of the same chain of events that this kid is going through? We are pouring probably half a billion dollars into this whole problem. Surely we can come up with something constructive.

Dr Pring—What we have been saying is that there is not enough money being used to try to deal with a problem which has multi-billion dollar industries pushing the substances into people's mouths and arms and so forth. That is what we are facing. You cannot do it with a few hundred million dollars or whatever.

Mr QUICK—So do we tax Marlboro at $10 a packet? Do we do something as radical as that? Do we recommend those sorts of things? Do we put cigarettes beyond the realm of normal people—so that only those earning $50,000 or $10,0000 can afford a packet of cigarettes? What does that do?

Dr Pring—That is an extreme, but we have recommended increasing taxes. One of the first groups that finds it harder to buy cigarettes and alcohol if the price is a bit higher is younger people. So it has two effects. It brings in more excise. If we were to spend more of that excise on drug control, we might actually get somewhere, and we might have services for that person on the ground. That is something that you as politicians can do something about.

Mr QUICK—But you are recommending less money out of those four strategies be put into early intervention, which I find rather strange.

Dr Martin—No, sorry; that is not correct.

Mr QUICK—I am sorry, but it says $12.5 million per annum into children, young people and families; 13.75 million per annum into national indigenous substance abuse; $41.3 million into illicit drugs; $18.8 million into alcohol, and $25 million a year into tobacco.

Dr Martin—What we have actually asked for is that there be appropriate funding of Medicare and the Medicare agreements. Appropriate funding of medical care and public hospitals and communities through Medicare and the Medicare agreement is another argument the AMA is making in a different area. So you properly fund the health system. On top of that you increase excise and you put more money into tobacco, alcohol and illicit drugs additional to what you are currently spending. So you have already properly funded the health system, then you put additional money into these areas for treatment, education, rehabilitation, et cetera. On top of that you have an indigenous strategy and a user strategy on top of that. So we are asking for a lot more money.

Mr QUICK—A lot of the manifestations of antisocial behaviour—I speak as an ex-school principal—are manifest in schools, but that has nothing to do with education. We are back into this silo thing. It is more than a health system problem; it is a social problem. The school counsellor pops in to Bridgewater High School once every couple of weeks, and cannot really cope because they do not have enough funding; the GP down the road is dealing with the same family; also the counsellor or the social worker at the housing commission is dealing with the same family; as is the family support worker; and the same family comes knocking on my door because they want a food parcel. It is all part of the same problem. How do we address community funding rather than the health system, the education system, the juvenile justice system or the sport and recreation system?

Dr Martin—Because we are a medical organisation we are talking specifically about the health side of the equation in our proposal. We are not arguing that there should not be

integration between health and education, and in fact we have just had an editorial published in the *Medical Journal of Australia* talking about, specifically in relation to indigenous children, the links between health and education—and that is not limited to indigenous children. The links are there. It is not just education; it is other services, and it is wider. So we completely agree with you.

Dr WASHER—One of the big problems is that if you push up excise you get illegal tobacco—chop chop now has increased incredibly in this country, as you well know—and so there is a price cut-off point where the illegal product comes into the marketplace in a big way. But apart from that, our policy on drugs and sport is extremely clear. Please tell me what position the AMA takes on drugs in the workplace, in relation to routine screening et cetera.

Dr Pring—I take the first question first. We understand that if you increase the excise enough the illegal product becomes more attractive, but on the other hand the legal product is actually marketed very heavily. This is often directed towards particular groups, like young people, and the illegal product does not have quite as extensive a marketing budget. So I think it is still worth looking at increasing taxes. In relation to drugs in the workplace, I do not think we have any definitive policies on record, but we certainly consider it an important issue. We believe that drug usage can contribute to workplace accidents and certainly to lack of productivity—but especially accidents. We would be reluctant to bring in draconian, mandatory or invasive methods of drug detection, but we would like to see an emphasis on appropriate education and peer support strategies in workplaces for drug problems—and the possibility for people to acknowledge that they have a drug or alcohol problem in the workplace, not lose their jobs but be able to receive an approach which supports the person to not use the substance or decrease the use of the substance, and be able to remain at work and maintain livelihood and so forth.

Dr WASHER—Let us go back to the marijuana issue for a moment. I, like you, agree that there are some leanings towards legalising small amounts. The practicality is: how do you envisage that? Would people grow their own? Would they buy from a dealer? The practicalities always get to the difficulties. Or do we give it to Joe Camel, they market it, so we get an increase? Then we have to try to advertise against it. How do you think we could do that practically, from a medical point of view?

Mr Pring—To get the information?

Dr WASHER—To legalise marijuana. What are the practicalities? Will it be only if you grow your own, for that amount? Who can you buy it from? How do you access that small quantity? You still have a market position to take.

Mr Pring—Yes. 'Market position' is a little unclear but, as I understand you, it is about the fact that it is not helpful for young people to have a criminal record. But any decriminalisation strategy has to be limited. It has limits. It is not perfect. There will be problems with it. But it is a process of trying to prevent young people, especially, from having a criminal record attached to them which may well affect how successfully they can progress in life, away from drug use and abuse and so forth. At the same time, it has to be combined with a publicly funded education strategy by the jurisdiction involved, and it has to be a continuing program.

CHAIR—You mentioned the need for a program of research on why youth get involved in the substance abuse issues. Is there nothing now? Is there nothing happening at the moment? I understood you to say that you have been an advocate for research into this issue.

Dr Pring—There is research being done, but we are pointing out that there needs to be more extensive research. I want to emphasise that we are not trying to take a purely medical approach. I hope we have not given the wrong impression. The research needs to be done at social levels, not just medical levels. It will include attitudinal research and, hopefully, longitudinal research. I suspect we need to look at groups of people over a period of time and see the influences that get people into using drugs and—

CHAIR—I suspect you are right. You have not given me the impression that it is so focused. I just wanted to be clear that there is something happening there.

Dr Pring—Yes.

CHAIR—I sense that you are right. We need to understand that a lot better than we do. I just wondered where you were coming from there; that was all.

Dr Pring—We can provide you with our knowledge of the research—a list of the information in that area.

CHAIR—Thank you. That would be very useful. You mention the almost $19 million figure. You would be aware of Collins' and Lapsley's work. They said the figure was about that nearly 10 years ago. Are you able to enlighten us as to the differences in the research?

Dr Pring—As I say, a lot of the statistical figures certainly require interpretation. I do not think they are necessarily talking against each other, if you look at the methodologies appropriately. The point about the latest figures is that they are based on the most up-to-date methodologies we have at the moment. Obviously, the earlier study happens to have been remarkably accurate. That is good, and is a tribute—

CHAIR—On any kind of estimate, $19 billion would become $30 billion in today's language, if you go to Collins and Lapsley. That is a personal view. I do not think any miracle has occurred since 1992.

Dr Pring—No.

CHAIR—I am just interested. If it is just different methodology, I am happy to leave it at that. As far as the media goes, you probably heard some of the earlier comments. The AMA is quite active in the media and uses it very effectively. What is your role in regard to the media and its presentation? Give me a broad statement—because there are journalists and journalists and there are editors and editors—regarding the media's portrayal of substance abuse and the improvement of that.

Dr Pring—We believe in freedom of speech, and it is good that we have a media in which issues get aired. There does tend to be a focus on extremes in the media, which often does not help understanding of complex issues. We have a strategy of providing awards to journalists

that provide in-depth and valuable comment about medical and health issues. We have a number of strategies to try and encourage more adequate media comment.

CHAIR—Have you awarded any journalists an award for their treatment of substance abuse, at this point?

Dr Pring—I am just trying to recall. I can't tell you. I can find out.

CHAIR—Tell us if you find some. I do not want to denigrate the media, but there is a concern that you heard today, and we are hearing regularly, that the portrayal of this issue by the media creates its own difficulties. It need not necessarily enhance the best practice, et cetera. I will leave it there. Anything you can help us with would be appreciated.

Lastly, I couldn't let this one go, knowing your background, Bill, in dual diagnosis of mental health substance abuse. In terms of the national policy where is the AMA on dual diagnosis? In our movement around the country we have seen one or two outstanding examples of the dual diagnosis management issue that really hit you in the eye. Where are you at in terms of a national policy?

Dr Pring—We are very much in favour of greater spending on programs with people with co-morbidity. I am actually a consultation liaison psychiatrist who works in the general health area a fair bit. Co-morbidity, to me, means not just drug and alcohol abuse and mental illness but often physical illness—severe physical illnesses—going along with it, too. I think you need a very broad strategy of dealing with all the conditions at once.

CHAIR—How well are you doing it nationally and where are you at? It seems to me we have a long way to go.

Dr Pring—We have a long way to go. It is not good enough, because often people do have these silos of funding and interest and so people get broken up into bits rather than treated holistically.

Mr QUICK—We will be hearing next from the Australian Association of Social Workers. They have given us some case studies. One sums up what we have been talking about.

Case study 1:

Joanne (35) consulted her GP because she was having trouble sleeping, was increasingly irritable and was unable to stop her negative thought processes. The GP was aware that Joanne had a number of stresses in her life including the recent death of her father. However the GP did not have time to talk with Joanne at any length and referred her to a counsellor. Joanne was unable to afford $100 per session with a private counsellor, and the GP suggested she try the Community Health Service. Knowing it may take some time to access the service the GP also prescribed one of the new generation of anti-depressants to help Joanne get through the period.

When Joanne called the Community Health Service the duty officer was unable to offer her an appointment. Since Joanne was already being treated for depression by her GP, … she did not fit the program's requirements. Unless she was in crisis or suffering a severe, ongoing mental illness Joanne would not be able to access their service.

That is the sort of thing that we, as federal politicians, are dealing with on a constant, daily basis, with evidence based strategies and silo mentalities and these sorts of things. This is just

one of many case studies that are in the next submission. How do we get to talk to each other and get something up and running? I will leave it at that.

Dr Pring—Okay. I hope I do not break the collaborative connection, because I think that is what it is all about. but GPs get a lot asked of them and I would not be a proper AMA person if I did not say, not cynically, that if we were able to implement the relative value study, general practitioners would be able to do a lot of good work.

Mr QUICK—I agree. I agree totally.

CHAIR—Thank you, Bill, and Kate, Jo and Carmel as well. Thank you to the AMA.

Proceedings suspended from 12.45 p.m. to 1.01 p.m.

GAHA, Ms Jo, National President, Australian Association of Social Workers

HORDERN, Ms Sarah Elisabeth, National Policy Officer, Australian Association of Social Workers

MAGERS, Mr Tony, General Member, Australian Association of Social Workers

O'CONNOR, Mr Maurie, General Member, Australian Association of Social Workers

CHAIR—Welcome. The committee does not swear in witnesses, but the proceedings today are legal proceedings of the parliament and, as such, warrant the same regard as proceedings in the House of Representatives. Would one of you like to make a short address?

Ms Gaha—I will talk briefly and then hand over to Sarah Hordern, who is the national policy officer with the association, and then to my colleagues, Tony Magers and Maurie O'Connor, who are members of the association and work in the area of drugs and alcohol. We would like to talk for a couple of minutes, Sarah for about the same time, and then we are going to ask our experts to take over from there. We will take up no more than 10 minutes.

CHAIR—Thank you.

Ms Gaha—I want to take this opportunity to introduce the association to members of the House of Representatives. The Australian Association of Social Workers is the voice of professional Australian social work with approximately 6,500 members. We have a board structure which is staffed by volunteers. In my paid employment, I work in the Department of Social Work at the University of Newcastle. We have some staff—such as Sarah—who are paid to do the business of the association on behalf of the board. We are not a registered profession; we are a self-regulating profession in this environment of competition policy. We self-regulate through a code of ethics, a complaints mechanism, continuing professional education and standards of practice that we expect our members to adhere to.

We have, as one of our primary objectives as an association, to pursue and support social structures that promote social justice and human rights. One of our major objectives is not about the profession itself, but about those with whom we work as professional social workers. Social work as a discipline and as a profession sits right at the interface of the public and the private. We work across society with those people who are negatively impacted upon by social structures or who are facing various lifecycle issues. We take as our brief to work with individuals, families and communities within the context of their broader environment. To use a term that we are often very familiar with, social work is right there seeing how the personal becomes political and how the political can impact on the personal—how social policies impact on individuals and communities.

In our submission, we highlight that the lower social stratum are significantly overrepresented among substance abusers, and that there is a large body of opinion that argues that, when people have an adequate standard of living and positive social and personal relationships, they are less likely to abuse drugs. This was certainly found in a study of one hospital emergency department

that I am very familiar with—the John Hunter Hospital in Newcastle—which found that 81 per cent of people coming into emergency with a substance abuse issue identified significant other problems, including homelessness, violence, mental health and isolation. I will now ask Sarah to tell you how we put the submission together.

Ms Hordern—We are a membership organisation. As Jo said, we have around 6½ thousand members across Australia who work across three major industries: welfare, health and education. They work in a variety of roles within those industries. We consulted with all those members and asked, if they had a point of view about the terms of reference for this inquiry, that they get in touch with us, and significant numbers did.

Our submission varies from the submissions of some of the other people who are appearing today, in that it is not a classically academically researched submission. It is very much based on those front-line coalface experiences of our members who are working across that range of industries. That is why we have presented that strong theme of substance abuse being just one facet of a much more complex picture, neither necessarily being a causal factor nor the result of other factors like domestic violence or child abuse, but that it needs to be viewed as part of a very complex and inter-related larger picture. I will leave it at that point because I want to give you plenty of opportunity to ask questions. I will pass to Maurie.

Mr O'Connor—As well as being a member of the AASW, I work in alcohol and drug services here in the ACT. I have been working in the alcohol and drug field for about 15 years at various levels. The strength of this submission is that it draws attention to the underlying problems in relation to alcohol and drug abuse and misuse that relate not just to the drugs themselves but to social and economic factors. I think that is one of the strengths of this submission. The other part that I want to pick up on is the role of social work in addressing some of these problems. One of the strengths of the social work perspective is that it crosses a number of areas. When we talk about looking at interventions or at responses to alcohol and drug problems across the spectrum, we are talking about early intervention, prevention, education and treatment. I think the social work perspective offers that to a large extent, and it is why social workers are really at a premium in the alcohol and drug field, because there are some other areas that people are coming from that give them a narrow focus.

We need a lot more training and education within the alcohol and drug field, and support for workers in that field. It is one of the things that has been sadly lacking in the past. We do not have enough resources and money put into education, training and retraining in that field. This carries over into a number of areas. Jo was just talking about the example of the John Hunter Hospital. That highlights a need for training, in terms of brief intervention and other intervention, for workers who are not specialist workers in the alcohol and drug field but who come into contact with many people with alcohol and drug problems, and come into contact with them in a situation where they can be effective in terms of early intervention or brief intervention.

When we look at the service shortfalls—and I refer to the submission at point 3.3.2—and the difficulty in accessing services, we see examples all the time. As a member of the treatment panel under the Drugs of Dependence Act in the ACT I constantly find magistrates and judges saying they want this person to have treatment and go to a residential rehab or they want them to do X, Y and Z, or whatever it may be. We find all the time that there simply are not the

services, the range of services and the diversity of services that there ought to be to cater for them. We have got massive waiting lists all the time to get into residential rehabs and a number of services that are not targeted that well towards people with alcohol and drug problems. In terms of this submission we need a whole range of services that cross a spectrum and offer people lots of options. Some of those options may not be that acceptable at times to some people, but those options need to be there.

In terms of adequate training and services on the ground, I can use the example we discussed when talking about this submission the other day. In the ACT there is a project in terms of dual diagnosis, which Tony is going to talk about in a minute. That project highlights the fact that in the ACT there are approximately 400 people working in mental health services. If you look at the statistics, mental health services are catering for a population of one in five, because we are saying that approximately one in five people in the population are suffering from a mental illness. We are also looking at the number of people working in alcohol and drug services, both government and non-government. In the ACT it does not total 100. We are looking at not even 100 workers servicing the whole population because alcohol, drug issues and problems really affect the whole population. We are not talking about people who are simply drug dependent; we are talking about people who need education, awareness and prevention measures. We have very few people on the ground to do that. That is probably a bit of a rave, so maybe I had better stop at that point. You can probably pick it up in questions later on.

Mr Magers—I am a member of the AASW, having graduated in 1991. Over the past 10 years I have worked in both adult and youth corrections, in adolescent counselling, in child and adolescent mental health, in drug and alcohol services and more recently as a project manager with the dual diagnosis project. That was focused around people with a mental illness or mental health disorder who were misusing or abusing substances. The research tells us that about 70-plus per cent of people with a mental illness abuse or misuse substances and that we can predict about 30-plus per cent of people with drug and alcohol issues have some underlying or mental health issues.

I was involved as a project manager with the dual diagnosis project in the ACT. I am employed in the ACT with the ACT government. I was involved in a project where the ACT employed some consultants to put together a brief called *Stopping the merry-go-round*. That project made 25 recommendations in the ACT and as a project manager I was charged with putting some of those recommendations in place. That included providing resources and looking at collaboration between services, training and education for both mental health workers and drug and alcohol workers. One of the major focuses of that was about getting the two systems working together. There is a fair bit of anecdotal evidence that often people between services fall through the cracks and are seen as too hard. A big part of that was developing processes predominantly between the two government services here in the ACT and also including non-government sector agencies.

CHAIR—The constant question is: why aren't there more services available? There are two areas: there is more resources and sometimes the reordering of priorities. In your view is it both? In other words, is it just a matter of more money or is it really a much higher priority on these sorts of issues within the system generally and within the health system? Would you care to comment?

Ms Gaha—I might comment briefly and then hand over to my colleagues. I would agree with you; I think it is both. I think it is more money and a reordering of priorities. We have seen this over time in the delivery of Australian social services—as we reorder priorities and see things differently, we have more success with the issues we deal with and, I think, a more holistic perspective around drug and alcohol misuse, so that we see all of the factors involved. Educating workers across the board would play a large part in addressing this issue. I am not currently working in that particular field, although wherever you work as a social worker you see people who have problems with drugs and alcohol.

Mr Magers—In the submission, we have tried to make the point that there is a range of issues. It is sort of folklore in drug and alcohol services that drug and alcohol issues are a symptom of the problem. I think that, seen in isolation, they will always be difficult to address. I have worked for a number of years with adolescents, and I think that if people do not have access to employment and that sort of thing—access to a meaningful existence—using drugs and alcohol becomes a viable or an attractive option. Very broadly and very briefly, I think that often drug and alcohol issues are a symptom of a much broader range of issues.

Mr O'Connor—I agree with that. I think it is both. The money needs to be there and it needs to be there in other areas apart from simply in the alcohol and drug area itself. It goes back to the thrust of the submission. It is about other social and economic factors that need to be strengthened. In terms of a focus, when the National Campaign Against Drug Abuse kicked off, it provided both of those things, in a sense. You could probably argue that it has lost its way to some extent these days, so many years down the track. What we are seeing in a number of jurisdictions around the country is a refocus, for example, with the drug summit in New South Wales and what is happening in Victoria and other places. It is amazing how these things have worked in those places, by virtue of the fact that there is money put in and there is a refocus and there is a direction. In the ACT, we are now second bottom on the list in terms of per capita spending on alcohol and drug services, and I think that tells. In the past, a lot of good things have happened in the ACT, but now one of our problems is that we are simply there with services that are not adequately funded and resourced. A re-emphasis needs to be there as well, I would say.

CHAIR—What I am leading to, in the more difficult part of the question, is how do you reorder priorities? With due respect, everybody likes and wants more resources, and that is the constant request of any politician, but in terms of the reordering of priorities and where the social worker industry fits in the general hierarchy of the system, where is your influence to change the senior managers' point of view? How do you influence the reordering of priorities? Would you care to share any thoughts with us? Where does it happen—in the management committee area? And how does it happen? Where do you sit in the general hierarchy of it all, in changing this priority?

Ms Hordern—You find social workers in all sorts of jobs. Maybe a comparison is with the welfare reform process at the moment, where you have Patrick McClure and three other high-profile social workers working on that, developing the policy. One well-known social worker involved in drug policy is Margaret Hamilton, who I gather has presented to you a couple of times already.

CHAIR—Yes, very effectively.

Ms Hordern—She certainly had input to our submission as well. I think one of the special things about a social work perspective is that social workers look at the client in the context of their environment. They are working at the interface between the individual or the group of people with a problem and those wider social structures. I think social workers are quite skilled at breaking down the barriers that sometimes grow up between different types of services.

CHAIR—I hear that, but what I am trying to understand is, in the management structure in your workplace, or at workplaces all over Australia, how does the social worker influence the management to change the priority, and what work has been done? Where are you at with changing the priority and challenging conventional management?

Ms Gaha—I think that is a very good question. In a sense it is right at the heart of what social work sees as its role, and quite often we as social workers regard not only the clients that come to see us as the people that we have to work with but also our colleagues in terms of reordering or changing their perspective. If I could speak frankly, I think it is very difficult to reorder social and personal priority in an economic rationalist environment. I think that is starting to shift because I think there is more of an awareness now amongst the public and private sector that if we ignore social costs it is at the peril of economic direction as well. I think the voice of social workers is starting to be heard more, that there is more of a receptivity to the voice of the holistic social needs within the economic frame of reference. So I think social workers everywhere would be working with their managers to try to bring about this reordering of priorities. That will not do it on its own. We need people like yourselves, and we need public opinion to shift in that direction.

Ms ELLIS—Can I ask you a couple of very practical social worker-type questions?

Ms Gaha—Sure.

Ms ELLIS—I think that is what they are. There are two conflicting things I want you to give me an opinion on. One relates to elderly people who some people say may be at risk if their major or sole carer is resorting to drug and alcohol problems. That is one area. To what degree do the elderly people in that circumstance run the risk of being abused by one or the other? At the other end of the scale you have children who become carers of people with drug and alcohol problems. They are both quite different but are in the frame. I am sure your profession comes across both of those cases. Can you discuss that with us? To what degree are either of those issues problematic, and how are we dealing with them? Obviously I can be so bold as to say probably not sufficiently enough, without wishing to predict your answer.

Ms Hordern—I might start off by talking about children in those situations because I have recently had contact with a group of social workers in child protection very concerned with that issue, particularly about the emotional unavailability to children of parents who are substance abusing. It seems that if children are being physically damaged it is obvious: there is external harm visible. People are more likely to intervene. Emotional unavailability, however, can be really quite crippling for children, and it is a hard thing to really prove in court. So I think we have a long way to go in identifying those sorts of situations as a first step, and then having people with the appropriate training and knowledge to support those families. Again the current preference is to keep children in families if at all possible rather than to put them into substitute

care, and I think we still have a long way to go in learning how to properly support those families.

