COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Substance abuse in Australian communities

THURSDAY, 14 JUNE 2001

HOBART

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Thursday, 14 June 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 Hall, Mr Quick, Mr Schultz and Mr Wakelin

Terms of reference for the inquiry:

To report and recommend on:

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

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

WITNESSES

AMES, Mrs Nell, Chairman, Management Board, Your Place Inc. 1039

BINGHAM, Mr Richard, Secretary, Department of Justice and Industrial Relations, Government of Tasmania 982

BOYER, Mrs Jennifer, Deputy Manager Pharmacy, Royal Hobart Hospital 1039

BRUNO, Mr Raimondo, Researcher, School of Psychology, University of Tasmania 1039

BUTTERS, Mr Tony, Deputy Manager/Case Manager, Launceston City Mission, Missiondale Therapeutic Recovery Centre 1039

CHURCHILL, Ms Kim Adel, Chief Executive Officer, Holyoake Tasmania Inc. 1025

CROWLEY, Dr Michael James, Senior Clinical Psychologist, Alcohol and Drug Service 1039

DIXON, Mr Michael, Board President, Holyoake Tasmania Inc 1025

GALEA, Mrs Nicola Katherine, Member, Hobart Branch, Catholic Women's League Australia Incorporated 1008

HAM, Ms Susan Jane, Chief Executive Officer, Colony 47 Inc. 1039

HOWARD, Ms Katherine Anne (Private capacity) 1039

IKIN, Ms Lucia (Private capacity) 1039

JACKSON, Dr David, Senior Staff Medical Officer, The Hobart Clinic 1039

JEANNERET, Mrs Carolyn Mary (Private capacity) 1039

JOHNSTON, Mr John, Deputy Commissioner, Tasmania Police 982

MASON, Mr Ron, State Manager, Drug Education Network 1039

McKEOWN, Ms Cecile Ann, State Manager, Alcohol and Drug Services, Department of Health and Human Services 982

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MULLAN, Ms Denise (Private capacity) 1039

MURPHY, Ms Esme Joy, State Project Officer, National School Drug Education Project, Department of Education—Tasmania..1039

ROBERTS, Mrs Betty Ann, Member, Hobart Branch, Catholic Women's League Australia Incorporated..1008

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SHADBOLT, Ms Cheryl, Board Member, Holyoake Tasmania Inc. 1025

SHIPWAY, Ms Kathleen, Director, Equity Standards Branch, Department of Education...................982

SPEED, Mr Anthony David, Acting Assistant State Manager, Commonwealth Department of Health and Aged Care 1039

TONKS, Ms Melinda, Manager, Your Place Inc. 1039

TRIFFETT, Mrs Maree, Member, Catholic Women's League Australia Incorporated......................1008

WALKER, Ms Elizabeth Mary, Registered Midwife, Women's Health Clinics, Royal Hobart Hospital 1039

Committee met at 8.46 a.m.

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

We have conducted public hearings in all states and territories, visited treatment facilities and jails around the country and spoken with hundreds of people working in the alcohol and drug arena, and hundreds more from across the community. We realise we have got a fair way to go on this issue, but we have made a reasonable start. We will be ready to write a final report in about 12 months time, which we hope will offer some useful recommendations as to how as a community we can more effectively deal with the issue of drug related harm.

This morning we will be hearing from a number of agencies which have put in submissions to our inquiry and later today we are having a roundtable which will give a number of individuals the chance to get their views onto the public record. What you have to say is important to us, and will form part of what we call our evidence. We will be able to refer to it when we write our final report. The committee does not swear in witnesses but we need to point out that the proceedings today are legal proceedings of the parliament and, as such, they need to be accorded the same respect as the proceedings of the House of Representatives.

[8.57 a.m.]

BINGHAM, Mr Richard, Secretary, Department of Justice and Industrial Relations, Government of Tasmania

JOHNSTON, Mr John, Deputy Commissioner, Tasmania Police

McKEOWN, Ms Cecile Ann, State Manager, Alcohol and Drug Services, Department of Health and Human Services

SHIPWAY, Ms Kathleen, Director, Equity Standards Branch, Department of Education

CHAIR—I welcome witnesses from the Tasmanian government. No doubt somebody would like to add to the submission or make an opening statement.

Mr Johnston—Can I say at the outset that we are particularly impressed with the work that is presently being undertaken by the committee, because the work that is happening now will inform the overall drug debate within this country. It is important that the views of those with whom you are talking become well-known and come to the table. It will not only inform the report that you are going to produce at the end of your time but it will also inform a whole range of other considerations that are happening concurrently with your deliberations and considerations. So we welcome you here to allow us an opportunity to contribute to your deliberations and to inform you as to the position within Tasmania.

The submission from Tasmania has already been circulated, as I understand. We would like to emphasise at the outset that we, like the Northern Territory, would claim to have entirely different drug issues from those that are experienced by most of our counterparts throughout the country. Those with much larger urban jurisdictions have different issues from those that we encounter in Tasmania.

Tasmania is fortunate not to have as significant an illicit drug problem as occurs in other jurisdictions, but of course that does not mean that we do not have a problem with drug use and drug abuse in certain aspects of our community. But we can say that the incidence of illicit drugs such as heroin, for argument's sake, is not as significant and therefore the problems associated with heroin addiction are not as evident within our communities in Tasmania. But, as I say, we do have problems of our own. That is not to say that we are not prepared to have a good close look at what we have here and what the problems are and to seek the best ways of addressing them. We do that in the context of the Tasmanian community, which we would suggest is the best way forward. That is, we should be alert the problems that exist within our community and consult with our community to find the best solutions to try and address them.

I can say that we in Tasmania are fully supportive of the National Drug Strategic Framework and the harm minimisation approach that is articulated so well in that document. We are supportive of the decisions taken by ministers in their endorsement of the harm minimisation approach and we also have a view that the drug diversion initiative is a very positive one. It is one which we have embraced; Tasmania was in fact the first jurisdiction to have it online.

Within this state, we try to take as holistic a view as possible on all drug issues that come before each of our various portfolios. Every agency within government work closely together within the framework of a cabinet subcommittee on drugs, which then translates into the working environment through the Intergovernmental Committee on Drugs which is chaired by the Department of Premier and Cabinet and which is informed by a range of non-government organisations as well as working groups underneath it. We do have a view which says that, all working together, we are more likely to achieve positive outcomes than each of us individually within our own silos, going in our different directions.

The final comment I would like to make is simply one that says that our approach to managing drug related issues is maturing, as it is throughout the country. I would suggest that the views of some 20 years ago were probably appropriate for their times, but the views that are now available around the country are far more mature than they were then. We have a much more responsible approach to the issues, and we are prepared to challenge and question a lot more than we were then. I think we are achieving better outcomes.

CHAIR—I suppose, as you have identified, each state and territory has its differences. But what would you pick up as the most common thread? You have touched on the issue of maturation of the discussion and the mechanisms for the management of it. I pick up an example from Risdon Prison yesterday where the clear view from some of the officers was that there is a fundamental change in individuals' views about drugs and the way that they approach the issue. You are dealing with a wider range of clients and with a different attitude. Could you comment on some things which are similar across the nation and identify those which are clearly different—perhaps heroin or perhaps morphine. Give us a picture of what is similar—this attitude may be one of those things.

Mr Johnston—I suppose it is trite to say that we should never lose sight that the two biggest problem drugs in our society are in fact alcohol and tobacco. But unfortunately most of the community concern focuses on illicit drugs. Unfortunately, in that process, the good work that is being done to tackle some of the problem issues with alcohol get lost in the debate. But, like every other jurisdiction, we confront exactly the same problems with alcohol so, in terms of the question you asked, I do not think we need to go into any more detail than that. I know that every operational policeman considers the people he deals with who are affected by alcohol to be a far greater problem that those who are affected by other substances.

If we are concentrating on illicit substances, in Tasmania we need to draw the distinction to say that the use of legal drugs illicitly is probably a bigger problem in scale than the use of illicit drugs as in heroin. But we do, in fact, probably have the same issues around cannabis that every other jurisdiction has. I do note some of the more recent research around cannabis does suggest that maybe we will more closely align with some of the problems in the community. I look at the recent DUMA studies that show that almost one in every two prisoners that appeared before a watch house were affected by drugs—mainly cannabis—so that is starting to show us that cannabis is an issue of some note in offending. As I said earlier, the heroin issue is far less an issue within Tasmania. That is not to say it does not exist here, but it is not anywhere near the same scale as it occurs in more populous areas of the country. The management of it again is different. Cecile will be able to talk about the way we manage the heroin issues here.

CHAIR—Can I just go to cigarettes? We agree that cigarettes contribute to the death rate right across the country, and that Tasmania would be similar. With alcohol, we appear to have had some considerable success. Maybe it is RBT; maybe it is intensive education—a whole range of things over the last 20 years have been getting our death rate on the road down. The growth seems to be more in the illicit area. Marijuana is an area where maybe the view around the country is changing a bit: it is not as benign as we thought, perhaps. I am endeavouring to understand all of this from the Tasmanian government's perspective. These things—the cigarettes and the alcohol—have been with us for a long time, but we feel a little more vulnerable with the newer ones. And that attracts media, and that therefore attracts a different attention span from parents and the community generally. I come back to the view about attitude regarding the marijuana/other substances issue. In terms of policing, would Tasmania feel they have noticed some change in terms of an ability to manage it which is quite different from cigarettes and alcohol? I am trying to understand how you feel about it.

Mr Johnston—As I tried to say in my opening remarks, the world is evolving, the issues are changing readily. The biggest challenge for us is to ensure that we develop strategies to meet the changing environment and that we don't remain static. I would suggest that 20 years ago that was not the approach. It was a very simplistic view of the world then where, for argument's sake, police were seen as simply being involved in supply reduction: they did not have any other role to play in relation to illicit drugs. We have found now that that is not appropriate for our times. It is about police having a role across supply reduction, demand reduction and harm reduction. It is about education having a role to play in every aspect of the problem. So yes, it is changing; yes, it is evolving, here in Tasmania as it is everywhere else. The biggest single issue is that as one event happens it captures the public imagination and the public attention when it may not in fact be truly representative of the actual environment across the whole of the state.

CHAIR—How do you feel about the balance between what is a legal issue and what is a health issue—the eternal balance that we are trying to strike with diversion programs and all that sort of thing? The deputy commissioner led off this morning. How do you feel about the balance? Did we legally sort of lose the plot and find that it almost overcame us and therefore we had to retreat to a position of dealing with it as a health issue, or did we become more enlightened and say, 'Well, this is a health issue and is not for the old ways of law enforcement,' as you have already said. Could you just talk a little bit about the balance as you saw it evolve?

Mr Bingham—Perhaps I could lead off with that. As you are aware, the department that I represent has a number of interests in issues relating to substance abuse. These range from the regulation of the poppy industry through to corrective services; but perhaps the most relevant in that context is the responsibility we have for supporting the criminal justice system: the courts and what they do, the Director of Public Prosecutions, and so forth.

I think it is fair to say that from my perspective this is not an either-or issue at all. I do think there are obvious health dimensions to it; similarly there are obvious criminal justice dimensions to it, and whether the balance is right at the present time is for others to say—others with more policy responsibility than I have. My perspective on the initiatives which have been taken in relation to diversion from the criminal justice system is that they are a very useful adjunct to the criminal justice system. I think that is a view that is broadly held, certainly by most players within the Tasmanian criminal justice system, and I think there is scope to consider the opportunity to expand those sorts of diversion schemes to other stages in the criminal justice

system. My perspective about it would be that I would not ever want to see it lose what I see as being a principal focus as a health issue and related to people's wellbeing—but the purpose of the criminal justice system ought to be to support that, and I think there will always be a role for that as well.

CHAIR—This is just a quick supplementary question: do you have a picture in Tasmania, other than a very general view, of what the estimate might be of substance abuse? Are you aware of the studies that show certain things, such as Collins and Lapsley? How do you feel about the general resource allocation of police and right across the board? Do you have some reasonable assessments happening? Where are you up to with that?

Mr Bingham—Mr Chair, if you ever ask a bureaucrat whether they have got enough resources you know what the answer is going to be. Certainly in Tasmania I think it is true to say that we have a much better understanding of the situation as it exists in actuality now than we had some little time ago, say, five years ago. I am aware of some of the work that is being done nationally, its ramifications, and its input from the Tasmanian context. Certainly I have the sense that we have a better understanding of those issues at the present time.

CHAIR—The figures that amaze me are that in the prison population, for example—and Risden is in our minds because we were there yesterday—of up to 30 per cent, off the top of my head, being directly related to drug-affected issues—and I do not think it was as high as this in Tasmania, but up to 80 per cent of those are people under the influence of substance abuse, if you like. Do you have a feel for that?

Mr Bingham—The situation in relation to inmates in Risden prison is that almost by definition they represent a range of needs, and there is no doubt that substance abuse and mental health needs are significantly higher within the prison population than within the community at large: that goes almost by definition. I think if you were to talk with our people—as you did yesterday—they would agree with those figures as being the sorts of numbers of people within the prison system who have needs that relate particularly to substance abuse.

CHAIR—Thank you.

Mr QUICK—My first question is about road trauma. I notice in your submission that at this stage the road toll had gone down tremendously—and as most Tasmanians know it has gone up like a skyrocket. You state in here that a certain percentage of fatalities and injuries is associated with mind-altering substances. I notice that other states have done some pretty adequate research into the percentages: have you got any later information about mood-altering drugs? Are fatalities tested in the autopsies so that we can say that a certain percentage of the road deaths are related?

Ms McKeown—As an opening statement I would like to confirm what Mr Johnston has said: in Health we are definitely committed to working within government, working across government and working with the National Drug Strategy and its implementation. Answering your question, there is data available through the coronial reports that could be supplied to you out of session. I am unable to provide exact figures at the moment but there is data that we could supply.

Mr QUICK—Off the top of your head, can you tell us whether it has increased by 10, 15 or 20 per cent?

Ms McKeown—I could not supply that at the moment.

Mr Johnston—It is worth saying that we are looking forward to the outcomes of the National Coroners Information System being developed even further.

Mr QUICK—Finally!

Mr Johnston—These things take time and money but there is a commitment across all jurisdictions, at all levels—that of the pathologist, the scientist, the coroner and the police—to better inform this discussion and to answer exactly the questions that you are now raising. Jurisdictions like Tasmania find it very difficult to go into great depth of research on issues such as this and we rely heavily on what is being done nationally and across various jurisdictions. We do look forward to that being able to inform us better.

Mr QUICK—One would assume that if you are going to be pouring hundreds of millions of dollars into a national drug strategy you would have some evidence upon which you base aims and objectives. Finally, after 30 or 40 years, we are getting a national coronial database put in place, but where do you spend your money? Do you say, 'We've got a problem; people are lying in the gutter'? In order to make a value judgment surely you should have some facts and figures that say, for example, 'Twenty or 30 per cent of Tasmanian road deaths are related to X, Y and Z and therefore we ought to change the strategy.'

Mr Johnston—That is not to say that it does not happen. What we rely on more is the work of groups like the Road Safety Taskforce and the road safety council who are much more advised of the various factors contributing to road crashes than we would be in a general sense appearing before you today. I am sure that if I brought along some of the people who deal in that area specifically they would be able to give us much greater detail about what you are talking about. Our strategies are consistent with national best practice and they do address issues such as substance abuse. As we all know there is no roadside testing available for the various substances that you would be concerned about—the mind-altering drugs, as you put it—so it causes great difficulties in management of those issues.

Mr QUICK—On page 32 of your submission you talk about cannabis diversion. That is only for arrests with possession—it has nothing to do with a person who is perhaps caught speeding or driving dangerously; there is no test available so the cannabis diversion program is for people who are caught in drug raids and the like. Is my understanding of the situation correct?

Mr Johnston—It goes much broader than that. It is anyone who is caught in possession, not necessarily in drug raids. It might be, for example, smoking a cannabis cigarette walking down the street. In relation to the issue of drug use and its effect on the management of road safety issues, where a police officer, for argument's sake, becomes concerned that the driver of a vehicle is affected by a drug other than alcohol, then the officer has the opportunity to undertake certain tests and then to require urine samples or blood samples. That is the same in every jurisdiction.

Mr QUICK—So there are three levels of caution. The first one states that they are provided with educational material. Can you tell me what sort of educational material? Do you say, 'You are caught. This is your first offence. Here is the ANCD pamphlet. Go away and read it and hopefully you won't re-offend.'

Ms McKeown—I have just been advised that that is specifically information that has been developed in Tasmania and it relates to the harms that the person might experience from cannabis. That is the first level of caution.

Mr QUICK—Can you provide us with that pamphlet?

Ms McKeown—Yes, we can. That will be available.

Mr QUICK—The second stage is a face-to-face intervention with a health professional. How soon after the second offence does that person—

Ms McKeown—As soon as possible, as soon as someone is available.

Mr QUICK—How long is that, a week, 10 days, three weeks?

Ms McKeown—Within a number of days. They need to make contact within three days and are required to attend within 21 days. That is a specific detail.

Mr QUICK—Okay. Who within the department checks up that that has taken place? You have got this interagency thing—the deputy commissioner spoke about silos. If that person does not front up do you then ring up the police and say, 'Person A has not fronted up to this thing?' He might have been from out at Cygnet and had problems with cars and the like. Is it all about case management?

Ms McKeown—Yes, it is about case management. The two coordination positions that we have are responsible for monitoring the workings of the Illicit Drug Diversion Initiative in Tasmania.

Mr QUICK—Why have we got cannabis diversion and yet, on the other hand, if you are caught drink driving, the penalty is prescribed—it says you lose so many points if you blow 0.15 or if you are a probationary driver? Should we have a diversionary alcohol program to say: look, you ought to be going in and doing some rehab, rather than just saying: if you are a drink driver there is an automatic sanction, that is it, end of story; there is no requirement on you to attend any other course? I notice that in some countries overseas there are some requirements that you actually do some sort rehabilitation in light of what they are doing with cannabis.

Mr Johnston—I appreciate the question. I would be very surprised if the communities of Tasmania were prepared to accept a notion that a drunk driver could be diverted from the criminal justice system alone to deal with the issue of their alcohol addiction. But I would suggest that maybe there is scope for rehabilitation options to be exercised by the courts. They can do it now, and I know that they do do it now, where some offenders come before the courts and are identified as having a problem; then they are sent off for assessment, they come back and the courts will determine whether or not some treatment, as part of their ongoing

rehabilitation, is a preferred option. I do not think that the day will come when someone who is identified as a drink driver on our roads would be diverted completely out of the criminal justice system just for treatment.

Mr QUICK—No. I am talking about some of the young offenders, first-time offenders. I know that with respect to P-platers and the like, if they are going to be heavy drinkers in their thirties and forties, perhaps there ought to be some diversion. If they front up for the first time with a P-plate offence, rather than just automatically losing their licence, perhaps there ought to be an additional package of rehabilitation. Rather than just saying, 'Well you have broken your P-plate provisions, end of story, lose your licence'—it is not our problem it is someone else's, perhaps there ought to be some health requirement as there is with cannabis.

Ms HALL—Do you have driver education programs where, if somebody has gone over the limit, they have an option of doing a six-week driver education program and then they come back to court and look at whether they are going to lose their licence? They have that in New South Wales.

Mr Johnston—No. Not as a matter of course.

Ms HALL—It might be worth while looking at.

Mr Bingham—From my perspective, from a criminal justice point of view and a corrections point of view, I think that it is a very valid point that is being made. Certainly, within our community corrections service, the provision of alcohol and drug programs is an increasingly important part of what happens when people are put on supervision orders or other forms of community correction. That is not to say that we have in place all the programs that we would want to have in place to enable these things to be met as they should be. But it is certainly an area which we recognise as being important and something which increasing effort has been going into. Having said that, there are a range of other needs that people on community corrections orders have as well. So there does need to be some prioritisation of that. But the point, I think, is well made.

Ms McKeown—I understand programs of this nature—driver intervention programs—have been run in Tasmania by Transport. We are unaware whether they are still running at the moment. I think the question really looks at the values, in a sense, in a broader way around how we perceive alcohol and cannabis, for example, in the community. Part of the historic context for the diversion of cannabis offenders, as it were, was a recognition that some of the damage that was being done to individuals going through the court system was actually greater than the damage to them when they were using the substance. There is a historic context around how we have handled cannabis in the past and what kinds of ways we intend to address that in the future—as well as the values we place on alcohol and its use in our community and within the Australian context. With questions like that we really need to look at a values context as well.

Mr SCHULTZ—I am not quite sure who to address this to, probably the deputy commissioner. On page 3 of your submission it says that it is estimated that six out of seven opiate users in Tasmania use pharmaceutical morphine with the remaining one using heroin. Do you have any idea as to what the source of the morphine is? Can you consider the question of

whether the GPs are over prescribing morphine and creating a market out there in the general public.

Mr Johnston—Can I, maybe a little politically, say that I think the source of the morphine here is legitimate sources. It comes from doctor shopping, where patients attend doctors who prescribe the product that they then go and acquire from a pharmacy. It also comes from burglaries that are committed here and interstate. The product comes to Tasmania from burglaries on chemist shops or other similar places. There is some evidence, although not all that strong, that some others in our community who are legally prescribed the substance for pain management then put it onto the illicit market to make money. They would be the three major areas from which it comes. The issue of over prescribing is not something I can comment upon. It is for doctors to exercise their judgment as to what prescriptions they issue to patients. There may be a view from the health department.

Ms McKeown—Certainly within the context of our work we continue to work with the medical practitioners in a range of forums and individual meetings. Another area where we do see diverted substances is in takeaway doses of methadone. Continually within the department we look at the number of takeaways each doctor might prescribe. We are intending in an ongoing way to approach doctors. In a sense, it can be a bit of an ethical question as well because, from a departmental point of view, we are then beginning to intervene in what is a doctor's right, in a sense, to run their practice and to prescribe as they see fit within their profession. It is certainly something that we are always aware of. We do everything we possibly can to alert individual doctors to situations that we identify.

Mr SCHULTZ—Can I respectfully suggest that, if you have six out of seven opiate users using morphine which could come from those sorts of sources, it is incumbent upon the government through its health department to try to get some detail and instigate an investigation as to why that amount of morphine is on the street.

Mr Johnston—That actually happens in two ways, but the issue we need to be concerned about is patient privacy, as far as possible. Within the health department there is monitoring of the amount of drugs prescribed by various medical practitioners of different types and qualities and the patients to whom they are prescribed. Where a problem is identified, as far as they are able they seek the cooperation of the police to address what might be a problem if the practice continues after their intervention. It is not to say nothing happens, but, as Cecile said, there are some times when things slip through the net.

CHAIR—On that issue, on page 6 of your submission, you say the Drug Use Monitoring in Australia project is not being trialled in Tasmania, as I understand it, despite the fact that the project may be able to deliver some useful insights. Have you had any discussion with the Australian Institute of Criminology about extending the project to Tasmania?

Mr Johnston—There is a project under way in Tasmania specifically, addressing the Tasmanian environment, being conducted by a PhD candidate working out of the Department of Police and Public Safety as part of the Crime Prevention and Community Safety Council initiatives, and she is using similar methodology to that used by the Institute of Criminology. She, as I understand it, is in regular contact with them. The AIC were recently at Risdon Prison interviewing a range of prisoners and this researcher followed them in not far behind and was

using that as an opportunity to validate some of their research while at the same time moving on her own.

CHAIR—When did that begin and when would you expect to have some useful results?

Mr Johnston—I spoke with the researcher just a couple of weeks ago about the issues and highlighted the fact that the information is of limited value if it is two years out of date by the time she has finished writing it up. She has agreed to provide us with preliminary findings and assessments later this year as she moves through the project, without wanting to compromise the final conclusions that she comes to.

CHAIR—It is useful to us to understand, considering we are working to a time line next year of about June.

Ms HALL—Deputy Commissioner, first off, and Cecile, is it? Are you from the Department of Health?

Ms McKeown—Yes.

Ms HALL—That is where you fit in. I would like to ask a question about alcohol. I notice in your introductory summary you said that alcohol abuse creates a lot more problems for the police in Tasmania. What do you think the cost of that is to your community, throwing in also the number of deaths that you think have been caused by alcohol abuse? I am sure you have got some statistics on that within the health department. And, if I could just slip in another thing on health, what is the number of deaths that have been caused from heroin, methadone and other drugs of abuse within your community here in Tasmania? Could you also tell me a little about some of the diversion programs that are in place here and some of the public health initiatives that you have taken within all areas of misuse of drugs and alcohol?

Ms McKeown—Within the context of the social cost and economic cost, as in all other states it is quite enormous. We do not have specific figures at the moment but there have been studies of course done by Collins and Lapsley across Australia that give us some very definite figures on the cost. On how that would stand at the moment we do not have current figures but I am sure the cost is tremendous both in monetary terms and in personal terms.

Ms HALL—Do you collect those figures in Tasmania?

Ms McKeown—No, we do not. We do not have the capacity to collect those figures at all. The speciality of being able to collect those figures would require specific research and specific skills to be able to extract that data. Economic costs I am talking of at the moment. There would be figures that could be drawn together from a range of departments and communities that may give us a local estimate.

Ms HALL—They actually do that within the area health service in the area I come from. So I thought you would probably have those figures for Tasmania.

Ms McKeown—I have not been exposed to those figures personally. The police may have some specific figures, yes.

Mr Johnston—As I said earlier, we put a lot of reliance on the national research that engages Tasmanian communities as well: the national household survey, the Collins and Lapsley work, which is about—

Ms HALL—It is quite old now otherwise.

Mr Johnston—But it is about to be recommissioned again, and that will then inform us of the more current environment. I suppose it is fair to say that every jurisdiction has pieces of data and pieces of information, and the problem is bringing it all together to answer specific questions as they are asked from time to time. The data is not collected in the form in which you are asking for it, but we are informed by bits and pieces. We are informed by the reports from the coroners annually, for argument's sake; we are informed by admissions to the Department of Emergency Medicine at the hospital. It is not to say that we do not have it; we just do not have it collected in the form that you asked. I am quite happy to try to gather up as much of that and to have it sent to you at the first available opportunity.

Ms HALL—That would be lovely. How do you plan your programs if you do not know the number of incidents and the cost to the community here?

Mr Johnston—The cost of alcohol to the community is huge. The methodology for determining the cost is a critical factor in the outcome of what you get from the study. Collins and Lapsley have shown that by asking the same questions in different ways you will end up with different outcomes. So the true cost of alcohol abuse in our community is a very problematic issue. It depends entirely on which body of research you use to inform you.