Ms ELLIS—Can we just take this particular instance a bit further. If the adult who has the alcohol or drug problem is coming into contact with any part of the system, be it criminal, judicial, the methadone program, health, detox, rehab—any of those—how do you believe we are dealing with the question of whether or not there are children in that family or in that household, and whether we are even attempting to do that identification and should be doing more? I know it would be difficult—I understand that—because I understand that the general pick-up of Kids As Carers at large has only just been done in recent years; and the Carers Association, through their Kids As Carers program is doing remarkably well, but that is for very evident caring cases. This is a little bit more subtle, in a funny sort of way, but the individual adult is still coming into contact with somebody somewhere, even if it is their GP. Do you believe we should be doing more in terms of worrying and caring for those kids who are the carers of those people?

Ms Hordern—Absolutely. I think one of the programs we talked about at John Hunter Hospital was the program coming out of the maternity section of the hospital. They actually have pre-childbirth classes and group programs operating for women in the region, and they have a focus on picking up any substance abuse issues—because they see the pregnancy period, before the child is born, as a very positive window of opportunity to get those women to relook at their substance abuse and make positive changes.

Ms Gaha—It really depends on who that adult is in contact with. In the case of this particular program at the John Hunter Hospital, if the adult is in contact with the John Hunter Hospital because of their awareness of this problem and the services they put in place, those children—or even unborn children, because they are targeted as well—get better service. But if it is, say, a GP or a methadone program or whatever, it depends on how well those people have been made aware and trained about the importance of child protection issues in relation to the adult and his or her relationship with the child. I think it is better than it used to be.

Ms ELLIS—We could apply the same sort of generalisation to the other situation—in other words, to the elderly, with the carer being the abuser. Of your 6,000-odd membership, how many, if any, are indigenous? Do you know?

Ms Gaha—We do not have exact numbers, but we could look that up. We have asked for it this year on our membership figures.

Ms ELLIS—So you know that you have some indigenous members?

Ms Gaha—We certainly do. We have a 14-person board of directors, and one of those is an indigenous Aborigine.

Ms ELLIS—Perhaps you could make that available, just as an observation. I am leading to a question, and it is about inhalant abuse. There is an understanding in our community that the only young people who abuse inhalants are, tragically, indigenous—maybe not only, but that is the major emphasis. Can you tell us, from the social worker profession point of view, your impressions of inhalant abuse in the general population?

Ms Gaha—I think we say in our submission that it is unfortunate that it is only seen to be amongst the indigenous population, because we think it is widespread among young children across Australia.

Mr O'Connor—I think it is widespread, but it is not as great as may be feared, in a sense. One of the things about inhalant use is that it tends to be cyclical and the use tends often to be at an experimental level, so most of the people that we are looking at who use inhalants are around 12 to 14 or 15, roughly, and are probably using them at an experimental level. We get very few people who then go on to use them at a more intensive level. When we are talking about adolescents, these are often people who have a whole range of other complex and underlying problems and, really, their inhalant use is part of their way of dealing with those problems. We see this running in cycles. Where I work we have a 24-hour help-line. We get a rush of calls at particular times saying, 'We have just found some bulbs on the oval at school. What will we do about it?' We get kids who are using nitrous oxide for a period and it peters out. It goes in a kind of fad, if you like. That tends to be a pattern that we see.

We do not get so many people who continue their inhalant use or abuse beyond that period, other than the ones I am talking about. We do not see too many people in their 20s who are using inhalants. The reason for that is that there are much better drugs around to do what they want to do. There has always been a problem about this because we have not been sure a lot of times. There has been a lot of controversy about how to respond to that problem and what to do with it. We cannot tell kids about this because if we tell them about it, they will do it. We get that problem all the time. This is more so with inhalant use than anything else. The same problems that we are seeing in the indigenous community we are seeing in other places but it is a different sort of problem.

Ms HALL—I may not even stay for the answer but I will read the answer. Excuse me for leaving after I ask the question. I am very interested if you could put a social worker's perspective on the role that poverty and unemployment play in alcohol and drug abuse and strategies that government needs to implement to address these issues. Excuse me, but I will read it in *Hansard*.

Mr Magers—There is no short answer to your question. From my experience working in the drug and alcohol field it is really interesting when, for instance, a middle-aged man that has been drinking wants to stop drinking. He is really quite focused. He comes in and is able to achieve that goal. He is able to become abstinent. It is quite interesting. Those people see that as the challenge basically: stopping drinking. They stop drinking and then what do they do if that person has been out of the work force and there are a whole lot of other issues? People expect that life is going to start once they stop drinking. There is a whole lot of interplay between a whole lot of different issues, as I was saying before, particularly for young people around meaningful work and life. It is about having sport, families being able to support them, being invited by us adults into the community and being a respected part of the community basically. I think I will leave it there. Does anybody want to add anything to that?

Ms Gaha—I would say briefly that there is good research around that indicates that employment and poverty are linked in Australia not only to poor health but also to every other social problem. Targeting unemployment and poverty needs to be considered seriously in attempts to reduce our social problems. We once targeted poverty amongst the elderly after the Henderson

report and we basically dealt with that issue through targeting. Now we need to look at where the poverty and unemployment is and what we are going to do about it.

CHAIR—Thank you.

Mr LAWLER—My question is not dissimilar to the previous one. In your submission you mentioned that a large group of those who are substance abusers—and I throw in here having a gambling addiction as well—are lower socioeconomic residents. By nature they are often welfare recipients as well. On the one hand, we are talking about detox and rehab. You cannot really separate that process from the ongoing social support and change in lifestyle that would come after the detox. Would there be advantages or do you only see disadvantages in using, as one only of the tools to assist people who have a demonstrated addicted behaviour to gambling, substance or alcohol, for them to receive their welfare payments every couple of days instead of weekly or fortnightly? I am thinking about the other members of the family in this case, such as kids who go without food and clothing because of the problems that the parents have. At least every couple of days some responsible member of the family has a chance of getting hold of some money. Certainly there are downsides of that. I am aware of that. Can you see some positive aspects to that?

Mr O'Connor—I have some mixed feelings about that. I work with a lot of families who want to do that because they see it as one of the solutions—'I will keep the money and hand it out to you every couple of days, et cetera'—particularly for people with gambling problems. We see a lot of people with gambling and alcohol problems, because they go together pretty much. My problem with that is that, even though it might sometimes be worth while in the short term with some people, it does not actually change much. If that is all we are doing—

Mr LAWLER—I did say it is only one of the tools.

Mr O'Connor—Yes, I know that. We are usually doing a few other things, but if they are the sorts of things that we are doing then we are not breaking the cycle in a sense, which we can do. If it is short term then maybe it is a good way of doing it, but there has to be some way of getting past that as well. There is no easy answer to this. We are dealing with families all the time who are suffering because of that dependence or behaviour that is going on. That might be good for a period of time, but it does not solve things a lot of the time. It does not get them out of their situation.

Mr LAWLER—I accept that.

Ms Gaha—It could be useful though if you are considering a battery of interventions and this were one of them. It could possibly be a discretionary change where someone with authority and appropriate training—either a Centrelink social worker or someone else—could recommend that for a period of time for this family this would be an appropriate thing to do. There are ways of intervening without it being that everybody has to have the same treatment.

Mr LAWLER—Absolutely.

Ms Hordern—The difficulty I see with it from a philosophical point of view is that many people with substance or gambling abuse issues sense they have a lack of control over their lives, and that would be adding to that sense of disempowerment.

Mr LAWLER—It would come back to who would be able to make the call there—whether a Centrelink person, a court, an Aboriginal elder or someone.

Mr Magers—Currently there are systems in place around mental health and disability services. I forget the name of the actual board, but it is quite a lengthy process. The rights of the person certainly need to be taken into account. So there are some examples in that area. I think it is used really quite limitedly.

Mr LAWLER—Over the years we have heard a lot about the rights of the individual. I think we really have to focus on the rights surrounding those people too.

Mr QUICK—I would like to go to 3.2—service shortfalls and the options. You mentioned magistrates perhaps having some discretion and diverting people into some program; the ability to access that; it not really being a departmental role; and that they have an industry and lawyers are employed so it is nice to have the same client coming back as it keeps their caseload busy. So how do we put in place service delivery models that are not restrictive?

You have given us some case studies there, one of which I read out to someone else. I could give you dozens of case studies. I mentioned Jason. I spoke to him during lunchtime and he is 'in' and it's like his first day at school. He wants to be a florist. He never completed adequate schooling. Hopefully, while he is 'in' for 12 months he will get some TAFE training that the organisation can run. He will need some ongoing counselling, but whose responsibility is it? Is it his parents who need to make sure he gets it? Is it the organisation that is looking after him now for a 12-month period? Is it the responsibility of Jason, juvenile justice, or DOCS or the Tasmanian equivalent?

Departments only act when they are up before the magistrate or when the local high school counsellor says that Jason is acting antisocially. If it is a housing problem, the social worker comes in and tries to help mum. Centrelink might get involved because Jason needs a special payment. But no-one assumes responsibility for that kid. Barry mentioned it—how do you change the magistrate's role and say that it ought to be part of juvenile justice? We should have a number of houses where we can get social justice for these young people as part of the justice portfolio. Whoever the Attorney-General is in Tasmania ought to be put on the spot to say, 'We are going to divert this kid. We have got houses—he can go straight in. We have social workers to pick him up who are here in the court, so they understand what he's doing,' rather than 'I'll divert him. Next case, please.'

Ms Hordern—I think you are quite right. The need for better integration or communication between these different sorts of services is something that the health and welfare industry needs to look more closely at, because some of these families—as you pointed out—can have maybe five or six different service providers involved with them. One person is thinking that is being looked after and it is not. It happens all too often. There are good examples around Australia of government departments putting some time, energy and resources into developing protocols and

training their workers so everyone knows, for example, that this is how you link with the police and these are the sort of joint programs we can deliver together.

Mr QUICK—But it is hit and miss though, isn't it?

Ms Hordern—Yes.

Mr QUICK—And the number of people we are dealing with—

Ms Gaha—That is true.

Mr QUICK—is tens of thousands. It is okay if you are dealing with a small community—you are obvious. But walking down the streets of Melbourne, Sydney or Brisbane—

Ms Gaha—You are not. If I understood what you were saying, you are suggesting that each service needs to not take such a limited view but one needs to be nominated to take ongoing responsibility for a person. Is that what you are suggesting?

Mr QUICK—Back to this juvenile justice: the Tasmanian minister for housing and children's services has got a place called Ashley, where they put young recidivists. She is spending $6 million to house those 30 kids who keep going through. I know some of them because I taught them but we never had the resources at my local disadvantaged school to sort them out. One is now in jail for the rest of his life for murdering his mother. There is a cost to society. But you need people there and then, not two or three weeks later.

Ms Gaha—Yes, exactly.

Mr QUICK—But whose responsibility is that? Does the school principal say, 'Here is a problem'? Is it the responsibility of the magistrate? No, they do not. It is too hard. They do not want to get involved. So these people fall down and there is a cost to pick up the families because they do not fit into the Centrelink guidelines or the criteria does not match. We need to change those rules and regulations so that when someone presents I can pick up the phone and get them a house straightaway—I can sort out the paperwork later. That is what Barry was on about. First assistant secretaries in departments or the GP should be able to ring the Royal Hobart Hospital and say to one of the senior staff there, 'I need to get someone in 6A. Treat them right now.' They can sort the paperwork out later. That does not happen.

Mr O'Connor—I think this is a problem we are dealing with all the time. I think there are many magistrates who are very much acutely aware of this because they are sensing the frustration. In some places this is done better than in other places because we have, for instance, protocols or memorandums of understanding—whatever they might be—between child protection services, alcohol and drug services or juvenile justice, et cetera and perhaps that has worked out a lot better. But it is a perennial problem. Maybe it also comes back to the training and education of workers and the idea of putting policies and procedures in place that are going to cross all these areas. Otherwise, we will still keep getting the agency dump all the time and we will still be getting responsibility shoved off, et cetera.

Dr WASHER—Talking about policies, Maurie, I want to run a hypothetical past you. The earlier the intervention, the better, as we all know. So now we have got the school teacher; 'Joe Blow' in the street is concerned because he observes the young child who behaves in a dysfunctional way. How would you suggest that society should be concerned about this child? There should be an assessment of this family to find out why they are dysfunctional and address, treat and manage that issue at an early stage before it gets to the legal stage. Who would we ring and how would we go about it? If that process is not in place, what would you suggest that we do to put something in place to address that problem?

Mr O'Connor—Who would you ring? That is a good question because it does follow on from the last one.

Dr WASHER—Yes, it is part of that.

Mr O'Connor—We may be talking about some sort of integration of youth services and skill services, essentially, and maybe child protection services, because really we are talking about a crossover of all those services which have some sort of role to play there. We could be looking at a model that works to, say, a key worker that is identified and supported by all those agencies. That may be one way of doing it; I do not know. I do not have any simple answer to that, but that would be one way of doing it.

Mr QUICK—But then most of the models are only nine to five.

Ms Gaha—Child protection models are not, so if it involves a child, and if the teacher makes a call to the state or territory child protection department, that should not be a nine to five service. That would be an appropriate thing to do. Some schools, particularly private schools, employ social workers over and above school counsellors, particularly because of our perspective of seeing the person in society and the interface between the individual issue and the political process and policy. If that teacher happened to work in a school like that, she or he could call in a social worker who could then manage a response.

Mr Magers—For me, it is really about having services that young people feel okay to access. If there was a teenager walking down the street who felt left out, I would be happier if there was somewhere that that person would feel comfortable to go and get some support, get some accommodation, get some treatment if they needed it, have access to medical services—that sort of thing. I think it is the responsibility of the community, basically. In services, when we talk about things such as legislation, we set up quite a few services that operate a policing system. We have family services that police the family, and we have the courts that police different aspects. We do not have a lot of treatment services. We spend money on policing but not on fixing the problems, so we know what people are doing and when they are doing it, but we do not have the resources or the services in place to turn some of those behaviours around and offer that particular young person some meaningful employment and some access into the community—having access to people who care about them and are able to provide systems and that sort of thing.

Mrs IRWIN—I want to get back to service shortfalls. It really concerns me that I read here in your submission—and I quote:

Many AASW members reported difficulty in accessing services for clients with substance abuse issues. Some reported intake waiting times to services being too long. By the time a place was available clients had lost the motivation to engage with the program offered.

I am hearing this within my own community and virtually right throughout Australia. I am going to talk about a young person who has a heroin addiction. They might go to see a social worker, and they want to go into rehab—they want to detox. They are told by the social worker to pick up the phone and ring around to various places—and it is very frustrating for the social worker who is also ringing up places to find that there are no places available. Can you give me at least one example of any cases that you know of? And what exactly happens to these people? They walk back out the door and you pray to God that they might come back in a week or two weeks when that service is there for them. Maurie, in your experience, are there not enough places even in the ACT for these people?

Mr O'Connor—In the case of people with opiate dependence, we are seeing this constantly. People will keep using because they have no other alternative, until there is something available at that time. It is exactly the point you are making: with drug dependence and drug abuse problems, services have got to be there right then, when people are ready to use them. If they are not there then, you have missed it, essentially, and that is it. It is something that we do not have enough of. There are simply not enough detox beds; there are not enough ready access or drop-in counselling situations; and there are not enough other services that people can access that easily. So they will go away. They will come back again. That is the point: they will come back again. But that initial occasion might be the time, and you never know when it will work, because that might be the time when they keep going with this process.

Mrs IRWIN—You are all practising social workers, so you are working on the streets with people with an addiction?

Ms Gaha—The two gentlemen are.

Mrs IRWIN—I will put my question to Tony and Maurie. As you know, we are looking at the effects of alcohol, tobacco and illicit drugs. I really want to talk to you now about illicit drugs. As social workers, and if you could put some form of legislation in place, what do you reckon is the best way for government to go? Tony, you are from the ACT?

Mr Magers—Yes.

Mrs IRWIN—Was it frustrating as social workers when the Prime Minister intervened to stop heroin trials and a safe injection room?

Mr Magers—I guess it is frustrating when options are limited. The way of resolving lots of these issues is to have lots of options. It is interesting, when you are talking about detox, rehab and that sort of thing, that people tend not to give up once, generally. They might go through a detox a number of times; they might go through a rehab a number of times. Sooner or later they will stop, and they pick up those skills and they decide that they want their lives to be different. So having those opportunities there is really important. That is my answer to your question: having those opportunities there is really important. Keeping people safe, keeping people alive, is really important, so that they can take that opportunity to change. To ensure that they are not picking up chronic diseases and that sort of thing is really important.

With respect to legislation, there should be a range of opportunities for people—and I agree with your point about when and where they need them—and it is important to strike while the iron is hot. My experience of working in the drug and alcohol area is that people change when they have a good enough reason to change. That can be a different reason for a different person at different times.

Mr SCHULTZ—I want to carry on from the points that Julia and Harry made with regard to facilities. Like Julia, I had a mother come in to see me. She had a 14-year-old son who was addicted to heroin. She had been everywhere. She lived in a rural town, 400-plus kilometres from Sydney. She came to me in desperation because she could not get anything to help her son. The son wanted to be helped. My ring-arounds got basically the same result, until I contacted the Salvation Army. They went out of their way to send somebody down and that little fellow, fortunately, is on the way to mending his health. The point I am making is that we are dealing in this inquiry with about 69 different agencies or organisations that are all wanting to do something about illicit and licit drugs throughout this country. Each of them is competing for dollars; many of them are not talking to one another. So everybody is looking after their own little box and have their own methods of getting the funding.

The end result is that a lot of good that could be coming out of the money that is going into those organisations is not being delivered to the people most in need—the people with the addictions and the problems. It is painfully obvious to me, as a rural based politician who looks after an area comprising 41,000 square kilometres—and that is probably an average sized area for a rural based politician—that we do not have enough rehab facilities or any of those facilities that can guide and help young people in particular. They are the ones that we have to get at early—the young people.

Can you give this committee any feedback as to whether you believe, like I believe, that there is a massive problem out there? We have a lot of good people who in their minds are trying to do good things but who are creating a massive problem for the people who need it. Do we have to look at how we are spending our money to the effect where we get these groups together and say, 'Right, we want one multi-functional organisation that is going to deliver all of the things that we need to deliver, and the end result, the positive outcome of that, is that we get people into a program that is going to help them'? Can you make a comment on that? Before you answer that, as politicians we have a problem in that when we get some detail—despite the fact that people might want us to get the detail—we are hit with privacy problems. That makes it very difficult for us to try and help them in that respect. That is another issue.

Mr O'Connor—Regional services are not that well set up and are not geared in that sort of sense, especially in rural areas. In the ACT, we have the only medical detox in the whole south-east region of New South Wales. We are simply not organising and targeting services in the sense of catering for rural and regional areas particularly. If we are structuring on that basis—if we are looking at the fact that there are detox services, other counselling services and a range of options that can be available on a regional basis—and if we are feeding into that, I think we are going to do a lot better.

CHAIR—Does anyone wish to quickly add to that?

Mr Magers—Services with competitive tendering have an interest in not sharing information because they are competing for the dollars, so you do get that isolation. My experience has been that you do get isolation amongst services and that it is a problem.

Ms Gaha—So that might not be the best way to allocate funding. It raises that question.

Mr SCHULTZ—I have just a quick comment to close off. The issue is that these young people have a minimum of six, seven, eight or nine months to wait before they can get into the serious treatment. That is the problem that I have.

CHAIR—Thank you very much, witnesses.

[1.58 p.m.]

GRAYCAR, Dr Adam, Director, Australian Institute of Criminology

MAKKAI, Dr Toni, Director of Research, Australian Institute of Criminology

WILLIAMS, Mr Paul, Head, Public Policy and Drugs Program, Australian Institute of Criminology

CHAIR—I invite representatives of the Australian Institute of Criminology to come forward. Welcome. I am sure you would like to make a brief opening statement.

Dr Graycar—I am the Director of the Australian Institute of Criminology. I would like to introduce my two colleagues—on my left is Dr Toni Makkai who is our research director, and on my right is Paul Williams, who heads one of our groups that looks at drugs and drug policy. I have a few introductory comments and I am sure there are questions that members of the committee would like to ask. The Australian Institute of Criminology is Australia's national centre for the development and dissemination of data relating to crime and justice. As such, issues relating to drugs are an important but not an overwhelming part of our work. We are not primarily a drug agency but we do undertake a couple of very significant projects that relate to drugs that I am sure people will be interested in. We certainly have a great interest in making sure that the data upon which public discussion takes place and policy is made is sound, accurate, informative and communicated in a way that is not there to mystify potential readers.

Within our fairly broad charter, our work on illicit drugs incorporates two major studies. Some of the papers that I have just tabled summarise some of those materials, and I can take you through some of those later on. Our two major drug studies we call DUMA and DUCO. DUMA stands for Drug Use Monitoring Australia. This involves interviewing police detainees, at the moment in four sites around Australia, on their illicit drug use and criminal activities, and cross-validating that data with urine analysis. We do quite lengthy interviews with people in police lock-ups, and we ask them to pee in the bottle so that we can confirm the illicit substances in their urine with the data they have given us in the interviews, and out of that we have an enormous amount of data that relates to their criminal activities. This study has been in progress for about two years, and we have data on about 2,000 detainees.

We have published a number of reports, but we are only in the four sites at the moment. Dr Makkai looks after DUMA. Our second big study is DUCO, which Paul Williams looks after. That stands for Drug Use Careers of Offenders, and involves interviewing sentenced prison inmates on their illicit drug use and criminal careers. This study has been in progress for about six months. Again, we have data on over 2,000 male inmates at the moment, and we will be obtaining similar data on females and juveniles in the next stage. These two are ways in which we gather original data about the links between drugs and crime. Basically, what we want to talk about today is that link between drugs and crime because that is our core business. We have not done work on the much broader areas of some of the social and family impacts; we want to confine ourselves to those and we will talk about some of the issues.

We also have other studies. We work on the illicit drug reporting system. We have just done an evaluation of the South Australian police market intervention in trying to reduce drugs that are on the streets. We are currently starting an analysis and evaluation of the Queensland drug Court. We are also starting a project on property crime and the markets for stolen property in the ACT. We are doing a project on drug driving. We are writing up a study on the links between property crime and illicit drug use, and another study we have done with legal aid practitioners on the drug careers of people that come through. So in addition to all that primary research, all of those projects fall within the areas of my two colleagues. In addition to that primary research, we have researchers analysing data out of smaller projects.

I will just take a minute or two to go through some of the key issues. Depending on how you define it, around 10 per cent of people who are in prison are in prison for drug offences. However, as many as 70 to 75 per cent of people who commit offences that we know about commit offences where there is some drug link there. We are finding this out of our DUCO work. So while most of our drug use statistics talk about the illicit activities of drug use, we do know that many burglaries are committed, we know that there is some violent activity that takes place as a result of drugs. It does not find its way onto the charge sheets and that is not the offence for which people are arrested or convicted.

We know from our data—and we go into it in a lot of detail—that drug users report committing more crimes than non-drug users. We know that people who are detained by the police are more likely to be drug users than not. People who are imprisoned are more likely to be drug users than not. Between about a quarter and two-thirds of property offenders detained by the police test positive to opiates—we find this in the urine analysis—and the reason that it is between a quarter and two-thirds is that in different sites we find different concentrations of drug use because the markets are different. The 64 per cent figure that we have is in Bankstown in New South Wales and the 23 per cent is on the Gold Coast. We can see that there are enormous differences in the number of burglars who use heroin, for example.

When we look at violent crime we find that between about 10 per cent and about one-third of violent offenders test positive to amphetamines. There is clearly a significant link and, in the report, those who use drugs are committing more crimes than non-drug using offenders. One of the questions in our DUMA study says, ‘In the 30 days before you were detained had you committed any offences?’ Of the people who use heroin, more than 53 per cent of dependent heroin users had committed a property offence in the 30 days before they were arrested—and this is not the offence that they were arrested for. Of the non-heroin using people only five per cent admitted to committing a property offence.

We collected the data very confidentially. We guaranteed the respondents that none of their individual data would go back to the police, that the information was purely for research. Also, in the 12 months prior to their arrest, the heroin dependent detainees had been arrested on an average of 3.8 times in the 12 months before, but the non-heroin users had been arrested about 1.8 times. So in all the data and all the stuff that we are starting to assemble we find that people who get caught for property offences—because you have to remember that in all of the data what we know about offenders is about those who are caught not those who are not caught and we can have some methodological arguments about those—are more likely to be drug users. Ninety-three per cent of property offenders said that they tried illicit drugs; 85 per cent had used them in the previous six months; 53 per cent had said that they were addicted; 41 percent said

that their offending was due to their illicit drug use, and about 26 per cent said they were sick for illicit drugs at the time of the offence and that they were really hanging out for them.

So these are some of the data coming out of material that we are doing in our DUMA project. We have not analysed the data in our DUCO project yet but these two are very significant studies because, by and large, the national data that we have in Australia on drug use and the relationship between drug use and crime, and law-enforcement and drug use, is very poor. Our data are very poor for the sorts of policy decisions that we are likely to be making. Our national surveys are useful for some of the social issues but not for drugs and crime. We do not analyse stuff at a sufficiently small area level. Our crime statistics do not tell us about cause and they collect fairly limited information. By and large, when we start to deal with some of the big questions about what comes first, drugs or crime, or whether drugs cause crime, or the options, or how well law-enforcement is doing, we do not really have the data to answer many of our big questions unequivocally and clearly.

Nevertheless, at the Australian Institute of Criminology we are trying and we hope that the two big studies that we have will go some considerable way to solving some of the information gaps. The papers that I have laid on the table are some of the things that we have done since we appeared before the committee last time. We gave you a bundle of papers then; these are all the new ones in the last 11 months.

CHAIR—Thank you, Adam.

Ms ELLIS—I am going to have to be brief because I have to skip out to another meeting and come back. I think you have partially answered this question in the words you were just using; most of the police budget, to an observer, seems to be going to doing something after a crime has been committed, and I am talking about the drug issue and all of those references you were just making. Is this the best way we can do it? Do you have an opinion on how police budgets—and I am using that term because I do not know how to put it—could be used more at the prevention end?

Dr Graycar—I think that is a very large question.

Ms ELLIS—It is.

Dr Graycar—The answer is that no one agency owns drug prevention. There are different policy issues and there are different intervention issues. We heard from the social workers a few moments ago, and there is a range of activities that are very important for them, there is a range of activities for police, and there is a range of activities for health people. One way to look at it is to try to dissect the policy issues, because you have a very different policy story when you are dealing with the import of illicit substances that are going to be used on the street as opposed to a group of high school kids who might be experimenting. It is not appropriate for the police to come in heavy on the 15-year-old kids, and it is not appropriate for the social workers to start dealing with organised crime. There are ways and means of pulling the bits together.

Ms ELLIS—From the policing on the street level then, are we doing it well enough, given the role they have literally in that area? Is there a better way we could do it at that level?

Dr Graycar—Let us unpack the issue. The most effective thing that police can do probably is to disrupt the markets. There are some very significant roles that they can play there to hassle people dealing in drugs, to make the dealing of drugs harder and to destabilise the situation. That is at the street level area. But these things only work if you have a good community policing attitude, the police are respected in their communities, they know who the good guys and the bad guys are, they can get information and so on. So there is a community policing role that is very significant and involves disrupting markets. When we start looking at a different issue—namely, preventing people from going further—then we need to bring into play a whole set of treatment options, and police are not the treatment people.

Ms ELLIS—Yes, that is when the bigger picture takes over.

Dr Graycar—It is the linking. It is for the police to be able to deal with the other agencies. In a lot of ways, the drug courts to some extent are that conduit that can bridge that gap between the criminal justice system and the health system, but it is important to work in partnerships in this area.

Ms ELLIS—You mentioned disruption of markets and so on. Does the institute have a view on the amount of stuff which is seized coming into the country versus the amount that we could predict is being used?

Dr Graycar—I do not know whether you have a view on this one, Toni.

Ms ELLIS—That is a really hard question. I understand that.

Dr Graycar—There is no data, you see.

Ms ELLIS—I know.

Dr Graycar—We have had big seizures in the last 12 months—

Ms ELLIS—And what is 'big' in relative terms to what we are talking about?

Dr Graycar—We do not know about what has not been seized. Furthermore, what we certainly know about our amphetamine use and our cannabis use is that a lot of it is produced locally and moved around locally, but there is a lot of importation of amphetamines as well. It is understanding the flows within those markets. It is something that we are very interested in, but we are not likely to be able to get the data to tell us what has come in and what has not. It is a much harder research question.

Ms ELLIS—So rather than getting data, is it actually drawing a hypothesis? Is it actually saying, 'Through all of our information, we have a guesstimate of X number of users in the country,' so we can guess on the data that we have got on these people? We somehow have to get a fix on this, for want of a better term, so you have to try to somehow draw some bits of information together. There are estimates of the numbers—to pick on heroin—of heroin users in the country, and then you can assume certain things from those numbers in terms of rate of usage and therefore dosage and therefore quantity. You can draw these theories. We are doing more of that obviously, because we cannot get the hard data. So in relation to that, do you then

try to draw a measure—and I am not trying to condemn the seizures; I am trying to get a feeling for what we are doing and how well we are doing it—of what we actually capture versus what we believe may be the picture of usage? Is that the other way we can do it?

Dr Graycar—That is another way. Methodologically it is much harder. Paul Williams has been responsible for the household surveys, and he got right into the household survey details. First of all, we have to believe that what people tell us is the truth. Secondly, when people say they use moderately or they use a lot, some people use a lot and some do not, and then it is just trying to build up this picture of how much is actually being used over what period of time. Thirdly, we look at what part of the supply is local and what part of it is imported. Certainly, at the Australian Institute of Criminology what we have tried to confine our focus to are the villains of the drugs and crime scene, because we have not reached out to people who use at parties or socially. Some of these people might do it very, very rarely, some might do it regularly, and some of the kids might do it together and never commit other offences. That is a different research question and a very important research question. It is something that I am sure we would be able to tease out with some of our colleagues, but it is something we would have a great deal of difficulty doing.

Ms ELLIS—I understand.

CHAIR—You noted in terms of the big picture questions those issues which you had not been able to address. You have been with this business for some time now. What about the issues that we have addressed in, say, the last decade? It seems to me that the heightening of awareness, for whatever reason, has drawn your organisation into this debate in an ever increasing way? Could you just take me through your experience—you can use a decade, or you can use your own time line—in terms of the focus on the issues that you have endeavoured to address? Can you give us a perspective? It seems to me that the linkage across police resources, incarceration or just general crime issues related to substance abuse has created a growth in awareness about this. Have we always thought in this way? Was there a change in thinking?

Dr Graycar—There has been a growth in awareness and there has been a growth in criminal activity. There is greater sophistication. Certainly, in terms of the papers that we have done, No. 205, which is titled 'Drug Detection and its Role in Law Enforcement', talks about the better technologies and how we can understand things better; No. 201, 'Age of Illicit Drug Initiation' by Doug Johnson, tells us that kids are using at an earlier age, so we know that; and 'Illicit Drug Use in Regional Australia' that Paul has done tells us that there is more illicit drug use in regional areas. As we go through them, there are lessons we can learn from each of them.

From what we have seen over the last decade, for example, it is interesting to counterpose the harm minimisation arguments against some of the law enforcement arguments. From a health perspective, harm minimisation has worked very well, because when we look at the big picture there are lower rates of HIV—lower among injecting drug users—for example, and more people understanding the associated harms and the way in which these can be limited. But on the crime front, in the last decade to 15 years, we have seen increasing crime rates, we have seen increased drug use, and we have seen, as I pointed out a moment ago, decreases in the age of initiation—that is, younger kids are using—and more who are using injecting. When we do our comparative work, we have higher rates of opiate use in Australia than most similar countries.

CHAIR—What I am endeavouring to draw out is: what was at the top of your research agenda a decade ago?

Dr Graycar—None of us was at the institute a decade ago.

CHAIR—How long have you been there?

Dr Graycar—I have been there for six years, and we hardly did any drug work when I came into the institute six years ago. The first paper in my time that we did was on the whole issue of the decriminalisation of cannabis and looking at the different range of penalties that related to that.

CHAIR—I have had an indelicate thought: that the improvement in technology and detection may be proportional to the improvement in the methodologies producing marijuana—but I won't get into that—in other words, hydroponics and the purity. Everybody is improving the system. We have a focus on this issue like we have never had before. While I respect the fact that there is a lot to be done, it seems to me we have an enormous amount of increased knowledge.

Dr Graycar—Very often the more you know, the more you realise there is a lot you do not know.

CHAIR—Yes.

Dr Graycar—I might ask Paul to tell us something about the household surveys. That, at least, is the community reflection of how much drug use there is. We know the crime rates have been increasing, and we know for the first time about the links.

Mr Williams—In answer to your question about why the institute is now concentrating on this—and other research people are—it owes its history to NCADA, the National Campaign Against Drug Abuse, and the National Drug Strategy. In 1985, it was first expressed and agreed by all states and territories that they were going to have a three-pronged approach: supply, demand and harm minimisation. When you start concentrating on supply measures, you need research, and that is why we became involved in it.

The household survey has been done on six occasions now. Previously it had very small samples—2,000 to 3,000. In 1998 we raised it to 10,000, and this year it is being repeated with 20,000. So the data that we got way back in the eighties is not very reliable in relation to these substances, which have low preference rates—we are talking about less than one per cent. The reliability of that data is very questionable. It was not until about 1991 that we started asking questions in the household survey about crime, principally alcohol related violence. Only in 1998 did we ask about whether they were committing particular crimes to support drug habits.

Generally, across that whole period, we saw a general escalation of drug use and other antisocial activities. Between 1995 and 1998 we saw the largest increase that there was over the full period.

CHAIR—What is your definition of 'regional'?

Mr Williams—For the paper I have done there, capital cities in the greater metropolitan area are considered to be metropolitan, and everything else is regional. Places like Wollongong would be considered regional.

CHAIR—What I am leading to is: how easy is it in your work? I can understand the definition of metropolitan, I can understand Wollongong and I can understand certain other cities around Australia. But, if you went to a population of 1,000 people, I would say that in your work it would be impossible to get a picture of every group in Australia, and there are a number of small communities.

Mr Williams—It is unlikely that we spoke to anybody in a population size of 1,000. The way we do the sampling is to ask ourselves: in all the census collectors' districts, which are generally a block or two, if we are going to give you 10 people in that census collector's district, given the total sample size that we need to interview, how many census collectors' districts do we need? We randomly draw a census collector's district, and then we randomly draw a household within that and then every two houses thereafter. So it is unlikely that we would find anybody in that under 1,000 group.

CHAIR—I am sure your research is very good; I just wanted to get a picture of what the basis of your data is.

Mr Williams—We have aggregated all the data for the regional areas across all of the household surveys to give us a sufficient sample size to make the results reliable.

Mr SCHULTZ—Can I compliment you on the papers that you put out and, more specifically, can I compliment Paul on his 'Illicit drug use in regional Australia' paper. I say that because in the mid-1990s as a state parliamentarian I was alerting the public to the availability of illicit drugs in rural New South Wales, and I was being ridiculed by the police at that time. Travelling through the countryside at all hours of the night and morning, I saw it being moved. I gave information, and a lot of that information was not acted upon. So can I suggest to you that you think very seriously about doing a paper relating to the community relationship with the police and illicit drugs. It would be a very good paper for you to do. I have had a situation more recently where I went into a town in my electorate. I represent the seat of Hume which covers 41,000 square kilometres. I walked into a dry-cleaning shop and I was immediately given some information on drugs, yet the police were doing nothing about the problem. That is my reason for suggesting that you might take that into the possible paper in the future.

Given the comments that I have made, have you in all of your experiences had any feedback from the community about that sort of relationship?

Mr Williams—Not in regional areas specifically. There is another study which we do, the drug reporting system, which I think the committee has been told about, particularly in Darwin when you were up there. That involves interviewing injecting drug users, talking to drug professionals including law enforcement and treatment service people, and collecting administrative data which is routinely collected as part of their normal activities. Included in both the key informant—that is, the drug professionals—and the injecting drug user surveys are questions on the relationship between the police and users and police and other professional agencies. We

have a lot of data there, but it is confined to capital cities in all of the states and territories. It does not go into the regions.

Mr SCHULTZ—On the issue of identifying more accurately the extent of drugs in the community, do you think it would be appropriate for more police to be given random drug tests to see that they are in fact not only in the role of law enforcement against illicit drugs but are not actively involved in using?

Dr Graycar—I think that is a matter for the police to determine in terms of their whole management process. There is a great difficulty in trying to understand where the police are actually at. The issue of random drug testing is an important issue to place on the agenda because we know that not only in police but in other occupational groups there are significant deleterious effects if people are intoxicated on the job, even if there are levels of drug use—using alcohol and other illicit substances. It is a significant industrial issue. I think there are some significant advantages in working this through, industry by industry, because the harms to the community are very great, right across the spectrum, if people in the workplace are intoxicated.

Ms JULIE BISHOP—Your information on illicit drug arrests, on pages 6 to 12, indicates that cannabis arrests are trending downwards, and heroin, cocaine and amphetamine arrests are trending upwards. In relation to drug seizures, there has been a considerable increase in seizures, from 761 in 1984 to 2,816 in 1998-99, a majority for cannabis. Is there any discrepancy there?

Dr Graycar—There are always discrepancies when we look at arrest data for drug offences, because what they reflect is not the amount of drugs that are in the community but the priorities of the police at a particular time. This is why our projects such as DUCO and DUMA focus on the drug use careers of these offenders rather than on what the police priorities are.

Ms JULIE BISHOP—So the answer to why the number of arrests for cannabis are declining is not that there is less cannabis coming in; it is just that that is not a priority? It is not the same priority?

Dr Graycar—Yes.

Mr Williams—A vast amount of cannabis is produced locally. We have a number of jurisdictions, of course, which permit possession of small amounts or certain numbers of plants, and that has expanded over the period of the last 10 to 15 years. And as Adam says, it is a reflection of police priorities. If police think that they can more effectively allocate their resources to other drugs, then cannabis becomes less of a priority.

Ms JULIE BISHOP—Yet the seizures statistics show the majority of the increase in seizures is for cannabis.

Dr Graycar—Again, it is the bigger question of going after the suppliers rather than the users. Secondly, for cannabis several jurisdictions have a cautioning arrangement in place that does not come into the statistics. People who use are dealt with. The offence is expiated rather than it going through the whole of the process. So it is really about the strategies of police

priorities dealing with legislation. If we see larger cannabis seizures, then one would see the logic of that being: let us go after the big supplier rather than the end user.

Ms JULIE BISHOP—In your opinion, what proportion of the illicit drug trade does the 2,816 drug seizures that were recorded in 1998-99 represent?

Dr Graycar—I would not even be able to hazard a guess because, as I was saying earlier on, we just do not know how much there is. We do not know how much has come in illegally; we do not know how much is grown. What we know in our data is about some people who are caught and their drug using behaviours and the other criminal activities that they commit. What we do not know we do not know.

Ms JULIE BISHOP—So there are no ways to ascertain what proportion that might be? We cannot even hazard a guess?

Dr Graycar—We could probably do some modelling out of something like the household survey to try and estimate how many people use, how often they use, what quantities they use, and then if you—

Ms JULIE BISHOP—And then translate that back to what is produced locally and what must be coming in?

Dr Graycar—And what is seized locally, if the question is what is seized as a proportion of what is used. But even that would be fairly hit and miss, as I was saying before, because we do not have as much data as we would like to have. If we started developing some sophisticated statistical modelling, what we could essentially be doing would be working with poor data and refining it and refining it and refining it. We would have to look at it methodologically very carefully. I am sorry I have not been able to answer your question. I am sorry I have not even been able to get into the same ballpark with you.

Ms JULIE BISHOP—There is nothing that you can think of, apart from this sort of modelling you have been discussing, that would enable you to gain the information that might give us a better picture of the extent of the illicit drug trade?

Dr Graycar—It depends—again, going back to the question of the objectives. In our work, we are particularly looking at people who commit offences. That has an antisocial and a very harmful and destructive effect within the community, so our work is saying let us do some more data on this—let us understand the processes, let us understand how the policing works, how the drug courts work, what the treatment activities are—to reduce criminal behaviour. That is our work. Other agencies may be able to do some of the modelling, but our role is to try and both prevent and reduce criminal behaviour and make our community a safer place.

Dr WASHER—I am fascinated by the stats here on amphetamines, the bulk being from the UK, and on cannabis, the bulk being from Europe. Is that because our detection is better because of our cooperation with these countries? Is this reflected in that, do you think, or is it just that these are bad dudes, basically? I have always wanted to call the British ‘bad dudes’!

Dr Graycar—First of all, things have fluctuated a lot. We found in our studies earlier this year in our DUMA project that amphetamine usage in Western Australia had just gone through the roof and there had been a very significant rise in the amphetamine in the urine of the people who come into police cells. We think that is a very good reflection of what is out there on the street.

We know that amphetamines can be moved in fairly concealable ways. We do not always know the routes the amphetamines follow. We do know that there are significant amphetamine factories in Burma. They come down through South-East Asia. We do not know what routes they come through. We also know that a lot of amphetamines are being produced in mobile laboratories within Australia. Even tracking the sources is hard. One of our suggestions is to look at trying to develop an amphetamine signature project to at least be able to identify where they come from because the ship that you get them off may not have come from the place where they were made.

Mr LAWLER—There is an apparent increase in the use of amphetamines or the level of amphetamine arrests is increasing in comparison to marijuana, but I understand that amphetamine arrests are also increasing in relation to heroin and cocaine. Is that right? Or as a group are they all increasing?

Mr Williams—All are increasing. Amphetamines are increasing at a faster rate than others are.

Mr LAWLER—Is there a difference in the types of crime that people are being arrested for in amphetamine related arrests versus heroin related arrests?

Dr Graycar—Remembering that our data is about the amphetamines and heroin in the urine of people who are arrested for other things, very generally—and Toni might elaborate on this—more people who are arrested for violent offences have amphetamines in their system and more people who are arrested for property offences have heroin in their system.

Dr Makkai—From our DUMA research, what we have found if we average across the sites, in the data from 2000, 18 per cent of those arrested for a violent offence tested positive to amphetamines. While for those charged with a property offence, 45 per cent tested positive to opiates, so we see a slightly different correlation. However, it is also important to realise that a number of the property offenders also tested positive to amphetamines. This goes to this issue of poly drug use. We find that many of these people are using multiple drugs, not just one drug.

CHAIR—In your work is there anything at all that is able to demonstrate a particular community where there has been a real impact on drugs compared to another community? Is there anything that has come out of the woodwork in all of your work which shows something which is quite starkly different anywhere in Australia? That is a very broad question but I need to ask it in terms of testing. Is there something that has very clearly happened?

Dr Graycar—We would like to do a study of that sort. I have been thinking about it in the last couple of weeks in discussions I have had with people in Canada, to take similar types of small communities and start to look at their capacity to build their social infrastructure and so on. The simple answer is that from our DUMA project. We concede that there are very different

patterns of drug use, for example, in the western suburbs of Sydney compared to east Perth, compared to the Gold Coast. The drug patterns are very different. Then we can start to dig down as to why. They are demographically different. The answer is yes, there are differences.

CHAIR—It is on the drawing board in terms of a better understanding of some of those things. This is to everybody but I want to come to Toni as well. I note in the crime related, substance abuse issue, women are showing at 90 per cent. I am quite curious as to why it is 70 per cent and 90 per cent. Can you give us some basic feel for that?

Dr Makkai—As to why there is a difference?

CHAIR—Yes.

Dr Makkai—It is really this methodological problem of how you measure. That is what creates the real problem. Depending on how you define it, ranging from whether they have ever tried a drug right through to whether or not they self-define themselves as dependent, you get very different levels in the relationship. We do not have a consensus across the research community in terms of what we define as drug dependent and how to measure that.

Dr Graycar—What happens is that very few women commit crimes. A lot of men commit crimes and they are across a wider spectrum. The small number of women who do commit crimes are more likely to have had drug problems, and you can go through a whole lot of other factors that they are likely to have had—abuse problems and so on.

CHAIR—That helps, but I thought that the base might be similar in terms of the criteria—that the 70 per cent and the 90 per cent were on similar criteria. That was the impression I had.

Dr Makkai—Sorry, I misunderstood what you were asking me before. Yes, that is true, if it comes out of the DUMA data. But the other thing to remember is that maybe the offences for the women are not the same as the offences for the men. We are looking at police detainees, so that data is aggregated up. To answer your question, we would want to disaggregate down to the actual offence charges and then look at those. What we tend to find is that women who come into the police lock-ups tend to be people who are more concentrated, in terms of having more serious problems, as opposed to the males, who come in for a whole range of offences.

CHAIR—It goes back to this narrower base, I suspect. I do not know. I have one last question. You have drug use amongst police detainees. The thing that I found fascinating was in terms of our jails. It is just accepted in this country that drugs will be in prisons and that the only place you might find a drug free environment in a prison is where the incentive is to have a better deal in another part of the prison. That is my experience. You can tell me if I am wrong. Has any work been done on the availability of drugs in prisons? Paul, I think has done a lot of work with prisoners. All three of you may have. What is the evidence coming out of the prison system regarding access to drugs and the management of drugs within the prison system?