But from a policing perspective, and you asked the question earlier, anecdotally—we have not researched it because it is an extremely difficult issue to research—70 per cent of those matters that police are involved in have some relationship to alcohol, and particularly incidents that occur after 6.00 p.m. We know that; we have not researched that. If you talk to a police officer and ask any one of them to provide you with their assessment, and they will all give you about the same figure. That is actually a figure that is produced nationally through the Australasian Centre for Policing Research and other sets of research that have been conducted. We do not need to do an in-depth analysis of that issue within Tasmania for argument's sake to know that we have a problem of that magnitude.

Ms HALL—That is good.

Ms McKeown—The other part of your question?

Ms HALL—The other drugs on the public health and the diversion programs.

Ms McKeown—We do have prevalence and incidence data. We have a range of information that tells us things such as the proportion of regular smokers in Tasmania and the proportion of regular drinkers. So within that context and within a national context we know that we need to do something about the health impacts of substance use in the state. Therefore, we use that data in order to be able to plan and implement different types of public health programs.

One good example is the ‘making a difference’ program developed in the north with statewide roll-out where we are working and will be working continually with families to assess the amount of harm from substance abuse and also to inform communities about the issues surrounding substance abuse. You focused on alcohol: at many public events we have displays of people being able to measure drinks. We give information based on National Health and Medical Research Council figures on standard drinks. They have recently been revised. That information will also go to the public when that campaign comes to the fore in Australia. There are a range of ways that we inform the community and individuals of the harms from specific substances. As we have already said, Tasmania is a smaller state so our capacity to do so is dependent very much on financial as well as human resources.

Ms HALL—Do you know the number of deaths from heroin, from alcohol? I notice that in your submission you had the number of deaths for cigarettes, but do you have figures in those other areas?

Ms McKeown—We could pull together some figures as well for you, yes.

Ms HALL—That would be lovely.

Ms McKeown—From the coroner, for example, we get figures that look at the number of people in the first number of months this year that have been found to have heroin, morphine or methadone. But when we look at specific figures we have to recognise that polydrug use is certainly the norm for our community. So it can be rather difficult to extract specific figures around specific substances. Most people who abuse substances or use substances in a really harmful way are using an often-complex mixture of substances. So being able to extract specifics from data is not always easy.

Mr Johnston—What was the question on diversion?

Ms HALL—Can you give us some information about some of the diversion programs that are in place here?

Mr Johnston—The first thing about diversion in relation to illicit drugs is that, as we all know, there has been a significant shift, a sea change in attitude towards diversion programs over the last three or four years. Prior to the COAG initiative in relation to illicit drug diversion, Tasmania had a cannabis cautioning program that was 12 months into its life when along came the new initiative. It really was not an appropriate time to evaluate the early cannabis diversion program. Suffice to say, it was considered by the people who did the evaluation from the university to be a successful program—whatever that meant to them—but at the same time it identified some deficiencies in the delivery of it; for instance, when it came to police attitudes at the front line, because that is a very significant issue when it comes to drug diversion initiatives. Since the COAG Illicit Drug Diversion Initiative has come into place, that has seen a very positive uptake. We think some very positive results are coming through, but again it is a bit too early to say because we have noticed some problems. There is a review being undertaken here in Tasmania by Jim Hales—I cannot think of the name of the crowd that he works for.

Ms McKeown—Health Outcomes.

Mr Johnston—Yes, Health Outcomes Australia. That is under way, and we had discussions about that just the other day. That is starting to identify exactly where any problems are. As the chair said a little earlier, we do not want to wait for the end of that study to find out what is wrong. We will get the feedback from that review very soon so that we can start other interventions to try to improve the effectiveness of it, because we are noting there is starting to be potentially some shifting of the balance. We need to be careful of that and need to be informed about that. So the diversion initiatives in relation to cannabis are positive and building.

In relation to other drugs, the justice department, premier's department and the police department are presently working on a proposal for court diversion for drug related matters and all crimes committed by those affected by drugs. But that is in its infancy yet and still to be further developed. The chief magistrate has expressed some significant interest in developing a program similar to that which occurs in Victoria and in other jurisdictions. There is no other front-end diversion scheme that I am aware of for alcohol.

But the other issues that need to be considered and that we often neglect when we talk about diversion schemes are the early intervention schemes that we have. These early intervention schemes are available through a whole range of programs and projects ranging across our schools, ranging across our various community activities and ranging across our health areas. There are so many of them, and we are fortunate in this state to actually have best practice in some of them.

Ms HALL—It would be good if you could send us a list of some of the programs that you have. It is hard to reel them off in a situation like this.

Mr Johnston—Sure, that is right. We would love to.

Ms McKeown—And not only programs but also individual practitioners when they are working with clients. What is very much a focus that we have is trying to intervene early in a particular development of a problem, and individual practitioners as well as wider public health programs impact positively on substance use.

CHAIR—Just to further my own understanding, has the drug diversion been in for about 12 months? Would that be the sort of time line in which it has been operating?

Mr Johnston—Yes.

CHAIR—As Jill Hall has said, if you could help us out with a list of the things that are happening, that would be useful. But is there something that stands out? What is a good outcome in a diversion program? I can think of a few, but it is not for me to lead the witness. What would be to your mind a good outcome, and is there such a thing in the short term that is obvious to you?

Mr Johnston—I think what we all hope for is a very simple good outcome, and that is that the people stop taking the drugs. That is really the objective of any diversion scheme. It is about saying, 'Please, look at all this, think about all these issues and at the end of that make up your

mind to stop using this drug that is going to cause you these harms. But at least have an understanding of the harms that they will cause you so that we can minimise them.'

Ms HALL—You mentioned harm minimisation. What does harm minimisation mean; does it mean stopping the drug to you?

Mr Johnston—No, the definition of 'harm minimisation' is quite clear in the National Drug Strategic Framework. It starts off by saying that it is actually about deterring, preventing the uptake of drugs—that is how it starts. Then it goes on to say, but if people do choose to use drugs, then it is about reducing the harms caused by those drugs not only to the person themselves but also to the communities. It is about preventing uptake in the first place but then, from there on, it is about minimising the harms.

Ms HALL—That is supported by the Tasmanian government as a whole.

Ms Shipway—We hope so, yes. I wonder if I could come in here: from the early intervention point of view, education has a very critical role to play. When we are talking about the diversionary processes in the state, from our point of view in education, we see that as probably one of the strongest ways to go. If we are going to minimise harm for young people in this regard, we believe that keeping them connected with the support networks within the school is probably the strongest, most effective thing that we can do for young people. Therefore, I believe that, by putting in place diversionary processes that therefore do not impede the access of those young people to schooling, we are probably doing among the best things that we can do for them.

I suppose while I have the floor because I have not had much to say—not that I particularly want to have a lot to say—it is worth saying a bit about the ways in which we can work in Tasmania. We have heard a view of the downsides of being a small state but there are clearly benefits from being a small state. From the point of view of education, these benefits are very clear for us. For example, we are able to work in a cross-sectoral way across the other systems—the Catholic system and the independent school system. I, for example, chair our committee for the national schools drug program, and we work very closely with those other sectors. We find that there is not a competitive stance in relation to the ways in which our schools are educating our young people about making appropriate choices and about their behaviour in relation to substance use and abuse. But we also do not have a sense in which 'this group is doing it better than this group' and we do not move our young people around. We have a very cooperative and very similar approach to these issues and we find that is a really positive way to go. That is one benefit of being a small state.

The other benefit is that we can do professional development activities in a relative short length of time across our 218 schools in our system, for example. With four years to do the drug program, as we are thinking about at the moment, we know that within those four years we can actually have uptake across all the schools; we can have policy review; and we can also have implementation and good practice. So I think there are some real strengths in being a small state. We do not have a lot of money but we do not have a lot of problems.

Mr QUICK—On page five of your submission you state:

It is therefore important that any policy development in this area involves and is credible to young people.

Can you give me some examples of where you have involved young people in policy development through your schools in the revised Tasmanian Drug Strategic Plan or is it just through teachers and from the top down?

Ms Shipway—No, it is not from the top down. The model we are using in Tasmania is that we have regional advisory groups—

Mr QUICK—Involving young people?

Ms Shipway—I have to say no, as far as I know, but I can check the membership of each of our three groups. But I suppose what we do know is that the connections between those groups and the schools are very close. They have principals on them. They are very close to our school system and to the schools. I can certainly give you, if you like, the lists—

Mr QUICK—We heard evidence yesterday from two schools in southern Tasmania where the brochure and the television ads that were distributed to every Australian family did not have the desired impact for a whole variety of reasons. If this state is going to develop a Tasmanian drug strategy and, as you say, it is important that they involve and are credible to young people, then perhaps there ought to be a process where young people—especially those, for example, in years 9, 10 and at our senior secondary colleges—have some input into the process of putting together the information that you distribute through those schools.

Ms Shipway—You have raised an interesting issue there, of course. What comes out from the Commonwealth as a result of the COAG effort is, to some extent, different from the ways in which we believe we can make a difference in young people's lives. I cannot comment on the uptake or the effect of most of those recent brochures that have gone out into our families, but I believe we have enough knowledge of young people, as educators, to know that, if we are going to make a difference, we will make it in a developmental way over a long period of time.

By providing appropriate supportive environments in our schools, we can endeavour and, hopefully, achieve the highest level of resilience in our young people, the best sense of their own self and their self-worth and their capacity, therefore, to make sensible decisions about their life choices. We are struggling with the notion that while one-off approaches are perhaps high profile, the longer term boring stuff of developing teachers' understanding, changing the curriculum and putting new material into the curriculum is really long term and slow effort. But they are, in the end, we believe, the things that will make the greatest impact over time on our young people.

Ms McKeown—I have a comment with regard to the health department, and the consultation process and youth plan that we are putting together. Within that, we have quite detailed consultation with a range of young people, in order to look at young people's needs in the state. They would be specifically health but, of course, health cannot be viewed in isolation. There is a range of other factors, such as social, economic, housing and unemployment factors that impact on health status. Within the context of the youth plan, there are very detailed consultation processes occurring with the youth and the state.

Mr QUICK—Can you give us the details of that?

Ms McKeown—Yes, we can provide that.

Mr ANDREWS—I am curious as to why there is a comparatively low rate of heroin use in Tasmania? Are there some peculiarly Tasmanian reasons for that? I use 'peculiar' in its proper sense, with respect to my colleague.

Mr Johnston—The answer you would expect from the police is that we actually have very good strategies in place.

Mr ANDREWS—Now I want the real answer.

Mr Johnston—I don't know that there is a real answer because there are so many factors that come to play. The information from the user community that we get is that they are relatively well supplied, as we talked earlier, by the licit market that is diverted to them and that is a much safer and better way for them to obtain their drugs because it is not as problematic as the problems of heroin use, as we all know, with the different purity issues and so on. Again, one of the benefits of being small is that, as heroin moves into our communities, we become informed very quickly about its presence which, in turn, gives us an opportunity to target policing strategies which comes back to something Ms Hall was mentioning before. We are able, without waiting for a lot of research, to identify the problem a lot more quickly and to tackle it. We do know when it comes, and it is a benefit of size as well as the availability of other drugs.

Mr ANDREWS—Secondly, can I ask about the diversion program? For the cannabis diversion there are three levels of diversion set out in the appendix. What is the recidivist rate from one level to another?

Mr Johnston—The best answer to that is that we do not know yet because it really is too early. If you have a look at the numbers, and I have them available here, there is a very significant number of first time people diverted but, because we are only 12 months into the program, we have not really had an opportunity to necessarily come across on a second occasion the same people who were diverted for their first occasion. We may not come across them for a couple of years because, unless there is a reason, you do not target these people and unless they come to our notice again they are not going to be a twice diverted person. It is going to take us time before we can properly analyse all of that. There is a bit of an uptake, but I do not have my numbers available right in front of me as to the first, second and third diversions, but some of them are from the old scheme as well. But it is not high.

Ms McKeown—We have information in Health, just anecdotally at the moment—through the practitioners working with the individuals—that a handful of people are coming through for the second time.

Mr Andrews—Deputy Commissioner, you used the expression 'We have noticed some problems,' when you were speaking about it earlier. Can you elucidate what you meant by that?

Mr Johnston—It is fair to say that in a lot of cases operational police officers do not initially subscribe to the benefits of a drug diversion program. A lot of the police officers who encounter

these problems on a day-to-day basis feel that the best approach to managing drug offenders is to charge them and then allow the courts to deal with their unlawful behaviour—which is what it is. It is important for us to engage with all police officers in the front line, to help convince them of the benefits of drug diversion initiatives. Until they are convinced of the benefits, we cannot be confident that the official cautioning program will get a 100 per cent take-up rate. Anecdotally, over the years, informal cautioning programs have been exercised by police officers using their discretion at the front end. In Tasmania, police officers have very wide discretion in their management of issues such as this, so we do not necessarily have a 100 per cent take-up rate from all frontline operational police officers subscribing to the benefits of a diversion initiative.

Mr ANDREWS—Finally, evidence the committee has received from other places is that there is an inadequacy of rehabilitation and treatment centres and longer waiting times than one would ideally desire. So far as I am aware, there was no reference to rehabilitation and treatment in the Tasmanian Government submission. Could you say something about the situation here?

Mr Johnston—Certainly—to the extent that your question relates to the corrections program component—I would agree that the services we have are embryonic in terms of rehabilitation and so on. I think that also applies more generally across the board. I do not know whether Cecile would want to make a comment about that.

Ms McKeown—With regard, specifically, to the Illicit Drug Diversion Initiative, we have committed that no voluntary clients to treatment agencies would be displaced by people who were referred as part of the illicit drug diversion program. Within a wider context, we do not have long-term rehabilitation facilities in the state but, from evidence over the years, it appears that long-term rehabilitation programs do not necessarily produce the effects that we expect. We have centres run by non-government organisations that have quite extended periods of stay. Sometimes these can be viewed further down the track as supported accommodation, in a sense, rather than actual rehabilitation. Within a best practice context, with regard to the idea or the proposal that we should have very long-term rehabilitation facilities, these have not been shown in the past to produce results that are any different to perhaps a more intensive stay of two to three months.

Mr ANDREWS—If someone voluntarily wants treatment, how long do they have to wait to get treatment in Tasmania?

Ms McKeown—Voluntarily, not very long at all. Most of the time we have beds available in 56 Collins Street. We do have a fairly high rate of bed occupancy but, as I understand it, it would be very rare that someone would not be admitted for withdrawal and detoxification. After that they are able to be linked with a community service in order that they get ongoing support once they are detoxed from their drug or drugs of choice.

Mr ANDREWS—So they can be admitted in days?

Ms McKeown—Yes, very much so, in the main—often on the spot. They can go at all hours of the night. They can be referred through the emergency department of the hospital or sometimes people go straight to the door. It is a well-known facility for clients.

Mr QUICK—Is that just detox, or rehab?

Ms McKeown—Just detox withdrawal.

Mr QUICK—What provisions are made by the state for rehab?

Ms McKeown—We do not have rehab run by the state, but we do have, as I explained, two non-government organisations in the north and the south that have longer term facilities and programs that are run within the philosophy of the—

Mr QUICK—Both run by churches?

Ms McKeown—Yes—run within the philosophies of church organisations.

Mr QUICK—The government does not provide another option, if you do not want to get involved in that?

Ms McKeown—We provide community outpatient support through one of our services in the south—at Clare Street—and through the northern Alcohol and Drug Service, but not rehab. As I explained, we do not necessarily see long-term benefits of rehabilitation.

Mr QUICK—How many people are in Missiondale and the Bridge Program?

Ms McKeown—I do not have the figures. We can get them for you.

Mr QUICK—You just stated that you do not see any reason to have—

Ms McKeown—I think that it would be very useful to have a—

Mr QUICK—Do you know how many people are going through Missiondale in a 12-month period?

Ms McKeown—No, I do not.

Mr QUICK—Or whether they have a waiting list? And the same thing for the Bridge Program? Perhaps the state government should put something in place.

Ms McKeown—I have been informed that 150 people go through the Bridge Program.

Mr QUICK—What about Missiondale, per year?

Ms McKeown—Missiondale is unfunded so we do not have any quality control. It is not funded by the government.

Mr QUICK—Wouldn’t it be nice to know? We are talking about a Tasmanian perspective, and I believe that you cannot just walk in to Missiondale, similarly with the Bridge Program.

Ms HALL—I find it quite puzzling that you do not believe in the long-term benefits of rehabilitation.

Ms McKeown—Evidence goes back over some years now and it shows that long-term rehabilitation is not necessarily beneficial.

Ms HALL—Before you said, 'the long-term benefits of rehabilitation', which is different.

Ms McKeown—I am sorry. What I was specifically talking about was the benefits of long-term rehabilitation—a year. Some rehabilitation services around the country have admitted people for up to a year and people get very institutionalised and very dependent on the kind of support that they receive there. In a sense, what they are often doing is utilising the benefits of having accommodation and not necessarily addressing their substance use. Certainly, two to three months is seen to be optimal.

Ms HALL—You can see long-term benefits in that kind of thing—three months?

Ms McKeown—Yes, definitely. I am sorry if that was confusing.

Mr QUICK—On page 12 you state that, of the specific drug related costs of the Royal Hobart Hospital, $2,765 per separation is for drug intoxication and withdrawal services, and that this is the most expensive service per separation. Do you know why that is the case?

Ms McKeown—It is fairly intensive medical intervention. That would be one of the reasons, as well as number of beds.

Mr QUICK—What is the standard protocol on presentation at the emergency ward of the Royal Hobart Hospital for a drug related admission?

Ms McKeown—An assessment would be done at the time people are admitted. Based on that assessment there would be a referral to an appropriate service—either 56 Collins Street or, if that is not thought appropriate, to the hospital if the person needed medical care.

Mr QUICK—We heard evidence yesterday that, under the Commonwealth hep C program, $70,000 is given to each of the states, but Tasmania diverts that money to the sexual health branch to employ policy officers. Is that true?

Ms McKeown—I am not entirely sure, but the addressing of hep C problems is specifically within the sexual health section of the department. I am informed that part of the moneys went to a policy officer position to develop a strategy because we do not have a position. You need to understand that, in order to have a long-term view on any health problem, we do need to plan and to implement plans that have long-term benefits.

Mr QUICK—The state did not have a sexual health branch?

Ms McKeown—It had a branch, but we are talking specifically about hep C here.

Mr QUICK—What was the cost of the policy officer’s salary?

Ms McKeown—I do not work in that specific area. I would imagine about $50,000.

Mr QUICK—That leaves $20,000 to implement the strategy. Would that be right? Can you get us some details on that?

Ms McKeown—Yes, we will.

Mr SCHULTZ—I want to refer to crime, violence and law enforcement, but more specifically to the recommendation of the 1999 Legislative Council Select Committee in its report *Correctional Services and Sentencing in Tasmania*, which states:

That the Tasmanian Government consider the establishment of a forum, representative of local government, education, justice, police, youth and other relevant agencies to meet regularly to discuss issues relating to all aspects of crime prevention.

Has the government established that forum?

Mr Bingham—Yes, it has. The Crime Prevention and Community Safety Council is located within the Department of Police and Public Safety. It is chaired by the Commissioner of Police. I am the deputy chair of it. It comprises the heads of agency from police, justice, education and health, a representative from the Department of Premier and Cabinet plus five community representatives drawn from around the state and across a whole range of sectors.

Mr SCHULTZ—Including youth?

Mr Bingham—Yes, including youth. The Youth Network of Tasmania is represented on the council.

Mr SCHULTZ—How frequently does it meet?

Mr Bingham—About every two months. It has just completed its first three years. There has just been a rotation of some of the community members. My view about it is that it has been a very successful demonstration of a practical working partnership between government and community groups. It has made some significant achievements in raising the profile of crime prevention and community safety in the state. Some specific programs which it has developed have been very successful, for instance, programs on fear of crime and public safety in the cities in Tasmania. It has done work on the prevention of repeat burglaries, and that sort of thing.

Mr SCHULTZ—You comment on page five of your submission:

It is therefore important that any policy development in this area involves and is credible to young people.

Can you give any examples of where you have involved young people in policy development—for example, in the revised Tasmanian Drug Strategic Plan?

Mr Johnston—It is worth saying at the outset, and I am picking up on something that Kate said earlier about management of these issues within schools and policy development within schools, that the young people in a lot of school communities play a very pivotal part in the development of a school's drug policy. That is the first step in informing the overall discussion because that drug policy is then informed upwards into the development of other policies that affect the region of that school—not only the school but the community generally.

From a policing point of view, Tasmania Police has a youth policy advisory group which is informed by a number of young people at various levels and that helps to inform our decision making processes in relation to youth. It has actually helped Tasmania Police develop a corporate priority for the next year, which is for early intervention for young people at risk. We are coming up with a range of strategies informed by young people on how best to do that, using facilities such as our Police and Citizens Youth Club. But we should never lose sight of the fact that a lot of young people do not want to formally engage in the policy development process, but they contribute by informing those in groups in which they operate. I use the Police and Citizens Youth Club as a good example. The young people who are at risk and who are benefiting from the programs that are provided are informing adults in that group with whom they can empathise and relate to, and those people are then bringing forward those views in various fora conducted with them and other non-government organisations which represent young people, families, service providers and so forth. All of those processes are coming together in the development of our next state drug strategic plan. It is all happening, but it is actually a cascading effect—we pick up on the views of not only young people but also the broader community.

Mr SCHULTZ—On page 24, under the heading '5.2.2 Opioids', the second paragraph says:

There is an increased number of people using opioids, with a decrease in average age and increase in number of female drug users (although this may be due to women feeling more comfortable in using drug services). Most users inject and there are increased rates of injecting.

Does that have any parallel with the introduction of the needle syringe exchange program and, if so, to what extent? If you do not know, have you done any, or are you intending to do any, studies as to whether the freely available needle syringes are contributing to the increase in the injection of opiates and other substances in Tasmania?

Ms McKeown—Certainly national studies do not show that.

Mr SCHULTZ—I am asking about Tasmania. I am not talking about national studies.

Ms McKeown—No, we have no specifics. We do have a specific document called *Illicit Drug Reporting System*. You can be presented with a copy that does include Tasmanian statistics, but there would be no reason for us to assume that our situation here is any different from elsewhere, which is that the provision of clean needles and syringes does not contribute to a greater rate of injecting. What it does contribute to is safer injecting. That is why the government is committed to supplying clean needles and syringes. It has never been shown to increase injecting in any study that has been done so far.

Mr SCHULTZ—I have not seen any figures that confirm that. You can talk issues all you like, but I have not, in the 14 years that I have been involved in asking questions about that

issue, had anybody deliver to me any figures that either confirm or deny that the introduction of a needle syringe exchange program or the explosion in the distribution of them has had a part in the increase in injections of opiates and other substances. That is why I asked the question.

Mr ANDREWS—Do you have figures on the actual distribution of needles on an annual basis as well as the trends?

Ms McKeown—Some needle availability programs in Tasmania at the moment run from our government services and some programs are funded through non-government services. We would be able to get those figures for you.

Mr ANDREWS—Both the government and the non-government?

Ms McKeown—We would be able to supply you with information on those services we fund.

Mr ANDREWS—What I am really getting at is this: is there any detailed data—either government or non-government—of the overall distribution of syringes and any trends over time?

Ms McKeown—There are some figures on trends over time that we could provide.

Mr ANDREWS—In addition, the usage per individual? I noted, for example, in the operational guidelines for the publicly funded agencies in Tasmania that paragraph 15.3 says that a guide to the number of needles and syringes distributed to the one client per visit should be a week's supply and that, for the majority of clients, this would not exceed 50 needles and syringes, but it may be increased at the discretion of staff where necessary. It would seem to me to be important, from a public policy point of view, to have some sense of the distribution both on a global scale within the state and in terms of client usage, and what the rate and the range are, if you like, of the usage of them. The question Mr Schultz asked cannot be accurately or safely answered unless we have the empirical evidence about this in the first place.

Mr SCHULTZ—I can give you a classic example of what I am talking about. Yesterday, I was at a needle distribution establishment and two males came in. One had a large bag and I watched what happened with the needle syringes. There was no counting of needle syringes or of any of the equipment that was given to that individual. It was just dumped into a large bag. I had no idea of the exact number of needle syringes that were distributed. The next person came in with a rather bulky bag and the same thing occurred. When you ask people about the number of needle syringes that they are distributing on a per person basis or on a weekly basis, you do not get accurate figures.

Ms McKeown—That may be the case, but the other issue that I think you need to understand is that, within the culture of drug users, often one person presents to an organisation—a non-government organisation, for example—and undertakes to be the collector for the needles and then distributes them within a particular user group. That can be part of the culture where people may not want to be known.

What happens as well, which I think is very important from a public health perspective, is that that person also undertakes to return used syringes. We do not involve ourselves in counting used syringes, for the obvious reasons of safety, but some figures are available from a particular point in Tasmania where the number of syringes that are returned is actually far greater than the number of syringes that are distributed. I suggest to you that this is a very important public health issue, in that users are becoming very responsible. We are getting through our public message and we are actually seeing more needles coming back to certain centres in our state than have been distributed from that point. We cannot give you the exact place where those needles might come from or where they might have been purchased or how those needles came to be extra needles, as you might say, in the hands of users, but that is a far better situation than having those needles on the street. I do believe that, to some extent, many of our users are becoming responsible and are listening to the public health messages that we are sending them.

Mr SCHULTZ—On that point, I disagree with you, because nobody yet has been able to accurately tell me, as a member of parliament or as a former member of the state parliament of New South Wales, the number of needle syringes that are returned. That is why the terminology was changed from needle-syringe exchange to needle-syringe distribution.

Ms McKeown—That is right.

Mr SCHULTZ—When, as a member of parliament, I see, for example, a distribution process in 1988 which was distributing 1.2 million needle syringes on an exchange rate in the state of New South Wales, and last year distributed 16 million needle syringes with no figures whatsoever about the exchange rate, as a responsible member of the public, I have a real deep concern about the unavailability of figures which tell me precisely what the volume of needle syringes being distributed across Australia is and what the intake is in relation to returns. That is a very disturbing situation. Taxpayers' money is being used to distribute needle syringes, without any accountability at all in regard to any exchange rate.

Ms McKeown—It would be useful to have a commissioned study into such information.

Mr ANDREWS—Can I follow that one step further? I take it from your last comment that you accept the wisdom of being able to have some empirical evidence about this. Does the Tasmanian government or do you or others, as advisers to the government, have in contemplation any program or policy to ascertain this data?

Ms McKeown—We do have some access to some data that has been commissioned, but the breadth and depth of information that I think we are alluding to here would require specific funding and probably a medium-term study to be conducted to—

Mr ANDREWS—I understand that. What I am trying to tease out is: is such a study in contemplation and is a recommendation for that funding also in contemplation as being put to the relevant officials or minister?

Ms McKeown—It has not been at the present time. It could be a consideration.