Dr Graycar—We have not analysed the data yet. Our preliminary data reflect what you are saying, but I think we are still coding. Correct me if I am wrong, Paul, but we do not expect to have all of our material coded until about the end of June. We will be running workshops with each of the jurisdictions between about August and September to take the data up. In the ques-

tionnaire, interestingly, we ask a general question and then we have a sealed section that asks people about their drug use behaviour in prisons. It is very delicate, very sensitive, and we do not know if people are telling the truth, so we have to work through a lot of methodological things there. But the answer is yes, there are obviously drugs and when we have an informed view, we will certainly communicate that.

CHAIR—We asked prisoners in the jail and they answered as discreetly as they could and said that yes, clearly drugs are available in the prison. That is an accepted part of the prison culture of Australia.

Dr Graycar—Right. We are going into where they get them from, who they get from and how, and what they pay and so on.

CHAIR—Yes. There are a whole lot of interesting issues around that. Once again, thank you for appearing before the committee today.

[2.44 p.m.]

LEAHY, Mr Denis, Program Manager, Pharmacy Methadone Incentive Scheme, Pharmacy Guild of Australia, New South Wales Branch

MAY, Ms Khin Win, Policy Officer, Strategic Policy Division, Pharmacy Guild of Australia

PHILLIPS, Ms Wendy, Director of Strategic Policy, Pharmacy Guild of Australia

CHAIR—Welcome. I invite you to make an opening statement.

Ms Phillips—Firstly, I apologise for the absence of our CEO, Stephen Greenwood, who was meant to be here today but has not been able to attend at the last minute. I have distributed a copy of the statement, but as it is rather long I thought I would just read a few points.

The Pharmacy Guild of Australia is an employers organisation, and our members are the owners of independent community pharmacies. Community pharmacies are the principal distribution points for prescription medicines and scheduled over-the-counter medicines. In addition to supplying medications, community pharmacists provide a wide range of services including drug information, quality use of medicine information, clinical interventions, medication management services and preventative care services. They also participate proactively in a lot of therapeutic decision making, providing advice and information over the counter. Research has consistently shown that consumers hold pharmacists in high regard as the most accessible health professionals in the community and as reliable sources of information and advice. Pharmacists already play a key role in addressing illicit drug use by providing methadone and naltrexone, dispensing other medications, facilitating needle and syringe programs, and providing professional advice and referral. Some of the major areas in which pharmacies can have an impact on illicit drug use include the following: the provision of community based pharmacotherapies for people in opioid dependence treatment; the provision of drug-related, specific services, such as needle and syringe programs and methadone programs; information and advice regarding general physical and mental health; information regarding drug-related conditions, such as hepatitis C, HIV/AIDS, et cetera; information to parents and friends of drug users; and provision of medication reviews to ensure that people take appropriate medicines appropriately.

We are currently involved in some projects which bear, to some extent, on this inquiry. Perhaps the main one at the moment is a joint guild and PSA national project. The PSA is the Pharmaceutical Society of Australia, the professional organisation. That project has been funded under the National Illicit Drugs Strategy and it is to train front-line workers. It is anticipated that that project will result in the publication of national education and training packages for pharmacists and pharmacy assistants, particularly in relation to illicit drugs, methadone programs, and needle and syringe programs.

Another project that we are currently involved in is not to do with illicit drug usage but with benzodiazapine and the withdrawal regime, to put in place some kind of coordinated approach. I

have given you a poster that is related to that project. That particular project aims to increase pharmacy involvement in an ambulatory treatment service such as the community detoxification scheme. The expected outcomes from the project are: a reduction in the amount of frequency of use of benzodiazepines; a cost benefit improvement in terms of financial reimbursement for pharmacists and subsequent improvements for the client; and a high level of satisfaction with the coordinated care provided.

Probably our main community pharmacy based programs in drug management relate to methadone maintenance programs, and needle and syringe programs. These programs are based on the principle of harm reduction embodied in the National Drug Strategy. One of the issues that we are particularly concerned with is our belief that there is a need to have a standardised, Commonwealth-administered methadone program to increase uniformity, as was recommended by the national review of drugs and poisons legislation in the Gabally report. We believe there is a case for a special category for harm minimisation products, such as methadone, naltrexone, buprenorphine and nicotine replacement therapy, so that they are affordable to people who need them most, and so providers can be properly remunerated. This also will assist in more pharmacies becoming involved in the programs. We want pharmacists to be encouraged to supply needles, syringes and clean equipment, and to act as a return for used equipment, but pharmacists need to be properly resourced and informed, so that this service is at least cost-neutral to them and so that it is promoted as a health professional role in the community We feel that pharmacies working with illicit drug users provide a gateway to other treatment and drug rehabilitation programs.

Our research has shown that one of the barriers to pharmacies' involvement in the provision of services to illicit drug users is the low financial return for work in this area. A partial solution to these barriers, identified by pharmacists, would be the availability of additional consultation-based remuneration to support the pharmacies' role in illicit drug services. For example, there is no item which currently allows pharmacists to case conference with doctors or other health professionals working in this area. Pharmacies already involved with needle and syringe and methadone programs have responded to financial incentives and may do so again in the context of providing services to illicit drug users. We believe that the implementation of a national standardised program would assist to involve a lot more community pharmacies and to provide effective treatment.

As I mentioned before, the guild believes that the Commonwealth should develop a special category for subsidising harm minimisation products so that they become more accessible to drug users who are usually those less well off in the community. Some other material that I tabled for your information was to do with the Quality Care Pharmacy Program, which is a system of improving standards through community pharmacies and ensuring that those standards lead to accreditation and ongoing auditing. We would see that something like the methadone standards would fit into that QCPP.

I would like now to hand over to Denis Leahy who would also like to say a few words. As I said, Denis is the program manager for the New South Wales methadone incentive scheme and is responsible for coordinating that program. The guild believes that that program that operates in New South Wales could well serve as the basis of a national model.

Mr Leahy—I have been a community pharmacist involved in addiction care for 23 years. The first person that I treated was 23 years ago. That young lady entered university, completed her course, completed a PhD, married and has a family now and is totally off everything. She was one of my very first success stories of people I have been involved with, and it continues right up until today. Whether or not the success is measured by people obtaining abstinence or actually getting their lives together, both of them are laudable goals and goals that are actually worth while achieving and presenting.

When I was reading the brief for the inquiry, one of the questions asked us to provide workable solutions. I put my mind to it, having been involved with this for such a long time, as I thought there must be some solutions that work. One of the solutions is that pharmacies, by acting as gateways, could actually be the first port of call as they are the people who are most likely to see the person who is out of control. You have two different categories of people. One is a person who is out of control and heroin addicted and another is a person who is in treatment. They actually look to be totally different people. They are managed totally differently and the response to them varies as well.

My proposition is that community pharmacies be developed as a gateway for people who are seeking needle exchange facilities in that we develop a standard set of information to go through community pharmacies. That information would contain a 1800 number that would be available to all people who wished to access drug information. Further, that 1800 number would be linked to an area health service providing treatment services to where the person lives. In the age of technology we live in, there is no reason that a 1800 drugs number could not give you counselling, could not say that, 'If you live in this particular area, the local hospital offers this drug and alcohol service, and I can put you in touch with them.' So all of a sudden we have a uniform message going out across Australia with the same information in it that may be actually useful for people to get them into treatment.

I have put up this proposal on previous occasions and it seems to get lost in the woodwork, but I believe it is a worthwhile endeavour to standardise our delivery of treatment. I also concur with what Wendy has said. From my experience of dealing with other pharmacies, a national system of addiction care that allows a safety net for those who cannot afford the treatment would be a very valuable asset to consider developing by the Commonwealth.

I suppose the other model that I would recommend people seriously considering is what I would call 'Guild methadone', which seems a funny name to call a proprietary product. It is not a proprietary product. It was developed back in 1994 and 1995, when I was working with Maggie Tynan and Danny O'Connor at the Royal Prince Alfred Hospital. We decided to coordinate the efforts of the pharmacists, the GPs and the area health service to deliver an end outcome for the patient. The area health service provided us with the safety net: it was the clinical safety net for managing people with whom, when they came to community pharmacies, we were having difficulty or who were more complex than we could handle. The GPs were able to refer them back to the Prince Alfred Hospital, and so were we. To help us, they were readily taking people back. The other arm of that safety net was that, with people who could not afford to pay for treatment in community pharmacies and who got themselves into difficulty, they would also take them back and re-establish their lives in such a way that later on they could come forward and back to us. That model of a coordinated approach using the GPs, the public facilities in the area health service and community pharmacies has a lot to recommend it, in

terms of both clinical outcomes and social justice for the people in treatment. I am quite prepared to answer any questions—I hope.

CHAIR—Thank you very much. Is it fair to say that the pharmacy business is right at the centre of the drug business?

Mr Leahy—Every day we see a lot of people with all sorts of problems. If our being involved in frontline giving out of needles and syringes is the drug business, we certainly do see a lot of it.

CHAIR—No, not necessarily in terms of legal, illegal or addiction, but generally; that is the stock-in-trade.

Mr Leahy—Yes.

CHAIR—Earlier I raised the philosophy of 'drugs can fix things'. In other words, clearly drugs are very valuable and we all at some time use them to good effect; some are life saving. There is another side to the coin that we are looking at as part of this inquiry, and this may not necessarily be in your area. Yours is a great service industry in that it does a fantastic job, but how can the Pharmacy Guild see the culture of drug taking as being good and then, on the other side of the coin, see some aspects of drug taking as being bad? I am curious: how does a pharmacist generally deal with that in the ethical way?

Ms Phillips—I will let Denis talk about it from a practical point of view. But I think that the fit comes with talking about taking medications that are appropriate for the condition and their being taken in a way which is compliant with the prescription or with the condition of the person. In recent times pharmacists have increased their role of looking at the management of the medications that a person has been prescribed and also the over-the-counter products that they wish to purchase. We think there is a lot of room for continuation and improvement in this area for the pharmacists to work a lot more with doctors and with the consumer about a medication regime so that the person is getting the best possible benefit from a drug. In relation to how they then turn from that to the illicit drug side, I might let Denis comment.

CHAIR—Of course, in there I am really talking about the pharmacy role as being a good role model for positive community education, which is very much a part of it.

Mr Leahy—We have had a number of educational campaigns run through pharmacies in New South Wales that were about the wise use of medicines. With the legally available medicines we said, 'The idea is to use something that gives you an end benefit, and that is specifically for you; the end benefit is for you.' In fact, by doing medication reviews, what normally happens is that you actually decrease the number of medications that people are taking. So it is not in the interests of the community pharmacy to say, 'We should give you more and more medicines.' That is clearly not a good outcome for the patient. If you are looking at outcome-based medicine, you must say that the outcome is the patient's wellbeing. So, as far as what we would call 'prescribed medicine' goes, we are going down the path of saying, 'Only take what you need to get a good outcome.' Those reviews clearly indicate that.

As far as the illicit drug use goes, I am very non-judgmental when people come into my pharmacy and ask me for syringes. I think that maybe one day it could be one of my children who is going to experiment and they may not have a clean needle, so I have a great compassion for the families of people affected by it. You cannot pass judgment. Addiction is like a flat doughnut: you are going to go round and round in circles, and one day you are going to be flat enough to get off, and you are going to find that point in time. If somebody is there offering you advice and help, maybe you will get off then or maybe you will go into treatment. It is the nature of addiction that people will keep on falling off, especially if they were hooked on heroin. So I think community pharmacies, by being non-judgemental, actually perform a great task because maybe one day they will offer the gateway to treatment with their local doctors or area health service people and get them to make some meaningful change in their life.

CHAIR—In your view, what is the evidence on pharmacy violence in terms of accessing drugs? Are there some pockets of concern about the violence and petty crime or serious crime—

Mr Leahy—In obtaining illegal drugs?

CHAIR—Yes, in any form of illegal activity, whether it is cash or whether it is in the pharmacy industry. Is there a concern about violence within that?

Mr Leahy—We are always very concerned about the security of our members. We actually do have, as part of our quality care standards, a safety aspect for our members to manage their our own business, which says, 'Don't put yourself at risk. Do the following in order to minimise your cash handling or the way you have your security or the way you handle your staff or the way you train your staff to respond to a robbery.' All those things are now part of the quality care standards for accreditation. So we are very much aware that we are potentially a target, but what I believe is—

CHAIR—Are you a target? That was really my question, but it was not very well asked.

Mr Leahy—No, no more than any other person in the community who is handling money. If you thought that community pharmacies doing methadone were more likely to be robbed, statistically it should show up. It does not show up. It shows that, if you are handling methadone, you are just as likely to be a target of a robbery as a person who is selling upmarket cosmetics. It is not material what you do; it is the fact that you are one of the retailers who may have access to cash. Some people are finding that a trouble.

CHAIR—Not every pharmacist says that to us or has said that to me—

Mr Leahy—Yes.

CHAIR—Other members did not witness somebody, whom we have seen recently, who was very adamant about the view—

Mr Leahy—Statistically it was done in Western Australia and Victoria. The research—

CHAIR—This fellow had worked in Western Australia. By the way, that is just one view and I just want to test it—

Mr Leahy—Statistically it is not proven that that is the case.

Ms Phillips—However, based on surveys that have been run, pharmacists certainly have a perception that if they become involved in methadone maintenance programs they will make themselves more susceptible to break-ins. This does not bear out in terms of the research.

Ms JULIE BISHOP—Would that depend very much on the preventative measures that the particular pharmacy was taking? I am well aware that in my own electorate pharmacies have armed guards outside their doors, quite visible, so surely that would make a difference to your statistics.

Mr Leahy—There would not be that many people who would be with armed guards, except if they were trading late hours.

Ms JULIE BISHOP—Whether the 9 till 7 pharmacies or the 11 till 11 pharmacies have armed guards or just guards that look like bouncers outside their pharmacies, they are quite evident. Wouldn't that impact upon whether they were likely to be a target for a burglary attempt?

Mr Leahy—If a large number of people were surveyed in Victoria and Western Australia, that would not impinge on the outcome of that significantly. If I had a bottle shop or a TAB and I was carrying cash at that hour of night, whether I had a pharmacy or a newsagency, I would actually have a guard there because I was carrying money, not because of the nature of the business I carried on.

Mr LAWLER—You have a report that says that community pharmacy based methadone maintenance programs have a higher client retention rate than others. I guess you would call them clinic based ones, so I would like you to comment on that. I just wanted to comment on my experience. The report says that a fitpack study conducted by Curtain University in 1997 found that pharmacies were the best place to reach groups of injectors, and that is fine. Do you find statistically that pharmacies are hander-outers, as far as handing out the fitpack goes, but not exchangers? So they do not get many back.

Mr Leahy—I will answer the last question first: New South Wales is the only state which is a genuine exchanger of fitpacks. Statistically we are getting back about one-third of the fitpacks that go out. That does not necessarily mean that the syringes are not properly disposed of in some way, in that the syringes go into the fitpack and they then do not become a hazard. We physically know that, of all the fitpacks we have given out through pharmacies, we get roughly one-third back out of the marketplace altogether. That is quite a significant number to get back. In other states—

Mr LAWLER—Do you have that broken down by city versus country?

Mr Leahy—We could have that. We can actually do that by postcode—

Mr LAWLER—I would be interested to see those figures.

Mr Leahy—because the guild administers the scheme on behalf of the government in New South Wales. Statistically we are able to do that. From the guild's point of view, the preferred option is to supply syringes only by way of a fitpack. Where our members have walked away from that path, we have put considerable pressure on them to get their act together, otherwise we will not support them. Basically, we want them to support only a system that can retrieve those used syringes from out of the community's use.

The first question related to success rates of people. There are a couple of things that would affect the success rate of people going into a community pharmacy, in that you are likely to be in an environment where you are personally known. If the community pharmacy supplies methadone to between three and five people, you are known to them personally. It is in your interest to keep them in your pharmacy, keep their confidentiality and be able to maintain them. Therefore they are more likely to succeed.

People respond to a personal approach. I know every one of my methadone patients by their first name. I am only too glad to be associated with most of them. I know they are not angels all of the time, but a lot of the time they are doing really well. I think that would be the general run of the mill in community pharmacies because there is a lot more intervention and known support there. If you go to the larger structures, where you might have two hundred or three hundred people in large clinics, it is very difficult to get that hands-on approach. It may actually be that intervention that gives you some better chance of keeping them on the straight and narrow in treatment. I think that is probably an element of it. To be fair to the people running clinics, they probably have the most difficult cases to manage—people with dual diagnoses and those who are likely to fall off the tree could well be based in a more difficult situation with a clinic. It is not all one way but there are certainly advantages in both people having a place in the delivery of the service.

Ms Phillips—And it works quite well to have the clinic as the backup so that, if the person does not work out in the community setting, the pharmacist can then say, 'You will have to go back to the clinic because it is just not working in this situation.' It is a very good backup to have, but it is one which does not occur in all states.

Mr SCHULTZ—I want to ask Denis a question which will help me with the comments that I am going make. Does the fitpack contain four needle syringes or six?

Mr Leahy—You have a variety: you can get three, five or ten, so it is like mass marketing. The philosophy behind it is that big is better. That is a very silly thing to say, but it is true.

Mr SCHULTZ—Fewer visits.

Mr Leahy—The reason that big is better is that, if you have more syringes in the marketplace, people are less likely to reuse them. The chances of getting HIV or hep C by reuse are very high. Even though it is not a good outcome to listen to, in practical terms it is the way that people in the AIDS bureau would prefer that system to be supplied. It is readily available. People who are heroin dependent are by nature impulsive. They see the need, they want to shoot, they want to use it now. They are not going to say, 'Well, maybe it is clean, maybe it is not.' It does not work like that. They are so keyed up with their craving that it is best to have it available clean.

Mr SCHULTZ—In 1998 I was a member of the New South Wales state parliament. If memory serves me well, at that time there were 1.8 million needle syringes being distributed in New South Wales. My first question is: was the 40 per cent that you referred to the figure that you were then distributing? The compelling point that I want to make is that today we are distributing 13 million needle syringes in New South Wales and that, to me, is a catastrophe that impacts on the number of people induced into using and on the irresponsible discarding of those needles. So I have enormous sympathy for the approach that the Pharmacy Guild takes over the program. In fact, I have argued that way at another place and another level, precisely because of the responsible way in which you were handling the fitpack needle syringe exchange program. I get a bit concerned when I see you are also using the word 'distribute', which disturbs me a bit. Would you be able to handle the volume of the needle syringe distribution program in New South Wales today or do you think—given that the control in the majority would go back to the Pharmacy Guild—that that number of needles would not be distributed?

Mr Leahy—I think the distributing of the syringes simply indicates the underlying demand that is there for use. I have brought along a graph showing the increasing level of use and exchange, and unfortunately, just as Mr Schultz said, it is going up directly in proportion to the availability of cheap, good grade heroin. In recent times there has been a shortage of heroin and more people have entered into treatment because it is harder to get the good stuff. The quicker we get rid of the good stuff, make it harder to get and make people more willing to enter into treatment, the better. Unfortunately I cannot tell you that just by distributing less we will stop it; I think it is a function of supply.

Mr SCHULTZ—Finally, the reason I asked the question about whether you would be able to handle it is that I am conscious, as a parliamentarian, of an industry that is growing and feeding the ever growing demand out there. I am talking about Alby Schultz as a private citizen going to the local hospital after hours—because the normal health services that operate during the day are closed down—and saying to the lady in charge of the hospital in a rural location, 'I'm Joe Blow from down the road and I have five mates, all heroin addicts. Can you give me five fitpacks?' I am not sure why they call them fitpacks but they are paper bags with condoms, sterile water and half-a-dozen needle syringes. I can pick up five bags and walk out of that hospital no questions asked because of the privacy rules. A visit this committee made to Cabramatta really brought home to me how irresponsible that is. The local council told me they employ a street sweeper to sweep up, four times a day, the needle syringes discarded in their car parks. It is a frightening situation and an enormous danger to the public that we have an industry driven by the distribution of needles to the extent where no questions are asked—they are just given out.

Mr Leahy—The other side of the coin is that if you are being judgmental and you turn them away they will say, 'Look, I won't go there any more. I will reuse the other one. I don't want anybody to hassle me.' Is that the lesser of two evils—that maybe sometime you will catch them into treatment? I really think that where we have not been able to do very well is to offer people guidance every time they come as to where treatment might be available. Some time ago we argued that the fitpacks should have a message on them, and the message should be: '1800—this is where you can get help.' There was some debate about whether that was a positive way to treat people caught in the addiction cycle. I personally believe it is a good way of doing it, because you keep telling people treatment is available and if they want to make a decision they will know where it is. I greatly advocate supplying an increased level of information with any

equipment being given out, in particular where counselling is available on a 1800 number—to divert straight into treatment.

Dr WASHER—I have a question for you, Denis. It seems as though you are caught up today answering most of these questions. We had a person in earlier who commented that the methadone program was fairly difficult in terms of time constraints on the people who are in it.

Mr Leahy—Yes.

Dr WASHER—My questions are, firstly, does one state vary from another in the way the program is run and, secondly, in New South Wales, how is the program run? Can you tell us just for the sake of documentation and simplicity? It is prescribed, obviously, for people with opiate addiction who are prepared to go in the program, but then how much would it cost them? How often do they have to present to the pharmacy? How is it delivered: in tablet or syrup form, et cetera? If you could answer those questions I would appreciate it.

Mr Leahy—If I were to go down that track and were presenting for the first time as heroin dependent, the first thing is to do an evaluation to see if I am heroin dependent. There is no point starting a 19-year-old on methadone, as that may well be a lifelong treatment process, without any goal. So to a great extent the idea of setting goals and treatment plans has started to come into place in New South Wales. The trick would be to know whether or not you would actually use buprenorphine or methadone to manage the treatment of a young person. I honestly believe that, if buprenorphine is listed by the Commonwealth for wide distribution to people who are addicted, we are going to get an enormous increase in the number of people seeking treatment simply because the course of treatment is not methadone. I would be quite happy to see those people come into treatment but we seriously would need to think now; just funding the medication will not be enough. Funding systems to support those people will be very important. If I were the person and I have now decided that, yes, I am going to come into methadone treatment, I could go to a public clinic or to a private clinic or to a GP who is accredited. That doctor would then register me with pharmaceutical services. They would allocate a particular doctor to a particular patient and that is the binding relationship that stays for the prescribing of that drug.