CHAIR—I think the committee has made a pretty clear statement about these concerns.

Mr Johnston—Do I take it from the views expressed by the committee that you will be supportive of the retractable needles study being conducted at the moment and will be supportive of trying to expand that to encourage the manufacturers of the retractable, single use syringes to make them available in our community, whatever the cost might be?

CHAIR—I appreciate the comment, and it is on the public record.

Ms HALL—I hold a very different position to Alby's and Kevin's. I saw two young men going into the needle exchange yesterday. One young man was given syringes, and the worker knew exactly how many syringes had been given and informed us of that afterwards. The second young person that went in made a supportive statement about the service and then walked out. I followed him out and he said that, if it were not for that service, he would be dead. It was not only the fact that he had been given needles but also the fact that they had offered him support when he was suicidal. He was very thankful to that service. Firstly, I have a very quick, short, sharp question. In Tasmania, do you have any mandatory testing within the workplace of workers to see whether or not they have drugs or alcohol in their system?

Mr Johnston—The short, sharp answer is no.

Ms HALL—My other question is to Kate. Yesterday we saw some very impressive young people at the Drug Education Network. They speak highly of your system here in Tasmania. My question is: if a young person in the school system is caught with drugs, what happens to them? What is the procedure in Tasmania?

Ms Shipway—As part of the integrated, cross-agency endeavours, we deal with that in the legal framework of requirements in relation to having drugs on any property. There is a memorandum of understanding, which is in the throes of being reviewed by the police and by our system, that ensures that principals and other people in our schools know exactly how to act when an illicit substance is discovered.

Ms HALL—Are they excluded from the school? Is there an exclusion policy?

Ms Shipway—Occasionally. It depends very much on the context in which the incident has occurred. As far as we possibly can in our system we adopt a case management approach to individual young people. If, for example, suspending or excluding a young person might be harmful to that person for a range of reasons, then schools would, depending upon their approach, consider other options very carefully. The schools would be encouraged to do that. We do use suspensions in schools in Tasmania to good effect. For example, if a young person were in state care, we would be loath—and our guidelines make this very clear—to insist that that young person go away from the school if the care arrangements were not able to meet that young person's requirements. Wherever possible, the needs of every young person are considered very carefully. It is also worth saying that in our department we have a very strong and quite highly resourced support service for every district. In each of those support services, there are social workers and guidance officers. The guidance officers are of course educational psychologists.

Mr QUICK—Can you give me an example of that? We heard yesterday that the social worker in Bowen covers an enormous area.

Ms Shipway—There are actually seven social workers in the Bowen district.

Mr QUICK—And in the other areas?

Ms Shipway—It depends how the district decides to allocate a particular resource going into the support services for those areas. For a range of reasons, Bowen has increased the number of social workers available to their schools. In other districts it might vary from about three or four social workers up to the number Bowen has—seven.

Mr QUICK—So there are seven for how many primary schools and high schools?

Ms Shipway—Again, as Richard said, every bureaucrat would love to be able to say we have enough resources, and we never do have. I suppose I would say, though, that we are one of the very few education systems that have social workers available to families and young people. We have really got to the stage where we are saying that we will support young people as far as we possibly can and involve the families wherever possible too.

Ms HALL—If a person is suspended or excluded from the school system, are they put into any outside program during that period or are they left to their own devices?

Ms Shipway—Again, it depends on the young person's capacity to take up any provisions that are made for them, but the role of the support service in association with schools is to work with the young person and the family. For example, if a young person is put on to a suspension or an exclusion as a result of a drug incident, there is the capacity for the social worker, the guidance officer, the support teacher or whoever to make a referral to a community agency for that young person. It does, in the end, depend on the young person's capacity and intent to pick up on those referrals.

Mr QUICK—Obviously, budget allocation and resource allocation are based on the number of presentations. For example, the deputy commissioner allocates a number of police because there is an outbreak of crime and it is all documented. Can you give us the pro forma, if there is one, of the reporting system for primary school and high school principals? If there are a whole bunch of kids at whatever high school in grade 8 selling benzos or if we have some cannabis at one of the state high schools, can someone in the head office in Bathurst Street say that the trend over the last three years has been for X number of presentations? Is there a standard form?

Ms Shipway—Yes, there is. We have a computerised administrative system across all schools, and they are required to enter data in relation to incidents of this nature, along with a whole lot of other behavioural incidents on the part of young people. This is warehoused in our central data system.

Mr QUICK—How many presentations over the last 12 months have there been within the education system?

Ms Shipway—I cannot answer that question.

Mr QUICK—Can you provide us with that information?

Ms Shipway—We could provide that information. It would depend on what particular category of—

Mr QUICK—I am talking about any drug related incident in the Tasmanian education system. Someone should be able to give me that information.

Ms Shipway—Yes, we can.

Mr ANDREWS—I have two things to say very briefly. Firstly, in reply to Jill's comment earlier, can I say that I was not expressing an opinion; I am simply trying to get empirical evidence on which I can form an opinion. Secondly, Deputy Commissioner, your comment about the retractable syringes reminded me that, as I understand it, the federal health minister has offered to half fund a trial with a state on retractable syringes and no state has taken up the offer to date. Is Tasmania contemplating it?

Mr Johnston—Not that I am aware of. I would not see it to be the place of this particular jurisdiction, which has probably the least problem when it comes to managing the issue of needles and syringes, to be making that agreement with the Commonwealth. I was referring to the fact that such a study has been done. It is difficult to get a manufacturer to manufacture something like this without some support. I think that is an issue that needs to be addressed.

Ms McKeown—Can I comment as well on the particular nature of injecting and the types of retractable devices that are needed. A user needs to pull back on a syringe in order to find that there is a little amount of blood in the syringe and then they are assured that they have actually connected with a vein and are able to inject. There is complexity around the design of retractable syringes. It is not a simple mechanism.

Mr ANDREWS—But isn't that a good reason for the trial to go ahead?

Ms McKeown—Definitely.

Mr ANDREWS—But it will not be in Tasmania?

Ms McKeown—Not in the foreseeable future.

Mr SCHULTZ—And that would stop the distribution of the butterflies.

CHAIR—I have three quick questions. On page 26 of your submission, you make the point that access to the rehab service for women and dependent children is very difficult. Do you have rehab facilities in Tasmania solely for women that can also accommodate children?

Ms McKeown—Yes, the Salvation Army Bridge Program does have some units. But certainly within a longer term process we are always considerate of the specific needs of women with regard to rehab and detox.

CHAIR—This is probably the Deputy Commissioner's area. It is about the poppy industry, and we know the area. Do you believe that any raw material has been diverted into the illicit manufacture of opioids in Tasmania?

Mr Johnston—The experience last year would suggest that the quantities that were diverted were so small that it is most unlikely. The reality is that the number of diversions from poppy crops in Tasmania is negligible in the overall context of the acreage that is planted and harvested. From time to time, there might be some that goes to the illicit industry, but the reality is that that is normally one or two users who put it into a large pot and boil it up.

CHAIR—I needed to ask that, Deputy Commissioner, because this is international. You understand the context in which this industry operates. I needed to put that on the public record.

Mr Johnston—There is no doubt that we have by far and away the safest industry in the world.

CHAIR—We are endeavouring to get an idea of how much money has been spent on addressing the alcohol and drug issue in all the states and territories. We will be doing some writing anyway—and I would not expect you to have the answer, Richard—but if you had some indication we would appreciate it. How much money do you obtain from the Commonwealth for alcohol and drug programs? How much in total is allocated to the state? We need to know the Commonwealth component and the state component so that we can get a national picture in 12 months time. It will help us understand the overall commitment.

Mr Bingham—I think the sensible thing for us to do is take that on notice. Cecile does have some information here but, as you will appreciate, it is difficult to describe.

Ms McKeown—These are the most recent figures that have been put together by one of the peak organisations in Australia. They looked at the population of Tasmania—they did the study for all of the states—the tax on alcohol and tobacco figures and then the revenue per head, and the funding for alcohol and drug programs through the health department at that time was $4.055 million. That figure would be higher now. Funding per head was sitting at $8.75 in 1997. The 1998 funding figure is $10.40 per head. Tasmania did not quite sit in the middle—it is certainly not the highest or the lowest per capita.

CHAIR—We will be working with you on that. Thank you.

Proceedings suspended from 10.25 a.m. to 10.38 a.m.

GALEA, Mrs Nicola Katherine, Member, Hobart Branch, Catholic Women's League Australia Incorporated

ROBERTS, Mrs Betty Ann, Member, Hobart Branch, Catholic Women's League Australia Incorporated

TRIFFETT, Mrs Maree, Member, Catholic Women's League Australia Incorporated

CHAIR—Welcome. The proceedings today are legal proceedings of the parliament and, as such, must be given the same respect as proceedings of the House of Representatives. Would you like to make a brief opening statement?

Mrs Roberts—Yes, I would. We represent the Catholic Women's League of Australia. We are all members of the Tasmanian Catholic Women's League, which has 450 members and 24 branches and has just had its 60th anniversary. The reason that the Catholic Women's League of Australia asked me to write part of the submission is that I have had extensive experience over 24 years with substance users and their families. Catholic women are very pleased that you have not focused here on the addict, but that the terms of reference apply to the rest of us—those others affected. We are very pleased about that. I forgot to tell you that Nicola has a commerce degree and over the past six years has had daily contact with tertiary students. She has worked with the underprivileged for seven years. Maree is a registered nurse. Between us, we have 15 children. I think we are talking primarily from the viewpoint of parents and the family.

The annual report of the International Narcotics Control Board for the year 2000 reads:

> Harm reduction continues to be a major element of the strategy on drug abuse in both Australia and New Zealand. While such an approach may help to reduce the incidence of communicable diseases, the Board stresses that harm reduction should not become a goal in itself and that such a strategy should not be adopted at the expense of a strong commitment to reduce both the supply of and demand for illicit drugs. Moreover, all such measures must be in conformity with the provision of the international drug control treaties.

In paragraph 524, the board notes with concern—so we are not the only ones concerned—that:

> … during the 1990s, parallel to the increase increasing abuse of illicit drugs, the social acceptance of illicit drugs in Australia remained high, with many people being vocally in favour of the legalization of drugs, particularly cannabis. Australia is among the countries with the most widespread cannabis abuse. The Board notes, however, that a majority of Australians are not in favour of the legalization of cannabis.

In paragraph 525 the report reads:

> The spreading heroin abuse in Australia has been followed by a rising death toll among heroin abusers. Therefore, the focus in that country should be on measures to reduce the number of heroin abusers. Some States unfortunately challenge the policy of the federal Government and choose to support policies that run counter to the treaty obligations ... by establishing heroin injection rooms where illicitly obtained drugs can be injected under supervision.

The Catholic women of Australia recognise that drug use and misuse is a serious problem for the user, the family, our health system and our society. The CWLA are opposed in principal to the harm minimisation approach because, as experience has shown, it normalises drug use. We have no desire to surrender to a policy of creeping drug normalisation but rather desire a policy

aimed at a drug free society—a policy directed to helping people overcome their habit rather than a policy of limitation or reduction of the associated damage. Families are decimated by alcohol and other drug use. I have seen that first-hand over 24 years. I have seen the damage to grandparents, siblings, spouse, children and friends of a person using powerful mood altering chemicals. Work mates and health workers are also affected. In our psychiatric ward, for instance, there are problems here in Hobart because of the unmanageability of some of the patients.

Australia now has 40 per cent of its adult population suffering health, financial or legal problems associated with the use of legal, illicit and prescribed drugs. One wonders whether the 40 per cent of marriage breakdowns in this country is purely coincidental. That is from one of your inquiries, 'To have and to hold'. Drugs are readily available in all parts of Australia, even to young people and children. It is not enough for us to concentrate on the user; there could be as many as 300 people adversely affected by any one person's focus on drugs. I know from experience that absenteeism from school is often associated with drug problems at home. How can a young person get to school following the chaos which reigned in their home the previous night? In Tasmania, almost a quarter, or more than 13,000, primary and secondary school students fail to turn up to school at least one day a week.

The Tasmanian Chamber of Commerce and Industry has called on the state government to legislate for mandatory blood testing in the case of serious work accidents. Upon inquiry, I found this 'safety call' to be unpopular with the unions, yet surely an employer is entitled to a competent and non-intoxicated work force, if only to ensure the safety of fellow workers. Decreased concentration can result in a life altering injury or death at work. I know of one worker who was decapitated due to the loss of spatial judgment caused by the residual effects of drugs. For the first time there are to be compulsory programs forcing drug affected welfare recipients to seek special assistance. Drug addicts and alcoholics will be forced to seek counselling or lose welfare benefits. This welfare reform has come about because, according to workplace relations minister, Tony Abbott, 'There's little point in sending people on drugs to job interviews or training courses.'

The review of the third national HIV-AIDS strategy puts the cost of needle and syringe programs at $13 million for one year. Is the fear of AIDS driving the drug agenda? One consequence of free needles and syringes is the current hepatitis C epidemic in our teen population. Greg Dore, from the Sydney based National Centre in HIV Epidemiology and Clinical Research, said that the growing popularity of injecting drug use was driving the epidemic in Australia and added:

> There's good evidence that the number of people who have taken up injecting have doubled in the last five years.

I know from personal experience that the availability of syringes has resulted in our young people, who may have formerly experimented by smoking or swallowing drugs, injecting anything they can get hold of from any source or medicine cabinet available. Australians can no longer deny the extent of illicit drug use and the physical, social, psychological and legal consequences of drug dependence. We strongly urge the committee to recognise the epidemic proportions of the problem, which threatens the stability of the family and the common good of the nation. Drug use can be made socially unacceptable, as tobacco smoking has been.

There are no quick fixes. A major source of frustration occurs when a user seeks help and is told by staff at an agency espousing harm minimisation that they need to ‘cut back’ and ‘use responsibly’. If the individual could use responsibly, they would not be presenting for help. We are encouraged by this public hearing on substance abuse, which reflects the first recommendation on page 14 of the CWLA submission. I am confident that each one of us wants a drug free home and family, airline pilot, bus driver, doctor, law enforcement officer, health worker and workplace—and, most of all drug, free youth so that they and their families may experience their full potential.

CHAIR—Thank you. Clearly you are implying that you believe the problem has got worse—and I think there is a fair bit of evidence to support that view. But, throughout history—if we just take a quick snapshot of the last hundred years—we have seen prohibition and a whole lot of struggles with programs to try to deal with it. You have touched on supply and demand and we hear about diversion, harm minimisation and all that sort of thing. At the risk, I suppose, of going over old ground—you have alluded to it but I would like to get it on the public record—why do you think we are seeing a rise in drug usage at the moment?

Mrs Roberts—I ponder that at great length, because we in Australia have a pretty good country. The standard of living is good and the opportunities are good. We need to ask ourselves the fundamental question: why do our young people need to avoid reality? Because that is what drug taking is.

CHAIR—It is probably not just our young people.

Mrs Roberts—No, but it is escalating, I think, at a faster rate among the young. It is not by chance that it is escalating. I think that it is being pushed. Even our government, in accepting the use of illicit drugs and supplying injecting rooms, seems almost to be condoning it. Parents are asking, with good reason: is Australia serious about tackling the drug problem or has it given up?

I see parents who are really anxious because they are struggling to keep their young people drug free in a society which does not seem to be supporting them. Parents are watching beautiful young people, thoughtful fun-loving young people, become selfish, self-centred and self-destructive strangers because of their drug use. We want society to support parents in their efforts to make—

Mr QUICK—Are you saying we have not been strong enough at a community level and at a government level in terms of sending a clear message that these are very negative things to be involved in? We have not been strong enough?

Mrs Roberts—Nowhere near strong enough. What has fascinated me is that we have relegated smokers to the pavements around town. It must be quite humbling to have your little puff on the pavements, but we are seeing it. We are saying, ‘This is no longer acceptable,’ yet simultaneously we are talking about legalising marijuana, which has far more tar and is a far more recognised carcinogen than tobacco. There is no logic in what is happening.

Mr QUICK—What would you say to the mother who goes and buys heroin for her son or daughter in order to keep them alive rather than see them go out and prostitute themselves in the street or put their life in jeopardy? What would you say to that mother?

Mrs Roberts—I would say to the mother, 'I understand your concern and your love for your child, but feeding them the very poison that they are becoming enslaved to, or are enslaved to, is not the answer.'

Mr QUICK—But at least that mother is keeping that person alive with the view that at one stage in their lives, hopefully, that person will come to the realisation that their life is stuffed and they would like to get into rehab or detox. We have had evidence presented that there are lots of those cases. To say that we would like to have a drug free society is a fine and ideal aim, but we hear evidence around Australia that there are parents so desperate to keep their kids alive that they will actually go and purchase the drug so that their child does not end up as what you saw on TV—a young 15-year old prostituting herself to an old man or kids lying in a body bag because we do not have some sort of empathy to keep those kids alive so that perhaps we can put in place some rehab and detox.

Mrs Roberts—It looks like compassion, but it is not compassion to keep your child enslaved to a drug. I have said often in public—and my husband advised me about saying it here, but I am going to say it anyhow—

Mr QUICK—You are covered by privilege.

Mrs Roberts—Drink, our favourite drug—which is alcohol—kills far more people than heroin does. Why don't you supply alcohol to the alcoholics and gambling tokens to the gamblers? Why is there special treatment for the heroin addict? Both heroin and gambling kill people. You know, Mr Quick, because you are local, that in the early days of the casino here in Hobart there were many suicides. Over time they have been less publicised because it is not good for business. I know stories of people taking home the week's takings and gambling them. The alcohol death rate—one of the ladies on my right or left may look it up; I am sure it is in my submission—is just tremendous. With all the emphasis on heroin, aren't we neglecting our favourite drugs which are, firstly, alcohol and, secondly—and a close competitor, now, I believe, especially in Tasmania—marijuana? I would not advise that she do that but I would advise that she seek honest rehabilitation.

Mr QUICK—There are two places in Tasmania: the bridge program and Missiondale.

Mrs Roberts—That is right.

Mr QUICK—For a variety of reasons, both are not all that popular with a lot of people. In lots of cases our young drug affected people go the mainland to try and get into programs there. We heard from the state government this morning that basically the state has an eight-bed detox unit in Collins Street and that is it, end of story. It is a case of washing our hands of it.

CHAIR—Would you like to respond to the issue around services?

Mrs Roberts—I think the services are quite inadequate. I particularly dislike the fact that so many of them are based on the harm minimisation philosophy. If you have done a successful intervention—as I have done many times over the years—and have broken through the wall of denial and got this person ready to accept help, and then they are told that all they have to do is cut back and use responsibly, it is terribly frustrating. I applaud the bridge program. I think they are doing a good job. They are expanding their buildings due to a fire that took place on their premises. I hope that they will go from strength to strength because they do have success. Yet the dollars, which are in short supply evidently for this problem, are being channelled all the time into innovative treatment programs—something new. What is wrong with channelling the dollars into programs that work and do succeed in rehabilitating people?

Mr QUICK—What is your opinion of the decision of Judy Jackson, the minister for health and family services, to spend $6 million rebuilding Ashley and Peter Patmore’s decision to spend $53 million rebuilding the jail in the light of the lack of funding for early intervention, rehab and detoxification in this state?

Mrs Roberts—It is all part of the same problem, Mr Quick, isn’t it? We have a captive audience over there at Risdon. We could have really successful rehabilitation programs operating there. With a lot of the problems—the unrest and so forth—you and I know that there are problems of drug use within the prison. Who knows why these young people committed suicide, truly? Many of them may have been suffering the depression of drug use. I do not know what the kids are up at Ashley for, but I suggest that young people who are homeless and acting out are often doing so because of the substance abuse at home. If you grow up in a home where your parents are using substances, the street is a lot more hospitable than your home. I think it is all part of the same problem. If money can be found for those two, then money must be found for rehabilitation.

CHAIR—Can I just come back to my original question? Why do you think there is the escalation?

Mrs Roberts—I turned that question back on you.

CHAIR—Please do. We can talk about a lot of the treatment and the detox and resources. It is an eternal debate in that area. I have tried to paint the picture.

Mrs Roberts—Because there is big money in it, Mr Wakelin. There is big money. It is a very big and profitable industry.

CHAIR—Whether it is cigarettes or alcohol or whatever.

Mrs Roberts—That is right.

CHAIR—So your view would be to turn it back on the industry itself?

Mrs Roberts—No, I think we have to look, like I said originally, at why our young people want to escape from reality. I do not know whether it is because we are a nation which inherited the strong upper lip. You see the people at the football hooting and hollering and really enjoying all the range of emotions, yet we as a society try to live without feelings. Feelings in the young

are very strong. It is a very painful place to be—a half-adult or half-child. Adolescence is very difficult.

Adolescence is very difficult and while drugs do not change anything much—they just change your perception—the pain of adolescence is temporarily removed. If all the young person gets from the drug is temporary relief from the pain of living—

CHAIR—We have agreed that young people are not just the issue.

Mrs Roberts—No. The parents—

CHAIR—For a lot of people the substance abuse itself it is not exclusive to age, it is right across the spectrum.

Mrs Roberts—It is.

CHAIR—I am trying to ask you an impossible question so please turn it back on me—I am not troubled by that at all. I am interested to know why you think that there has been an escalation in the last five or 10 years. Why are we are more concerned about it?

Mrs Roberts—The harm minimisation approach has accepted that young people are going to use drugs anyway.

CHAIR—But harm minimisation is there because the escalation was there and no-one had a solution which seemed to be able to hold the perception that we had a problem that was escalating.

Mrs Roberts—Yes. Even Alex Wodak, who was really the architect of a lot of this, is saying that we have failed. If, as you say, it was brought in because of the escalation and the architect is saying that it has failed then could we, the Catholic women of Australia, also say that it has failed, that it is suspect and that it is making what is illicit acceptable? Here in Hobart—I talk too much, I know, so stop me won't you—we have just had an inquiry into prostitution. The solution is to legalise prostitution. The reason that we legalise it is that 14- or 15-year-olds are being used sexually in order to get money for their drugs, et cetera. By legalising it you are going to make the whole situation a lot worse for these young people because you are legalising something unacceptable: the use of one person by another for sexual gratification. Are we not doing the same thing with drugs?

CHAIR—I hear the point and that has been argued. But let us just go to my one last question—you have probably answered it but let us be quite clear: what would you offer as the main solution? Would you offer some more treatment services, rehabilitation, better education, a challenge to the harm minimisation approach? If you had one thing, what would you do to turn it around?

Mrs Roberts—Firstly, I would maintain the sanctions—but that is not what you have asked me. From my recommendations I have to pick one—

CHAIR—A priority—take three if you need to.

Mrs Roberts—Thank you. Remove the stigma of addiction, because a lot of families are really suffering—

CHAIR—Yes, excellent.

Mrs Roberts—on account of the fact that they do not want—

CHAIR—This is a legal health issue—

Mrs Roberts—That is right. They do not want to expose their family problems.

CHAIR—They cannot get help like that.

Mrs Roberts—They are protecting their kids. Encourage early intervention and rehabilitation and, as I said earlier—this is No. 4 but it is referring to something else that I said—channel the money into tried and true programs with the goal of abstinence. Nobody sets out to be addicted. People try drugs out either socially or experimentally or on prescription, and they like the feeling. They like it so much that they go back and they do it again and again. Some people who do that do not get hooked and that is where the confusion arises.

CHAIR—So you would have abstinence as a very clear option.

Mrs Roberts—Once you are hooked.

CHAIR—But right from day one I would have thought that abstinence should be a clear option. Does anyone else want to comment about abstinence?

Mrs Triffett—I would like to address a different set of issues—and it will probably be confusing if I do.

CHAIR—No, that will be fine; we are all confused on this issue.

Mrs Triffett—I would like to address the health issues. I am a registered nurse who has been nursing for over 30 years. As you would have noticed in the Tasmanian papers lately, nurses are under increasing pressure. I refer to the *Mercury* a few weeks ago when a survey was done by the AMA which said that 70 per cent of doctors and nurses, an overwhelming majority, believe that—as it says:

> ... public hospitals were on the brink of disaster and would be incapable of meeting community needs within 10 years.

Nurses are under increasing pressure. In our hospitals we have problems with patients with dementia. Unless we look ahead at this time and unless we address what the drugs are doing to the mental capacity of people, as is coming through on the trends of the research—it is not definite but the trends are showing it—drugs like ecstasy are going to cause permanent brain damage. They are causing the same symptoms as are found in elderly demented patients.

We are now having trouble with hospitals and dementia. At the moment we have got 122,000 people in Australia with moderate to severe dementia. By the year 2006 we will have 195,000 people with severe dementia—this does not include the lower scale of moderate dementia. On top of these figures, will Australia's health system have the capacity and personnel—nurses—to deal with a new wave of dementia in a younger age bracket, the result of drug abuse? These figures are for people over 65. The psychologists say that dementia is showing up in people who are taking ecstasy only 10 times a month. That is not a lot—

CHAIR—But it is creating its own huge national problem. Do you have any information on marijuana—changing the debate around to marijuana? It is not as benign as we thought.

Mrs Triffett—No, and I will refer to your own government publication, the *Handbook for medical practitioners and other health care workers on alcohol and other drug problems* by the Commonwealth Department of Health, Housing, Local Government and Community Services, 1993. It details all the problems that cannabis triggers with lung cancer and schizophrenia. Going back to cancer, I know personally—and two hospitals in Florida have detailed also—how head, neck and jaw cancer was completely unknown in young people and is now appearing. Florida had 40 patients in those hospitals who had all had smoked marijuana and 50 per cent were dead within about a year. There is an immense health problem out there, but unless we deal with this problem as a health issue—

CHAIR—The bigger issue is the potential to—

Mrs Triffett—It is health and it is a real problem.

CHAIR—Thank you.

Mrs Galea—I want to take a slightly different angle because Betty has spoken a little about rehabilitation and detox, and Maree has spoken about health. I was really impressed reading about how other countries have treated their drug solutions, in particular Sweden, which started with one of the highest rates of drug use in Europe. After about 10 to 15 years Sweden have the lowest rate. They particularly looked at detox and rehabilitation and law enforcement. But an integral part of their program was education. They looked at their whole education system and incorporated education about drugs, not just in health classes but throughout their system. In mathematics and statistics they were learning about drug statistics and changes in drug use, and so on. In science they learnt about the chemical structure of the brain and how chemicals from drugs interfere with brain action. In particular they took teachers who were 100 per cent committed to a drug-free society to guide the students and to encourage them in their learning about drugs.

They wanted people who were not ambiguous in the signals they were giving to the kids. It was not just the kids they were looking at in their education program; they also looked at the parents, the older generation. There were two reasons for that, because, as you have said several times, the drug problem is not just with the youth but with all age groups. So in going to the parents they are looking at another age group. They were educating the parents about the drugs to back up what the children were learning at school and to give the parents the feeling that they were supportive in trying to help their own children.