The difficulty is in the first three months of treatment, and in particular the first two weeks of treatment. They are very difficult times for people entering treatment. They have come from a life where their drug has dominated their life and where they could feel secure in what they were doing—it is the only lifestyle they have known to a large extent—and you are going to say, 'Turn the tap off, take this magic syrup and you will be better.' That is cloud-cuckoo-land. It does not work like that. It is a long, hard process of getting to where you can cope with what is happening. So the first few weeks of treatment are very difficult. The person has to come to grips with the treatment service they have been put on. The advantage of using buprenorphine would be that you can put them straight onto detox. After day five they can make a clinical decision: 'I would like to keep on using buprenorphine. I would like to go to methadone. I would like to go to an abstinence program. I have an ability to do something for myself having gone through the door at detox.' So that is a very important element that we have not had available in Australia previously, and hopefully we will very shortly.

Having done that and having decided to, say, go down the track of methadone, in New South Wales the idea would be that there are no takeaways given to people for methadone treatment in the first three months. It is their most difficult phase of coming to grips with their new lives. It is their most difficult phase of treatment. After that three months then there is an opportunity, if the people are displaying elements of stability, for them to go to a community pharmacy and they can continue their treatment with a GP community pharmacy model. That treatment may have goals that say, 'Let's see if we can come off in one year or two years.' People may achieve that. It depends how much support you give them. A lot of my patients have come off in the last few years. We have been quite successful with them. Two of the local GPs are terrific prescribers and they are terrific listeners to the people. There are other people whom we know, whom I have had for many years, are most unlikely ever to come off. Those outcomes are equally as good as the outcome of the person who got off altogether.

It is a long-term treatment process. If the person is actually stable, they would then be given some takeaways during the week. That would give them some chance to assess their ability to function, work and get about. That actually has a goal. It has a danger in it in that some people misuse the takeaway but that is a clinical judgment that the doctor would make—saying that the person is well enough to have it. That is basically how it works in just about every state of Australia—to supply it in that way. If you want to go interstate, you have to apply for a transfer. Here is the difficulty: the treatment stops at the border. The person has to see a prescriber interstate, who assesses the person and then has them dose locally. So maybe there is a role for a universal system of registration for people who are in treatment. At the moment, it is not available to people in treatment.

Dr WASHER—Denis, could you tell us the cost?

Mr Leahy—The cost for an individual? If they go to a community pharmacy, most community pharmacies are probably charging the patient somewhere between $20 and $35 a week. Those are ballpark figures. Almost three years ago, we went to New South Wales Health and said, 'What about an independent study that tells how much it costs for the community pharmacy to supply that service?' The figure they came up with was about $25 a week, which took into account all labour and non-labour costs. You can see that a community pharmacy is not actually making a lot of money out of providing the service.

To some extent that is a bit of a drawback for people to become involved, in that they are doing it as a community service. Most people who I see get involved with it do it because they feel they have an obligation to the community to supply the service. That is the real trigger. Somebody will come to them and say, 'My son or daughter is in big trouble. They are on the program. Would you help them?' I have never said no. That is going to be the trick: to get every pharmacy in Australia to never say no and to give it a go. If you went to a clinic, you would be asked to pay a lot more than that. The going rate in a clinic is about $45 or $50 a week. They have different cost structures, different expertise and a different range of services and maybe that figure is justified.

Mr SCHULTZ—Just on that cost basis, how many milligrams a day on average per person and how many doses a day?

Mr Leahy—The person on methadone has a single dose of methadone syrup once a day. If you said that the average stability dose is about 60 milligrams to 100 milligrams a day—it varies depending on the person—that is between 12 mls and 20 mls of syrup per day. The advantage if buprenorphine was coming in, because it is a much longer acting drug and it is taken sublingually, is that you can actually give the dose every second day to the majority of people who are actually able to cope with it.

Mr SCHULTZ—What is the cost differentiation for that particular drug compared to methadone?

Mr Leahy—The cost, we hope, would be funded in a similar way to the way methadone is supplied by the Commonwealth. The raw material or the actual drug would hopefully be supported by the Commonwealth in that way. Therefore, we would think that the on-site dosing could fall in the same price range as obtaining methadone syrup from a community pharmacy.

Ms JULIE BISHOP—I want to raise the issue of amphetamine production. On the basis that I have no personal knowledge of how to produce amphetamines, can we go through this step by step? I take it from your submission that pseudoephedrine is a necessary element from which methylamphetamine is extracted. Because of the reformulation of these over-the-counter medications, is it still possible to extract methylamphetamine from them? Is it more difficult but possible?

Mr Leahy—It is possible, yes. The spike has been overcome.

Ms JULIE BISHOP—Is it possible for over-the-counter medications of the type we are referring to here to be totally useless for the illegal production of amphetamines?

Mr Leahy—I think the manufacturers would have to come up with an answer. I clinically do not know how they would do that. They have tried but from my information the people who are involved in that industry are also very clever.

Ms JULIE BISHOP—Do you know what impact the changes that Warner Lambert introduced had on the incidence of raids on pharmacies to get these over-the-counter medications from which to make amphetamines?

Mr Leahy—I believe that the real impact on it was not the reformulation that occurred but was the step taken by the Pharmacy Guild and the Pharmaceutical Society to tell their members to keep very low quantities of those particular drugs to make them aware of the high abuse rate that is likely to occur from it. In most pharmacies they certainly have been withdrawn from open sale and placed in the dispensary or in the schedule 3 area. In my pharmacy, not only have I withdrawn them from both those areas but I now keep them out of sight of anybody who walks into the pharmacy, and I will only sell them on my professional discretion that the person actually needs them.

Ms JULIE BISHOP—In relation to the national code of practice that is referred to here, I am not quite sure what you have in mind. A code of practice involves liaison between the pharmaceutical industry, the police and community groups. What do you have in mind, and do you think it will be sufficient to deter the illicit production of amphetamines?

Mr Leahy—I think one of the problems is that the reporting mechanism is so far behind. If you knew that there were large quantities being shipped out from the wholesalers, the wholesalers would need more immediate access to police reinforcement to say, 'Look, why are certain people selling so much pseudoephedrine?' That would curtail their activities in a much quicker way than getting reporting that is some time out of date. So it is the ability to get timely data that may actually influence the outcome of stopping that progressing further up the scale to a larger scale. The guild and the Pharmaceutical Society would be totally in agreement in having very large penalties put down on people who did not follow the letter of the law and carefully supervise the supply of any of those drugs.

Ms Phillips—I think it was also referring to involving the pharmacy boards more actively in taking action against pharmacies that did not comply with the code. But we might go back and have a look at that and perhaps we can give you something in writing to give you more detail.

Ms JULIE BISHOP—We would appreciate that.

CHAIR—Thank you for appearing before the committee today.

Proceedings suspended from 3.27 p.m. to 4.02 p.m.

AULICH, Ms Judy (Private capacity)

BARNARD, Mrs Bronwyn Louise (Private capacity)

BIRMINGHAM, Mr Simon John, National Manager, Public Affairs, Australian Hotels Association

BRANDT, Mr Peter George, Manager, Compliance Branch, Health Insurance Commission

COOK, Ms Penny, Executive Officer, Australian Council of State School Organisations

CRIMMINS, Mr Peter Aloysius, Executive Officer, Australian Association of Christian Schools

DOYLE, Ms Bridie, Coordinator, Women's Information, Resources and Education on Drugs and Dependency (WIREDD)

DREW, Dr Leslie Raymond Hill (Private capacity)

FLETCHER, Ms Jan, Overseas Assessment Manager, Australian Nursing Council Inc.

GENDEK, Mrs Marilyn, Chief Executive Officer, Australian Nursing Council Inc.

FITZWARRYNE, Ms Caroline Margaret, Alcohol and Other Drugs Council of Australia

GARDINER, Ms Ann (Private capacity)

GARDINER, Mr Michael (Private capacity)

GRAHAM, Mr Desmond, Chief Executive Officer, Mental Health Council of Australia

HINKLEY, Ms Carmen, Policy Officer, Mental Health Council of Australia

KENDAL, Mr Stephen Leslie (Private capacity)

LIEBKE, Mr Steven Robert (Private capacity)

McCONNELL, Mr Brian, President, Families and Friends for Drug Law Reform

PAGE, Mr Geoff (Private capacity)

PEARCE, Ms Jacqueline, Executive Director, Toora Women Inc.

ROBERTS, Ms Julie, External Representative, Australian Council of State School Organisations

ROSEWARNE, Mrs Anne, Archdiocesan Secretary (Canberra-Goulburn), Catholic Women's League Australia Inc.

UHLMANN, Mrs Mary, National Bioethics Convenor, Catholic Women's League Australia Inc.

SHAW, Dr Janis Margaret, Director, National Centre for Aboriginal and Torres Strait Islander Statistics, Australian Bureau of Statistics

SKINNER, Ms Elizabeth, Acting Director, Assisting Drug Dependants Inc. (ACT)

CHAIR—Welcome, ladies and gentlemen, to this segment of our public hearing. I need to point out that whilst the committee does not swear in witnesses, proceedings today are the legal proceedings of the parliament and, as such, warrant the same regard as the proceedings of the House of Representatives. My name is Barry Wakelin. I am from South Australia, and I am the Chairman of the Family and Community Affairs Committee.

Mrs GASH—I represent the electorate of Gilmore which is on the South Coast of New South Wales—Nowra-Ulladulla.

Mr QUICK—I hold the seat of Franklin, which is the very bottom part of Tasmania.

Mr ANDREWS—I hold the seat of Menzies, which is in metropolitan Melbourne.

Ms ELLIS—I am the member for Canberra. Welcome to my electorate if you are not from here.

Mrs IRWIN—I am the member for Fowler in south-western Sydney. I represent a fantastic electorate that goes from Cabramatta right through to Liverpool.

Mr LAWLER—I am the member for Parkes in western New South Wales, which goes from Dubbo out to Broken Hill.

Mr SCHULTZ—I am the federal member for Hume.

CHAIR—I understand that you probably know the general ground rules but I will repeat them. There will be a three-minute presentation from each of the, I think, 28 people. I will gong at about 30 seconds from the conclusion to give you a bit of an indication of how you are going. We will start on my left. Judy Aulich, would you like to begin, please?

Ms Aulich—I am a teacher, writer and the mother of a recovering heroin addict. I am also the author of *Saving Jessie*, which was published by Random House in 1999 and written under the pseudonym of Imogen Clark. This is the story of my youngest daughter's battle with heroin addiction and the effect it has had on our family. *Saving Jessie* has been nominated for several

literary awards and has been shortlisted as well. I was also a contributor to *Heroin crisis*, which is an anthology of essays examining drug abuse, also published in 1999, by Bookman Press.

There are several lessons which can be learnt from my daughter's slow and painful recovery from heroin addiction. She has now been clean for 3½ years, and is not better or over it. She is still working at it a day at a time, but doing well. The chronic relapsing nature of heroin addiction makes any prediction of outcomes extremely precarious, but our family feels cautiously optimistic. These things assisted Jessie's recovery: we were a close family and we did whatever we thought would help to support her, but not always wisely; she always expected to have a good life and wanted to be drug free; and she had great strength and resilience. All these factors contributed.

Government policy has no effect at all on these issues, but the federal government does have an impact on other issues which assisted her. Government can legislate wisely so that addicts have the maximum chance of recovery once they have made a commitment to recovery from their addiction. Government policy and funding does determine availability of detox centres and rehabilitation centres suitable for young people. Jessie was fortunate enough not to have to wait an agonisingly long time once she had made the commitment. Government policy and funding determine access to supported housing and halfway houses. Jessie lived in supported housing run by the Salvation Army for 16 months after she left rehabilitation, while she learnt to establish conventional, responsible patterns of living. This support was of inestimable value to her during her most vulnerable time. Jessie's health is intact. She does not have hepatitis C or HIV, and for that I thank the needle exchange program. This, along with other harm minimisation programs, must continue to be widely available. If she does relapse some time in the future I hope she chooses to use in the one safe injecting room in Australia. Is there any parent here or elsewhere who would want less for their child?

Mrs Barnard—Good afternoon. I lost my brother in 1996 from a heroin overdose, following six years within the family of assisting him to manage his addiction. Two of those years involved just chaotic drug use, and following that he went onto the methadone program. I have nothing but praise for the people who work in the program, and am thankful for those who administer it close to home. For Dean it was a daily trip—transported by his mother—to the other side of town, before he could then follow on to work. He was fully employed the whole time of his addiction, and his employer was aware of his circumstances and very, very supportive. For that we are eternally grateful. Dean chose of his own volition to detox and lasted approximately three full weeks, before he then overdosed and died. The impact on my family has been absolutely enormous. My parents' lives will be forever in turmoil—and the loss of grandchildren that they will never know cannot be calculated.

I ask the federal government: who has the right to deny any person with a chronically life-threatening illness access to treatment? Would we deny someone with cancer the right to a new treatment? I ask the federal government to enact a heroin trial. I am supportive of safe injecting rooms, I am supportive of rehab, I am supportive of detox, but I want the full range, because you never know when they will relapse again. It might be long-term maintenance, but alive is far better than the alternative. Thank you.

Mr Birmingham—I would like to deliver an apology from our national executive director, Richard Mulcahy, who is unable to be here today. The AHA and the broader Australian hotel

industry joins other sectors of the community in viewing this issue as one of great importance to our society. I know that you have heard from many speakers today about the extent of substance abuse in both illicit and licit substances. In this brief presentation I do not intend to go over this ground again but to reflect on some of the factors that the hotel industry, particularly in our role as a responsible supplier of alcohol, believe are important to keep in mind during discussions on this topic.

Firstly, we commend the government for their initiatives in the Tough on Drugs campaign against illicit substances, and urge a committed focus on these particularly addictive and harmful drugs. However, with regard to legal and acceptable products, particularly alcohol, we must work to achieve a healthy balance in their availability, supply and consumption. The overwhelming majority of Australians consume alcohol in a responsible and safe manner. It is a product that has broad community acceptance and support, spread right across social and economic barriers. There is even increasing evidence to suggest that, when consumed in moderate doses, alcohol has a positive health effect. Recent research published in the journal of the American Medical Association found that moderate drinkers had a 32 per cent lower risk of dying from a heart attack then non-drinkers.

The importance of research like this and the increasing weight of both scientific and anecdotal evidence to this effect is that in strategies to promote responsible consumption we should not, to use the colloquial, scare the horses. Further enhancing consumer awareness and educational campaigns, coupled with targeted assistance for those with a problem, must be the focus of our future efforts. It has been our privilege to work with Commonwealth health authorities on previous educational campaigns, particularly television advertising, and we hope to continue this work in future years.

One of the most effective public health awareness campaigns conducted over recent years has been the promotion of the standard drink concept. Now widely understood by many in the community, the hotel industry is of the view that this measure of alcohol consumption should continue to be a centrepiece of future responsible consumption initiatives. Having achieved strong levels of community understanding, it would be foolish to change paths midstream.

The hotel industry urge this committee to consider recommending further funding towards this sort of educational campaign directed at increasing awareness of safe levels of consumption and promoting a responsible approach. We also urge some caution in regard to areas of competition policy where the threat is to open up the market for sale of liquor. We take the attitude that alcohol is a separate and different product from, say, fruit juice and other substances. It should not be available on every street corner, so we urge caution in that area as well.

Mr Gardiner—I introduce my wife, Ann, and our daughter, Carol. Our son, Carol's brother, died on 19 August 1996 from a heroin overdose, aged 28. Patrick had a great compassion and concern for others less fortunate than himself. Patrick was a beautiful human being whom we were very proud of. I would like to pass his photo around. Patrick never missed a day's work in his life. In fact, he worked on the day he was taken to hospital. Patrick had a sickness he did not want. We believe Patrick died because of our punitive drug laws based on fear, ignorance, prejudice and lies, and we can give backup evidence for that.

As the evidence clearly shows, the present drug laws in this country are a total failure. Laws modelled on world's worst practice are causing the deaths of thousands of people—and God knows how many more people have been maimed for life—forcing great eternal pain on those families and friends who have experienced the death of a loved one from illicit drugs. We are using strong and, at times, crude language here, but please try to understand that we as a family are victims of this war—a war we believe is being waged not on drugs but on decent people like Patrick and our family, and thousands of other decent community members.

Patrick never got to the stage where he was forced through his sickness to steal, thank God, but he did feel sad about those addicted boys and girls who were forced to walk down lonely, dirty laneways or go into filthy toilets to prostitute themselves to get money for their sickness. We use the word 'sickness' because it is beyond doubt that drug addiction is a health problem—as is stated quite clearly by every major health organisation in the world. It is quite clear that there is no rehabilitation that has an instant success for people addicted to illicit drugs. The major point of the whole debate, we believe, is how you keep people alive by using every available treatment.

We must, as a community, confront whether we are prepared to do all that is humanely possible to keep illicit drug addicted people alive before they can get to rehabilitation and between periods of rehabilitation where they are likely to relapse. It could take many years for these vulnerable people to reach permanent remission. The appalling casualty rates prove that rehab, education and law enforcement are not working. Yet our law-makers continue to cowardly hide behind failed methods. This is the dilemma, because there are thousands of people in our community with a health problem—illicit drug addiction—where their lives are in grave danger. Yet, as the evidence proves, everything humanely possible is not being done.

We find it extremely offensive when, for political expediency, a few politicians promote fear and hysteria in the community against drug law reform. What they are really promoting is a vulgar, perfidious crime against humanity. We can only come to one conclusion: that the people who promote these laws do not have compassion for sick people in pain. For these people, whether they know it or not, are sending a frightening message to the community—that is, illicit drug addicted people's lives are expendable.

Speaking on behalf of my family is an honour because, since Patrick died, the last five years have been very painful for us. I am very proud of my wife and daughter and thank them for their support and love. For the past five years we have together made it our business to learn as much as possible about illicit drug addiction, the war on drugs, world's worst practice and world's best practice. We beg our law-makers to show compassion, courage and leadership to stop this madness as soon as possible. Our Patrick was a victim—certainly not expendable.

Mrs Gendek—I am the chief executive of the Australian Nursing Council. It is a national body and its core business is the regulation of nursing. I am here with my colleague Jan Fletcher, and Jan has prepared the introduction.

Ms Fletcher—We are involved in the development of national standards for the regulation of nursing in Australia with the state and territory nurse regulatory authorities. Within a regulatory context, our concern is with the safe practice of nurses and public interest in a framework of competence and professional conduct. We have developed guidelines and standards for this

purpose which allude to impaired health of nurses through the use of alcohol and other substances.

Within the various jurisdictions, the nurse regulatory authorities are responsible for dealing with nurses whose practice is impaired through substance use. Being cognisant of the safety of the community, we do not want to waste valuable resources—which nurses are—or the expensive education that they have undertaken. So nurse regulatory authorities tend where possible to deal in a rehabilitative way with nurses who have a problem with substance use, which may include referral to drug and alcohol specialist services and programs approved by the boards. We therefore see access to treatment in whichever way possible as one important aspect of substance use.

Ms Doyle—I am the coordinator of WIREDD—Women's Information, Resources and Education on Drugs and Dependency—which is a local drug and alcohol service in the ACT. Our client groups are predominantly at the fairly extreme end of addiction and alcoholism. Most of them would be polydrug users and long-term users and many have had contact with family services, justice departments and so on. One of the things that is pretty consistent for most drug and alcohol services around the country, along with ours, is that about 80 to 90 per cent of the women that we see have experienced some form of child sexual assault. I guess we are saying that a priority around early intervention on child sexual assault is ultimately going to have an impact later on drug and alcohol use.

Most of the women that I talk to in counselling say that they actually told somebody at some point —whether that was a doctor, a teacher or, as I heard today, a police officer. One young woman became pregnant to her father when she was 12½. She told the teachers, but the whole thing slipped through the system. For her and for other women who tell and for whom nothing happens, the message is the same: about it being their fault—which is what perpetrators tell them—which increases their chances of picking up drugs and alcohol. Basically, we are saying there is a real need to educate teachers, police and everybody in the general community about how to intervene in this context.

At the other end we would say that we need to investigate and provide the full range of options for long-term users to encourage community compassion and hope about the rehabilitation of long-term users, and that range of options needs to be specifically targeted to the needs of women, Aboriginal communities, people from non-English-speaking backgrounds and the full range of different service users.

Ms Fitzwarryne—I am the CEO of the Alcohol and Other Drugs Council of Australia. ADCA made a presentation to this committee about a year ago, at the start of the inquiry. Time has moved on since then, and I want to re-emphasise the priority for implementation of good practice programs and resourcing them adequately. This is becoming more and more urgent. The community supports this. There has recently been a *Bulletin* Morgan Gallup poll in which a staggering 11 per cent of the population surveyed said that drugs was one of their critical issues. This means there is no question that it is a very strong community concern. It should be something that should get priority in the budget and it should be a key issue in the upcoming election.

I want to tell you what ADCA hopes will come up in the budget—what we have recommended through ADCA in our budget submission. If these things do not appear in the budget, we hope that they will be considered as recommendations of your inquiry and also will be key issues for consideration in the next election. The key issues that we think should be in the next budget are: development and implementation of a national prevention initiative focusing on risk and protective factors—$100 million is needed for that; expansion of the treatment grants program, as the treatment service is totally inadequate—$75 million. These figures are over four years. Implementation of a national heroin overdose strategy—$10 million. Implementation of the national tobacco strategy—$240 million. Development and implementation of a comprehensive national indigenous substance misuse strategy—$55.2 million. Development and implementation of a national co-morbidity strategy—$20 million. Creation of a national alcohol and other drugs work force development program—$5 million.

This might seem to be a fair amount of money, but we believe that that money could come from hypothecated alcohol and tobacco taxes. So if we take the money from alcohol and tobacco and put it towards dealing with the drug problem, we will be at square one.

Dr Drew—I am a psychiatrist and I have had a lifelong involvement in drug treatment and drug policy. I was the senior adviser on mental health and alcohol and drugs for the department of health from 1975 to 1988. I have got many interests in this particular area. Most importantly, I am very disappointed with the continued commitment to prohibition as our major social policy in this area. I can only address that issue briefly here.

With respect to recreational drugs, things have progressively got worse since prohibition was introduced in 1954. This is well documented. Prohibition is not working and historically prohibition has rarely worked, regardless of the subject. It is time that we admitted this and sought alternatives as our basic policy. I would like a bipartisan admission of the failure and futility of prohibition as our basic social policy and a bipartisan commitment to a national drug summit to consider options, as was done in 1985. Finally, I inform the committee that a debate will take place tomorrow at the College of Psychiatrists congress at the Convention Centre titled ‘Is Drug Prohibition Affordable?’ Some of you might like to attend.

Mr Graham—I am the Chief Executive Officer of the Mental Health Council of Australia. My senior policy officer, Carmen Hinkley, and I are very pleased to be here on behalf of the council, and we thank the committee for the opportunity to speak with you again. The Mental Health Council of Australia is the peak national non-government organisation established to represent and promote the interests of the Australian mental health sector. The council has an interest in this inquiry into substance use, as the council recognises the numerous physical, emotional and psychological effects of substance use, not only on the individual but also on family, friends, the workplace, the health care system and the general community.