I think a lot of parents feel a bit overwhelmed and are a bit ignorant about the effects of drugs and the scale of drugs and, for instance, what to do if they find that their child is involved with drugs. So their education on drugs had a multi-pronged approach. They have had a remarkable degree of success. I think it is extremely important to have drug education not just looking at schools but in all forms of education, because in Tasmania we have a wide network of home education. It should be a public thing, not just directed through institutions. We have so many media forms to reach people in their homes and we need to be tapping into everything we can find if we are really serious about stopping kids starting drugs.

Prevention is the best way to alleviate this problem. In looking towards the next generation of kids you have to look at every facet you can to get a good understanding of this and to make sure the kids not just understand it intellectually but are taking it on board. They need to understand that, even if they might have smoked a joint once and did not drop down dead, there are real serious long-range problems associated with this.

I know that at the school I went to we were very involved in visiting old age homes and so on. I think community service should be part of how children are brought up. If they can see first-hand the wide ranging effects of drugs on society, it will help them to take it on board. They are just a few pointers.

Mr QUICK—As a parent and in light of your knowledge of what is happening in Sweden, the booklet that you and every family got, and the television ads, what are your children telling you? What are you saying to them as a parent? Are they effective? Can it be done better? What do the Swedes do?

Mrs Galea—Number one, we do not have a television in our house, which is pretty rare. We want to influence our children. They see television at other people's places, but I have not seen the TV ads. I have talked to my children, who are in upper primary school, and some of their friends as well as tertiary students. With the younger kids we talked about the nuts and bolts of how it works. We looked at brain function, cells, how synapses work and communication in the brain. When they see that to get from A to B you need chemicals in your brain—and they can smell the chemicals when they walk past a tobacco smoker—they have a tangible sense of how chemicals get into their bodies. Even though they are young kids, they understand that much, obviously, and they are able to take it on board to that degree—illicit drugs are made illegal because they harm you, because they are affecting the chemical nature of your body. I think I have wandered off your point a bit there.

CHAIR—That is fine.

Mr SCHULTZ—Can I say at the outset, Betty: keep talking, the community needs your strong voice. I want to refer to page 4 of attachment 2 of your submission, which incorporates the recommendations of the report of the Archdiocese of Melbourne's Drugs Task Force in May 2000. You refer to negotiations for the greater provision of detoxification services so that ultimately detoxification is available at the time of request. Is it the view of the league that governments should dedicate more resources to treatment and rehabilitation?

Mrs Roberts—Absolutely. I am constantly placed in a position where I have done intervention and then sought detoxification because the rehabs will not accept a person unless

they have been detoxed. You have to phone in the morning. You have done this thing last night, you phone to get somebody in and you cannot. You must strike while the iron is hot.

A lot of people do not want treatment, but how can you seek your own wellbeing when you are intoxicated on some drug? You are not in your right mind. You have got through the fog and the denial and have said, ‘Yes, I want help,’ and then we cannot get them in anywhere. Even if we get them detoxed, sometimes they keep them for only two or three days and then they are back in the environment where all their friends are using. There needs to be a safe haven and ongoing rehabilitation for at least 28 days. I will tell you what I like—the best program in Australia. Do you want to know where it is? It is the Phoenix program at the Manly Hospital with 28 days of concentrated rehabilitation and—a very rare thing now in our society—it is on Medicare. Most of them cost an arm and a leg. I got a girl into a private clinic in Sydney which charges $3,000 a week. People simply cannot afford that. So the Phoenix program at Manly is fantastic.

CHAIR—On Medicare?

Mrs Roberts—On Medicare. It is 28 days from beginning to end and is closely allied to the 12-step programs of AA and NA. As you know from film stars, if you know anything about Martin Sheen, Barry Humphries and that famous Australian, the glamour boy, Mel Gibson, and that Englishman, they all got clean and sober through AA and NA. It works. Since the Iron Curtain disappeared, Russians have taken to the 12-step program—and, let’s face it, they have a monumental problem—as if they were starving.

Mr SCHULTZ—Do you think that governments should devote more energy, research and funding to detoxification programs such as the one undertaken by Dr George O’Neil in Perth using the blocker naltrexone?

Mrs Roberts—I do not believe in quick fixes. I have seen so many people die from overdoses of methadone. I have not seen them die from naltrexone, but I know that they have died and I do not believe in quick fixes. If you are going to get well, you have to make a 180 degree turn. As I said to the chair earlier, we need to teach our young people how to deal with their feelings without recourse to drugs. Putting down your drug is the first step. You have to learn how to live without it and that takes time. The first 12 months in a person’s sobriety is very painful because it is a learning phase and an acute phase. They need all the help they can get. So I say no to the quick fixes, Mr Schultz.

Mr SCHULTZ—To what extent do you believe over-prescription of drugs is creating a problem within the community in terms of addiction?

Mrs Roberts—Mr Schultz, this may offend the medical fraternity, but I do not wish to label them all. There are doctors servicing addicts who have a ready-made practice. If you can rely on a number of addicts to present fortnightly for their script, you have a ready-made practice. I do not wish to offend the medical fraternity by saying so, but it is a reality. For years, Australian women referred to their nerve medicine and they were becoming hooked on valium.

CHAIR—I suppose I could add that we cannot be too concerned about defending people—you are under privilege here, anyway—because if the problem is serious enough we may have to offend a few people.

Ms HALL—I noted in your initial submission that you support mandatory testing of workers in the workplace. I also noted that you were supportive of the withdrawal of payments to recipients of Centrelink benefits that were involved in the use of illicit drugs. Firstly, do you support the mandatory testing of all people applying for Centrelink benefits? Secondly, do you see any problems with respect to increases in crime, et cetera, in our community with the withholding of payments from Centrelink clients?

Mrs Roberts—I would be opposed to the withholding of payments. I would be opposed to the mandatory testing of Centrelink clients, but I do want mandatory testing in the workplace because of the safety of the fellow workers—not just the person who had the accident but those around them.

Mr ANDREWS—The data you quoted about dementia, Mrs Triffett, what was the source of that?

Mrs Triffett—Carer experience, which is put out by the Commonwealth Department of Family and Community Services. It is a national action plan for dementia care.

Mr ANDREWS—In the second part of the league's submission there is a reference on page 9 at section 4, which says:

Many families are torn apart when family members become associated with illicit drug taking.

As you know, one of our terms of reference is to look at the cost of substance abuse with regard to family relationships. I was wondering to what extent this is the cart and the horse—that is, do you have any comments on the impact of breakdown or dysfunction in family relationships leading to drug abuse, whether it is licit or illicit drugs?

Mrs Roberts—As we said in our submission, it is the highest cause of family breakdown, marriage breakdown. We are living in a society now where we are experiencing 1,000 divorces per week. Strangely enough, the symptoms of addiction are there—the violence, the inability to support the family, the unreliability—but drug use per se is not there. I know from first-hand experience that it is a precipitating cause of breakdown within the family and divorce.

Mr ANDREWS—In one of the attachments to your submission, attachment 2, which was the recommendations to the archdiocese of Melbourne in the report of the Drug Task Force of May 2000, the first recommendation was:

Parishes to be encouraged and assisted to develop a drugs program responsive to local strengths and needs.

Has this been taken up beyond Victoria—in Tasmania, for example, or anywhere else?

Mrs Roberts—No. I think in Western Australia they might be doing something, and I know that they are doing something in Victoria. I am hoping that they have people working with those

that they are helping who understand that though they are beautiful, lovable people—addicts—they are the most manipulative people on earth. I am hoping they choose wisely when they choose the people to work with, those they are helping. I was manipulated for many years by addicts. I love them, you see—they are very lovable people—but I now know the difference.

CHAIR—You have been done over a few times.

Mrs Roberts—Yes, many times. I really think you must have love, you must give them love—they are hungry for love—but it has to be a strong love, not easily manipulated. It takes time to work out how to love them and not succumb to them.

Mr ANDREWS—What I am trying to explore is not even so much the church context, but rather where services can be provided and how they are provided—

Mrs Roberts—In the private sector.

Mr ANDREWS—Yes. Can I just say something and then seek your comment? In your experience or in your view, is a local response—and a parish would be an example of that, but it could be a neighbourhood or a town—one which is more likely to result in positive outcomes than a response at a much higher level, in terms of a region or a state? What I am trying to get at is—

Mrs Roberts—Little cells.

Mr ANDREWS—Is that something that, because of the close connections with people, has a better chance of working or not?

Mrs Roberts—I do not know, but I suspect it might work extremely well. We have not had the experience to go by. Here in Hobart I have been proudly associated with Caroline House over some 24 years. Caroline House has always taken the people that other people do not want. For example, if somebody is discharged from the psychiatric ward and nobody wants them because they are too hard to handle, Caroline House will take them. In its wisdom, the government has now decided to have only one women's refuge in the south. Caroline House has been absolutely stoic throughout the years. Other refuges would ring them up and say, 'Come and take this person. We cannot handle her,' and Caroline House invariably did.

Now there is some threat to its very existence because of some sort of rationalisation. You see, the decisions are made up there. Over the 24 years, I have gone and been talked at by young, energetic, intelligent graduates who have not experienced the problem. That is where the decision making is done—with theorists. As the deputy commissioner was saying earlier this morning, they need to get to the grassroots. Remembering that an addict is manipulative and that addicts will find 20 reasons to serve themselves before serving the deputy commissioner, we need to get with people who have had the experience—

Mr ANDREWS—Can I just ask you one final thing?

Mrs Roberts—and then it would succeed.

Mr ANDREWS—Drugs are not new. Heroin is not a new drug; alcohol and tobacco have been around forever and a day, yet whether we are talking about illicit drugs or licit drugs, there seems to have been in the last 10 to 20 years a huge increase in the usage of them. Amongst secondary school students—and I suspect it is no different in Tasmania to how it is Melbourne or elsewhere in Australia—there is increased binge drinking and heavy rates of drinking by secondary school students. Do you have any views about whether this is a manifestation of something else and, if so, what it is?

Mrs Roberts—I think we know that it is physical, mental, emotional and spiritual illness. Insofar as we know that, the Australian Aborigines are more likely to come to grips with that than the white Australians, because they are prepared to accept that it is a spiritual sickness. There is a great void inside our young people, I believe, and the futures that their parents could look forward to are largely disappearing. Once upon a time it was, 'Go to university and get your degree, young man—or young woman—and your future is made.' The pathway to the future now is uncertain and employment is uncertain, but these are not necessarily the causes, because a person who is whole can face all those difficulties and survive. There is this void within which I am unashamedly calling 'spiritual starvation'. I often think that the drugs, whether they are taken orally or through injection, are a sort of attempt to fill the void.

Mr QUICK—Tasmania is unique because it has three centres of population over widespread areas. The state government obviously sees detox as eight beds on Collins Street and rehab as someone else's responsibility. Lots of the problems are occurring in our small country towns, and there is a stigma attached to that: everybody knows that such and such a family is having problems. How do we go about ensuring that the net is strong and that the gaps are smaller and smaller in a society in which everybody knows everybody else? If there is a suicide, someone knows someone who is related to someone who knows someone. We seem to have dozens and dozens of players in Tasmania involved—you could get a list from the state government of all the organisations that have been funded. Yet we still seem to have the problem jumping out of the ground. All the trends are going upwards. What are we doing wrong? Do we need to give it to one body and say, 'Look, have a state-wide perspective'?

Mrs Roberts—No.

Mr QUICK—There are hundreds of millions of dollars funnelled into Tasmania through the drug program. What are we doing wrong?

Mrs Roberts—You have asked me two questions: about the smaller community and the shame that is associated with this problem, and about funding. I believe that one of the basic faults in our funding system is that we are always looking for something innovative. What is wrong with funding the tried and true? The demonstrable goal of the program must be to be drug free. That is the sort of program that I would fund. The government seems to have succumbed to this harm minimisation thing, and even the private sector has succumbed in some instances. But you must look at the goal. For instance, various workers go into the prison. You are dealing with a very sick person—a person who is sick emotionally, mentally, physically and spiritually. If you then address the person with three or four different philosophies, you are scrambling them, aren't you? It is really very important to have a definable philosophy. They talk about outputs these days. You must have a philosophy geared to your goal. If your goal is

abstinence then the whole of the philosophy needs to lead towards that goal. As far as the small communities are concerned we must remove the stigma of addiction.

I am going to say another thing my husband told me not to say: we are a very young nation—only 200 years old—and drink has been there right from the beginning. We paid our troops and our citizens in rum. They were sad, sad people who had come to the opposite end of the world. They were in pain. They were using the alcohol to suppress the pain. It is our heritage to use something. The only difference between now and then is that we have a smorgasbord to choose from nowadays. That is the only difference.

CHAIR—We have a few more choices than just rum.

Mrs Roberts—Exactly. There is a little town down the channel there which has three hotels in one little community. Now you have got the newcomers to that little town down the Huon and they have brought a different drug with them. Those who are not at one of the three pubs in that little community are somewhere smoking pot.

Mr QUICK—But there are no facilities down there for the parent whose child gets sucked into one of those drug addictive regimes. You have to come up to Hobart.

Mr SCHULTZ—There are none here, either.

Mr QUICK—There is a detox here but there is no rehab, unless you want to get into the bridge program and, as you said, you cannot get in when you need to get in. The state government would say, ‘Look, we’re funding all these places and there’s an article in today’s *Mercury* about all this community money going to 48 little groups that are busy doing good things in their community.’ But no-one seems to accept the responsibility of saying, ‘I’m holding the net; you’re all part of this net but I’m holding it.’ There is a net out there and good luck to you. The Commonwealth says, ‘We’re throwing this money in and hopefully Tasmania will also, through the prisons, the juvenile justice, the education and housing departments, and we’ve all got social workers and there are protocols and memorandums of understanding.’ But I am sure that we could go out onto the streets today—a freezing cold, snowy day in Hobart—and there would be people going into some of these little organisations desperate to hang on to their life’s thread. That is appalling in this day and age.

Mrs Roberts—There is a program—representatives of it are speaking after me—called Holyoake that does excellent work with families, but—

Mr QUICK—They are underfunded.

Mrs Roberts—they are underfunded. One of the founders in Western Australia, where the Holyoake program commenced, is now working in the south-west of Western Australia. In answer to Mr Andrews’s comment, she goes out from a central area and provides her help in a sort of a radius, from Bridgetown actually in Western Australia. I think that the idea of these small communities is very good but someone knowledgeable needs to be at the centre to feed them, because, when you are giving to people in this area, it takes a lot from you and you need a network to support you in that giving.

CHAIR—I have two or three questions—we have touched on it—on the spiritual issues: don't talk; don't trust; don't feel. What type of service would be in place to help children in these circumstances? Is there anything you would like to add? What services deal with this—don't talk; don't trust; don't feel?

Mrs Roberts—It is very important, in my view, to work with the children of addicts, because there are three rules that a child of an addict learns: you do not talk about it, because what happens at home stays at home. Were you told that when you were a kid?

CHAIR—Yes.

Mrs Roberts—You do not trust anybody because most of the people that you should have been able to trust in your home environment were untrustworthy insofar as promises were made and never kept.

CHAIR—They are in deep trouble themselves a lot of the time.

Mrs Roberts—And if feeling is so damned painful that they choose not to feel rather than feel the pain of living in that environment—

CHAIR—The risk of the pain.

Mrs Roberts—That is right. If you have been given those three rules when you were a child, you grow up not being able to relate to anybody.

CHAIR—Betty, we have touched on it: is there anything we should add? How do we attempt to replace it? You and I could have an hour-long discussion—

Mr QUICK—We have done all we can.

CHAIR—Is there anything we should add? The bureaucracy and the government do not having anything that gets close to dealing with it, and yet I acknowledge the absolutely vital role of that. How do you actually design a system? We can talk about schools; we can talk about a whole lot of things, but how do we design something which can help pick up those people. We have social workers but they still slip through the net; Harry has touched on that. Is there something there that you can think about?

Mrs Roberts—The poor old teachers—I do feel sorry for them.

CHAIR—Yes, absolutely.

Mrs Roberts—They are picking up the pieces of a broken society because this problem is decimating our society.

CHAIR—We cannot ask them to do everything.

Mrs Roberts—No, we cannot. Instead of teaching, they are often forced—I heard a lady this morning talk about the number of social workers. It is pathetic. There are three schools. You are lucky if you can get the social workers for an hour a week, but somehow or other we have to deal with it at an educational level, not at a welfare level within a school, but at an educational level. All feelings are okay—it is what we do with the feelings that is wrong. I have a family member at the moment who is heartbroken because he has been rejected by his girlfriend. His grief is showing up in anger, depression, all the ‘if onlys’, the self blame and everything, and it is terrible to see the pain that that young man is in. If I did not have the training that I have to deal with it and accept it as normal, I would be ‘up the river’, as we used to say when we had an ‘up the river’—but it has all closed down now. I am humbly grateful for the ability to accept these intense feelings as normal.

CHAIR—So we need people with skills to help people who are in trouble.

Mrs Roberts—That is right.

CHAIR—My second last question is on rural communities. We have touched on the small communities. Is there anything you would like to add about rural communities?

Mrs Roberts—There are well-motivated doctors. There was a doctor in Kempton, Mr Quick, who desperately wanted a program there. At the time he asked me I was too busy to provide it. But I think that well-motivated general practitioners could well be the motivators, because they know all the secrets of the community. But there is all this secretiveness. I have been to schools and I have spoken to parents. I have said to them, ‘You have to share the problem openly with one another instead of hiding it, because parental strength is great if it is united.’ But if all of us are holding onto our secret—‘We’re an okay family; there is nothing wrong with our family and we do not have any problems’—then we are not going to harness that energy which is parental power. So I think parental power and GPs will help.

CHAIR—My last question is: is abstinence uncool?

Mrs Roberts—No, it is not. I know lots of sober and clean addicts. When they put down their drink and they learn to live without it or whatever other drug they are using, they grow and they grow and, far from being uncool, they are leaders in their communities. I took two young men up to talk to 300 air cadets at Brighton two or three years ago, and I took with me two very valuable people, these two young men who were clean and sober. They could say from their hearts—and they did speak from their hearts—what a hell it was; how short the euphoria is and how long the hell. But it is dangerous to use practising addicts. From people who have achieved sobriety and are clean of drugs and have grown—it must be beyond a year clean—there is a wealth to be learnt.

Mr SCHULTZ—A year 10 student told us that yesterday.

CHAIR—Thank you very much.

Mrs Roberts—Thanks for the compliment.

CHAIR—Thank you very much, Betty Ann Roberts, OAM, Nicola and Maree for coming today. Good luck to your families and your 15 children, because this is what we are here about as much as anything.

[11.47 a.m.]

CHURCHILL, Ms Kim Adel, Chief Executive Officer, Holyoake Tasmania Inc.

DIXON, Mr Michael, Board President, Holyoake Tasmania Inc.

SHADBOLT, Ms Cheryl, Board Member, Holyoake Tasmania Inc.

CHAIR—I welcome you to our meeting today. I need to point out that although we do not swear in witnesses, the proceedings are legal proceedings of the parliament and need to be treated in the same regard as proceedings of the House of Representatives. As the previous witness was saying, we do have the protection of privilege. Would you like to make any addition to your submission or to make any opening comments?

Ms Churchill—I thought I would give a brief overview of some of the programs that we offer. Holyoake Tasmania is a very small non-government organisation in the state. It is affiliated with Western Australia and is becoming licensed under Holyoake in WA, which is quite a large service. We provide limited services due to funding shortfalls. Primarily our core program is the FOCUS program for support for partners, parents or adult children of people with abuse issues, not just substance abuse, as gambling and addictive behaviours fall into that category. We also have a fully funded adolescent program for young people between the ages of 15 and 19 who have committed an offence where drugs and alcohol have been a contributing factor. They are referred to us for a community conference, by self referrals or by an illicit drug diversion program. The basis of our submission was looking at the FOCUS program, which is the family support program.

CHAIR—Your submission talks about cannabis. You would be aware of the diversion program for marijuana.

Ms Churchill—We do run a program under the diversion initiative.

CHAIR—You made the comment about the problem in relationships and aggression towards parents. Over the last 25 years, there has been a belief that it was a fairly benign substance, and you would be well aware, as I am and we are, of the general debate within the Australian community over the last 25 years.

Ms Churchill—Yes.

CHAIR—I think many people are now of the belief, based on research and pretty obvious examples, that this substance is nowhere near as benign as it was once believed. Therefore, what should we be doing about the issue of cannabis generally and particularly for young people and their parents in these relationships? What are some of the things that we can do which challenge the belief that cannabis is fairly benign? Quite frankly, I think at least half the population believe this; it is in the culture of our country.

Ms Churchill—I think that is it—the awareness that it is not necessarily benign. I think a lot of the kids are aware of that. With our adolescent program, they are realising in themselves that there are quite a few issues that they have to look at in association with dope use. They use the term 'addicted'. They see it as an addictive drug that they enjoy and are having difficulty with.

CHAIR—In dealing with your client base, have you noticed anything which is just a bit more effective than something else? Every individual is different in all of those situations but is there something that stands out in the way in which you have been able to challenge behaviour? We were asking the deputy commissioner earlier about what is working and what is not. The response was, 'It's pretty early and we don't know,' which you would expect. But we are really keen to try and understand some of the things that might be happening, that might be useful.

Ms Churchill—One of the focuses that does not seem to be very common with these services is to look at the whole family dynamic, to get the parents involved. They are the ideal point of intervention. Eighty-six per cent of people aged between 15 and 19 are living with one or both of their parents, according to the Bureau of Statistics. The kids cite their family relationships as the most important by far. Parents are willing to help and are desperate for some ideas on how to do so. I think it is an ideal area.

CHAIR—Do you invite people in and sit down and have a yarn about it, just work through the issues, give people information and some strategies they might use?

Ms Churchill—Yes, we do. Initially we just invite people in. We discuss what we have to offer, which is quite an intense, structured 12-group program. It is over six weeks, they come twice a week if they choose to come into that program, and it is really focused very much on feelings. The primary cycle that families seem to be caught in, if I can use that term, is fear and shame and grief. One seems to slip into the other so they are on a circuit of emotions, where nobody is able to really just stand back and say, 'This is the direction that I want to go in.' Parents are blaming themselves constantly. The recent ad campaign by the federal government saw quite a rise in the number of parents coming to us in extreme fear that their child would be the next one in that body bag.

Ms HALL—So it had a bit of a negative impact?

Ms Churchill—Yes. It is fine to promote family communication but those skills are not always there. These parents are already feeling inadequate.

CHAIR—We had the architects of that program in last week and quite clearly this has emerged in our discussion—that group of people that do not relate that well, those that really need the help, find it quite terrifying.

Ms Churchill—Yes.

Mr QUICK—I am interested in this drug diversion program. Is there a formal relationship with Tasmania Police, the Royal Hobart Hospital and high schools that seem to have it as a problem? Is there a memorandum of understanding or are you just one of the places that people know about—that this is the place that does the right thing and if we cannot get instant action

we can at least ring up Holyoake and something can be put in place that at least is a sort of transitional mechanism?

Ms Churchill—This is for the adolescent program?

CHAIR—Yes.

Ms Churchill—A variety: community conferencing is our primary referral source and the other one is schools, but they do not have a lot of real opportunity to demand somebody attend.

Mr QUICK—Should they?

Ms Churchill—There has been discussion about having it as an option to expulsion or suspension, at least.

Mr QUICK—What is your understanding of what happens in a Tasmanian high school if there is a drug incident?

Ms Churchill—They are really given the option to get some assistance, so there may be disciplinary action but there is not a lot of opportunity for intervention. I have spoken to the education department about this, and they are not unfavourable to it—it is a matter of being able to put that in place.

Ms HALL—Could you design a program for those kids that are suspended and work with them if it was written into the education system here?

Ms Churchill—Absolutely—and our clients that are referred from a community conference. They are unwilling; they come because they have been told to and it is quite a challenge; but the responses we are getting from them are very favourable indeed.

Mr QUICK—Back to my question about relationships with, for example, the Royal Hobart Hospital: they can put them in a psychiatric ward or down to detox in Collins Street, but then they are sort of left on their own and no-one is helping; it is not the hospital's problem. In the justice system as well, when people are released there is no real pre-release program when you are coming back into society. What sort of links have you built over the years?

Ms Churchill—Not a great deal in catering for clients in early recovery of detox: that is something that the state alcohol and drug service here has virtually got the funding for. Our funding is very limited and the parameters of what we do are quite limited. We can take self-referrals, so if an adolescent for instance goes through a detox, they can certainly network with us on their own.

Mr QUICK—So with respect to your relationship with Wyadra, which I think is the state organisation, what is their modus operandi? How do you work with them, or don't you? Is there competition, the way there is in lots of other fields?

Ms Churchill—We do not seem to work very closely with the alcohol and drug services; in fact we do not get many referrals for family members from there. I am not sure of the basis for that, but I think there are communication issues in Tassie with all the services. The non-government organisations have just formed a peak body and we are trying to get that established so that communication can improve.

Mr QUICK—You are basically dealing with people in the south of the state and you have got two-thirds of the population up north, so what happens?

Ms Churchill—We cannot offer any service to the north—we do not have the funding to offer a service down here. We receive the same funding for our focus program from the state as we receive from the Boag brewery—it is a very small amount.

Ms HALL—Could you please detail how you are funded and the level of funding you get?

Ms Churchill—For the focus program, which is the reason we are here first up, it is $13,500 per year from the state government.

Ms HALL—Do you charge people who are involved in the program?

Ms Churchill—Yes, we do, and I must say in addition to that core funding we receive $12,000 a year regularly from the Boag brewery, so that is our core funding for that program. We beg, borrow and steal from everywhere we can, and we charge a fee for service. We ask participants earning a wage to pay $25 a session and for those who are unwaged it is $15; but I would say that for 25 per cent of clients we just waive any fee.

Mr QUICK—I notice you got some money today out of the community chest—I think Holyoake was mentioned in the paper today?

Ms Churchill—The Tasmanian community fund?

Mr QUICK—Yes.

Ms Churchill—No, I received a letter to say we did not.

Mr QUICK—Right. I thought I saw Holyoake mentioned in the paper today.

Ms Churchill—Maybe I will have to chase it up. I certainly submitted; I have submitted twice within that.

Mr QUICK—Okay.

Mr Dixon—Funding for us, but particularly in our FOCUS program, is now becoming a critical issue. Just yesterday I had to ask someone to step in more or less for another day working with our FOCUS group. We do not have the money but we are going to have to pay her. Yes, funding is a serious issue. It is very hard to get through to government, particularly in our FOCUS program, to get some more money, or from anywhere—we will take it from

whoever pours the money into our hands. But it is like pulling teeth. There is no abundant supply of funds for this area. You have just been hearing for the whole of the morning how desperate the need is in modern society.

Ms HALL—Do you have an annual report that you could give us a copy of with the breakup of your budgets, your funding and all that sort of thing?

Ms Churchill—Yes.

Ms HALL—If you could send that to Shelley, please.

Mr QUICK—Does it not seem rather strange that a brewery is contributing a fair share of your annual budget—

Mr Dixon—It comes from a trust fund set up by one of the original shareholders who was apparently a man without descendants. He set up a fund to be distributed to areas like the Holyoake program. We get the bulk of the funding from that particular trust.

Mr QUICK—You probably heard me ask this question of Betty Roberts, ‘What would you say to the mother who is out buying heroin in order to keep her child alive?’ What is your response to the same mother who comes along and says, ‘I understand you are involved in the issue of drugs. What advice can you give me?’ I have a letter here that was given to me today by a couple from Lindisfarne whose son got involved in marijuana and had to be referred to the Royal Derwent Hospital. What would you say to the mother?

Ms Churchill—To get them into the Royal Derwent Hospital is difficult. They are getting thrown around like tennis balls because Drug and Alcohol will not deal with them; Mental Health will not deal with them; and mum and dad are going crazy. I do not have any quick fix. If I had a magic wand I would be very delighted. I think I would listen to the concerns of the client and hopefully get them some support through the process of looking at the issues that they are facing. But it takes time. Consider how long it has taken for the family to get to that situation. It takes time to work through all those emotional issues to start getting some clarity.

Mr QUICK—You must have heard me talking about the net. There are dozens of players in Tasmania.

Ms Churchill—Indeed, there are dozens of services; that is right. If that net were to support the families, which are primarily the ones with the fingers on their pulse—they know what is going on—then we think that would be the ideal approach.

Mr QUICK—My last question, Mr Chairman: one would think that in Tasmania, with 464,000 people, our problem would be a lot less than it is in Sydney, Melbourne and the conurbations of Australia. There are linkages in all communities in Tasmania and we ought to be able to do it better than it is being done anywhere else. But we seem to be having the same sorts of problems as the western suburbs of Sydney because while there are lots of players and lots of money, no-one seems to assume responsibility to say—

CHAIR—Is there much denial?

Ms Churchill—I think there is. You would possibly be interested to visit Burnie to look at denial. There you have quite an issue in a tiny little town. I think there is a lot of denial. The net concept is a wonderful one because everyone seems to be working in isolation. That is where trying to develop this peak body is fundamental in tackling it because, as we all get together, each service is working in a different area. We have our expertise. If we can network then we are going to have a much better outcome.

Mr ANDREWS—Can I ask you about the FOCUS program because I understand it is for adults living with a spouse or partner who is addicted; it is not for adult and child?

Ms Churchill—Yes, it is. It does cater for adult and child. The basis of the study that I put in with the submission was specifically looking at spouses with—I do not think it covered drugs; I think it related specifically to heavy alcohol use. I guess that was just to isolate the study area.

Mr ANDREWS—What is the nature of the program itself? What is the underlying paradigm of the program?

Ms Churchill—It is emotive behavioural therapies. It utilises the social learning model and hence the group therapy. That is enhanced and supported by one-to-one counselling throughout that time. It is not ideal for parents, put it that way. I think a parent specific program is the way to go. We do not have funding for that. It is something that I am trying very hard to get. But I think the parent issues are different from spouse issues. I think the issues of self-blame and grief are far more significant for parents.

Ms HALL—Do you use any systems counselling as well in the program or just the emotive behaviour?

Ms Churchill—It is a family systems model that we have with Holyoake, and that is good. People identify very strongly with that because they look at their role within it and start to be able to question some of the choices that they are making.

Ms HALL—You do a crossover?

Ms Churchill—Yes.

Mr ANDREWS—Is your anecdotal experience of the results and outcomes similar to what the study shows?

Ms Churchill—I would say with partners, yes; I am not sure with parents. I know that to see the parents as clients in their own right, absolutely, the stress levels come down and the self-blame starts to reduce. Overall, I would say there is an improvement in communication rather than knowing whether there is a reduction in use for the young person, but I think that is well on the way to getting things moving.

Mr ANDREWS—A final question: apart from here and in Western Australia, is this program presented anywhere else in the country?

Ms Churchill—Yes, there is a Holyoake service in Brisbane. There are also services in Newcastle, in Sydney and in Alice Springs.

Mr ANDREWS—I take it from what you are saying that there is no national umbrella body of programs that are what I would call educational/therapy programs for addictions. There is no national umbrella body for agencies and organisations presenting these programs; is that right?

Ms Churchill—For the Holyoake model or just generally?

Mr ANDREWS—No, more broadly.

Ms Churchill—No, not that I could cite.

Mr ANDREWS—For example, in marriage counselling there are a number of national organisations. There are some umbrella organisations in marriage education and family therapy but there is nothing in this area.

Ms Churchill—Not that I am aware of.

Mr ANDREWS—Would it be desirable to have something? I am just thinking off the top of my head now, but it seems to me there is a role for government in sponsoring that type of organisation, seeding it to get going?

Ms Churchill—The Australian National Council on Drugs has been having some discussions on that and has been particularly looking at a national system for families in this situation, yes.

Mr ANDREWS—Thank you.

Mr Dixon—I would like to return to a question asked before and that is the question of the program that we give to parents—we do want to expand that area but we do not have the dollars. So we cannot employ the people to work in those areas. You were asking the previous group about getting into the small country towns. We would desperately like to do that, but you have to have money. I realise there is a finite limit to government money. I had 40 years in government so I know what is attainable. But we can offer it so much more cheaply than government—that is the other point.

Ms HALL—Is it a problem with the submission based type of funding that is available?

Mr Dixon—The answer would be yes. But not only that; have you ever seen the things that are sent out to you to apply for funding—50 pages of them?

Ms HALL—Some of them.

Mr Dixon—We almost do not have the resources to do them. We in fact pay people sometimes to do those submissions. I spent my life doing submissions. At least in the private sector you are not put through that sort of wringer.

CHAIR—Could you design a form that would cut it down to about 10 per cent or five per cent of that which would suffice? You made the point about the private sector not doing this type of stuff which drive us all mad. I just wondered whether someone could design something which gets Sir Humphrey off our back and still keeps the accountability for us.

Mr Dixon—You could. Another part of my life was designing forms for the community designing.

CHAIR—Right, well, you are just the man.

Mr Dixon—But really you just wonder why some of the questions are asked because they are patently silly. You assess the program on whether it is going to deliver a service. You do not need 50 pages of questions. You all know this business where you twist the thing to say that we fit that hole. It is silly.

CHAIR—Fine.

Mr SCHULTZ—The question I am about to ask may be a bit controversial in terms of your organisation and other organisations. But my observations are that, whilst there are a significant number of organisations out there in the community that are doing excellent work in different areas of assistance, some of those organisations are duplicating each other in some of the services that they are supplying to clients. The funding situation is such that there is enormous competition between those groups for a limited funding package. Do you think that there needs to be a serious look at not so much the networking that we just talked about but perhaps an integration of groups so that the number of groups out there decreases but offers a much more positive service to the people requiring the service? I would just like your views on that, because it is a serious issue. It is compounded by the point that you just made about the smaller groups not having the expertise that larger groups have, such as hiring a person who does nothing but chasing up funding on a full-time basis. I have a concern that, whilst there are a lot of groups out there and they are delivering good services to the people in need, there appears to be too many of them and in fact the industry is growing rather than stabilising and projecting the positive outcomes for the clients themselves at the coalface. It is a longwinded question and observation, so I would be interested in your comment.

Ms Churchill—It is a difficult question to answer.

Mr SCHULTZ—That is why I put it to you.

Ms Churchill—Thanks. As our core programs, most of the services have identifiable areas that are not overlapping but, to get the funding in, we are all scrambling and trying to fit ourselves in and then the overlap starts. But I think as our core funding each service is offering a different thing. If we could just focus on the core programs, what we are really good at, then that funding dollar might be better spent.

Mr SCHULTZ—It is unfortunate too because, when you are at that competitive edge, it would appear that many good service providers are going to the wall and going out of the business, and the end result is that the people who suffer are the clients who are in need of the service. That is the reason why I asked the question.

Ms Churchill—Yes. Recently there has been some funding which we fitted beautifully into, but we are not big enough to submit for it.

Mr SCHULTZ—What you are saying is there should be a bit of flexibility in the guidelines related to specific programs?

Ms Churchill—And some awareness of the individual state's situation, because that might have been fine for New South Wales but in our state most of the NGOs are small. It just needs to be catered for.

Ms HALL—So you have to make yourself fit the guidelines rather than them fitting your services?

Ms Churchill—Yes, and that is where we are hoping that the peak body for the non-government organisations might assist. We may be able to put some input into how those submissions are put together.

Mr SCHULTZ—Yes, that is a very positive objective to steer yourself towards.

Mr Dixon—We have also taken a step in that direction inasmuch as we have taken on Toughlove. Toughlove is another organisation out there and we now manage Toughlove so there is already a bit of that coming in. Really there is no need for the competitive scramble because there just is not the funding.

Mr SCHULTZ—Indeed.

CHAIR—Toughlove is part of your organisation now?

Mr Dixon—Yes.

CHAIR—For how long?

Mr Dixon—About a month.

CHAIR—I will just go to a couple of things and then Harry Quick can conclude. How did the organisation of the peak body basically come about and how long ago?

Ms Churchill—We had our first meeting a week or two ago to form it. It is very new. It was the first meeting.

CHAIR—Somebody had driven this. Somebody decided that this was important for all the reasons we have just spoken about?

Mr Dixon—The one that I talked about.

Ms Churchill—Yes, that is right. One of our directors, who is also involved in the ANCD, is the non-government representative for that body and for the state. She called a group of

organisations and it was a very interesting meeting. Everyone was in agreement on nearly every issue.

Mr SCHULTZ—Yes, that is good.

CHAIR—How will you go forward? You probably do not know yet exactly but you would intend to meet as an executive on a monthly basis?

Ms Churchill—Yes. We have an interim committee. We have put in a letter of intent to form this and we will just take it from there.

CHAIR—We have talked about the stress and strain on families as well as the shame and not coping with this issue of addiction and the issues around them. This seems to indicate to me that these people are trying very hard to accept responsibility. We were talking about denial earlier. The people are really trying but they just have not got the skill or they have not got the capacity—

Ms Churchill—Absolutely.

CHAIR—and the whole cycle is just one of great pressure for those people.

Ms Shadbolt—Can I make a comment on this?

CHAIR—Yes.

Ms Shadbolt—The FOCUS program is really the core from which Holyoake operates. It is highly effective. It provides partners of people who are using with skills—the skills not to continue to buy into the problem, the skills to be able to get on with their own lives and to start working towards their own personal healing and the skills, to use a phrase we sometimes use, to detach with love.

CHAIR—I am sorry?

Ms Shadbolt—To detach with love. It is very difficult to detach yourself from the problems of the using partner. One of the main goals of the FOCUS program is to provide those skills and it is effective. It is really effective. It is almost ironic that it works so well and yet we have such a struggle to stay in existence. I think one of the reasons why that is the case is that whilst Holyoake has been in existence in Tasmania for several years it started off largely with the support of volunteer workers. We are moving away from that model now. We really have to. It is the way a lot of voluntary organisations are going and, of course, that leads to a much more critical need for funding. We got by in the past but we cannot get by on the level of funding we used to have so there is a certain irony that these other linked programs we are running are able to be funded, albeit with a time limit, but the parent organisation is struggling to stay alive and this is where we really need—

Ms Churchill—And we talk about early intervention. This is just an ideal intervention point and it is being missed. It is the most willing client base you will ever find and the strategies—

CHAIR—They are raring to go.

Ms Churchill—Absolutely. Your statement about taking responsibility—that is where we are pulling the parents back. They are taking responsibility for the lot, rather than taking responsibility for their wellbeing and allowing their young person to feel some of the consequences of the choices that they are making. They are just coping strategies that, after a long time, can often turn into problems.

CHAIR—Tasmania and Hobart may not be the ideal place, and this is something I should have asked in other states, but it seems to me that while the community and government are always there—and we all know there is always a call on government, as the people's representative, which is entirely appropriate—that industry has a responsibility. Tasmania may not be the appropriate place to suggest that, because it is tough enough. I just raise that, and you may not have a comment on it, but it seems to me now that industry has a vested interest in it for a whole range of reasons, and some of them are within our terms of reference. Industry could consider, in some way, how it might provide support.

Ms Churchill—We have 50 per cent support from one industry in our funding terms for our FOCUS program, through a signed bequest from Boag & Son Brewing Ltd. We have received money from Rotary, and ANZ Bank has given us some money this year, but it is difficult in Tasmania.

CHAIR—The next part of it is the welfare component. It has been put to me that—and this is not perhaps in your brief; it may be more appropriate to ask another NGO—in terms of rehabilitation and perhaps even detox, maybe there should be some connection with the welfare system in terms of management of clients. Do you have a view about that?

Ms Churchill—I think all parties need to communicate better.

Ms HALL—We were talking about funding and the fact that you missed out on funding from the community fund. What is that community fund?

Ms Churchill—That community fund is from the sale of the Trust Bank. It was funding that was put aside to go into the community as a result of the sale of the state Trust Bank.

Ms HALL—Is the funding six-monthly, every year?

Ms Churchill—Yes, this is the second lot of funding. We put in for funding for a parent program both times. The first time the funding went more to bricks-and-mortar programs. This time, I do not know what happened to it.

Mr QUICK—You did not make the list, unfortunately. Alby has had a look. Sorry.

Ms Churchill—You got me a bit excited there.

CHAIR—The research report out of Wollongong refers to the creation of a 'waitlist' control group re the 43 study participants put through the FOCUS program. There were 40 males and 3 females, as I recall. What do you mean by 'waitlist' control in the FOCUS control group?

Ms Churchill—I cannot say.

CHAIR—That is fine. It is just important to try to understand what sounds like a very good program. You might give something to the secretariat if you have a few minutes.

Ms Churchill—Yes.

CHAIR—Perhaps we should communicate regularly with the Wollongong people.

Ms Churchill—There were two groups: immediate entry and the waitlist control.

CHAIR—Yes.

Ms Churchill—I guess that would be where we would be saying, 'In three or four weeks time, you will be coming into this program.' I do not know why they would make the distinction in the study.

Mr Dixon—Bear in mind that it is based on our Western Australian counterpart. If you are going across to the West—

CHAIR—Yes, we were there last year and we will be revisiting everywhere before we finalise our report.

Mr Dixon—That is based on the program we offer.

Mr QUICK—On the third page of your submission, you mention the World Health Organisation's European Charter on Alcohol, which I think is a wonderful mission statement. I have just made a few additions and deletions which I think might be incorporated in our interim report. The charter says:

All people have a right to a family, community and working life protected from the negative consequences of alcohol consumption.

All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption.

All people with hazardous or harmful alcohol consumption and members of their families have the right to accessible treatment and care.

I have changed that to:

All people have a right to a family, community and working life protected from the negative consequences of drug addiction.

All children and adolescents have the right to grow up in an environment protected from the negative consequences of licit and illicit drugs.

All people with hazardous or harmful addiction and members of their families have the right to accessible treatment and care.

I think if we do nothing else but adhere to those three dot points, and put in place a framework realistically with the NGOs, state and Commonwealth governments, we will go a fair way to addressing some of the problems.

Ms Churchill—And really highlighting that area of need which I do not think is well identified.

Mr QUICK—Finally, could I put on the official record my appreciation for the excellent work that you do.

Ms Churchill—Thank you.

Mr QUICK—One of my staff here is on the board. If I do not get to meetings first-hand Cheryl keeps me informed. I have a real vested interest in the work they do. I would like to congratulate the organisation for the wonderful work they do.

CHAIR—Well said, Mr Quick. I can only endorse those words.

Mr Dixon—There is just one thing I would like to say. On the question of funding, one of the current trends, particularly in Commonwealth funding, is that you get seeding funding for three years, after which there is no funding. It is going to come from 'there', wherever 'there' is. You talked before about the private sector. The private sector has run dry for begging charities, which we are. I know our counterparts in other states are funded much more extensively than we are. We are talking up to 80 per cent in some cases. It is a foolish move for government to wander out and set up bodies with funding for three years, at the end of which your funding dries up. I belong to another organisation which has a very real threat over it. It is an excellent organisation with good beginnings.

The state does not have the money. This little state does not have corners of reserves that other states have. It is not just Tasmania crying poor; we are little. We have a population the size of probably Bankstown, so we do not have that residual money that government can give. A lot of it has to come originally from the Commonwealth if funded through the state as the administrator. There are going to be bodies within the next year or two looking for money and competing further for this pool.

Mr QUICK—So should we convince the state government that, say, two per cent of gambling revenue can go into another bag of money to provide money for organisations like yourselves?

Mr Dixon—Yes, because we do deal with addicts of gambling. The talk here has been mainly about drugs and the prevalence.

CHAIR—I think it is broader than that. Harry is right in terms of the alcohol issue and the drug issue. Because it is the issue around illegal drugs it is not an obvious revenue base. Well, it is an obvious revenue base, but how do you round it up? This is where I come back into it. I do

not quite agree with you on money. I preface my comments by saying: this is probably the worst state in which to make those comments. We are learning as we go. It seems to me that industry has a stronger function, including the alcohol industry. We have had some submissions from the wine industry. Some say they are concerned that there is a degree of self-seeking in a lot of the presentations. Therefore, the focus that this inquiry needs to bring in terms of taxation revenue—the sort of model that Harry is talking about—is very important. Take into context the smaller states and the state differences. That is something that we really do need to address. I believe that industry has a responsibility and there is a capacity within consumers and hotels or clubs or gambling institutions to acknowledge that someone is going to pay for it somewhere.

Mr Dixon—We have two breweries. One is Boag's. The largest brewery is Cascade, which is owned by Carlton United. Carlton United is not headquartered in Tasmania; it is headquartered in Melbourne. You name the industry headquartered elsewhere. That is our problem which differs from the other states. Management tends to see inside their own bailiwick.

CHAIR—I am from South Australia so you can appreciate that we—

Mr Dixon—Have exactly the same problem.

CHAIR—Yes. So I think it is something we need to address in terms of sovereignty. Melbourne maybe does not have quite the focus on Hobart. Remind Melbourne that there are some pretty keen consumers down here as well.

Mr Dixon—They are a very egocentric state.

CHAIR—On that note, thank you very much.

Proceedings suspended from 12.31 p.m. to 1.30 p.m.

HOWARD, Ms Katherine Anne (Private capacity)

IKIN, Ms Lucia (Private capacity)

JEANNERET, Mrs Carolyn Mary (Private capacity)

MULLAN, Ms Denise (Private capacity)

AMES, Mrs Nell, Chairman, Management Board, Your Place Inc.

TONKS, Ms Melinda, Manager, Your Place Inc.

BOYER, Mrs Jennifer, Deputy Manager Pharmacy, Royal Hobart Hospital

WALKER, Ms Elizabeth Mary, Registered Midwife, Women's Health Clinics, Royal Hobart Hospital

BRUNO, Mr Raimondo, Researcher, School of Psychology, University of Tasmania

BUTTERS, Mr Tony, Deputy Manager/Case Manager, Launceston City Mission, Missiondale Therapeutic Recovery Centre

CROWLEY, Dr Michael James, Senior Clinical Psychologist, Alcohol and Drug Service

HAM, Ms Susan Jane, Chief Executive Officer, Colony 47 Inc.

JACKSON, Dr David, Senior Staff Medical Officer, The Hobart Clinic

McKEOWN, Ms Cecile Ann, State Manager, Alcohol and Drug Services, Department of Health and Community Services

MASON, Mr Ron, State Manager, Drug Education Network

MURPHY, Ms Esme Joy, State Project Officer, National School Drug Education Project, Department of Education—Tasmania

ROBERTS, Mrs Betty Ann, Member, Hobart City Branch, Catholic Women's League of Tasmania

SPEED, Mr Anthony David, Acting Assistant State Manager, Commonwealth Department of Health and Aged Care

CHAIR—Welcome. The committee does not swear in witnesses in a formal way, but the proceedings today are legal proceedings of the parliament and as such they warrant the same respect as the proceedings of the House of Representatives. I ask the people who are here in a

private capacity to make three-minute statements, and then we will go to those who are representing organisations.

Ms Howard—I am 44 years old and I grew up in Hobart. I am here to represent the average person and the youth of today. I have had a variety of circumstances in my life that have involved the abuse of multiple substances—growing up in an alcoholic environment; consuming cannabis at the age of 11; practising actively as an SRN for 25 years and administering narcotics, and at times nearly abandoning patients at the end of that process; living with a chronic cannabis user; and having cannabis grown on my property twice, with resultant police intervention and court proceedings. I currently have a 21-year-old son in rehab for multiple substance abuse, which he has had from the age of 13. I have a stepson with a $3,000-a-week speed habit living in Victoria, and my door is always open to any youth in crisis who actively seek my help.

I have 13- and 15-year-old sons who are currently living with me full time, and I feel passionate about being able to place them into society without any destructive habits. My personal experiences lead me to believe that the majority of people who use substances rarely investigate why, but when they have the courage to honestly probe inside themselves they appreciate that these are their antidepressants of choice in a world that to many is hopelessly out of control. I find once people realise this process they can then give themselves the option of responsible choice, and this allows them to function with a manageable habit. The key is, of course—as it is with so many of the basic issues in our lives—self-esteem. I believe we need to legalise marijuana because we have to get it out of the black market and out of our schools, we need to rebalance the revenue, and we need to allow appropriate research to be conducted so that standards can be implemented. We need to radically change our education system so that the focus is on self-esteem and real life skills, allowing the option of positive life choices that would lead to wanting to learn. I believe legalisation would show a marked improvement in Australia's overall mental health with the disappearance of the inevitable paranoia that accompanies criminalisation and the 'us-them' mentality.

I choose to use the scouting movement as an active tool to supplement what I am trying to achieve in my home with my two youngest sons. As a sole parent, I appreciate the positive adult male role modelling they receive. It is the only youth program that caters to the whole individual, nurturing every aspect—social, mental, physical, creative, spiritual and environmental. It also provides them with a very strong personal mission statement.

Ms Ikin—Thank you for inviting me to be part of this roundtable discussion on substance abuse. I am doing so as a private citizen. I am the mother of three sons. I am also a qualified special education teacher and serve on a number of boards of management, such as TASCOSS and Volunteering Tasmania. My knowledge base comes from experiences in the area of illicit drug use. Two of my sons have become heroin addicts. They were young Tasmanians off to greener pastures in Melbourne. Although one almost did not make it, both are recovering addicts now. One is back in Tasmania permanently and the other is in Melbourne wishing to come home if there is a job. Both detoxed here in Tasmania.

My experiences are with on the ground, direct dealings and situations of what it is like to be a parent of an addict and what it is like if you are an addict who wishes to dismount from that lifestyle. I am not sure how many users are part of these discussions, but we must listen to their

stories to hear their needs and voices. I speak about my sons who know they have ongoing support from me, but how many others live incredibly sad lives—young people without a safe, reliable, consistent and caring place to go? According to one local professional I spoke with, that is about 99 per cent of recovering addicts—and that is alcohol and illicit drugs.

I would like to just give a quote from my son to highlight some of the issues. I will give you a comment made by my son, who recently went through detox here in Hobart to get clean from methadone. As he left to go back to Melbourne after two months at home he asked, 'Why did no-one get in touch with me? Why wasn't there a follow-up? What about all those alcoholics who are coming back all the time? No-one noted that I am clean. If I had not been able to stay in a safe place, I would have been pounced on by the dealers.'

There is really so little time, but there are a whole lot of issues that I have come across in the dealings with my two sons. I will just give you the issues, rather than the stories, but they are all backed up by personal stories. There is a need for more support for home detox, a need for more residential services and a need for more shelters—male, female, mothers and children. There is specifically a need for dry shelters for people who come out of detox and have got nowhere to go. They could only go to a shelter where drugs and alcohol would be. There is a need for halfway houses, there needs to be attention for medical services, particularly psychiatric and dental care.

What I would like you to take back to Canberra—because it is important—is that services here need to be integrated and cooperative. They need to refer clients to one another. Services exist for clients, and we need to seriously reflect the lifestyle of clients and not operate only from nine to five. Services could provide more options for treatment if there was more funding. The federal government expends money in the areas of education and prevention, research and treatment, as well as the criminal justice system, but is that in balance? I hope that through education and awareness we can change the perception in society that problems associated with illicit drugs are always criminal—in other words, to promote a view that problems we as a society are faced with are not always related to criminality, but are aspects of individual and community health.

CHAIR—Thank you very much. It is very difficult, isn't it, to define that in such a short period.

Mrs Jeanneret—I am a social worker. I am appearing as a private citizen. I have a particular focus on and interest in at-risk families. I engaged in residential care before I did my degree in the early nineties, and I am a mother of four. I will be addressing issues to do with substance abuse problems with identified at-risk families in general and, in particular, service delivery. I will start with some points from Norma Finkelstein. According to Finkelstein, families with substance abuse problems, particularly those with young children, 'need programs that provide coordinated, comprehensive and family centred care.'

Research—as addressed in the submission that I was involved in and as borne out constantly in practice—shows that these programs need to cover the following five foci of intervention: one, substance abuse management, with varying options; two, parenting support and help and/or training where needed; three, concrete practical assistance, such as housing, child care, moving away from a dangerous environment with dealers and peer group, household goods at the most

basic level at times, and a host of other resource needs; four, personal development, including therapeutic needs, relationship issues, recreational needs, skills training and spiritual needs; and, five, social and service network strengthening—for example, integrated programs and planning, collaborative partnerships that focus on a balance of early intervention, and restorative programs with effective alcohol and other drug support. I would like to thank St Anthony's, Melbourne, and McKillop services for the identification of those five foci, and I give them the credit for them.

Programs should be holistic and empowering for families, with a focus on safety and optimum developmental opportunities for the children. Programs need to cover all three levels of treatment programming. Each of the treatment programs should include those previous five points. The three levels of treatment programming are: one, intensive at-home support and outreach; two, day centres with parenting support and peer support and child care attached; and, three, live-in programs. Staffing at all program levels requires intensive interdisciplinary and interagency collaboration, including family therapy, family support and parenting workers. Without adequate staffing and without adequate funding we cannot provide these resources for the at-risk families. If we are to maintain hope for families at risk, ensure safety for the children and maintain a positive fabric in our society, we must find ways to have a commitment to find the financial resources and bureaucratic means and look at new approaches and innovative thinking, as well as restructuring our health and human services delivery system to support legislation for these families.