Many aspects of my three-minute presentation you will have already heard, but given the importance of this inquiry, it is important to reinforce some key points. The council’s particular concern is in the area of dual diagnosis, or the occurrence of substance use together with mental illness. Mental illness can lead to alcohol and other drug dependence when individuals resort to self-medication to control the symptoms of illness. Conversely, psychiatric disorders can result from the abuse of alcohol and other drugs. Research suggests that 46 per cent of females and 25 per cent of males with substance use disorders also experience a mental illness. People with

dual diagnosis are recognised as having poorer health outcomes, including increased experience of psychosis, poorer treatment compliance, housing instability, homelessness, medical problems, poor management skills, greater use of crisis orientated services, greater risk of suicide attempts, increased hospitalisation, are difficult to engage, and have poorer prognosis.

The conventional separation of mental health services and drug and alcohol services is a particular barrier to comprehensive service delivery. There are very few services available to effectively treat individuals with dual diagnosis. Specific services must be developed for people with dual diagnosis and staff must be adequately trained. At present, individuals with dual diagnosis fall between services. Mental health services say that dual diagnosis patients are the responsibility of drug and alcohol services and, of course, drug and alcohol services say they are the responsibility of the mental health service. As a result of service division, both fields are unclear as to who should take responsibility for care, often resulting in individuals with dual diagnosis receiving no treatment or service and ending up in the homeless population, or being cared for by family or friends, who receive little support from professional services in undertaking their important role.

Promotion, prevention and early intervention strategies are crucial. Such strategies need to identify people at risk of drug use and those beginning to experiment with drugs, and divert them from progressing to harmful drug use, which may lead to dependence, disease or criminal sanctions. Prevention programs must focus on controlling access to substances and educating people about harmful effects. Unfortunately, many of the comments made by the 1993 national inquiry concerning the human rights of people with mental illness remain relevant today. In consideration of the fact that close to half of females and a quarter of males who have substance use disorders will have mental illness, the council urges this committee to revisit those inquiry findings and the recommendations and make substantial gains in progressing them.

Ms Pearce—I am the director of Toora Women Inc, which provides crisis accommodation and other related support services to women in the ACT, many of whom are homeless. The women that we work with are often affected by chemical dependency or they are affected by someone else's chemical dependency. Their lives, right from the beginning, have been affected by violence in all its forms—emotional, physical and sexual. By the time we get to see them—which is when they are over 16, and can be anywhere from there to in their 80s—they have often begun drug use and progressed to very harmful drug use in their own lives.

The women that we see have also experienced abandonment in their lives. Many, as was already spoken about, have a dual diagnosis. Probably over 50 per cent of the women we see do have a dual diagnosis of a mental health issue and problematic drug use. I would urge that service providers and any services that are working with this client group start to work with people who have dual diagnoses. It is not possible now to work with one aspect of the client group, because so many of the clients that are out there now do have mental health issues and drug use issues.

Many of the women we work with are escaping domestic violence. Lots of those women who are older or are from non-English-speaking backgrounds have gone to their local GP and have been prescribed drugs to deal with the fact that they live with violence. Often those women have been using benzos or antidepressants for up to 30 years, for long periods of time. They have been prescribed drugs as a way of dealing with their life situation. There has been no support for

them; they have not been offered other support. We also work with indigenous women and, obviously, there are huge issues for them around disadvantage within the Australian community and issues of dispossession. So any future allocation of resources needs to address their issues.

Lots of research now supports the fact that, even from conception, children can be affected by what goes on in the home and that the first five years are the critical years of development. One of the things we would strongly recommend is that support is provided for all family groups, no matter what. I am certainly not blaming the family here; often families have been affected by their own experiences as children. We have a variety of family units now, so we need to be able to support the variety of family units that exist within our community. Those critical first five years are when early intervention and support may make a difference and would certainly deal with some of the social and economic costs to the community resulting from problematic drug use.

Another issue that I think has been touched on already is attitudinal change. At the moment, much of the community views addicts in a discriminatory way. It is time that we looked to viewing our community in a much more compassionate way and with much more hope. People do recover and change is possible, but only if there are a variety of services and if services can work with people where they are at, not where we would like them to be at. We are acknowledging that meeting someone where they are at is critical and that we need many more resources for a variety of treatment options so that people can get their needs met in the community.

Mr Page—Before starting, I wish to emphasise that I in no way underestimate the dangers of currently illicit drugs or the impact they have on addicts and their families. I know enough of these impacts through personal experience and through those of others whom I know well. I also have no illusions that regulation or legalisation of these drugs will magically remove the reasons why people take such drugs in the first place. It is possible that my recommendations might even make the situation worse in the short term before it improves.

The first question to ask in all this, however, is: why are these drugs, particularly heroin, illegal in the first place? They have not always been so, and there may well be an argument for returning to that situation. The standard argument is that these drugs are highly addictive and therefore potential users have to be 'saved from themselves' by not being given the chance to sample them. This argument has lots of problems, the most obvious being that we already have two major addictive drugs, alcohol and nicotine, which are not banned and which it would now be quite impractical to ban. We need only recall the prohibition era in the US to remind us of that.

Some might wish that we had banned these substances also and saved many lives. It is obvious to almost everyone, however, that such a ban on two such well-entrenched substances would cause massive problems of compliance, destroy a range of important industries, deprive the country's governments of much needed revenue and cause massive corruption in law enforcement agencies. On balance, then, the banning of tobacco and alcohol does not seem a good idea, even though the health risk involved in these substances is indisputable.

It is here that we come to one of the most ignored aspects of the present debate. In a secular, democratic society, what right does anyone have to ban a substance and/or behaviour which

gives pleasure to the user or participant and causes no direct harm to anyone else? We are familiar with the small 'l' liberal dictum: your freedom ends where mine begins. Thus, while we do not ban tobacco, we have the increasing insistence that people smoke outside rather than inside public enclosures. We do not ban alcohol, but we do have random breath testing on the roads to protect the rest of us. The majority of us have no great wish to bet regularly on the horses, apart from a flutter on the Melbourne Cup, but we are happy to see those who do use a legal and unobtrusive TAB rather than involve themselves in the criminal activity of SP betting.

Similarly, we also have the relegation of legalised brothels, unused by the majority of the population, to nonresidential areas. We do not, any longer, ban prostitution altogether. The problems with doing so have become only too obvious over the years. The argument that cigarette smoking is not in our fellow citizens' best interest is ultimately irrelevant to the case. The consumer or the participant has a right to information about a particular drug—for example, the statistical connection between tobacco smoking and heart disease, lung cancer, et cetera—but it is hard to see why he or she should be forcibly prevented from using it. In a democratic society, it is obvious that the greatest right we have in such circumstances is to warn: to proselytise rather than to legislate.

Another problem in this debate has been the confusion between what are clearly straight-out poisons—for example, rat poison—and mood altering drugs which people, be it ill advisedly in many circumstances, choose to use for their own pleasure. Obviously, the availability of arsenic and strychnine needs to be regulated. We do not want to make it any easier for curious children than we need to. Substances which people use for their own pleasure, however, are clearly in a different category. Alcohol and nicotine are ultimately as deadly as arsenic and strychnine if taken in the appropriate doses, but we do not choose to ban them. We regulate them to ensure or try to ensure they are available only to those who are old enough to make up their own minds about the risks involved.

It should be emphasised that I am talking about adults here, about voters. The arguments against allowing drugs of any kind to minors not yet in a position to make an informed judgment are much stronger. Those who sell drugs to children, whether it be heroin or cigarettes, are in effect exploiting their ignorance and inexperience and must be deterred. Admittedly, this is not going to be a lot easier than enforcing the current prohibition on the use of illicit drugs by adults, but at least it would be being attempted for logical and morally worthwhile reasons.

Mr McConnell—I am representing Families and Friends for Drug Law Reform. It is 50-plus years since the introduction of the prohibition on heroin, and longer on some other drugs: prohibition that promised so much, but the performance has really been lamentable. The UN itself recognises this in the preamble to the latest multinational drug treaty, the 1988 United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. I will quote just a couple of points from the convention. The parties to the convention are deeply concerned about:

... the magnitude of and rising trend in the illicit production of, demand for and traffic in narcotic drugs and psychotropic substances—

and also—

... the steadily increasing inroads into various social groups made by illicit traffic in narcotic drugs ... and particularly by the fact that children are used in many parts of the world as an illicit drug consumers market and for purposes of illicit production, distribution and trade in narcotic drugs ... which entails a danger of incalculable gravity ...

They recognise:

... the links between illicit traffic and other related organized criminal activities which undermine the legitimate economies and threaten the stability, security and sovereignty of States ...

It is a wonder that the international community resolved in the 1988 convention to intensify the strategies of the previous 80 years since the 1909 Shanghai convention, rather than engage in a radical review of them. A commercial enterprise that persisted with such fruitless approaches would have gone to the wall long ago.

Drugs of all types are used in our community. Some are legal, some are prescribed, some are illegal, some are used without problem and with beneficial effects, some are used in a problematic way and can cause harm to the user. In these cases, the immediate family may also be affected; however, when the drug is illegal, the laws that make them illegal magnify the harm. They promote stigma and shame for the user, his family and his immediate community. The comparison study of cannabis consequences between South Australia and Western Australia provides a small illustration. They diminish the quantity and quality of treatment and intervention options. They promote the black market, crime and corruption.

For many in Families and Friends for Drug Law Reform, the laws and policies did not help our families. For many, the laws contributed adversely. Our personal experience led us to examine the history, the issues and the evidence and to conclude that the laws needed to be reviewed. Many experts and ordinary people want that review and that change. The committee would have heard and read from many of those experts and expert groups. These include doctors, lawyers, judges and professionals in the field. If there are so many that want change, then why is this review not occurring? This is a question that Harry Quick asked earlier today.

As a society, we must, if we are to make progress on this issue, look to the evidence of what works and use that as a basis for drug policy. There has been some good but slow progress made in this area: the needle and syringe exchange program has prevented many from being infected by blood borne viruses, and Australia is a world leader in this regard; drug courts divert selected drug users away from jail and into treatment; the federal government has recognised and adopted harm minimisation as a strategy; and there have been practical and realistic approaches by some police by not attending overdoses and by not arresting for personal use of illicit drugs. There is also increasing recognition that drug addiction is a health and social problem.

The change that needs to happen is to make drug laws and policies more effective—for example, to take drug control from criminals and return it to governments, to remove the need to commit crime to support an addiction, and to enable addiction to be recognised as a health and social problem. The change is happening slowly, but I am optimistic that this committee will have the courage and conviction required to speed up that process.

Dr Shaw—I am going to talk about the ABS indigenous statistics program. The Australian Bureau of Statistics plays a leading role in collecting and coordinating indigenous statistics nationally and is implementing a strategy for providing regular statistical information on the Abo-

riginal and Torres Strait Islander population across all areas of social concern. The priorities over the next few years will be reflected in four broad statistical programs: the five-yearly census of population and housing, next conducted in August this year; population estimates and population projections; a program of surveys that collects data from indigenous persons and communities and which allows comparison with the general population; and a program of work and partnership with other agencies to improve the availability and quality of data from administrative collections. This statement provides the committee with an outline of currently available ABS information on Aboriginal and Torres Strait Islander people's use of alcohol and other drugs, as well as plans for such information to be collected over the next 10 years through ABS surveys and administrative data systems managed by other organisations.

First, in relation to the currently available ABS information, the ABS conducted the National Aboriginal and Torres Strait Islander Survey, known as NATSIS, in 1994. The survey provided information on frequency of alcohol use and whether tobacco had ever been used. Findings at the state and territory level were published in 1995 in a national report, providing information on the frequency of drinking alcohol and the number of cigarettes smoked daily by either age group or sex. Separate reports were published for each ATSIC region in 1996. Subsequent ABS publications have analysed and reported further findings about alcohol and tobacco use from the NATSIS. These include the *Health of indigenous Australians*, released in 1996. The publication *The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples*, which was first released in 1997 in collaboration with the Australian Institute of Health and Welfare, also analysed NATSIS information. The NATSIS statistics continue to be used and accessed by government and non-government clients through ABS statistical consultancy services.

The National Health Survey, or NHS, 1995 identified Aboriginal and Torres Strait Islander respondents and provided information on alcohol and tobacco use as health risk factors. Information on smoker status and alcohol risk level provided results that compared the indigenous and non-indigenous populations cross-classified by age group and sex and were published in 1999 in the report *National Health Survey: Aboriginal and Torres Strait Islander results*. Further analysis and interpretation of the survey data were published in 1999, the second collaborative report with the Australian Institute of Health and Welfare.

In relation to planned ABS collections, the ABS National Health Survey 2001 will collect information from an indigenous sample supplement of about 2,800 Aboriginal and Torres Strait Islander people across Australia. The survey will ask questions on alcohol and tobacco use as health risk factors. As in the 1995 NHS survey, the data elements regarding alcohol and tobacco use for the indigenous supplement will be equivalent to those in the NHS for the general population to provide comparisons between the indigenous and non-indigenous populations. NHS 2004 and 2010 will have indigenous sample supplements and will provide information from a larger sample of about 11,000 Aboriginal and Torres Strait Islander persons. Content of the survey is yet to be agreed. However, the importance of producing time series data for alcohol and tobacco use would provide a strong reason for replicating questions from 1995 and 2001 surveys. Comparisons between the indigenous and non-indigenous populations will be possible.

A new ABS social survey will be conducted in 2002, then repeated in 2008 and six-yearly after that, collecting information on a range of general social issues, also to include about 11,000 Aboriginal and Torres Straight Islander persons to produce estimates at the state and

Northern Territory level for a range of topics on the use of alcohol, tobacco and other substances currently proposed for inclusion. There is a final note on the Australian Institute of Health and Welfare's proposed collection, through the administrative data sources that will come up through the National Minimum Data Set, Alcohol and Other Drug Treatment Services data. The range of information includes demographics, client utilisation and the Australian standard classification on drugs of concern.

Mr Liebke—I would like to start by tabling a document I have here for a model for cannabis regulation, if this could be distributed. I do not mean it to detract from the attention I or anybody else gets. I appear here as author of the as yet unpublished cannabis users harm reduction handbook. To start, I would like to dispel a couple of myths that I have picked up during the day, my area of expertise being cannabis. One, there seems to be a misconception that there are allowable amounts of cannabis under legislation in the ACT, South Australia and Northern Territory. While on the surface this may appear to be the case, it is not in fact. Legislation in these state and territories allows for police discretion, so any amount of cannabis certainly comes under criminal guidelines as well. I would also like to point out that in South Australia they have what is known as the expiation notice system, whereby people picked up with a small amount of cannabis can be given an on-the-spot fine. The rate of expiation is under 50 per cent, and of those people who do not pay their fines about 92 per cent receive an automatic criminal conviction for the original offence.

I would also like to pick up on a comment made by Ann Roche from the National Centre for Education and Training on Addiction. She seemed to downplay the incidence of cannabis dependency, quoting the figure—that I have as well—that about 10 per cent of cannabis users will become dependent. I would just like to point out that when you consider that about 2½ million Australians are cannabis users, that equates to about 250,000 Australians who are in fact cannabis dependent.

I will not go through this entire model that I have. I would just like to read an extract from it. It reads:

While many may find an exponent of drug harm minimisation espousing cannabis regulation somewhat antithetical in nature, the realities of the current situation alone warrant at least a very close look at approaches that are absolute in their deviation from the 'norm'.

Regulation would not involve a Dutch style network of cannabis cafes. It would not tolerate public use of cannabis, nor driver intoxication, work-place use, etc. It would not put cannabis in the face of any who have an aversion to it (unlike our societally ingrained preoccupations with alcohol and tobacco). It might upset a few people aligned to traditional dogma but, so what?

Regulation *would* involve the growing of specific cannabis varieties known for their cannabinoid content and, therefore their potency and largely predictable effects. It *would* ensure that cannabis is of a far less substantial financial cost to the consumer, thereby alleviating hardship for dependents and medical users … as well as a recreational user. It *would* significantly reduce property crime, with obvious widespread implications. It *would* end the current criminal monopoly of the cannabis industry, with the black market unable to compete on price and reliability of service and supply. It *would* allow relevant government departments and organisations to design and target education and rehabilitation programs with much increased validity and efficacy. It *would* pave the way for intensive, transparent research into the many medical uses of cannabis. … It *would* … pour millions, and probably billions of dollars into government coffers and save millions more in cannabis law enforcement.

At this point, let me state the obvious. The kind of model I am presenting here is not just applicable to cannabis. The same basis can and perhaps should be used for every drug considered illicit under the current regime.

Mr Kendal—I do not represent any particular organisation. I am simply a citizen from Monash in the Australian Capital Territory. I am currently studying in a doctoral program at the University of Canberra.

Policy makers should give credence to the scepticism of those who rely on the present tough but imperfect regime of regulation intended to prevent harm and abuse of illicit drugs. There is sufficient evidence and experience now to encourage a more humane approach. Illicit drugs need not be sanctioned, but drug dependent people should be able to administer their drugs in medically controlled situations. The medical prescription of heroin and other illicit drugs for addicts should be investigated, and preferred to a policy which enables the black market to be the principal supplier of such substances. The present regime makes exclusive the criminal and corrupt provision of these highly dangerous substances and encourages the breakdown of law and order and proper management of the administration by users of these drugs, which can result in death by overdose.

Emphasis on harm minimisation has not proven a viable approach, despite its good intentions. Complete prohibition of illicit drugs, although desirable, has proven impossible and counterproductive. There is, of course, a need for resourcing strong measures to inform the public of drug abuse. Addicts need to be more humanely treated and their problems treated as a national health tragedy, and adequately serviced, just as any other major breakdown in public health or public order.

Mrs Uhlmann—I am really here in support of my colleague Anne Rosewarne, but having attended a previous hearing I would like to say a couple of things. I was sought out by a mother at that hearing. She told me the story of her efforts to assist her son to become drug free. She was very opposed to safe injecting rooms and had in fact demonstrated here in the ACT. I would like to make the point that those who are against safe injecting rooms are not unfeeling about the tremendous problem and cancer, in a sense, in our society of drug abuse and what it is doing to our children. You are not the only compassionate ones if you are for injecting rooms. The other thing that concerned me was to hear the 'no direct harm to anyone'. Have I had experience of it? Yes, I have. My nephew became involved with a group. He apparently was not addicted to heroin, but as the result of a home invasion he was murdered in 1993. As the result of that, for my brother, who suffered a heart condition, his great sorrow caused his death. He rang me at 3 o'clock in the morning—and I will never forget it—to say to me, 'Mary, I hope this never happens to you. It has torn my heart out.' So do not think that we come from an area of not understanding. Many of our parents are experiencing the same things. But I do commend the government's efforts so far. I do believe, as a retired principal of a school, that it is possible to teach children. We must teach them to say no. If we can spend enormous sums in the carry-on we have with smoking and what is required in restaurants and so on, then we insult our young people if we say we cannot teach them. We may lose some—and that is a great tragedy—but we can save some.

Mrs Rosewarne—I thank you for this opportunity to speak to the inquiry on substance abuse on behalf of the Catholic Women's League of Australia. We believe that substance abuse plays a

leading role in the breakdown of family life and is disruptive to the wider community. Our nation's drug use has grown to be among the highest in the world. Drug use imposes an enormous toll on the community, and effects are seen in health and welfare costs to the nation as well as in crime, homelessness, road trauma and broken families. In the event of legislation regarding the sale and use of products encouraging drug dependence, we believe that the future of individuals is at stake. Some lives will be diminished. Others will waste their youth without ever fully realising their potential. Experiments must not be carried out at people's expense. The primary duty of the nation is to safeguard the common good. We recommend seeking to implement policies of true prevention aimed at building a drug free society. Sweden has replaced their once permissive policy reforms with a restrictive drug policy, which includes health and education measures, and is now the lowest drug user of Western nations. School age drug use is less than one-fifth of that in Australia.

A drug free society is a vision, expressing optimism and a positive view of humanity. Drugs can be restrained; a drug user can be rehabilitated. We need to have a grand vision for the future of this nation. We are firmly opposed to a harm reduction policy, which we believe will lead to the normalisation of drug use and send the wrong message to our young people. We believe that Australia needs to set about making drug use socially unacceptable, as it has done with tobacco. The debate on substance abuse is about not only heroin but all mind altering drugs and ultimately destructive drugs.

It is widely accepted that drug use can precipitate mental illness. Young people need to be taught to find the means of dealing with their feelings and emotions without resorting to drug use. Despite the cost to our economy, we are doing too little to get addicts drug free and back to a normal lifestyle. Proper assessment and early intervention are vital. Treatment facilities need to be provided to follow intervention. We believe that a policy of court order, detoxification and rehabilitation needs to be adopted. Australia should consider investing some of the revenue from alcohol and gambling into trusts and then apply the proceeds to drug rehabilitation and family programs. In 1998-99, Australians gambled $102.85 billion.

Australians had a grand vision of displaying the best ever Olympics and they worked to achieve it. Australia needs to have a similar vision for our young people to have a truly great Australia—a drug free Australia.

Mr Brandt—I am from the Health Insurance Commission. On behalf of our managing director, Dr Jeff Harmer, I would like to thank the committee for the opportunity to come here this afternoon. I would like to talk briefly about one of the projects for which I am responsible, and that is the doctor shopping project.

The doctor shopping project started off in January 1997 and had two principal aims: one was to achieve a better health outcome for people identified to be at risk of taking large quantities of pharmaceutical drugs; and the other was to achieve a cost saving for Medicare and the Pharmaceutical Benefits Scheme.

There are three primary elements to the doctor shopping project. The first is a counselling process, whereby pharmacists employed by the Health Insurance Commission counsel people—identified at risk through the activity of obtaining large quantities of prescriptions and taking large quantities of medication—in relation to the dangers of this behaviour. The second is to run

a hotline to allow mainly medical practitioners to telephone in to obtain information about the use of pharmaceutical benefit prescription drugs by patients that they may be treating. The third is the voluntary agreement process, whereby people identified at risk through doctor shopping behaviour can nominate a practitioner of their choice to whom the Health Insurance Commission can provide data on pharmaceutical and Medicare use, to better manage that patient's condition.

As I said, the project has now been running for just over four years. The number of people that we have identified within the project at the start has dropped by about 35 per cent. We feel that we have achieved a significant contribution in relation to better health outcomes. Not only has the total number of people dropped but also the number of original prescriptions that people were obtaining has dropped, the number of repeat prescriptions has dropped and the number of prescribers that these people attend has also dropped. We feel that this is an argument in favour of a better managed patient. We have also achieved cost savings for Medicare and the Pharmaceutical Benefits Scheme of approximately $16 million over those four years.