Ms Mullan—My son hanged himself in Risdon prison on 10 January 2000. He suffered from schizophrenia which was induced by 12 months of marijuana abuse. I discovered through this experience that only once did a small window of opportunity present itself in which Fabian willingly sought help and treatment before embarking on a path of self-destruction and harder drugs. This path on the whole was taken to mask the symptoms of schizophrenia but in fact exacerbated them considerably. Had a specialised facility been more readily available at the time, I believe the end result may have been different. What is needed is a unit where these people can attend, be monitored, counselled, have treatment commenced and monitored until a structured release program is put in place to get them through the initial frightening phase—a unit where family members are also educated and counselled so that they are well-informed and able to cope with what lies ahead.

When parents are first confronted with either drug addiction or co-morbidity, the first question is: where do I go from here and to whom? If these carefully chosen specialists are either unwilling are unable to assist in the immediate future, then it can be pretty much all downhill from that point and parents face watching their child self-destruct in front of them, powerless to help. We need to have more counsellors, doctors and psychologists trained in dealing with the co-morbidity condition and the associated problems.

I have been fortunate in being able to listen to nursing staff and counsellors discuss this topic, and I am floored by the lack of understanding exhibited. I am left wondering what hope these kids have if the very people looking after them lack the understanding and the in-depth knowledge of the problems that they face. If anyone had previously suggested I may have been able to contribute I would have thought my knowledge inadequate. I have since learned that experience is an excellent teacher. Because Fabian was an inmate at Risdon Prison I have a passionate interest in the rehabilitation of the offenders over there. I am taking steps towards

that, anyway. You would have gauged by yesterday that they definitely need more rehabilitation and treatment. If they are going to cope in society when they come out, it is mandatory that they have a more structured program while they are inside.

Another problem I have is the prescription of legal drugs by doctors and the way in which they deal with that. They have a responsibility to the community and also to these children. Fabian was given legal drugs by these doctors which made his condition worsen considerably. There were times when those doctors were asked to butt out because they were interfering with the treatment he was already on, and that should not be necessary. We do need to have a link with the medical profession so that if these kids do go ‘doctor shopping’ they are picked up very quickly.

I was also fortunate to have Dr Clive Stack as my counsellor during this time as he was able to assist me in understanding Fabian’s behaviour. He also has his own program that he tries to undertake on a limited budget where he counsels these kids and their families. The counselling of the families is crucial. It is not a disease of one person, an addiction for one person; it is a family disease.

CHAIR—Thank you. We will now hear opening statements from the representatives of organisations.

Mrs Boyer—I am here as the Deputy Manager of the Pharmacy Department of the Royal Hobart Hospital. I have not come with any prepared position. I have a co-worker from the Royal Hobart Hospital who will speak when her turn comes. I am happy to contribute to discussion or answer any questions as appropriate.

CHAIR—Thank you very much. I think we will get everybody to contribute and then come back with questions.

Ms Walker—I am a midwife at the Royal Hobart Hospital. I work in a clinic that has been set up for chemically dependent women who are pregnant. This clinic was started in about 1995 by one of the consultants who saw a significant rise in the number of people who were admitting to drug use—that is, legal and illegal drug use. There was nothing being put in place until a baby was born and then it was obviously having problems because of the mother’s use of drugs. This consultant started seeing these ladies initially and then got one of the midwives to help him. It was then apparent that some of these clients also had social issues, so the social work department was asked to help as well. It slowly grew until, for the last two years, we are also having help from our drug and alcohol nurses. We have started taking statistics, which I will give you now.

The number of clients for the year 2000 was 46. We have broken that down into age ranges: 15 and under, there was one; 16 to 20, there were 13; 21 to 25, there were 20; 26 to 30, there were eight; 31 to 35, there were two; and 36 and over, there were two. We had 25 primps and 21 multips. The first time we saw them: under 10 weeks, there were four; 11 to 15 weeks, there were 20; 16 to 20 weeks, there were 12; 21 to 25 weeks, there were four; and 26 weeks and over, there were six. The average number of visits for these ladies was eight. The breakdown of drugs involved—some of these ladies were using more than one type of drug—is marijuana 31, speed 22, methadone 11, benzos four, alcohol three, cocaine two, heroin one and ecstasy one.

These are from the people who will disclose this information to us. There are people who do not disclose information and, until their baby is born, we are not aware that they are using drugs.

Of the 46 clients involved, four had Aboriginal heritage, eight were hep C positive, four had to have assistance from intake and assessment, and five had babies requiring medication following birth. Thirty-nine of these babies were born at term; one was born at 35 weeks; one at 32 weeks and one was a foetal death at 22 weeks. Of the Apgar scores at birth, which is a score out of 10: 38 were nine; one was two; one was six; one was three; and, one was five. Three of these ladies subsequently delivered interstate and, as I said, one had a foetal death.

Mr Bruno—Together with Professor Stuart McLean from the School of Pharmacy, I am responsible for the Tasmanian arm of the Illicit Drug Reporting System, which, until recently, was a national monitoring system designed to provide information on emerging trends in illicit drug use. I am sure the committee has been briefed about the idea as to its findings, so I simply have two brief points to present. The first is that continued, concerted and systematic drug trend monitoring at a jurisdictional level is critical for the continued development of drug policy that is responsive to the needs of our local communities. This issue is of particular importance locally. Our studies such as the IDRS have indicated that Tasmania has a fundamentally different pattern of drug use in comparison with other jurisdictions.

So it is inappropriate for states like us to rely on data and trends coming from different states and to base our policies on that data. Continued support for such monitoring is critical as Tasmania simply does not have the infrastructure to do this work otherwise. Unlike other states, we do not have any specialised research bodies investigating drug and alcohol issues such as Turning Point in Victoria and NDARC in New South Wales. Simple reliance on data collected from the government and the NGO sector is also not feasible as, due to the workloads and pressures on the staff involved, routine information collected at an agency level is often highly variable in quality and provides a piecemeal picture of the issues faced within the state.

The second point is that the 2000 IDRS found that, in addition to the existing high level of injection of pharmaceutical morphine, last year saw an apparent large increase in the injection of benzodiazepines, in particular the gel capsules of temazepam, within the local injecting drug user community, with over a third of those sampled in the study injecting the drug in the first six months of 2000. Because both these preparations are known to cause a great deal of long-lasting physical harm through the unintended injection of particulate matter, including vein and lung damage, this is a very serious health issue within the injecting drug user community and some very carefully considered action needs to be taken as a high priority to reduce the harms associated with this particular drug use. If no action is taken, these issues will not only cause a huge personal burden to the users but will also produce a very costly burden on the public health system in the coming years. Experience with such use of morphine in the Northern Territory has shown that steps to reduce supply have had virtually no impact on the level of use, but simply have served to increase the cost of the drug to users.

Possibly the only pragmatic solution is to make appropriate safe injecting equipment such as pill and biological filters more readily available within the state's needle availability program. The experience from local outlets suggests that users do care about their health and are very willing to use such equipment appropriately but they can only do so if this option is made available to them. However, these solutions are simply not possible within the current level of

funding for the state's needle availability program, and the support for such public health initiatives may need to come from other areas as a matter of priority.

Mr Butters—I am the Deputy Manager of the Missiondale rehab centre in Evandale in the northern part of Tasmania. We are the only non-government funded rehabilitation centre in Tasmania. We are fully funded by the Launceston City Mission, and we have been working since 1997. We started in 1997 taking in males only. In October last year, the Queen's Trust approached us and asked us if we would be interested in taking on ladies. They advanced us $5,000 to do that. We now have ladies in the program. We currently have 15 males and four females, ranging in age from around 19 to close on 60.

In the last 12 months we had nearly 60 males go through the program. They stayed with us for a period of two weeks to a maximum of about four months. Our program actually runs for 12, but we cannot make them stay; if they want to leave they are entitled to do so. We are currently receiving a grant from the sale of the old State Trust Bank of $200,000. We have now got to find $100,000 to upgrade the facilities to increase the ladies program to 15. To do that we need more staff. We only have three full-time staff and two part-time staff. For the rest of the time we rely on volunteers. We do not receive any funding. We are struggling at the moment and anything that the federal government or the state government can give would be most appreciated.

Dr Crowley—I am the Senior Clinical Psychologist at the Alcohol and Drug Service in Tasmania. I have been in that position for the past six years. Our agency, as a state government service, has community centres in the south, the north and the north-west of Tasmania. There is also a 10-bed detoxification unit in the south. Our community centre in the south has a psychological unit, an education and training unit and a team of community workers who do outreach, community development and health promotion work. I have substantial input into the nature of the counselling undertaken at our service so I would like to take these few minutes to scratch the surface as to what may be at the core of much of our clients' substance abuse.

We have experienced the paradigm shift that has been fundamental to changing the way that we work in Tasmania. My training in clinical psychology involved the process of being immersed in the language of pathology and the perspective of dysfunctionality. We are trained to seek out disordered thinking patterns, irrational beliefs, dysfunctional behaviours, et cetera. However, when I listened carefully to my clients, I was struck by the manifest functionality of their behaviour.

In our agency, working with clients who present with substance use issues has led us to the realisation that our clients do not have alcohol and other drug problems but rather alcohol and other drug solutions. We realise that the most useful question we can ask is not, 'What is the dysfunctionality of our client's behaviour?' but rather, 'What is the functionality of their substance using behaviour?' from our client's perspective. When we explore this, what invariably emerges as a major function of their substance use is to do with attempting to get some sense of control in their lives—for example, temporary relief from the negative thoughts and feelings which keep making one's life seem out of control. One of the things they generally do not have control over is how to feel good about themselves.

The difficulty with substance use comes when the client loses control of or perhaps loses the motivation to control that which he or she used to establish a sense of control in the first place. Many of our clients also present with co-morbid anxiety and/or depression for which the perceived lack of a sense of control over events is increasingly being recognised as a central issue. While many of our clients come from family environments of pervasive uncontrollability and unpredictability and lack a sense of personal control, they may then have to contend with elements in our systems and processes of service delivery that are further disempowering.

Martin Seligman, in his recent presidential address at the American Psychological Association Convention, said that to do effective prevention:

We need practitioners to recognize that much of the best work they do is amplifying the strengths rather than repairing their patients' weaknesses.

He then said:

I propose that we in psychology reorient ourselves from being a victimology to becoming a positive social science.

So the empowerment approach that we use and that we have adopted focuses on helping the client identify strengths and then amplifying those strengths. Positive changes from one session to the next are related to the client's personal agency. Over the past two years I have trained over 450 practitioners throughout Australia in this approach. Many of those practitioners and some whole agencies have adopted this way of working. I have now evaluated this work with two groups of Vietnam veterans with multiple issues including substance use issues and have had very positive and enduring outcomes with both groups.

Ms Ham—I am the Chief Executive Officer of Colony 47. Colony 47 is an independent non-profit community organisation providing a range of services to people who are homeless or at risk of homelessness and people who are facing barriers to participation in society, particularly because of issues relating to employment, training, housing or isolation and lack of social and family networks. While Colony 47 does not provide specialist services for those affected by substance abuse, the issues around substance abuse do have a significant impact for many of the people who use our services. I just want to talk briefly about some of the services that we provide and the impact in those areas.

On services for people with mental health issues, we provide Contact and Oasis services. We see the daily impact of the combination of illicit drugs and medication for mental health illness by some clients that have resulted in attempted suicide, family breakdown and depression. But there is a very inadequate group of support systems in the community and we need to break down the barriers between mental health funding and drug and alcohol funding in this state as well as federally. Substance abuse amongst clients with mental health issues has also exacerbated their social isolation and marginalisation from the mainstream community. This further impacts on their ability to develop and maintain stable relationships with immediate and extended family members.

In relation to our employment services, many of the young people attending Colony's JPET program have been affected by substance abuse. Substance abuse results in young people becoming isolated from their family and siblings and significantly increases their risk of homelessness. It also increases the complexity of barriers that prevent them from achieving their

educational and employment goals. Again, there is a very inadequate level of resourcing for these sorts of programs. A number of people in Colony's community support program are affected by drug addiction and some of these clients are participating in the methadone program. There are a limited number of pharmacies and GPs who participate in that methadone program and participants are finding it quite difficult to access this program and are facing negative attitudes of some health care professionals. Such barriers impact on supporting those people beyond these issues to address some personal goals which will lead to increased participation in the community.

On our community services and housing services, substance abuse is a consistent underlying factor in tenancy failures. Housing debts are now in the thousands rather than hundreds of dollars. Other debts such as to Aurora and Telstra are also increasing. Money spent on substance abuse means that the poverty trap is impossible to escape. It is also placing far greater pressure on every day release and community service.

On an organisational level, Colony 47 has felt the impact of substance abuse through worker, health and safety and productivity issues. In mental health work sites the effect of client substance abuse on workers is enormous, with staff unsure what to expect from clients coming off the street, and the unstructured nature of those services places workers at continual risk. Clients are also sometimes afraid to leave their houses because of neighbourhood disputes, violence and fear of drug dealers, again placing our Colony 47 outreach workers at greater risk. We need more resources in the community sector and additional training and skills for those people providing a broad range of services to people affected by substance abuse.

Dr Jackson—I am the Senior Staff Medical Officer at The Hobart Clinic, a private, not-for-profit, psychiatric hospital. It is a 24-bed unit which deals with inpatients, outpatients and clients of the Department of Veterans' Affairs. The clinic provides a fully integrated service for both patients with mental health problems and alcohol and drug problems such that there is a staff psychiatrist, staff medical officer, two psychologists, well-trained nurses and a community nursing service all provided from the one unit.

The main point I would like to make about The Hobart Clinic is that it is very rare to have a patient with a purely psychiatric mental health problem. They nearly all have a coexisting alcohol and drug problem. Many of the patients we see have a pure alcohol and drug problem, so the main point I would really like to make is that we believe the clinic provides a model through which a fully integrated service for people with pure alcohol and drug problems right through to people with major mental illnesses and associated alcohol and drug problems can be treated. A corollary to this, but it is a secondary point, is that we see—and I particularly see because for nine years before working at The Hobart Clinic I worked in the public Alcohol and Drug Service—a totally different standard of treatment provided in the public sector where there is a total separation of mental health patients and alcohol and drug patients.

The alcohol and drug patients are probably on a lower rung than the mental health patients as far as stigmatisation and the provision of facilities, at least partly because, in this state anyway, they are a totally politically powerless group. In the nine years that I worked for the Alcohol and Drug Service services went backwards and, from my observation from the private sector now in The Hobart Clinic, they continue to go backwards. Somebody else has already said that

Tasmania has peculiar problems particular to this state and quite different from the mainland. Different solutions and different research is required.

Mr Mason—I am the Manager of the Drug Education Network. I am going to describe the services that our organisation provides. The Drug Education Network is a non-government state-wide organisation providing alcohol and other drug services to the Tasmanian community. We have offices in Hobart, Launceston and Devonport and have been operating within the sector for the past 15 years. The Drug Education Network fully supports and operates within a harm minimisation philosophy, including prevention and harm reduction, and approaches all of its work from this philosophy. Our primary target group is young people and all those who come into contact with young people. As you can imagine, this includes a whole raft of individuals and groups including teachers, parents, young people, youth and other allied health workers and service providers both within and outside the alcohol and drug sector.

The Drug Education Network provides basically two programs. The first program is school drug education and the other is community development/education. During the last two years we have been working on a collaborative basis with the education department around school drug education, so I will defer to Esme Murphy to describe that project. As I said, our other program is community development and/or education. Under that program we offer a number of services. The first one is brief interventions. The DEN is a provider to the illicit drug diversion initiative operating in the state. As well, we offer as part of our core business one-to-one brief intervention sessions to individuals who may be experiencing a drug-related issue. A large proportion of clients accessing this service are parents or family members of a person who, from their perspective at least, is experiencing a drug-related issue. Where more intensive or ongoing support is required we refer to the appropriate agency. Our brief interventions are conducted in a number of scenarios. It could either be that someone comes into the office, someone rings us or, especially as it relates to at-risk young people, we will conduct these sessions on an outreach basis.

The DEN also provides a number of information sessions and has long conducted these sessions and workshops for parents, teachers, students and other community groups around alcohol and other drug related issues, including the provision of strategies to minimise harm. A notable example of this has been the Making a Difference Program, which has been a collaborative effort between the alcohol and drug services and the DEN, which now delivers parent information sessions in a consistent and uniform manner.

Lastly, we provide training to allied health professionals within the sector, and this too encompasses a large proportion of our work. The groups that we work with might include, for example, Northern Group Training, TAFE Tasmania, youth groups and centres and neighbourhood centres. Our audiences range from pharmacists, carers, welfare workers and youth workers to other alcohol and drug workers.

Ms Murphy—I work for the Tasmanian Department of Education and I manage the Commonwealth funded National School Drug Education project, a four-year project that began 18 months ago. It supports schools to comprehensively review their approaches to drug issues on a range of fronts. The obvious ones are: policy and protocols, curriculum and professional practice of teachers, support structures for young people in relation to getting into trouble with drugs, connections with family and community, and the extent to which family and community

are involved in the school and in decision making for young people. Most importantly, this project asks schools to examine the extent to which they broadly support the capacity of young people to make good decisions in their lives, to grow into strong adults, to believe in themselves and to do all the things that people have been talking about around the table.

Schools can make a difference for a lot of kids. School is just about the only institution left which provides some sort of structure and predictability for kids. Schools have clear expectations of kids in a way that a lot of the world does not. They offer a set of values where churches and other institutions, even the Boy Scouts, seem to have lost their capacity for that kind of reach. We know from good research what the risk and protective factors are that can make a difference for young people, and we know how schools can maximise the protective factors to support kids in the way I have described.

A contingent project has developed to help schools focus on making that kind of difference for kids. It is called the Health and Wellbeing Project, and it draws together four Commonwealth strategies which should have been brought together in the first place: the School Drug Education Strategy, the Sexual Health Strategy, the Youth Suicide Prevention Strategy and the Mental Health Strategy. This recognises that they all have one major feature in common—that is, they are all about supporting kids and teaching them to manage their lives well, to manage relationships and to cope with life's difficulties in a positive manner. They are about teaching resilience and creating kids who know what to do when life gets tough and how to bounce back.

We train people from around the state and from all education sectors to work with schools in relation to all four Commonwealth strategies to focus on that core issue. The project looks beneath the layers of what is going on out there in society and why kids are doing drugs and says that the broad social and emotional wellbeing and health of kids are at the core. That is the issue—that kids do not do drugs if they are in fine shape. They will not take sexual risks, they will not self-harm and they will not suffer depression if they are in fine social and emotional health. How do we maximise that?

The work of the education department aims to shift school cultures to focus on teaching young people, not on teaching subjects, and to show schools how to support kids to grow into healthy, participating, strong and resilient adults who do not need to use drugs as a means of controlling their lives. Their lives are out of control, and Michael referred to that before. We think that is what is going to make a difference in the long run—working at the early intervention level and changing the culture.

Mr Speed—I am pleased to have the opportunity to address the committee on behalf of the Department of Health and Aged Care. There is no doubt that the social, personal and economic impact of the misuse of alcohol and other drugs is a significant burden on the Australian community, particularly in the context of health care costs. However, I would like to address my introductory comments primarily towards problems and approaches to illicit drug use and note some of the collaborative actions that have been taken here in Tasmania.

The evidence presented in the Illicit Drug Reporting System demonstrates, notwithstanding the considerable efforts of governments, that illicit drug use in Australia has increased. Population surveys indicate that lifetime cannabis use in the 14- to19-year age group may be as

high as 45 per cent. The use of ecstasy and amphetamine type stimulants appears to be becoming more widespread amongst teenagers and people in their 20s. Heroin related deaths and overdoses have increased markedly. Poly-drug use and injecting as a preferred method of administration are becoming more common practices. Finally, the age of initiation for those who experiment with drugs seems to be trending downwards.

In summary, there are some worrying trends in the diversity of drugs available, their patterns of use and the harms they are causing. Why is this so? On the supply side, global production of heroin and cocaine has been growing steadily for many years. This is contributing to the increased availability of these drugs in Australia. Prices have been falling and drug purity has been increasing. Whilst Tasmania does not have the heroin and cocaine prevalence of some of the larger metropolitan cities, indications in the *Tasmanian drug trends 2000* state that mixed reports from injecting drug users have been received, but that the availability of heroin in Tasmania has, at the very least, remained stable. Australia is confronting a ruthless, well-organised and well-resourced global industry. Our extensive coastlines and proximity to opiate production and distribution centres present a particular challenge for our law enforcement agencies. This is also causing great concern in the alcohol and drug sector within Tasmania as some front-line workers feel that the state presents a virgin target for drug markets.

Notwithstanding the considerable efforts and resources applied, which have resulted in some record drug hauls, the overall picture suggests that when it comes to limiting the supply of drugs we have not yet got the upper hand. Australia is not alone in this regard; many other countries are also experiencing an increasing prevalence of illicit drugs. Factors contributing on the demand side to drug consumption are complex and often interrelated. It is certainly hard to put a weighting on the different factors at work. However, factors that seem to play a part include: particular influences, such as family stress and conflict; physical and sexual abuse; isolation from family support; and low income, unemployment and homelessness.

Some commentators also suggest that changing patterns of social influence are also shaping the decisions of young people, with a particular focus on freedom of choice, keeping options open, and living for the moment. Beyond the interplay of these specific influences, but also related to them, research suggests that in some sections of society there is an increasing sense of social isolation, insecurity, powerlessness and loss of control in individuals, families, and communities. Attempts to address this sense of vulnerability are being made through the Commonwealth government's Stronger Families and Communities Strategy announced by the Prime Minister in early 2000.

Previously, in April 1999, the Council of Australian Governments agreed to make a new investment in combating drugs by combining strong national action against drug traffickers with early intervention strategies to prevent a new generation of drug users. The centrepiece of this early intervention prevention approach is a nationally consistent diversion initiative, which targets illicit drug users early in their involvement with the criminal justice system. I am pleased to be able to tell you that in Tasmania we were the first Australian state or territory to implement this initiative, due in no small part to the collaborative approach adopted by Commonwealth and state government agencies, police and the community based sector.

The Tasmanian Illicit Drug Diversion Initiative has been operating since March 2000, and so far over 700 Tasmanians who may have otherwise proceeded into the criminal justice system

have been instead diverted into assessment, brief intervention and treatment. It is the complexity of the influences on both the supply and demand sides that explains why it has been so hard for governments, both here and abroad, to make further inroads into the drug problem. It was clear the need to do something extra, and decisively so, lay behind the Prime Minister's Tough on Drugs Strategy and the reinvigoration of the national drug strategy.

CHAIR—How are you going, Anthony? Do you want to wind up?

Mr Speed—Let me conclude: I will be happy to answer any questions the committee may have.

CHAIR—Melinda and Nell, would you like to take a minute or so each to make a statement?

Ms McKeown—I would like to comment as well—I was asked to attend today and I have a couple of extra comments over and above those I had the opportunity to put to the committee this morning.

CHAIR—Fine. The representatives of Your Place Inc. will speak first.

Mrs Ames—I am the chairman of the board of management of Your Place here in Tasmania. I was also a founding member of that board, which has been operating now of 12 years. There have been many changes over that period of 12 years. Basically, our service is dedicated to youth counselling services. We have seen a change in numbers—originally we had two clients; now we are up to several hundred. Probably the thing that affects me most—and I will pass you over to Melinda for the nitty-gritty—is the difficulty of getting people on as board members. It does not seem to be a popular area—perhaps people think, 'No, I do not want to be seen there. They will think my kids have a drug problem.' So it is very difficult getting people to go onto boards, and I have a continuing problem with this. Melinda will outline the service and what happens.

Ms Tonks—I am the Manager of Your Place Inc., a drug and alcohol counselling service for young people. When we say 'young people', it is very broad. We actually deliver a service for 12-year-olds to 30-year-olds and above, depending on where they are. We are funded to offer prison counselling and education, and that is where our above-30 age group comes from. We have one prison counsellor employed full time who is expected to service the entire prison population of male maximum and medium security, the women's prison, Hayes Prison Farm, remand and probation and parole in the outlying areas. That is basically what the brief is. As a result of that, one of our other counsellors goes into the women's prison and the remand centre two days a week so that the counsellor over at the prison does not go totally insane.

We also operate an outreach service after hours, which at present operates three nights a week. Unfortunately, the funding that we have for that does not allow us to travel much outside the CBD, although we have actually travelled as far as New Norfolk and probably Sorell and Huonville when we have absolutely had to. We are also funded to provide assessment and treatment under the illicit drug diversion initiative, which hopefully will continue to get up and running. These are some of the issues that arise for us in particular at present. Funds allocated are so limited that areas of service delivery are limited by them. Treatment options for people in terms of detox, rehab and maintenance therapies and psych services are incredibly limited.

Those problems are getting more so. Our age group average has reduced in the last financial year from an average of 22 years to 19 years, and that is only our day service. Our night service is seeing much younger children—12-year-olds who are on the street at night in crisis because of the lack of services. Where do we send them if they have no accommodation?

At present there are three women's services which have to tender for two allocations of money, and the problem is getting worse. There is the prevalence of hepatitis C. Our organisation did research two years ago with current injecting drug users asking them whether or not they knew about hep C and, if so, whether their behaviour changed as a result of the education messages they were getting. It was obviously clear that they knew absolutely everything about hep C transmission, but they were not changing their behaviour. There is a huge gap there somewhere, and hep C does not seem to be something that is being taken seriously in this state, in particular.

CHAIR—Ms McKeown, did you want to make a brief statement?

Ms McKeown—Yes, I did. I was asked to attend today. As well, I attended this morning. As you are aware, I am the State Manager of Alcohol and Drug Services. I have been living in this state and working in this position for something like 16 to 17 weeks. I am very impressed with the level of work and the level of professionalism that occurs across all the government departments here within very, very tight resources; and also with the level of cooperation that we have within government and non-government organisations, so I would like to emphasise that. I would encourage governments, both at the Commonwealth and state level, to consider the facts around the association between the common causes of illness and alcohol and drug use, and the high aetiological fractions. I have a document here by Holman et al, 1995, that outlines a very high proportion of a condition that can be attributed to alcohol and drug use. I would like to make that comment and I would like to make that document available.

I would also like to make some comments about levels of funding. I would like the Commonwealth government, as well as the state government, to consider the tax dollar and how it might be spent in the future. I have come from Queensland where we had approximately a population of about 3½ million—it may be slightly higher than that. I understand that in Tasmania we have approximately half a million, give or take a few, depending on how many people have left and how many people have come to work.