The other element in relation to the doctor shopping project is action in relation to practitioners who may be prescribing inappropriately for some patients. We also have action in relation to those practitioners under the inappropriate practice provisions of the Health Insurance Act.

Mr Crimmins—I am the Executive Officer of the Australian Association of Christian Schools. I am also the father of a 32-year-old heroin addict daughter. My response will take account of both of those factors. The focus of our response to date has been on the use of legal drugs, specifically alcohol and tobacco. It has also taken account of the abuse of prescription and counter-sale medications. Today, it will take account also of heroin and other illegal drugs.

Australia has a cultural tolerance for alcohol. This cultural tolerance manifests itself in the acceptance of alcohol as part of Australia's social life and economic wellbeing. A campaign by the alcohol industry, 'Shout', designed to resist the GST on beer, is indicative of this cultural acceptance. Unfortunately, with widespread acceptance of alcohol comes abuse. There is widespread statistical evidence of increasing rates of alcohol consumption by young Australians, including those legally under age and still at school. Associated with this abuse is the phenomenon of binge drinking—more often than not a characteristic of young and inexperienced consumers.

The abuse of alcohol, particularly by the young, often results in road accidents, death, violence, breakdown in family relationships, and unanticipated and often unintended occupational health and safety risks at school and at work. Commonwealth and state authorities have consistently over time, and somewhat successfully, warned the entire population of the detrimental effects of the abuse of tobacco. Alcohol, however, seems to have been treated with kid gloves. While its long-term health effects are still to be documented, there seems to be a reluctance to confront young people in particular, and the wider community in general, with the detrimental social, health and economic effects of the abuse of alcohol.

The restrictions imposed by the government via legislation on the tobacco industry have seen its disappearance from billboards and sporting arenas. It would, however, appear that girls and young women, in particular, have not always absorbed the message regarding the detrimental

health effects of tobacco. A more realistic and targeted program is needed to assist young women in resisting tobacco and in breaking the habit.

The abuse of prescription and counter-sale medications is now only manifesting itself in the wider community. Organisations such as the AMA, in collaboration with the government, need to vigilantly educate the medical profession and particularly GPs in prescribing drugs where alternative remedies may be more appropriate. Treating heroin addicts as criminals and incarcerating them and ostracising them from schools or the communities in which they live is a dangerous tactic. Equally dangerous is the non-pursuit of the drug trafficker. I would encourage the committee and members of government to consider addiction as a health and social problem and trafficking as a legal problem with the full force of the law.

Ms Roberts—Penny Cook and I are representing the Australian Council of State School Organisations. ACSSO is the national organisation representing the interests of parents, citizens and students associated with government schools throughout Australia. ACSSO firmly believes that the goal of school drug education is the minimisation of harm, ideally through prevention of inappropriate drug use. Harm minimisation as defined in the national drug strategy accepts that interventions that reduce the risk of harm associated with drug use, without necessarily eliminating it, can have important benefits. In contemporary Australian society, drug use and/or abuse occurs in three major contexts: the control of health, legal drugs used for recreational or social purposes, and illegal drugs or substances used in unacceptable ways for the purpose of intoxication or getting high.

Drug education must, therefore, encompass all three contexts. The appropriate information about the use of drugs must be presented before discussing the consequences and the problems of misuse. School drug education programs should be long term and fully funded by government, and they should not just be there for the life of government.

Ms Cook—I am an executive office of ACSSO and I would like to support what my colleague has just said and emphasise the importance of early intervention by education. Remember that we represent the largest family in Australia and that parents are the first educators in the critical first five years. With adequate resourcing, we can be hugely effective in this area.

CHAIR—Thank you very much. Has everyone had their say? I do not think we have missed anyone. I am not sure what we want to do with the accumulated knowledge in this room at this time. We could start by having some questions of us in terms of specifics about our inquiry, and then members might have some questions of their own.

Ms Cook—Was an invitation given to any illicit drug users to be part of this round table, and if not, why not?

CHAIR—We would have to ask the secretariat. My understanding is that we are submission-responsive. Therefore, I am not sure how many submissions we had from illicit drug users. We certainly have heard from prisons and a number of other organisations. We have come into contact with a number of illicit users. Are there any further questions?

Mr Kendal—Does the committee consider it necessary and important to contact the state and territory governments and try and work out common grounds?

CHAIR—A standard part of our visits to the states is to have a state government response, and in discussion we take public evidence from them and then we question them on various aspects of their submission. It is a standard practice in terms of trying to understand where they are coming from as well.

Mr QUICK—Transcripts of all the hearings that have taken place over the last 12 months are available. One of the things about this debate is that it is polarised. The more that people read and hear first hand some of the evidence here today the better. We also heard from Fairfield council, and from parents who have touched it first hand. As national legislators, we get an opportunity to wander around Australia and see and talk to a range of people. If we make laws that are not popular because people are unaware of what should happen or what might happen, we will sell everybody short. I would advise you to talk to all your friends and say, 'Pester the secretariat,' and get the evidence and take it to your parents and friends councils, your student representative councils and aged citizens centres and talk about it, because it affects everybody.

Ms HALL—We have been to most states now and we have met with not only elected representatives, but heads of government departments—those people who are responsible for implementing the policies—and it was very successful everywhere except in the Northern Territory, where the government refused to let any of their public servants meet with us.

Mr McConnell—My question is about the timing of the committee's report: when do you expect to report, what are the implications for the upcoming election, and what are your expectations of your recommendations being picked up?

CHAIR—There are three or four parts to that question, Brian. It is our intention to put down an interim report. What recommendations, if any, at this point leading up to a federal election is an open question for us. We are very keen to protect the bipartisan nature of this committee, and so that we do not get into the divisive stuff unduly. We all accept that the inquiry has at least another 12 months to run in terms of going through a federal election and then further evidence-seeking, going through a number of stages and then writing a final report and presenting it to the parliament. Perhaps 12 months is a little long, but I think it is realistic in terms of the time span of these things. Therefore we are very keen, as I say, to carefully work through and, without suppressing debate, of course, to keep a bipartisan nature to our committee and our findings.

Mr McConnell—The elections have an implication for the composition of the committee, and you have spent considerable time learning about it.

Mr QUICK—We have a pretty good track record. Just about everybody on the last committee has come back in this parliament.

Mr SCHULTZ—The new ones have no intention of not coming back.

CHAIR—It is always a risk, Brian. We are at the mercy of the people in that regard. The other thing I should have added is that it is dependent upon a referral from the minister of the day, and we would expect them not to stand in the way of completing the inquiry.

Mrs IRWIN—I am sure that everyone in this room is aware that once the report is finalised, which, as the chair said, will be in the next parliament, the committee will put recommendations to the government of the day. It is entirely up to the government of the day whether to take those recommendations on board. As the chair said, we hope to have bipartisan agreement on the report that we hope to table in 12 months, so we will have to wait and see what happens.

Mr McConnell—But the committee expressed disappointment about the last report that came out of this committee.

Mrs IRWIN—This is the indigenous health report?

Mr McConnell—Yes.

Mrs IRWIN—I was not actually on the committee that looked at that, but it has been tabled and no recommendations have been taken on board, which is very sad.

Ms ELLIS—I have brought that to the attention of the House.

Dr Drew—Will the whole process be dropped or will you have to start again?

CHAIR—That would be very unlikely. We are mere mortals in the process, as is everybody, but it is my personal opinion that it would be very unlikely. We think that there is a momentum in it.

Dr Drew—The new committee will have access to what has gone on before?

CHAIR—Yes.

Mr SCHULTZ—We have bipartisan agreement on that issue.

Ms HALL—That is why we are preparing a summary of all the evidence that we have received to date, so that will act as a starting point for the new committee. In the last parliament, this committee had partially completed the indigenous health inquiry, and the first task of the new committee was to complete that inquiry.

Mr SCHULTZ—Half of this committee is new members and we finished the previous committee's report.

Ms ELLIS—Now just a minute!

Mr Liebke—Just a point of clarification of the process: as this committee reports to the federal government, and drug legislation being the realm of the states, I can only assume that the federal government makes recommendations to state governments.

CHAIR—That process is as old as federation.

Mr Liebke—So there is very little chance of there being consistent drug legislation amongst the states and territories.

Mr QUICK—That is happening now with marijuana. The laws in Tasmania are different from those in South Australia.

Mr Liebke—Absolutely. That is the basis of my question.

Mr QUICK—I would like to think that the report would be the blueprint for a national approach rather than the rail gauge mentality of so many decisions that are still made in Australia.

Mr ANDREWS—It is open to federal parliament and committees such as this to make recommendations that the Commonwealth and the states adopt a national approach through the process of the COAG arrangements. Simply because this is a federal committee does not preclude recommendations that have consequences for the states.

Ms Fitzwarryne—Would you consider putting out a very brief interim report before the election so that some of the key areas on which you are agreed could at least go up before the election?

CHAIR—That is certainly our intention. As I said earlier, the recommendations will depend on the deliberations of the committee—but certainly there will be an interim report.

Mr Page—Is it inside or outside of the charter of this committee to recommend to the government eventually in favour of the importation of heroin for heroin trials in a state or territory? Obviously that is a power that federal government is currently exercising, and I wonder if it is within the power of this committee to make a recommendation either way.

CHAIR—Certainly, it is.

Mr Kendal—I am seeking an assurance that the final report will be public, and that it will not just go to an executive government agency somewhere.

CHAIR—They are all tabled in the parliament, and are all public documents. The interim and the final report will both be public documents.

Ms HALL—My first question is to the educators in this room. One of the things that really concerns me in this whole debate about the massive problem that faces us in our society is the fact that when a young person in a school is caught with a drug in their possession or using a drug they are immediately excluded from the school. That exclusion usually involves them being left to their own devices, and without any program in place to either help them back into the system or to help them cope with their problem of addiction. Do you think that, as educators, that is something that needs to happen? Do you think that there needs to be an

approach that is more than just exclusion, that is looking at inclusion and getting those young people back into the education system, functioning and hopefully into employment?

Ms Roberts—I am a mother. I became involved when I was asked to hand over my two most precious gifts to total strangers. I refused to do that, and so, as a mother, I became involved in my children's education right from the beginning. To answer your question, I would not endorse any school excluding a child from it.

Ms HALL—But that is what happens around Australia.

Ms Roberts—It happens not so much in the government system because we are under different rules. The new protocols that were developed as part of the national education strategy go some way to addressing those issues and putting programs in place to ensure that those children are not excluded from the educational process. They may be taken from the school setting but they are not excluded from that process.

Mr Crimmins—We have had to revisit that. We have a lot of indigenous students in our schools in the Northern Territory, and excluding them from the school or expelling them is sentencing them to death. We cannot do that. We are really having to rethink our whole approach to this. We have to think of another way. The best advice I got in connection with my daughter was, 'Keep her alive,' and that is what we have to do with all the young people we encounter, whether they are in government schools or non-government schools. We have to keep them feeling as though they are an important part of the community, but at the same time not jeopardising the interests of other children and their families. That is a very difficult road to walk, but we have to walk it. If we just abandon the road and take an easy cut, we are probably wiping some kids out.

Ms HALL—My other question is to Simon Birmingham. I am yet to be convinced that the hotel industry is involved in the sensible serving of alcohol. I could name numerous occasions where people, usually young people, are being served alcohol when they can barely stand up. Can you tell me what action is being taken within the hotel industry to bring hotels that are involved in the irresponsible serving of alcohol—which is a large number, believe me—into line?

Mr Birmingham—It is a problem, we acknowledge, that there will always be certain elements who do not do the right thing. We certainly do not stand for or condone that as an industry. Our members have, by and large, embraced responsible service of alcohol initiatives. Most branches of the AHA around the country, in most states and territories, now operate courses that the majority of hoteliers put their staff through to undergo responsible service training. Staff will get to understand their legal obligations—which are in place in most states—not to serve people who are overly intoxicated as well as their social obligations and the manner in which they can address the issues with patrons. It is sometimes difficult for a staff member to address those issues with a patron, and they need to know how to do so in a manner that does not get them embroiled in trouble or problems with those patrons.

I would be interested to look at the differences between the types of venues where over-service and intoxication seem to be a problem. The Hotels Association does not represent night-

clubs in many areas; we tend to represent more the traditional hotel licences. I suspect there is a differentiation between the two that is worth the committee taking note of.

As far as federal government programs to promote responsible service to patrons are concerned, we have taken all steps possible with the Department of Health and Aged Care and other bodies to promote those programs through point-of-sale promotional material, and so on. We are more than happy to continue to do that and work through those issues. It is an education campaign for our staff, for our members and for our patrons. We would not say that the job is done by any stretch, and we would be happy to assist further both within our association and in the broader industry.

Ms HALL—Finally, what level of alcohol consumption do your members consider to be too great? When do you tell your members to pull the plug and not serve any more alcohol?

Mr Birmingham—That is part of the training that staff undergo. It is a symptomatic thing because you do not know how much someone has had before they walk into a venue, and you cannot expect staff to keep tabs on how many drinks someone has had whilst they are in a venue. The issue really is to look at behavioural symptoms and patterns.

I suspect the line that is drawn is beyond the driving limit, but it is a line that should be drawn before people are falling over or staggering out of a place. That is unacceptable and, in many states, is a breach of the obligations placed on members. I would be happy to get some documentation from the branches on what guidelines staff are given and what symptoms they are told to look for, if you like.

Ms HALL—That would be appreciated, thank you.

Mr QUICK—My first question is to Steven. We heard evidence in Queensland that, if we legalise marijuana, which is a $5 billion—that is a guesstimate—non-taxable industry, probably just about every sugar town in Queensland would shut down because quite a few sugar farmers supplement their income when the price of sugar goes down. We would probably double the unemployment rate, which would probably scare the Jesus out of federal members in those areas in marginal seats. Weighing it up, do we suddenly increase the unemployment rate and do we legalise marijuana? How do we guarantee that, if we sell it through these cafes as you suggest—

Mr Liebke—That is not the way I suggest. I suggest that cannabis should be sold through government shopfronts, that all buyers are registered and that all growing and processing be done under government sanction; in fact, by the government itself.

Mr QUICK—That would create massive unemployment in certain areas of Australia where they are doing it in the dark at the moment.

Mr Liebke—Obviously, that is a difficult question. If you are talking about employment based on a black market, I am not sure that you would want to perpetuate that, would you?

Mr QUICK—I do not know. I am asking you.

Mr Liebke—I do not think the Institute of Criminology would be terribly impressed by that. Obviously, it would offer new opportunities for people to grow marijuana under government regulation.

Mr QUICK—Is it happening anywhere in the world, that you know of?

Mr Liebke—No, not that I know of. It is a new approach. As I said in my model, it would not involve a network of Dutch style cafes. Every buyer would be registered and every sale would go into a national database to provide figures on who is using and how much they are using across the demographics. I think it would open a whole new industry and off the back of that you would have a much more credible opportunity for a hemp industry in Australia as well.

Mr QUICK—My second question is to Carmen. Concerning mental health and shifting blame from one lot to another, is any state or region actually biting the bullet and saying that we need an interagency approach to deal with this, rather than shooting them on Bondi Beach, that sort of approach?

Ms Hinkley—I am not aware of any best practice models that are happening at the moment, but it is recognised that that needs to happen. Whether it is happening, I cannot comment, sorry.

Dr Drew—There is currently a project in the ACT. There have also been quite a number of projects in New South Wales. The one in the ACT is ongoing at the moment.

Ms Doyle—It is about education for both drug and alcohol and mental health workers, crossing the issues over—they do some education together and some separately.

Ms Pearce—But so far the projects are significantly underresourced. Part of the problem is that they are allocated small amounts of funding and the amount they can do is minimal.

Mr QUICK—Something like that obviously frustrates the parents who need to access the service.

Ms Pearce—Yes, absolutely.

Mr QUICK—Do you suddenly move up to the ACT from Tasmania where I come from because there is not a service down there, or if you live in South Australia or at Tamworth? How do we get a national approach, rather than some people with vision in the ACT setting something up but it does not happen anywhere else?

Dr Drew—It is an issue in the national strategy on mental health. That would be one way of getting it through—as part of the national strategy on mental health—over the next five years, to give attention to dual diagnosis. I think you will find that that is already part of the strategy.

Mr QUICK—My last question is to everyone. I would be interested to hear your opinion on the book which you received in your letterbox from the Prime Minister, on a rating of one out of 10.

Ms Doyle—Zero.

Ms Pearce—Disgusting.

Ms Roberts—I have just moved to Canberra from Tasmania and I have not received my copy.

Mrs Barnard—I find the television ads with the body bag very offensive—extraordinarily offensive. In all the time my family was dealing with Dean's addiction, nobody ever came to our door offering any help. It was all down to us, and it was a daily task. He was extremely well until he decided to detox off methadone. Life then became chaotic, and he was very unwell again. On the night he died, we had a houseful of police. There were six police in the house, Dean was dead on the floor and he lay there for many hours. They came in with really big cameras and took photos. They sat my mother down at the kitchen table and interviewed her for more than three hours. They sat her there, with her son dead on the floor. When they took him away in the body bag, we were witnesses to all of that. Nobody came to see my family the next day or since. The only kind words to my mother about this enormous experience were from the coroner here in the ACT. He was spectacular in his summation. He congratulated her on the level of care and spoke to her very personally. Our only contact with people in authority over this issue was people in uniform, who were totally without emotion and were there perhaps to make us feel guilty that we had a drug user in our family. We have to accept how isolating this issue is and we must address the needs of the family. The body bags have to come off the telly.

Mr Gardiner—Chair, when you do your final report, will you make it quite clear that the people who are against prohibition should produce the factual evidence to prove their case, and that those who have the opposite view should make their evidence quite clear? What I am saying is that those who do not want drug law reform should produce the factual evidence to back their case.

CHAIR—Specifically, the question is: can I guarantee what will be in the interim report? I cannot, because it is yet to be written and yet to be agreed upon, but certainly I accept your point.

Ms Aulich—I would like to go back to the booklet in the publicity campaign. I think you are dudding parents if you give them the impression that, just by talking to their kids, that will somehow drug proof their kids. An example of that is drink driving. We have had a very thorough campaign about the evils of drink driving. I think there is not a 17-year-old anywhere who gets their licence and does not realise the dangers of driving and drinking, and I am sure parents talk to their kids about that, because it is one of parents' general widespread fears. In spite of that, we know that kids will still get into cars and take risks, and some will have horrendous accidents with terrible consequences. It is simplistic to suggest that if parents sit down and ask, 'Are there drugs at your school? Would you say no?' that somehow that will give the parents reassurance that their child will not use drugs. It is just not on.

Education is very difficult. As a teacher, I have yet to see what I think is a really good drug education program. But I think we have to be much braver than we have been, in the same way we have changed about sex education. We used to feel that, if we gave kids really explicit, accurate sex education, somehow they would go around bonking like rabbits but, in fact, there were

fewer unwanted pregnancies and fewer STDs. Kids' drug education programs need to be quite widespread and wide ranging, but they also have to be quite explicit. We have to give kids information that we probably feel very uncomfortable giving them, in the same way that we had to talk to them about condoms, and so on. Even then we need to realise that it will not reach everybody. We still have unwanted pregnancies, we still have drink driving cases and we still have young people who undertake risky and foolish behaviour. We have to have all the things in place to pick them up when they do.

CHAIR—Thank you, Judy.

Mrs IRWIN—I want to ask Bronwyn about the uniform. You were saying that the police came and these men were in uniform. Do you find that it is a lack of training or a lack of understanding? As you know, Bronwyn, I have Cabramatta in my electorate and we have some dedicated young officers there. They have spoken to me recently and said: (1) they have not been trained to understand the culture; (2) they have not been trained to understand the language; (3) and they feel they should have the correct training. Like your family—you lost your beautiful brother. The police should have known how best to handle that situation. They should also be able to understand the kids on the streets and their addiction. There are a lot there who do not.

Mrs Barnard—I think the situation for the police is absolutely horrendous. They have been placed in an absolutely horrendous situation. They were instructed to attend our house because there was a death, and they were investigating whether that death was suspicious. Why there had to be six of them—they literally stood over every room in the house. I came in and sat with my deceased brother on the floor, just to be there for a few moments. I dared not touch him because this female policewoman was standing very close to me, watching every move I made. He was about to be taken away. I knew that the ambulance was coming and I just wanted to spend some time with him there.

Mrs IRWIN—Some quiet time; some private time.

Mrs Barnard—Yes. It was very offensive. There were also the lights on these cameras they wanted to take pictures with. They have to have enormous lighting. They lit up the whole house. They seemed to be there forever. I do not understand why they had to interview my mother that night. In all honesty, what difference was it going to make? We had nothing to hide. We were not suppliers of a drug. Whether they considered that we might have been—I do not really understand what possible thing they could have been hoping to learn from a deceased body and from my family. So I do not understand that.

I do understand their need to assess the situation to make sure that nothing wrong had happened. Why there were so many of them, I do not know. Dean was not a dealer. He was fully employed. He had not even touched the stuff in years because he had been on the methadone program. So it was all a bit strange. I do feel that the police are in the worst possible situation. I have no respect for the police now, none. I am sorry. I am a very law-abiding citizen but I have no respect for them. I think this must constantly happen to them. They really are out there wanting to do the right thing by the community and uphold the quality of our lifestyle, but they constantly get undermined. The sooner we repeal prohibition and get an honest, up-front supply—the supply is there; people get the drug. Let's do it through medical supervision; let's do it

the proper way; let's not do it underhandedly at the back door, where they will sell to anybody, of any age, come what may—'I've got the goods here.' Let's get it through our doctors and people who are properly trained. Let's do it properly would be my suggestion.

Mr Crimmins—I would like to add something in response to Julia's question and Bronwyn's answer to it. If it were not for really good health professionals, my daughter would be dead. So I must say that my contact with the health profession is that they are extremely compassionate and competent. Like Bronwyn said, I think the police are in an impossible situation. They actually have to criminalise the drug users. That is the whole area in which they operate, so they take on that persona. It is the traffickers that we should be harnessing their energies towards.

CHAIR—Yes. Decriminalisation was going through my mind. They have to act in this way and it just seems that it is totally out of kilter with the reality of the tragedy.

Mr Crimmins—If the people who had gone to Bronwyn's home had been health professionals, it would have been an entirely different experience.

Mrs IRWIN—Because that health professional is trained; whereas, the police are not trained.

Mr Crimmins—That is right. Marilyn and Jan's attendance would have been entirely different.

Mr Gardiner—I would like to say about catching the traffickers: it is a naive assumption. America spends nearly $20 billion a year trying to stop it, and they have got the worst problem. It is total failure, and it is wrong to say that.