The Commonwealth agenda is enormous now. In the past Commonwealth dollars used to come to support that. The Commonwealth are now seeing themselves as purchasers rather than funders, so we work within that resource constraint as well. In Queensland, where I come from, we had a corporate office looking at campaign initiatives and a whole lot of prevention initiatives. We had a government office of about 65. In our state here we have a corporate office of four professional people. If we were to multiply that out by the proportion of the population, we would expect that Queensland should have about 32. Those kinds of proportions are very similar across all other states. We do appreciate the work that governments are doing, but I would like to draw your attention to long-term cost savings that can be made with the dollar if we look at prevention initiatives and the impact of alcohol and drug use across a wide range of other health problems. Thanks for the opportunity to add those comments. I will make that document available.

CHAIR—Thank you very much. Betty, could we have a quick minute or two to sum up?

Mrs Roberts—I would just like to say that the comments around the table have been very interesting but we have drifted a bit, haven't we? The terms of reference for this are for the rest of us and not the person with the problem. I think we keep slipping back to the person who is using rather than the effect on the whole community. That, as I understand it, forms the terms of reference for this inquiry.

Mr QUICK—It is about family relationships. You cannot isolate people. Are we talking about perpetrators? I would also like to make some comments about levels of funding as well, and the Commonwealth government.

Mrs Roberts—No, we are talking about the difference between focusing on the user and focusing on all the rest of us who are affected by that person's use.

Mr QUICK—We have people using glib phrases like 'shooting galleries' rather than 'safe injecting rooms'. It depends on which angle you come from. I was appalled to see part of the *Four Corners* tape. Peter Patmore said:

I feel no sympathy for the prisoners of Risdon.

Mrs Roberts—I have great sympathy for anybody who is using powerful mood altering drugs acting on the central nervous system. However, it was the points of reference of the inquiry over which I was saying: aren't we drifting a little in talking about them? The terms of reference were:

The social and economic costs ...

family relationships;

crime, violence (including domestic violence), and law enforcement;

road trauma;

workplace safety and productivity, and

health care costs.

It is not that I lack compassion, Mr Quick. It is just that I do think that the terms of reference for this particular inquiry are very good.

CHAIR—Would you like to stop and leave it there?

Mrs Roberts—Yes.

CHAIR—Thank you very much. I am going straight to Harry.

Mr QUICK—We heard this morning from the Tasmanian government that everything seems to be fine. Yet it is interesting to hear Cecile mention tight resources. I would be interested to

know through Anthony and Cecile how many probably hundreds of millions of dollars are poured into Tasmania. Every agency that we have spoken to over the last two days has said they do not have enough and we need greater cooperation. People talk of silo mentalities. That will all obviously come out today.

I have two questions to Katherine and Denise. We have heard views on the education system and police. It is interesting that, after the four tragic deaths in Risdon, Tasmania seems to have an enormous mind-set change. Things are actually happening and there is modification. Katherine and Denise, what are your reflections on the police with respect to your sons? They obviously went through the education system. We hear that there are changes: suspensions, referrals and access to agencies on the board, and schools have policies, and school counsellors and social workers. I would just like your views. Katherine, would you go first?

Ms Howard—My personal experience is that the first time the police came to my home, my partner was growing 75 plants on the property. He had threatened to kill me if I told anyone or if I had removed those, and it was a relief when the police turned up. But the trauma that they left behind was quite extensive to the children and to me. We were the ones who were left to pick up the pieces and face the violence, because the police had taken all of the user's substance away so he was immediately put in a position where he had to go cold turkey. At that stage—I have three sons, he had three sons as well—we were talking about six children between the ages of about 15 and seven, and they were severely affected.

We had one child who ran away. He had come home after school to find about seven policemen running around on the property; their guns were quite visible. He thought that we were going to be shot by the police and he did a runner, and he did not come back until 8 o'clock that night. It had quite a profound effect on him. I think there should be some sort of service that comes in to check, after this has happened, to see how the rest of the family is coping. Like you were saying, all their services need to be integrated. The police are only doing their job, and I appreciate that at times they probably need guns.

Ms Mullan—I found on the whole the police were excellent. They obviously need to be trained more in looking for symptoms of mental illness, because I think they are severely lacking in that aspect. With the education department, I would like to see the schools take a more active role in advising parents if there is a problem at school. They most probably did advise me, but it would have been through Fabian, so I did not receive any of that information—obviously—because the problems were starting and were exacerbated later on.

Mr QUICK—So your son was excluded during primary and early high school years?

Ms Mullan—No.

Ms Howard—Mine was.

Mr QUICK—Tony, how can we expect you to provide the best service that you are willing and able to provide if we do not fund you adequately? To me, as a Tasmanian federal member of parliament, it is appalling that the state government has nothing in the way of rehabilitation services whatsoever. We have heard from Michael that there is a 10-bed detox and there is a community centre, but all the evidence that we have heard over the last couple of days, both

inside the jail and outside, in talking to parents is that the service is appalling. Whose responsibility is it? Is it a Commonwealth thing, is it a state thing? If we talk to Anthony he probably says, 'We give enough money to Judy Jackson; it is the state's responsibility,' and Judy would probably blame the Commonwealth. In the meantime, you do not have any money and you are scrimping and saving trying to provide a second-class service when you want to provide a first-class one.

Mr Butters—I would definitely say that it should come from both governments. We cannot continue to fund if we do not receive money. We rely solely and simply on the sale from the second-hand store at Youngtown. If that cannot fund us, the residents that come to us pay $150 a week, which covers the cost of their board, their lodgings and all their course materials. We are currently, this year, running under a $100,000 deficit on our yearly budget. We asked for $180,000 and got it knocked back to $100,000. This next year it is going to be the same situation. We cannot keep on funding if we do not get money, and we have asked time and time again for government to do something.

I know of a particular case when the Premier went to Launceston. He went to a morning tea at the Launceston City Council and left $225,000, and he came to our place for dinner and left $5,000. Their attitude to us is that there is no such thing as a drug problem in Tasmania. It is solely and simply that. They tell us that all the time.

Mr QUICK—My last question is to Raimondo. I am interested in the trends with the injecting of benzos and the like.

Mr Bruno—What the Illicit Drug Reporting System does every year, because we are trying to examine emerging trends, is interview around a hundred regular injecting drug users under the theory that this will be a good sentinel population, so, if there are any new drugs available, people who regularly inject illicit drugs will be seeking out these new drugs. Last year was the first year where we actually got the funding to interview users themselves.

Mr QUICK—Who provided the funding—Commonwealth or state?

Mr Bruno—Commonwealth. Anthony will be able to answer that.

Mr Speed—It is the Department of Health and Aged Care.

Mr Bruno—Yes, the Commonwealth department of health, and we got the funding for the Injecting Drug Users Survey from the National Drug Law Enforcement Research Fund. So we interviewed 100 people who regularly inject illicit drugs and we found that, within the state, there is a particularly high level of injection of pharmaceutical preparations of morphines, particularly in the gel capsules of temazepam and things like that, and that is a very unusual trend in comparison with other states. Only Tasmania and the Northern Territory have a similar issue with the injection of these pharmaceutical preparations. We also found that the injection of benzodiazephines was a third of the sample—that is, about 100 people had injected benzodiazephines in the six months prior to interviewing—and that is more than double the trend in the other states. The injection of these drugs is causing a significant amount of harm to the user.

Mr QUICK—Are you doing a longitudinal study or is this a sort of pilot project with one-off funding for 12 months and then the funding disappears so you go and get some funding for something else, and do the results go to the Commonwealth and the states not know about it, and then do we take another section of the pie and focus on it?

Mr Bruno—The research has been very well utilised at both the Commonwealth and the state level. The state government seems to be very keen to have the information. They are doing a lot of things with that information.

Mr QUICK—Can you tell us what they are doing?

Mr Bruno—I may have to refer that question on to the appropriate person.

Ms McKeown—I have a copy here. Certainly we do use the information. I would like to make a comment as well about our future research project. Is that what you are wanting to—

Mr QUICK—Yes, we would love a copy.

Ms McKeown—Yes. All right. I think you can have this one; I do not think I have written on this one. So within the context of the intergovernmental committee on drugs, we certainly are looking again at being able to fund research of this nature. Unfortunately, now Tasmania is being asked to contribute from our funds to support this, and our ability to do that is not forthcoming. I am at present investigating other ways of getting this information working with Stuart McLean at the university with the possibility of a PhD student now being able to get funding from the university. That probably illustrates some of those funding issues that we have.

Mr QUICK—I mentioned this this morning and I will reiterate it in front of the cast of thousands. To my mind it is absolutely appalling that we can find $53 million to rebuild Risdon Prison and $5 million or $6 million to rebuild Ashley when we cannot find enough money to resource and adequately put a safety net in for a population of 460,000 people. I think it is absolutely appalling. It is an indictment—and I hate to say it because they are on the same side as me—but I am lost for words, I really am.

CHAIR—Does anybody know what Harry is suggesting it might cost? Is there anyone in this room who is able to tell us this? I know for some it would be inestimable, but I just wonder whether anyone has done any work on this sort of safety net program that would be required to—

Mr QUICK—Sue has not got enough money; Tony has not got enough money.

Ms McKeown—The last time this publication, *Drugs, Money and Government*, was put out was 1997-98. It is a very interesting document put out by the Alcohol and Other Drug Council of Australia. It highlights each state and the funding levels per capita, revenue per head, and revenue from the alcohol and tax dollar. I would like to make that document available. Even though it was a couple of years back, I imagine the situation would not be much different at the moment. That is the only information that I am aware of that has been compiled at a national level and comparatively.

Mr QUICK—Could I ask all those here to put their hands up if they are aware of any of these documents, as they are service providers. David is.

Dr Jackson—I am aware of that document. Usually, in most years it has been produced, it has rated Tasmania worst of all the states. You might look at some of the facilities that are not provided in Tasmania. New South Wales, for example, has 305 public detox beds. If you used a per capita basis for the number of beds in Tasmania it would be 22 beds; in fact, there are only 10 public beds in Tasmania. So again that is only half as many as there should be. There is no sobering-up facility in southern Tasmania at least, and not a very large sobering-up facility in northern Tasmania. So it goes on and on, and these are the reasons why Tasmania usually comes last.

Mrs Ames—Could I make a suggestion that some part of the state income from gambling could be diverted to the drugs rehabilitation or whatever. There is a huge amount of income from gambling. We are all aware of it; Tasmanians know what the statistics are. I am quite sure that part of that could be diverted into what we are trying to do with too little money.

Ms Murphy—There is $900,000 available twice a year that some of us cannot get our hands on.

Mr Butters—It amazes me how the state government can put money into horse racing, for instance. With the Hobart Cup and the Launceston Cup, thousands upon thousands have been put into those two events plus others. Yet when you talk about drug and rehab, they say no.

CHAIR—We talked about this booklet this morning. It shows the revenue per head for Tasmania and the Northern Territory, which as you might expect is a little bit higher, around $300, while for Tasmania it is nearly $220 per head. The funding per head in 1997-98 was around $10 a head, so you have $200 in and $10 expended. But it does not talk about the cost in the hospitals, I would not think. We are talking about specific programs. In terms of statistical evidence there would be those who would argue that your big costs are your hospital costs. Does anyone in this room have a view about it? It is something we need to do a lot more work on. If we are saying that it is $200 a head collected from every Tasmanian and $10 spent on a program, it looks pretty silly. It is the Commonwealth that collects the revenue here and we are pretty interested in that, but we do not appear to have good evidence on it. Do any of the committee members have any comment on that? You can see it does not look too good. Someone yesterday talked about there being ‘money in them there hills’, and there is revenue collected by the Commonwealth. We need to be pretty honest about this in terms of the money coming back into programs. If there is a perception that it is not fair dinkum, then we need to talk about it.

Ms McKeown—From my perspective, when there are buckets of money there are always submissions to be put in; there is a competitive process. But for all of us yet again there is the time and resources—the time that that takes for a non-government organisation, for example, to do that, and a government organisation. What I would like to see is permanency of funding, permanent positions in place so that we really can have a mid- to long-term view and we are not continually thinking, ‘Oh, my goodness.’ At the moment, two of four positions in my state office will run out of funding at the end of June because they are Commonwealth funded for a specific purpose. It is that permanency we need to bed into, I believe in much bigger dollars, a

whole-of-government and non-government budget in order to really get serious about the shorter term, the medium term, a five-year and a 10-year projected plan.

CHAIR—I hear that, and I think we all support the concept of stability and want some surety about funding, but if we are collecting $200 from every Tasmanian and we are spending $10 there is a gross imbalance. What I want to try to understand is this: where should the debate be heading? I have an idea where the debate should be heading; you don't have to be Einstein to work that out because there is a significant cost benefit. If you want to be just a hard economic rationalist about it, then printing more money will give you a better outcome down the track; that would be the hope. What I am trying to say is this: if the Commonwealth collects $200 but all that we can muster, from Commonwealth and state from what I can see, is $10 a head, are these figures fair dinkum? That is why I have to ask the question. If we do not have the answers, we need to find the answers. That is why I am challenging us all here. Does anyone know anything about the legitimacy of these numbers?

Mrs Ames—Cecile, could I ask a question, please? What is the percentage of state funding, as opposed to federal funding, directly into Alcohol and Drug Services? You probably have not been here long enough to know that, but I would be interested if anyone knows.

Ms McKeown—Historically, we have had good Commonwealth support. As I noted earlier, the Commonwealth are going more to a purchaser role now, as I understand it, rather than a provider. No, I could not tell you exactly what those amounts are because some funding will be in the future going direct to services as well and bypassing state governments, and other funding comes through us for our distribution to non-government services. Traditionally, in the alcohol and drug field, with the National Drug Strategy since 1986, all states have received a good injection of Commonwealth funds but, as I intimated, some of those have limited timeframes. While we establish good projects and good positions, we are always left with, say, a two-year end or a four-year finish to that funding. Certainly, overall, I believe we probably would not be as far as we are down the track already without the support of the Commonwealth, and that is Australia wide.

Mrs Roberts—I would just like to say, if I may, that the funding very much favours those people who espouse the harm minimisation approach, despite the fact that the federal government has now espoused the Tough on Drugs approach. I think that particular bias deprives people like Missiondale, which is doing a mighty fine job, of much needed funding.

Mr SCHULTZ—Firstly, to Raimondo, picking up the answer that you gave to Harry Quick, was the research that you did extrapolated out to find out where the opiates that are out there, such as pharmaceutical morphine, et cetera, are coming from? If the research is not extended to find that out, what is the purpose of identifying how much is being used if we don't know where it is coming from and whether we can plug the hole?

Mr Bruno—Firstly, I should say that the IDRS is designed as a drug trend and monitoring system. It is designed to be a springboard for identifying trends, which can be then focused further in on down the track with specific focused research paradigms. We do, however, ask people where they usually get their drugs from, and the only information that I can give you is that, in terms of the pharmaceutical morphine and benzodiazephines, they seem to be coming primarily from dealers rather than being directly prescribed by doctors. I think our local GPs are

very aware of the problems associated with prescriptions of morphine and benzodiazephines to people that may be suspected of using drugs, or of using them inappropriately. They may not necessarily be coming from places within this state because morphine on the street in Tasmania gets a lot more money than it would in Melbourne, Sydney, Adelaide or Perth.

Mr SCHULTZ—My other question is basically a broad based question across the whole parameter of the comments that have been made. There appears to me to be a consensus in this room that we need to have sufficient funds to ensure that we get more education, and detox and rehab facilities. There is obviously a consensus of opinion that there is an enormous shortfall in terms of those sorts of facilities. Can anybody tell me—I think somebody mentioned a figure of 22 places—what the need is in terms of detox and rehab facilities? I ask that in the context of being a rural based MP who faces the same sorts of concerns from my constituency with regard to the lack of availability of counselling, detox and rehab facilities in rural Australia. The waiting list is up to nine months in many instances at the nearest facility that is available to them. Can somebody comment on that, or would a number of people like to comment on that particular issue? I know it is basically broad based but it has a common theme in terms of the concerns that we hear.

Mrs Roberts—Mr Schulz, some years ago we planned a social detoxification down to the last detail. We had it costed, we had a plan for it and so forth. All we needed was hospital bed backup, that being the perception of those people working at the social detoxification site. Because we could not get that assured backup from our public hospital, the plan never went ahead. Obviously there are big cost savings to be had through social detoxification rather than medical detox, and I recommend it.

CHAIR—What was the approximate budget of your proposal, Betty?

Mrs Roberts—It was too many years ago, but should you—

CHAIR—In the millions?

Mrs Roberts—No, it was not. It was quite good. I have lost my copy because of a fire. I handed it on to the Salvation Army. They may still have a copy and if they have I will let you have it.

Ms McKeown—With regard to that comment, most people around the room here who are involved in the alcohol and drug field who would be aware of the importance of family support when a person is going into rehab/detox. I cannot comment on the dollars that might be required but certainly ideally we would need, position wise, at least several rehab facilities around the state so that people would be close to family and friends to gain that support. We have focused now the need for rehab and a couple of other areas, but I would like to bring the committee's thoughts back again to the importance of prevention and early intervention initiatives. We do need more of a focus there and we need the capacity to be able to run with Commonwealth prevention campaigns when they occur so that we can get messages to the community. We can get messages on the screen, when people are watching, about standard drinks and smoking.

CHAIR—Cecile, can I just interrupt? We hear about being collaborative, we hear about being holistic and we hear about all of the various needs and parts of the jigsaw puzzle. Is

anyone anywhere starting to succeed in putting all of the pieces together? The deputy commissioner talked about maturation of the debate. We hear that the NGOs are starting to get together in Tasmania.

Ms Tonks—Betty mentioned a submission that went in years ago. Submissions go in from time to time, and have done for several years for various detox/rehab facilities, and they get knocked back for whatever reason, whether it be because therapeutic community is not the flavour of the month or total abstinence is not the flavour of the month or whatever. My concern here is that we are hearing fragments of this—that everyone agrees that, yes, we should get together. But, as I mentioned to the committee last night, until we are funded adequately and we do not have to compete for every single cent that we have to submit for, we will never ever work as a cohesive unit. At the risk of sounding political, I think the government finds it politically sound for us to be seen fighting against each other because it keeps us in place. That may be totally outrageous and seen as being the wrong thing to say, especially in *Hansard*, but I will stick to what I am saying—

CHAIR—You have parliamentary privilege here; you can say what you like.

Ms Tonks—What we are failing to see here is that every person who uses—I prefer to use the term 'use' rather than 'abuse'—

CHAIR—That is a fair statement.

Ms Tonks—a substance and becomes addicted to that substance has issues surrounding the substance that they use as individuals. They should be given a range of choices, whether they want to go the way of holistic, abstinence, 12 step, therapeutic or whatever. They should be given those choices. We should not have to just say to people, 'Look, I am really sorry, but you cannot do your five days detox because there is not a bed,' or, 'You cannot do your very short-term rehab because the Salvation Army are full or Missiondale are full,' or, 'They don't have the money therefore they cannot take anybody else on.' We should be able to say, 'Yes, you can go and do your 12-month rehab with all these support services and your children, while you are in detox or rehabilitation, will be adequately cared for and you will have access to them.

Mr SCHULTZ—Can I just say from my point of view that the compelling issue seems to be that we are not treating drug addiction, or whatever you like to call it, with the strength that we need to address it as a health issue. It is quite obvious from the document that Harry just showed me that governments, particularly state governments, are not treating the issue of drug addiction or use or whatever as a serious health issue. It is low on the priority list. It is down at seventh on their list of priorities.

Just in closing, Mr Chairman, we have to keep our minds focused on the health issue, and I think everybody here agrees with that. The people who are affected by the problem are the people in need of assistance. We cannot give them assistance if we do not adequately fund those programs and facilities that are going to get them to a level where they can either be fully cured of their addiction or have some means of getting away from their addiction.

CHAIR—Carolyn, you had something on the general holistic issue. Does anyone understand what it would take to do it? Then we will go to David on the other issue, and Sue.

Mrs Jeanneret—I would like to address something that you were saying. With the focus on health, I think it has to be on social health because the two—psychosocial issues and health issues—are so intertwined that that needs good assessment. I would suggest that. I also agree with Melinda that there should be some choices in how—what I would call from my perspective—family recovery programs are put up. But, to answer your question, I think you were asking how we can define 'holistic' in a way that makes sense.

CHAIR—Maybe you can try to.

Mrs Jeanneret—With the NGOs, just with limited—

CHAIR—No, broader than that—is it a dream or should we be doing it?

Mrs Jeanneret—I think we should be. For example, if you take those five types of intervention that I brought up, they have been proved in research to be a good way of managing it—obviously some families do not want everything at the one time—but it gets sabotaged. For example, a recent pilot family recovery program from a holistic basis, where there were children quite at risk and one child had been injured, fell apart partly because the dad was not at the right place in the cycle of change in the addiction cycle to actually follow through and also because his choices were so limited by the lack of rehab beds.

CHAIR—It is wheels within wheels to coordinate it.

Mrs Jeanneret—Yes. It is what you get if there is a lack of a rehab bed. One rehab program does not want to take him for one reason and another one does not want to take him because there is a price on his head and there is a danger to the others, therefore there is no safe place—there are no safe houses for this family. It is almost automatic. But if the resources are there and those five kinds of intervention are addressed, then it is worth pursuing.

CHAIR—And you have a better chance of getting an outcome.

Mrs Jeanneret—That is right.

Mr SCHULTZ—Picking up Betty's point, Mr Chairman, I think that is going to continue until such time as we do something in the way of government assistance outside of the focus on harm minimisation. Harm minimisation sounds nice and easy and it is an easy opt-out for a lot of organisations. But the reality is that, if you continue to have those sorts of philosophies, you are still going to have the problem because the addiction is still there. That is the point I am trying to make, and I agree to some extent with what Betty Roberts just said.

Dr Jackson—There are two things I wish to raise. Firstly, I will just repeat the New South Wales figures. New South Wales is the only government, as far as I know, that has carefully investigated the need for detox beds and it has come up with 305 public, not counting private, which equates to 22 in Tasmania. The other aspect which shows that successive governments in Tasmania have not been at all concerned about the people with alcohol and drug problems—

CHAIR—Sorry to interrupt—22 beds is not big dollars in the overall picture, is it?

Dr Jackson—No.

CHAIR—It should not be beyond us.

Dr Jackson—The last time I costed it a detox bed was about $300 per day compared with one in a teaching hospital which was about $700 to $800 per day. If you do not have the patients in a detox bed at $300 per day, then it is costing you $600 or $700 per day in a teaching hospital.

CHAIR—Within the scale of things it is not big dollars.

Dr Jackson—It is not big dollars. The other thing is that successive state governments have tended to look at the dollar rather than the patient. When they have wanted to look at the number of detox beds, they have ended up with about six reports over the last eight years from interstate experts. In none of them have they sought comments from the people who use the facilities or their relations or anything like that; they just had an interstate expert come in. They have shelved all of those reports except the last report, which they adopted because it was the one which gave them the answer they wanted—

CHAIR—You mentioned stigmatisation, but go on. In the context of Mr Schultz's point about the pecking order of priority and stigmatisation, can you draw that together as well as a part of that?

Dr Jackson—I think it is stigmatisation when a government looks at the dollar cost rather than at the needs of the person who is affected by alcohol and drugs. As I was saying, the most recent report on detox services recommended basically no detox services, and that is the report that the government adopted 12 months ago and has not been able to implement as yet.

CHAIR—Can you describe who did the report and how—

Dr Jackson—It was a so-called expert from New South Wales which has, as I say, 305 public beds. But to my mind that is showing stigmatisation when it looks at the dollar and not at the needs of the person.

Ms Ham—I wanted to make two comments. My first comment is on supporting the need for greater expenditure in prevention and early intervention, but at the same time we need to increase the funding for the people who are in this cycle at this very moment. That needs to happen, and it probably means a huge increase or a hump in funding expenditure by the state government and the federal government to tackle this issue.

CHAIR—Can I challenge you on that just briefly in the sense that: is it huge in the context of the budget? This is what we were trying to say earlier and that is what I am trying to identify: I think you want to be careful about saying it is a huge increase because you could frighten we politicians. You see, it may not be that huge. It sounds huge when you know it is $1 million but, in the context of the Tasmanian budget or the national budget, it may be but a fraction. The benefits down the way may be strong and we may know that, if we can be successful or even half successful, we are going to get significant benefits from it. Do you feel it is big?

Ms Ham—I guess in terms of the expenditure that the state government makes in the non-government sector area for drug and alcohol—

CHAIR—It is huge.

Ms Ham—It is quite significant. The second point I would like to make is that beyond the detox and rehabilitation programs that we need and the increasing beds and programs there, we also need to tackle approaches to connect people with their communities and to connect people with employment and training opportunities that support them either coming off drugs or working within a harm minimisation framework. We need to tackle other portfolios at a federal government level to increase the funding in, say, programs like JPET and the community support program—one being funded through the Department of Education, Training and Youth Affairs and the other being funded through the Department of Employment, Workplace Relations and Small Business.

Mr ANDREWS—I am not sure who this question should directed to—maybe Raimondo—but perhaps to the government: if your calculation of $300 per day for a detox bed is in the ballpark, then an extra 10 beds in my rough calculation is about $1 million a year. Has anybody done a cost-benefit study in Tasmania or elsewhere of a detox bed in terms of that cost versus the cost to the community? It would seem to me that there is probably a much greater cost than $1 million a year to the community for 10 detox beds.

Ms McKeown—The Collins and Lapsley study looked at the economic costs of substance abuse and, as we pointed out this morning, there is soon to be another study from Collins and Lapsley. But the detail in that may not be exactly what you are looking for. The Collins and Lapsley study has been the main study for Australia.

Dr Jackson—Looking at the budget for the state health department, what is spent according to this figure is $4 million out of a total state health budget of about $800 million. So it is about one-half of one per cent and so far this year we have had at least 12 drug related deaths, and it could be much more.

Mr ANDREWS—But the deaths, with due respect—I do not want to sound insensitive—are probably not the major cost—

Dr Jackson—No.

Mr ANDREWS—It is the unemployment, the social dysfunction and the impact on families, et cetera.

Dr Jackson—If a state this size has 12 deaths in less than six months and you can take that figure out to the social and other economic costs, then the figure of 12 deaths represents a huge amount in social, health and other welfare costs.

Ms McKeown—David, you were speaking mainly of illicit drug deaths? When we factor in—

Dr Jackson—I am not talking about smoking and alcohol.

Ms McKeown—If we factor in the smoking deaths, which Australia wide are 18,000 or 19,000; if we factor in the people who die from alcohol abuse; and if we factor in the people who are killed on the roads because someone is intoxicated or under the influence of either alcohol or other drugs, the costs are enormous. One comment I would like to make is that we need to always look at risk and protective factors. I think we need to go further back than looking at just a health related problem. We need to recognise the role of the family. I believe governments need to take note that we need policies that support families. I do not mean we need women and children to stay in violent situations unreasonably—I am not talking about that kind of approach—I am talking about a reasonable approach whereby our policies support families and recognise the protective factor that a good family atmosphere and a good family home provide. I will say nothing more.