Mr Crimmins—Okay.

Mr McConnell—I just want to go back to the police issue. My son overdosed on an oval not far from our home. My daughter called the ambulance, but the police also came. This was some nine years ago. The effect of that was that they were harassing my wife and my daughter. They asked me questions, but I was too preoccupied with going with the ambulance. When we got to the hospital we were told to wait outside, and the police went backwards and forwards. My son came to in the hospital ward with the police at the end of his bed, and that frightened him. We did not see much of him for the next two weeks, and he took a hurried holiday. We saw him once or twice during that fortnight before he went on a holiday and he overdosed and died.

The police were implicated in that process. If they had not been there he would not have been frightened and we might have got a chance to talk to him. I am not blaming the police, because they were doing their job at the time, but the police here in the ACT and a number of other jurisdictions have changed and they say they no longer attend overdoses. They advertise it freely here in the ACT. They do it in Victoria when there is a batch of heroin that is particularly strong on the streets, and they publicly advertise it. I would think something that might go in your report is along those lines—that it be adopted, if it is not already, across all jurisdictions.

I think it is also that the police are, as Peter says, treating the issue as a criminal issue. It is a health issue. The ambulance officers and the hospital were dealing with him quite adequately.

The criminal side of things could have been dealt with at a much later stage, not at that critical point.

CHAIR—Brian, did I understand you to say that they do not attend in the same way now in the ACT?

Mr McConnell—The police now no longer attend overdoses, unless there is some other reason to do that.

CHAIR—My question, therefore, is: do we know whether that was a regulation or an act of parliament?

Mr McConnell—I think it was just operational, police practice. I was talking to a young policewoman from the Cabramatta area just recently, and she said that in that area if they see someone who has overdosed they call the ambulance and then they step back and do not get involved. So I suspect it is something that is spreading, but I suspect it is not throughout the whole of Australia.

Mr Page—I think there is an assumption some speakers are making that there is a clear division between drug users and drug dealers, as though they were a different species, when in fact a lot of the dealing is done by low level users. That is certainly not always the case. There have been a number of users who have done absolutely no dealing, but in my experience of it, through my son being on methadone for several years and people that I have known who have overdosed, it is very hard to take the position, 'Well, if we could only stop the drug dealing, then there would not be a problem,' because the dealing is going to happen at the lower level, irrespective. That is what leads me towards the idea of legalisation of some kind, because then you would not have that complication. It could be along the lines of the marijuana suggestion that has been made by Steven, something like that—that it would be publicly available in a restricted way or in an organised way to those people who were registered as users.

Mr LAWLER—I understand in your model, Steven, that anybody above a certain age, or whatever, would be able to access this shopfront and have their information recorded. Would you, from the reading you have done—and, obviously, you have put a lot of thought into it—anticipate that the use of marijuana would increase, decrease or stay the same under that model?

Mr Liebke—It is hard to say. In the Dutch experience—from the reading I have done—there has been no significant increase in marijuana usage. I suggest that you might get an increase in some sectors of the community and a decrease in others. Adolescents tend to engage in risk taking behaviour, and something that is illegal is equated with risk taking, so you might in fact have a decrease in that sector. Conversely, people who would normally be conservative and not engage in illegal activity might feel it was okay to at least try cannabis. But, having said that, I think that with people who are just in an experimental phase and do not have the underlying reasons for continuing usage leading to dependence, it is unlikely that they will become dependent. Like I said, it is very difficult to say. I have not seen or read of any model like this before that has been implemented, but I would suggest that if there were any increase at all, it would be negligible.

Mr LAWLER—At least in that situation, the substance you are talking about is available when someone walks up. Bronwyn, I have trouble getting my head around this—if you did have heroin provided by prescription from the doctor, there would still have to be an underlying market of heroin for people to start using. I would presume someone would not just roll up to the doctor and say, 'I want to start using heroin.'

Mrs Barnard—You will never eradicate it. The same way now that you cannot stop young children from getting cigarettes if they really want them or alcohol if they want it, there will still be some availability of illicit substances. But, assuming that most people are selling illicit substances to fund their own illicit drug need, then if we are getting enough people into treatment and enough people are getting their needs met through prescription, it would be my hope that we would significantly destroy the availability on the black market. People predominantly sell because they need the money, and people would rather sell amongst their friends and associates than break into houses, prostitute themselves and commit robberies. Because they are users themselves, they would rather sell amongst their immediate friends and add one or two or three new people to their circle. I would hope that if you met that person's need, then slowly over time you would reduce the illicit supply.

Mr McConnell—I have got some figures. Tony, you were asking about whether it would increase under Steven's model or not. The closest equivalent we have got to what Steven is proposing is the Dutch model, in which cannabis is sold through coffee shops. The latest household survey figures show that the percentage of the population that has used cannabis in the last 12 months for Australia is 17.9 per cent. In the Netherlands, which has got roughly the same population as we have—about 18 million—it is 4.5 per cent. So there is a significant difference there. And it is worth noting also that the Netherlands is primarily a transit point for a lot of shipping, and the drugs go through the Netherlands because it is a shipping point as well.

Mr Liebke—I would just like to comment on that. It is hard to compare those figures, simply because I think the difference in those figures that you have quoted is at least partly due to cultural reasons, rather than legislative reasons. While the Dutch model cannot be said to have contributed to low rates of cannabis use, I think that the education system over there could well be very different from the education system here, and cultural difference could well explain at least part of that away. I think if you put the Dutch model into Australia, you could well see a significant increase in cannabis usage.

Dr Drew—I would like to respond to the issue we have been throwing around and ask the committee not to get itself too involved in details, and certainly not to commit itself to details, but rather to commit itself to principles. I would not argue with what Steve said, but somebody will and say that there is another model. The important thing is for the committee to be attached primarily to principles and then to perhaps say, illustratively, 'We might go down this path or another.' What we need is a quantum leap into a new policy. If you worry about detail, people are going to quibble about that. We need to question our current policy and explore new policies—not get hooked up on the details.

Ms ELLIS—Mr Crimmins, I preface my comments to you by saying that some of you have been here all day, but a lot of you have not. Earlier in the day we had some discussions about the polarising of the community in relation to the question of drug and substance abuse and the difficulties that that gives all of us, because it is a community issue—it is not a political issue—

and how do we then make decisions on how to advance what we think is the beginning of solutions when we have such polarised debate. Briefly, the very best example to give is to say that you could have two parents in front of you, both of whom have lost children, and one says to do one thing and the other says to do the other, or you could have reformed users in the same position.

The reason I am putting all of that in front of you is because I think that your association is going through a really interesting process. You have had a view as to how you will deal with some of the issues affecting some of your children and now, as you have said to us this evening, your association is in a position where you believe you need to review that—you need to think about it. I think this is a very important journey for anybody to go through, particularly when you have had a position—and we have them all around us, left, right and centre. I would like you to share with us how you, or your association, and your colleagues are beginning to deal with that shift. I know that on the surface it is because you have children you do not believe you should treat in that way, but other people have people in that position and they are not making that journey. I am interested in how and why you are, and what the impetus is for all of you to come to that point and wish to advance it.

Mr Crimmins—Our indigenous students would be the impetus, and our indigenous students in the Northern Territory. The polarisation you refer to is in our schools. It is in our school movement and it is in every one of our schools—just as it is in this room. However, our people in the Northern Territory, where all our schools are systemic, found that when they encountered young Aboriginal people coming into the schools who were the victims—and that is the word to use—of substance abuse, excluding them from the schools and then having them face the consequences of that back in their home communities often sent them on a journey of even deeper drug abuse. That journey often resulted in detention and that could easily end up with loss of life. We cannot pursue that. There is no case for pursing that path. As hard as it is, people in the Northern Territory—in fact, one of my colleagues is down here—are in the process of reviewing that. Convincing our colleagues in the rest of the country that that is a journey they need to take is not going to be easy. You probably saw *60 Minutes* last night. Even families that have had the experiences that Bronwyn, Michael, Judy and I have had—and obviously Brian as well—are divided about how to deal with it. They say, 'Zero tolerance,' 'Legalisation'. Last night the people were speaking so angrily to each other that they had to cut to ads.

Ms ELLIS—It was very depressing, wasn't it?

Mr Crimmins—It was distressing for them and it was distressing for those watching it if they had been caught up in that. Our community is going to have to go on a journey that says, 'There are many solutions to this problem, and unless we look at all the solutions objectively we won't find the answers and save the young people of this country.'

Ms ELLIS—I do not want you to get into specifics, because I do not think it is that sort of issue, but obviously you have already begun that within the Northern Territory. To what degree has that consideration or awareness started to wash into your other divisions? Has it started already or is that still ahead of you?

Mr Crimmins—The more urbanised the school, the higher its socioeconomic status, the harder it is to get that message accepted because, for reasons that I suppose you can understand,

parents who are coming from reasonably middle class and affluent backgrounds do not want their children in schools where they think there are drug users or where they think their children could be exposed to trafficking.

Ms ELLIS—So, to put it crudely, it is almost like that little kindergarten girl in New South Wales back in the eighties who ended up going to New Zealand to go to school.

Mr Crimmins—Yes, I remember that.

Ms ELLIS—It may not be quite the same but it is almost getting to the lifeboat situation: that we do not like this or want it so we are going to put a little fence around ourselves and pretend that it does not happen.

Ms Roberts—Any parent in this country who thinks that taking their child out of one school and putting them into another is going to stop them somehow coming into contact with drugs is deluding themselves.

Ms ELLIS—Or any other behaviour, for that matter.

Ms Roberts—I sit on a national committee with parents representing Catholic children and parents representing independent schools. It is not in one school, it is in every school in this country. We have to start looking at protecting our kids. Education is a right for every child in this country, it is not a privilege for some, and every child has a right to be in school. Schools reflect the problems of society: if we have got drugs in our schools it is because we have got drugs in our society.

Ms ELLIS—So this whole thing advances what a lot of us in the room here have been saying today.

Ms Roberts—And we cannot solve it in our schools.

Ms ELLIS—No, it is a community problem needing a community solution. None of us has the answer, none of us is completely right or wrong. Without community solidarity and devotion to wanting to do something about it as a whole, we will never get there.

Ms Roberts—And it does not matter how much money you have got, you are not going to buy your way out of this problem.

Ms Doyle—It is perhaps a case in point for having a full range of options and making them specific that, in fact, what will work for schools in the Northern Territory will not work for those in urban areas. We might try to find one model to fit in a whole lot of places but in fact we need to be very specific to fit the community in which they live.

Mrs Uhlmann—I have been thinking about those who want things to be freed up. What would you do then? You have to check on people's health. Anne Deveson wrote a wonderful book about her son and her battle; it was beautiful and sad to read. Because he had had some problems at his birth, she believed marijuana was the trigger to his schizophrenia. It is just so

sad that we lose all these wonderful young people. Have we tried to find out—and people might have done—what are the common elements? I think when someone is in trouble with drugs you should not send them out into the community. That is wrong. It takes a community to bring up the child—a village, we would have said once—so we really have to think about how we are going to help these people because the parents are distressed. The only way is to work together. I think people are having a great deal of success in turning children around from committing crimes when they conference with them, because some of those children, from whatever sorts of families, have not developed a feeling that they are hurting someone; they just think about what they are going to do on the spur of the moment.

I have six children, who are all grown up now, but I remember being called to school about something my son had done. When we sat down to talk I said to him, 'Why did you do that?' He said, 'Whose side are you on?' But through that we found out from the other boy that the reason he had punched my son in the mouth was because, as he said to his father, who was sitting there, 'You are so busy earning money you have never got any time to talk to me.' The father said, 'But I am doing it for you, to try and give you a better life than I had.' So I do not totally disagree with the booklet because it says that we have to talk to each other. I am starting to talk to my grandchildren now and the first thing I tell them every time I see them is how beautiful they are and how much I love them.

Ms ELLIS—This discussion has proven the point for me; that is, there is no right or wrong answer. A variety of approaches will be required, and some things will suit some and some will be the worst thing you could suggest. But unless we have an honest appraisal of what is available—which I do not think we have had yet—we will never know what does fit and does not fit.

Mrs Uhlmann—Could I say one more thing before we go. We are wasting the grey power of this country.

Ms ELLIS—There is no doubt about that.

Mrs Uhlmann—There are wonderful people out there who are very willing to mentor and walk with children. You have to have programs, you cannot do it off the top of your head, but that is what a lot of them need. Sometimes the parents, as much as they love their children, are not the best people to talk to them.

Mr Gardiner—I find Mary's statement very offensive. We spoke to our son many times. I know a lot of people who have lost children and they spoke to their children too—just the same as you did. Do you see where I am coming from?

Mrs Uhlmann—I am not judging you. That would be very foolish of me.

CHAIR—People are starting to leave, and we will need to start to wind up.

Mrs GASH—I will be very quick. I have been sitting here ever so patiently.

CHAIR—I am just acknowledging those people who are leaving.

Mrs GASH—I am going to give you a different perspective. My electorate has the third largest Aboriginal population in New South Wales and an average income of $24,500 per year. It also has some wealthy people. I have a daughter, a brother and a son-in-law in the police force. I have had children in state schools and in private school, and I now have six grandchildren. I have shifted my thoughts two or three times throughout the years.

You are talking about how it affects you personally, and I understand that. But have we ever asked the police what they feel with regard to the legislation? My daughter is 37, and one day she came home from a shift and said, 'That's it.' I asked, 'Why?' She said, 'Mum, I have tried to do the right thing.' I hope she was brought up in the right way. She said, 'They will sell their mothers for the next fix.' She has the scars from trying to reason with somebody who was on drugs. Admittedly, it could have been your son or your daughter, or it could have been mine. It does not matter; we do not differentiate. But she still has the scars where she tried to reason with someone, and they could not be reasoned with. She never complained, she never charged him, she never did anything. How far do you go if the perpetrators, the dealers in this world as you have said, are still walking the streets, still doing the same things, and there is no legislation that says what we are going to do with them because there are people in society who say we have to be kind to these people because they do not know what they are doing? How do we judge that? What do we say to the person who has been in jail overnight and gets out the next day and says to my daughter, 'Told you so'? There is nothing you can do. I get emotional about it too.

Mr Gardiner—Prohibition is destroying police too, isn't it?

Mrs GASH—Is it? I do not know. I cannot answer that. Or is it that the laws have not been adhered to? Are we too generous? Somebody mentioned zero tolerance. I do not know. Mary, I do not know.

Mrs Uhlmann—I do not know, and I never mean to offend people. I think it is a great tragedy about that beautiful boy. We weep with you. But I do not think that giving everybody the right to do what they want is the answer either.

Mr Gardiner—But they already do what they want.

Mrs Barnard—America has enormous resources and very well equipped police with extraordinary powers. They can bash in the front door on someone else's say that they think, with no evidence, that there are 'drug things' happening in that house. I have a book called *Shattered lives*, which has stories about people in jail in America. We can go as extreme as we like. In some states of America they can put you away on someone else's say. America has, per head of population, by far the most people in jail, and still they have the Statue of Liberty—the country where dreams are made. I find that the most offensive thing in the whole world. They criticise China and other countries for locking people away, but they have a lot of people in jail. I really believe America is the example. If we want to go tough and hard and use the law to deal with this issue, that is what we will get. We will get more prisoners.

The daughter of a friend of mine was released from jail four weeks ago. For her first touch with the law, they did the diversionary thing and they recommended her to an abstinence based rehab. The first night she was there, she was approached for sex by another resident. She is very

attractive. She told him to get 'whatever' and he kept approaching her. So she physically hit him. The next morning she was out on the street. Her mother forced her to go back to the court. She was sent to Sydney because they had a women's only program that she could go to. When she got there she was the only woman in the program. They put her with a group of men on a Salvos program. It was abstinence based. The men in the group told her what they would love to do with her if the teacher would just leave the room for five minutes and they were left alone with her. So she ran away.

It took us nine months to retrieve her from the streets of Kings Cross, at which time she was brought back to the ACT with criminal convictions a mile long for shoplifting to support her habit. She came before the judge here in the ACT and he said, 'We have tried everything possible, young lady, to rehabilitate you, and at every turn you have failed.' I just wanted to yell at him, 'You didn't try methadone. In another 12 months you could try buprenorphine. For goodness sake, try everything and make prisons an absolute last resort.' Nothing good happens in prisons. Drugs are in prison. Needles are in prison. Disease is in prison. This girl is now out of Mulawa, and we cannot get her a job. Nobody wants to employ her. We cannot get her accommodation in the ACT. There is no housing. We are hanging on to her by the skin of our teeth. Prohibition, going tough, does nothing. Her level of respect for the community is pretty tattered.

CHAIR—Approximately how old is she?

Mrs Barnard—She turned 21 in jail.

CHAIR—So she is just 21?

Mrs Barnard—Yes. She is articulate, well educated, very employable and very attractive. We have to get employers on side. People with an addiction can be treated. Treatment works. When you get the treatment right—at whatever part of the spectrum it falls, be it anywhere from abstinence to maintenance—and you stabilise that person, for heaven's sake get them a job and allow them to be themselves and do not value them on whether or not they are drug free. That is irrelevant. The important thing is whether they are well and functioning.

Mrs GASH—Steven, I am Dutch. I was born in Holland. Euthanasia is legal, too. Whilst the incidence of marijuana may not have gone up, the incidence of prescription drugs is very high in Holland.

Ms Aulich—I would like to make a comment. It must be extremely difficult for police to deal with extreme cases, and there are extremes in every case. I do not think it is always the best way of judging by judging the extremes and the worst cases.

Mrs GASH—I would like to jump in here. I did not use the word 'extreme'. In some cases it is the norm.

Ms Aulich—No, I chose the word 'extreme'. I imagine police training is much better now. Eight years ago when our child first had contact with the police, she was 15 and smoking cannabis daily. It had become a police matter for another reason. Their best advice to us, which we took because we knew no better and felt they should know, was that she needed to go to

Woden Valley Hospital detox with middle-aged male alcoholics—and initially we followed that advice. I would like to think that police are now much better trained. That was our first call, our first cry for help, our first attempt to get any assistance. It is not that I blame the police, but had they been wisely trained they might have directed us to good drug counselling and the outcome might have been quite different.

You talk about those terrible cases of people, but I do not think any of us can really understand the pull of the drug. I have a lawyer friend who said to a person up on a very serious charge to finance his drug abuse, 'You must do almost anything to get heroin,' and he said, 'Not "almost anything".' That is why it is so important that it is a health issue. It is inconceivable for people who do not use to understand the pull that that drug has.

Mr McConnell—I would like to respond to Joanna's question: have the police been asked? I was at a recent futures forum which included very senior police from all states and territories. Our purpose was to look at what sort of future we wanted, concentrating on drugs and so on. The overwhelming response from that particular forum was to change the system. Some of the police officers even said that we have to legalise the drugs. In the workshop I attended, which was a subset of that before we went back to a main forum, this was initiated, firstly, by the police officer in the workshop that I was with and, secondly, by the magistrate. They were the people who raised the issue first and said that we have to change the system.

Mrs GASH—The word you used was 'extreme', and I did not use that word. You used 'senior policemen', and I did not use the words 'senior policemen'. Ask the people on the beat and ask the people who attend those functions. I am not saying they are right or wrong; I am merely saying there is another school of thought. Ask some of the elderly victims in my electorate who have been severely bashed and robbed. I have to deal with that as well, as you would have to do in your electorates. You see the victims and you see the perpetrators. It is not an easy decision to make, and I do not have the answers now.

Mr McConnell—They are robbing people to pay for a very high priced illicit drug. If the drug were not so high priced and was available in a regulated form, you would not have the robberies.

Mr QUICK—The thing that worries me in this is the whole lot of phrases. To my mind 'perpetrator' has a different connotation to 'someone who needs medical assistance'. There is a difference between 'a shooting gallery' and 'a safe injecting room'. They are the same place, but with one you immediately think of the bad and with the other you think of assistance and support. People swap backwards and forwards, depending on which point of view they want to get across. I think we need to think of some new phrases and different words to deal with this, otherwise we are still going to have this division.

Mr Liebke—I have three quick points off the back of what Bronwyn was saying about the US war on drugs. I think the worst thing we can do here is privatise the prison system. Obviously, like any industry, its goal is to maximise its customer base and the best way to do that is to prosecute drug users. Jo talked about pharmaceutical drug use in the Netherlands. Probably a lot of that is attributable to international pharmaceutical companies and their driving of accepted medical practices. More to Peter than anyone else: we can really reduce the

incidence of drug abuse, as opposed to use, by de-emphasising success through material gain and social status and concentrating more on the individual in the education system.

Dr Drew—I would like to personally thank the committee for allowing us to come and talk to you today. I ask that in your deliberations and preparation of the report you look at history. If you go back to the 1970s there were two very significant reports, one from Professor Sackville in South Australia and the other by the Senate committee of inquiry in 1977. I think you will find that all we are talking about today was very well canvassed there. It would be lovely to see as much movement forward from this report as we got from Senator Baume's report. That changed the way we thought about drugs in Australia. It changed the way we dealt with alcohol particularly. I think we have made a very good development with alcohol since then. I am hopeful we are going to see some changes once your report comes down.

Mr Brandt—I want to make a very quick comment. I can understand the emotive side of the illicit drug discussion from first hand. I had a sister who was a heroin addict as well. I would like to remind the committee that it is substance abuse and the issues are a lot wider than illicit drugs. The issue is pharmaceuticals, alcohol, tobacco and even petrol. There is a huge amount of substance abuse a lot wider than illicit drugs.

CHAIR—Thank you very much, Peter. Jacqueline Pearce, there was something that you said that troubled me. It was about older women or people of quite senior age and substance abuse and how they are dealing with it.

Ms Pearce—We see a lot of older women who have been addicted to pills for many years, not necessarily high levels. They may have gone to the doctor years ago either because they remembered about abuse from their past or they are currently living with violence. There may be some grief; there may be a loss. There is a huge range of reasons for the fact that that woman may have decided to go to the doctor for some assistance. As a result of that interaction, rather than being referred perhaps for some counselling, a variety of things or even offered some options, what she has been offered is a solution from pills. That just goes on and on and on for many years.

CHAIR—Thank you very much. Ladies and gentlemen, can I just acknowledge your great contribution. I am sure we, as members, very much appreciate it. It has been quite a long day. The one thing we can agree about is we have not got the solutions. We only wish we did have. We are acutely aware of our responsibilities. You are also one of us. You are Australians too and you know as well, if not better than we do, there are no easy solutions. We know incrementally there are opportunities to do better but you also know that we all are vulnerable to the same issue, particularly our families. With that, thank you very much.

Resolved (on motion by **Mr Quick**, seconded by **Mr Lawler**):

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 6.18 p.m.