Mr ANDREWS—I have two more things to follow up on that. Is there a state drugs strategy in Tasmania with short- and long-term goals?

Ms McKeown—Yes. Our present Tasmanian Drug Strategic Plan for 2001-04 is in its final draft. It has been developed since the beginning of the year when I arrived here. There has been very wide consultation with community, non-government sector and government sector organisations. There have been multi-layers of consultation. That plan has five key focus areas: community development, protecting the community from harm, community safety issues, building community capacity and then co-morbidity—those issues around co-morbidity and supporting individuals' health and wellbeing. That is the draft document at the moment. I would anticipate that it will be presented to the government probably in early July.

Ms Roberts—Since it is in draft form, do you think we might set about identifying children in the classrooms—I estimate there are as many as four in every classroom in the state—who have this problem at home and do something to address their problems so that they are not carried on from generation to generation? I just suggest that that might be part of your plan.

Ms McKeown—It is. Esme and I are colleagues and work closely together, and certainly the education department, as part of our government, does work within schools to create supportive environments. As Esme pointed out, families as well as schools are very important environments.

Mr ANDREWS—That leads to my next question, which is to Esme: you spoke about the work in the national school drug education project and bringing the four strategies together. How do you measure your outcomes?

Ms Murphy—How long is a piece of string? It is extremely difficult. We are talking about very long-term longitudinal outcomes which we do not have the capacity to measure. We would have to start measuring now for a four-year Commonwealth-funded project, and the outcomes are going to be measured when young people—the kids who are in school now, particularly primary school—are in their 20s and 30s.

Mr ANDREWS—But there must be some measurements along the way. For example, let us take a practical issue that was raised this morning. What happens when a student in a secondary school here in Hobart is discovered to have some drug related problem? What is the manner of

dealing with that and what is the outcome that is measurable which leads to some positive result for the student, the family and the school?

Ms Murphy—What happens will vary from circumstance to circumstance, depending upon the particular kid involved and what his history is and the school he is in—there is a whole range of possibilities here—but there are support structures in place to attempt to support that student to not use drugs problematically for himself. Problematic drug use in schools is about stopping kids learning essentially, quite apart from their own physical health issues. What is the system able to do for circumstantial behaviour which arises not just from school intervention? We are talking about behaviour which has arisen over quite a long period as a result of a range of other factors that the school does not have much control over.

Mr ANDREWS—I do not want to sound insensitive but, from a public policy point of view, if governments are going to spend millions of dollars then there has to be a measurement. We have to be able to say after a period of time that we have actually achieved something with the millions of dollars we are spending, otherwise we may as well put it into a few more detox beds, or a few more police on the street, or something else. How do we measure it?

Mr QUICK—There could be the situation where Kingston High School does not have any reportable drug related offences for 12 months—that would be a wonderful outcome. Taroona High School could be the same, and Woodbridge—

Ms Murphy—That is the kind of outcome we are looking for, but can we achieve that in four years?

Mr QUICK—But has the goal been set to say to Kingston High School, ‘David, this is the goal we would like to set for you. Here is the challenge’?

Ms Murphy—The school has to set its own goals, Harry. The school has to decide for itself what it is trying to achieve in that time. The Commonwealth wants us, through the drug ed program, to put the structures in place which, in the long term, will produce those kinds of outcomes, but the schools are only one of the factors that can cause that kind of intervention. We can only do this much and the whole world has got to do the rest.

Mr QUICK—But David is liaising with—

Ms Murphy—He can make a difference.

Mr QUICK—He is liaising with a whole lot of other people—Sport and Recreation—

CHAIR—Esme took us through the system.

Ms Murphy—He can make a difference, but he cannot make the whole difference in the lives of every kid.

Mr ANDREWS—I understand that you say it has got to be on a school basis, but are you urging the schools to actually develop? We live in an outcome-driven world. In your

department, in what we do, in what everybody around this table—whether government or non-government—is involved in there is an outcome that we are striving for. For each of those schools, are you urging them to actually aspire to certain outcomes which they publish and which are transparent and which we can at least make some judgments against? It might be that two schools have the same outcomes, and one reaches it and another does not, but at least that gives us some way of measuring why one has reached it and why the other has not. This is not from an economically rational point of view. It is from a social point of view of saying, 'How in hell do we overcome the problem if we do not even have an objective to try and reach?'

Ms Murphy—I agree. What Harry was saying is quite right: a school can have the kind of objective he has described. If you know what your baseline is and if you know what your environment is, you can aim to reduce perhaps the number of kids who are involved in drug related incidents in the school, and you will do that by the whole programs that you put in place. And yes, you can make a difference.

Mr ANDREWS—You can, but my point is: are we asking them to do it?

Ms Murphy—Yes.

Mr ANDREWS—Are we saying that in a year's time, if we go around every government and non-government school in Tasmania—and, for that part, the Commonwealth—and ask, 'What is your objective in relation to drugs?' then you can at least say, 'Here is a document that says what we are achieving or trying to achieve. We may or may not reach it, but at least this is what we have sat down with our teachers and students and school community on'?

CHAIR—We have quite a line-up of people wanting to speak. David.

Dr Jackson—If you are just looking at a return for an intervention in the whole alcohol and drug field, methadone stands out. For each $1 you spend on methadone, you save the community something between $4 and $20, depending on which study you look at. That is savings in health costs, in crime costs, in costs right across the board. Yet in Tasmania there is a huge waiting list for methadone. People that are opiate dependent cannot get onto methadone. On the other hand, you can look at school education. You have to look at what happens in other countries. If you look at the DARE program in America for drug awareness and resistance education, you see that there have been 12 huge reviews. A meta-analysis of the result has shown that all money that has been spent and continues to be spent on that program in America has been, at the very best, wasted. It may actually have increased drug use in America. You cannot ignore that. And similar things have shown up in Australia. So if you are looking at return for your money, you have got to look at methadone because that is the one that research supports so much.

Mrs Jeanneret—I have a couple of comments. Following on, first of all, from what David was saying about methadone and saving dollar for dollar in relation to opiate use: yes, but there is a broader perspective too, in that it has been proven that, with early intervention across psycho-social issues in drug affected families, for every $1 spent, $7 is saved later in police, welfare and judicial costs. And there are other figures now to back that up.

On outcome indicators: you were asking, Kevin, how you work out specific outcome indicators. For each agency, school or program there is going to be some kind of different motherhood statement, which is that broad stuff that you were talking about, but how do you break it down to the individual stuff? I was just having a look at some outcome indicators I have got here, which I use in relation to drug affected individuals or families that I am working with in different parts of agencies. You can break it down into overarching indicators. It would be different for a school child, for example, from what it would be for a drug-affected mother. But there are some principles here.

For the outcome 'reduced substance use' the first indicator is acknowledgment of need to change. This breaks it down to each individual, so that you could have some stats on that intervention or numbers of interventions with those kids, or with those mothers or whoever, in whatever agency. Other indicators are improved knowledge of harmful effects—these are concrete things that you could actually tick off—knowledge of relapse prevention strategies, changed behaviour, number of drug-free days, and reduction in usage. They are concrete. For reduced high-risk behaviour, the indicators are increased knowledge of that connection of high-risk behaviour with the drug use—I actually did that with a kid yesterday—safe practising increase, and reduced attempts at self-harm if that is relevant.

Other outcomes can be observed and measured in kids at school too. One kid I was talking to recently said he was getting headaches and his grades were dropping. Improved physical health indicators include the counselling support and the resources being put in, say, in a school situation—which is not my field at the moment, but with kids, yes. Are his headaches reducing and are his grades coming up? In other words, there are social outcome indicators, such as positive changes in his physical health statement, and successful engagement in appropriate health services and referrals. These are for a specific purpose.

CHAIR—So you can measure it.

Ms Jeanneret—There are measurable things that can be done, such as improved emotional and psychological wellbeing indicators—and they are all into drug use, of course, so it is the sort of stuff that Michael was talking about before. There are ways to draw up and find some concrete things in indicators.

There was another point that was raised with regard to costing. I have observed in 20 years in the welfare industry that if we do not do it in a way that is manageable and holistic, the costs come out in other parts of the system, such as relationship breakdown or more costs to the health system. I observed with some drug addicted families when I was working in the hospital that we had more DEM admissions, and we had more admissions—I am not speaking for the hospital, I am just speaking as a social worker who happened to work in that context—with the families who were not getting their stuff together, who did not have the support, who were just ending up in hospital with emergency admissions and stuff like that.

Once they move into child protection, the cost of case management complexities goes on and on and on for years. Just the cost of maintaining some kids over a period of months, with the complexity that undergirds what is happening, even in a three-month period with a crisis driven family of drug affected issues, is absolutely phenomenal. If the money does not go into the right

place in the system, it is just going to come out in another part of the welfare system, the police system or the youth justice system.

CHAIR—Good point.

Ms Boyer—I want to make a comment about the methadone program, which has come up a couple of times, both times because of the problems of access to that program. David would know more about this than I do. Tasmania relies entirely on the willingness of a GP and the willingness of the community pharmacy to set up that program—certainly southern Tasmania does. There is no public facility available for people who cannot get onto that program through that mechanism. I am involved with the Royal Hobart Hospital pharmacy department, and we have been approached several times for either short-term bandaids to make sure that people can access it while they are in transition to community or for various other circumstances. We have always been fairly reluctant to take such things on because of the inappropriateness of an acute care hospital for a methadone program.

Our inability to provide the facilities on the ground and the staffing to run that sort of program is probably addressed in the strategic plan for alcohol and drug services for the next four years. But certainly there needs to be something done by the state to provide a facility which is accessible to people and does not rely on private practices of GPs and pharmacies. Let's face it: if you have a very comfortable GP practice or a very nice pharmacy, you may choose not to take on patients on a methadone program because you are concerned about your image and about retaining your existing customers. The image thing comes through very strongly.

CHAIR—Time is getting on. We need to stop in five or six minutes and stretch our legs. Are we just about done? Have we just about chewed it for as long as we want to go? It is an endless subject. Maybe we can break at about 3.30 p.m. for three or four minutes and then come back for 10 or 15 minutes and wind it up after that, if you like.

Ms Jeanneret—I have just one short comment with regard to access to methadone programs. There is an absolute lack of GPs willing to commit themselves. Sometimes it is about the time it takes with these patients. Some people want to commit themselves to skilling up in that area. But there are longer consultations, and that is something that Dr Stack drew my attention to. There need to be more service provider numbers for longer consultations for the GPs who are willing to actually commit themselves in addiction medicine.

Dr Jackson—It is not just that. Each methadone patient has to pay about $1,300 per year, which is again an example of stigmatisation of drug users because everyone else in the community has a ceiling on their pharmaceuticals. No-one has to pay $1,300, except methadone patients. Every methadone patient in Tasmania pays $1,300 a year. The only way they can achieve that money is to sell one of their takeaways on the street, and that is one of the reasons Raimondo has those figures. Because the pay is $1,300 a year you have to get money from somewhere. You can do a burglary or you can sell one of your takeaways because there is a ready market for the takeaway. Just sell your takeaway and you have paid for your methadone.

CHAIR—They are pretty practical consequences.

Ms Howard—I would like to back that up. I know my son used to get diazepam which he then used to sell to the dealer in exchange for morphine.

Ms Ames—I am just questioning the whole point of the education process. To my mind it has not worked. When you ask for an outcome in schools, I think probably in most schools in Tasmania if a child is caught with drugs or suspected of having had drugs, they are immediately suspended.

Ms Howard—It becomes very traumatic.

Mr Mason—That is not always the case.

Ms Ames—It is not always the case, certainly—it depends on the school and their policy.

Mr Mason—The Drug Education Network is called quite regularly to schools to work with young people who may be suffering an alcohol and/or drug problem at school.

Ms Ames—Good. I was not aware of that. The other thing is: how do you get a school to say, 'We have been drug free for a year'? The school has that child in their custody for about six hours a day. Who knows what happens at half past seven when they go out for a bike ride or something. You really cannot judge it by that.

Mr QUICK—I am talking about, as an ex-teacher, senior staff spending 60 per cent of their time dealing with 10 per cent of the kids in the school with antisocial behaviour. There is an increasing percentage of antisocial behaviour that is related to drugs—whether it is them or their mother's or their father's or mum's de facto or dad's de facto or extended family—and quite often the manifestation is at school.

Ms Ames—I would be curious to see in past days, like when I went to school—and it was not yesterday—what percentage of time was spent in schools dealing with antisocial behaviour—not drug addiction or drug taking, but the fact that the kids stole from the corner store or their parents were being bashed up at home. All those antisocial behaviours have gone on since time began and dealing with them it something that teachers, for want of a better term, have to fit into it. So the drug scene is really just replacing other things that were antisocial years ago.

Ms Howard—I had my first illicit drug experience on education department property. Every one of my children that has had involvement with drugs has done so on education department property. That is where they are accessing their drugs. If you go back to my generation, the problem in high schools was alcohol, and the children were bringing it from their parent's liquor cabinets. Now the children are accessing their parent's marijuana and their parent's alcohol and they are still bringing them onto education department property. But none of my children has started using drugs, including heroin, on the streets—it happened in the school.

Ms Ames—Does education work? That is what I am asking.

Ms Howard—We have got to educate our children in how to say no. That was a question I had for Esme: you talk about having a drug policy in the education department; what age does

that start at? Because it should be in kindergarten and it should be about their self-esteem so that they have the ability and the power to say no.

Ms Murphy—This project should run in every school in the state from kinder to year 12.

Ms Howard—The funding has to be to the family who are the ones who are actively addressing the drug problem in our community. I am the person who picks up the pieces for my son. I am also the person, because of the nature of what goes on, who my children bring their friends home to. I do what I can for those children and try to give them wise counsel and encourage them to make wise choices. So it is people like me who need to be funded, to feed those children when they come in hungry and all the rest of it.

CHAIR—That was an excellent comment and it just shows the diversity and the complexities. We will have a short break now.

Proceedings suspended from 3.30 p.m. to 3.34 p.m.

CHAIR—Did you want to add a couple of words?

Mr Speed—I would like to draw the committee's attention to a program in the UK called Sure Start which is committed to measuring outcomes over a 20-year period. It is a similar program to the Stronger Families and Communities Strategy that we have in Australia. My comment relates to the point that Kevin was raising about how we measure outcomes over a period. A commitment to a 20-year period allows us to really see that generational change come through in terms of the strategies that Esmé was talking about, such as resilience and connection with the community. That was my point.

CHAIR—Thank you. Harry is not with us but he will no doubt join us shortly. Lucia, earlier you had some stuff there and I rudely interrupted you because of our time constraints. Did you want to add anything? I am looking now to people who have not said a lot during the afternoon. Now you have heard a bit. You have contributed. Is there anything—not immediately but in a few minutes—you might like to say a few more words about, or would you like to say what you have got out of it? Raimondo, I had a question for you in terms of the Drug Use Monitoring in Australia project not being trialed in Tasmania. Are you aware of that deal?

Mr Bruno—This is the DUMA project?

CHAIR—Yes.

Mr Bruno—No, it has not been started in Tasmania, as far as I am aware.

CHAIR—No, it has not been. That is why I am interested in your view.

Mr Bruno—It would be a very useful project. However, there has just been a study conducted within the prison system. The Drug Use Careers of Offenders project collected similar data.

CHAIR—Yes. The Deputy Commissioner did refer to another study that is occurring. I think he had some concerns, on the public record, about when it might be available.

Mr Bruno—I actually did that. It should be available within the next few months.

CHAIR—But generally the question is about making sure that Tasmania is involved in the Australian Institute of Criminology project. That is what I am trying to understand. Should we be more vigilant about making sure Tasmania is involved?

Mr Bruno—I think most definitely. Given our particular—and, as David was saying, peculiar—patterns of drug use in our state in comparison to other jurisdictions, it is critical that we do continue to monitor trends in as many different ways as possible.

CHAIR—Thank you. Elizabeth, can I ask you—randomly selecting—about that wonderful piece you gave on the Tuesday clinic. Not being a technician, I do not technically understand

some of it. We might seek further information from you. Do you have a view on or have you come across this issue of foetal alcohol syndrome? Another one was to do with the Apgar scores. There are two separate questions in that. Can you give us a bit of background? I think what you are suggesting here is quite important.

Ms Walker—The Apgar score is a score out of 10 that a baby is given at birth—whether it is breathing, whether it is pink or whether it is blue, whether it reacts to stimuli, its heartbeat. You want a good Apgar score. Eight or nine is usually what you are aiming for immediately at birth. Sometimes babies just need some oxygen or some stimulation. It is scored again at one minute and then at five. If the score is nine or 10 at those times, then it is considered healthy and there is no intervention needed. If it is a low Apgar score then often the baby needs to go to a special care nursery or neonates depending on what the Apgar score is and the reason for that.

CHAIR—This, one presumes, is of national significance?

Ms Walker—International, yes.

CHAIR—And where would we best seek the international and national perspective? It seems to me it is very important in terms of understanding these relationships. The other one is foetal alcohol syndrome. Do you know of work or know of other views about this? Has it been discussed very much?

Ms Walker—I have not done any recent reading on that. I am aware of it. Certainly, that is one of the things we screen for when we see ladies who are pregnant who admit to high alcohol use.

CHAIR—It has been raised with us.

Ms Walker—We certainly screen them and care for them more carefully and we are aware of the risks to the baby. The paediatricians are also brought in during their pregnancy so that they are aware of this lady and the possible outcome for her baby as well. You could talk to Dr Bury if you need to. There are a couple of points that I wanted to raise. You were talking about beds earlier. I work just in the clinic area, which is where the ladies come when they are pregnant. A couple of times ladies have come in who have been using drugs and who are quite chaotic because of their drug use. We have needed to find a bed for them, preferably in a hospital, but because they are a maternity patient it is a maternity bed and sometimes it has been very difficult to access that sort of care for them in a maternity area. That is something we need to look at.

With respect to resourcing the clinic, I know in other states there are dedicated clinics for people who are using drugs and alcohol and there are dedicated workers. That has not happened here yet. It is hopefully going to happen and there is potential for it, but another midwife and I are just given time when the clinic is running, which is on a Tuesday afternoon, to see the ladies. We are given a little bit of time occasionally to do statistics. The girl who did the statistics has done the work in her own time, so that I could bring these along today. We do need more resourcing to commit ourselves to do that, instead of us doing that and other people in the clinic thinking, ‘Why aren’t they helping with clinic work?’ We would like to include dieticians.

We would like more input from the pharmacology department and other things like that which will hopefully happen in the future but it is hard at the moment.

Mrs Jeanneret—Do you think that the midwives are getting adequate psycho-social support in case management with the complex cases now or do you think that is a resourcing need?

Ms Walker—That is definitely a need.

CHAIR—Michael, is there anything you would like to add from what you have observed?

Dr Crowley—I would always be pleased to have more resources in the work that we do. There is quite a heavy demand on our services at the Alcohol and Drug Service. We try to work as effectively as we can and as efficiently as we can. I have heard people say that there are delays or waiting times to get treatment services here in Tasmania. Anyone ringing up for counselling services at the Alcohol and Drug Service will not wait any more than about seven days—within about a week, or two weeks at the outside.

CHAIR—It raises a good point, doesn't it? What would be ideal? What is the fair thing here?

Dr Crowley—Ideally, if they could ring up today, they would be in tomorrow to see someone. I can assure you—and I am not speaking about other aspects of the service—certainly, as far as our counselling work is concerned, you will get in within a week; at the outside within two weeks.

CHAIR—You might get in within a day if you are lucky.

Dr Crowley—Yes, you could get in the very next day.

CHAIR—What about the degree of desperation in moving through the pecking order? How do you determine urgency?

Dr Crowley—Because we try to keep working as effectively and efficiently as we possibly can, we do not prioritise. Basically, we take people and hopefully provide a service for them almost immediately.

Mrs Ames—Can I quote an actual incident that occurred at our facility a couple of years ago where a young man came in who was totally under the influence of drugs. He was psychotic, homicidal and suicidal. This was, I think, on a Thursday afternoon and we could not get anyone to see him for about two weeks. This was an emergency situation. Surely, there must be some way of supplying treatment or counselling for those people. If you leave him for two weeks, he will murder someone, kill himself or just forget about it all and go off and do more drugs. So we need that emergency facility, 24 hours a day.

Ms Ikin—I came here to be able to say to the committee how I, in a much more personal way, had experienced the services in Tasmania, particularly from my son's point of view. From what I have heard in the last 1½ hours, it is still very fragmented. The services need to be more integrated. Again, to use the example of my son, who was here recently, when he left detox he

felt there was nobody who was really interested in him. A person who had just been in detox for two weeks really also needs a hand that reaches out. The example that he used was that the people whom he had been to previously in Wyadra and the two services are geographically not under one roof, and that already makes it difficult. If the people he was going to see in Wyadra had come to the detox, then that barrier would have been broken down. It would have been much easier for him to then make a connection with other services.

That was only one service. He was told of other services, but he was told that he would have to be the person who took the initiative. People who have just come off drugs often do not have that level of self-esteem. They really need ongoing support. Getting through detox is one thing. If you are in detox you can be there 24 hours and you are taken care of, but when you stand on the street you are alone. What happens then? It was explained to me that it is up to the person themselves to seek out services, but often they are not able to do that at that point. They need ongoing support to gradually change their lifestyle.

CHAIR—Thank you very much.

Ms Tonks—There was something that Denise mentioned earlier. I am not talking about the fragmentation. I agree that we are fragmented, and I will reinforce that it is as a result of one of the reasons I gave earlier. Denise was bordering on that breach of confidentiality stuff. We have to be so very careful as workers when we are working with an individual not to step over those boundaries of confidentiality. I think it is absolutely reprehensible that, if somebody is in detox and they are told, ‘These are the services you can access,’ they are not asked, ‘Would you like us to call some of these people to come in and see you?’ Our services do go in and visit people in detox and in dem. Wherever we are called to we will go. It is usually a worker who calls us on behalf of a client if the client is in a facility somewhere else, including Ashley Detention Centre and wherever else. So that is obviously something in that service that needs to be addressed.

I agree with this roundtable that case conferencing needs to be done, but you still have to get the client’s permission to do it. If they are not in that mindset because the services are probably forced upon them for whatever reason, they are not going to go and say, ‘Yes, I give my permission.’ Or they may not even have the wherewithal in terms of their mental capacity at that time to actually make a decision like that.

CHAIR—Thank you.

Mr Butters—With regard to the comment about the client or the person having to contact a rehab or somewhere themselves, we operate in that way. I have often had Michael and different ones ring me about different clients. We talk to them about what we do but we say that the client themselves must ring us and make that appointment to come and talk to us. If they do not, and if Michael sends a person through or something like that, that person will not stay. If they have not got that commitment to ring up and make a time to talk to somebody, they will not stay in a rehab. You just cannot go to them and say, ‘You go to that rehab,’ because they will not go there.

Ms Ikin—But what if they ring up and you do not have a place? That is what happens—people lose faith.

Mr Butters—They have not rung us, I am sorry.

Ms Ikin—My son did.

CHAIR—Okay, there is the linkage again, and it is very important. I might wind it up about now, unless anyone has got any burning points. We have had a pretty fair session.

Mr Mason—I was not going to bring this up because it is not strictly about resources, but Michael's comment actually sparked it in my mind again. I am speaking on behalf of NGOs, and what I would like to see is equity in terms of resources for the NGOs. For example, one of my workers gets paid $38,000 a year to do what she does; her government counterpart gets paid $52,000.

We are expected to do—and we do—exactly the same work. We are therefore expected to attract people of talent on budgets such that we cannot keep them. They might come to us because they need a job, but you can bet your bottom dollar that when they are offered $50,000 by the state government they are going there. Then we are left with this problem that we cannot have continuous service because we get a continual rollover of staff. It is completely inequitable. When you look at this $10 spent out of $203, it is just abysmal, absolutely abysmal, and something needs to be done about it.

Dr Jackson—No-one has mentioned the particular Tasmanian thing that $100 million worth of opium poppies are grown in Tasmania. I think we would all remember the time that Anna Wood died an ecstasy related death in Sydney. It was on the front page of the *Mercury* here. That very same month a 15-year-old girl, exactly the same age, died from a poppy overdose. There was not even a single line in the newspaper.

The Drug Enforcement Agency of America—not the United Nations—visits Tasmania once a year to check that there is no abuse of the poppies, because if there is any abuse they will stop buying them. That is a whole area that is kept very hush-hush and is not talked about at all. It is getting worse because with genetic engineering they are making them much more thebaine strong. The poppy seed is an $8 million industry to go into poppy cakes and things. No-one knows if there is any thebaine, which is a strychnine like substance, in that, and the companies themselves will not tell you.

CHAIR—We have had some discussion and it has aroused an interest. We were not aware, but it has aroused our interest. I will perhaps leave it at this.

Mr Mason—The US has used the poppy seed to manipulate social policy in Tasmania.

CHAIR—Is there anyone else who would like to quickly say something?

Ms McKeown—I have one very quick comment. I want to thank personally those people who have expressed their own pain with regard to their losses in the area. I think that needs to be recognised. It is not an easy thing to do it any time, especially in a forum like this. I would like to thank those people who have come as individuals.

Mr Speed—I still have one quick comment to make about the fragmentation in the NGO sector. The Commonwealth has just offered seeding funding for a peak body of NGOs in Tasmania in the alcohol and drug sector. However, it is only seeding funding, and we do not have the ongoing funding. I would just like to make that point.

CHAIR—Thank you. We did hear someone with links to the Holyoake foundation talking about the NGOs coming together.

Mr QUICK—I thank my parliamentary colleagues for coming down to Tasmania. I am sad to say that lots of committees do not come down here; they neglect us. I would like to thank Alby, Barry, Kevin and Jill—who has left for Newcastle—and the secretariat for coming down here. I also thank all the people in the roundtable for their frankness today. As you can see, it is a very complicated issue. Hopefully, we will have a draft report out some time later in the year. You will get a copy of that so that, unlike perhaps with some state reports, you can draw lines under things and perhaps suggest some other modifications. In 12 months time, when we write the final report, your thoughts might, hopefully, be included in some of the recommendations.

CHAIR—Remember when you receive that interim one that you will get a second bite at the cherry if you want it. You can really have a go at it and we will try to get it right the second time. We get two bites.

Mr SCHULTZ—It is always easy to visit a good local member, Harry.

Mr QUICK—Thanks, mate.

CHAIR—Some mutual admiration here. Thank you very much.

Resolved (on motion by **Mr Schultz**):

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 3.54 p.m.