COMMONWEALTH OF AUSTRALIA

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Substance abuse in Australian communities

THURSDAY, 15 AUGUST 2002

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Thursday, 15 August 2002

Members: Mrs Hull *(Chair)*, Mrs Irwin *(Deputy Chair)*, Mr Cadman, Mrs Draper, Mr Dutton, Mr Edwards, Ms Ellis, Ms George, Mr Pearce, Mr Quick, Mr Cameron Thompson and Mr Wakelin

Members in attendance: Mr Cadman, Mr Dutton, Mr Edwards, Ms George, Mrs Hull, Mrs Irwin, Mr Pearce, Mr Quick, Mr Cameron Thompson 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

Committee met at 8.33 a.m.

CHAIR—I declare open this inquiry into substance abuse in Australian communities. Our first item of business is to receive submissions.

Resolved (on motion by **Mr Quick**):

That submissions Nos 231, 233 to 234, 236 to 237, 239, 241 to 243, 245 to 248, 252, 255 to 257 and 259 to 265 be accepted as evidence and authorised for publication as part of the inquiry into substance abuse.

CHAIR—This morning we are here to commence our two-day roundtable on substance abuse. On behalf of the committee, I would like to welcome you all to the first day of the roundtable. Today's seminar has been organised by the House of Representatives Family and Community Affairs Committee as part of the committee's inquiry into substance abuse. The proceedings will be important in helping the committee refine its thinking on the subject of substance abuse in Australian communities. In particular, it will help us draw our conclusions about substance abuse in Australia and the recommendations that we might make to the government on this topic.

Substance abuse is an important issue in today's society because it causes great social and economic harm. The effects of smoking and the abuse of alcohol are particularly costly, and illicit drug taking is a focus of concern for us all. To give you a sketch of the history to this inquiry, it was commenced during the 39th Parliament when that committee fought quite hard to obtain terms of reference for an inquiry into the social and economic costs of substance abuse. The committee brief under the terms of reference was to pay particular attention to the five topics that are the subject of today's seminar—that is, health, families, roads, workplace and crime, and violence and law enforcement.

The committee of the 39th Parliament carried out considerable work into the inquiry, and by the time the parliament was dissolved last year it had received 222 submissions and had also travelled extensively throughout Australia. All in all, a vast amount of information was collected and then last September, just before the end of the 39th Parliament, the committee tabled a discussion paper that summarised this information. That paper is Where to next? Inquiry into substance abuse in Australian communities. Unlike a committee report, the discussion paper did not contain conclusions nor recommendations to the government. This is the task that the new committee formed in this parliament has taken on. We have taken on the same terms of reference as in the last parliament and will be building on and finalising the previous committee's work. We have planned this roundtable to assist us in this process. Predominantly, our committee members are new committee members, and they have undertaken some visits during July in order to familiarise themselves with various aspects of substance abuse within Australian communities. They found that very informative and, I think, very productive towards coming to some resolution.

The two days that we have in front of us now will be comprise of five main sessions that correspond to the inquiry's terms of reference. We will be covering health care, families and workplace safety and productivity today; and road trauma, crime and violence and law enforcement tomorrow. The format of the program will be presentations by invited speakers, followed by questioning of the speakers by the committee members. All of this is covered by

parliamentary privilege. Members of the public have been invited to attend as observers but will not be taking part in the formal part of the roundtable. The presenters have each been asked to briefly outline the main issues in their topics, current approaches to dealing with these issues and options for improved or new approaches into the future. We look forward to listening and learning over the next two days.

On behalf of the House of Representatives Family and Community Affairs Committee, I would like to sincerely thank each and every presenter and participant for giving up their valuable time in their hectic lifestyles to assist us in delivering a beneficial outcome to this inquiry. I would also like to thank those members of the public who have given up their time and who have been interested enough to attend in order to understand the future of substance abuse in our community.

The next two days will be very intense and on a tight time schedule. If I could be so bold, I remind presenters that we really do need to stick to time for our presentations. There will be ample opportunity for you to expand your comments and be more informative to the committee during the question and answer segment. Once again, I welcome you all. I would like to now invite Major Watters, from the Australian National Council on Drugs, to start the proceedings with a brief outline of the role and work of the ANCD before we start the first of the main sessions on health.

[8.39 a.m.]

WATTERS, Major Brian Fletcher, Chairman, Australian National Council on Drugs

Major Watters—Thank you, Madam Chair. I would like to congratulate you and each of the committee members on your appointment to this very important committee. I would like to acknowledge and endorse, as you have, the work of the previous committee under Mr Barry Wakelin. I would also like to acknowledge my many colleagues, as I look at the great expertise that is represented in the people who are going to speak here. Thank you for the opportunity to appear at this broad ranging and important inquiry into drug abuse in the Australian community—and, I might say as Sydneysider, for the privilege of enjoying a minus-two degrees morning in Canberra as well!

Drugs are a serious social, moral, medical, legal, economic and, I believe, spiritual problem in Australia. As the community becomes more aware of the health and economic costs of drug abuse, and drug use in general, there is a growing realisation that drug strategies must be comprehensive, strategic and inclusive to be effective. It is encouraging that the most recent national household survey of drug use clearly shows that, for the first time in many years, we are beginning to see a downturn in the levels of illicit drug use in Australia. I believe this is a result of the impact of a range of measures that aim to reduce the supply of drugs, the demand for drugs and the level of harm generated by drug use in the community, and that cannot be underestimated. The ANCD has also noted the continuing and extraordinarily high harm associated with alcohol and tobacco use in our community. The reports we get from around the nation are that these are still the great worries, not only statistically but in terms of social impact.

In the short time I have this morning I would like to focus on the role and work of the ANCD as a current example of a comprehensive and inclusive approach to developing and implementing a drug strategy. The ANCD was established by the Prime Minister in March 1998. It is the peak advisory body to government on drug policy, and it ensures that a broad voice of the drug and alcohol sector, with an emphasis on the non-government organisations, is heard and influences policy. The council's membership represents expertise in medicine, law, law enforcement, academia, education, treatment services, families who have suffered loss, those who have been personally affected by drugs, the Indigenous community and government. There is also a diversity of location of membership right across our nation which serves us well in our efforts to inform on jurisdictional drug issues and feed them into the national picture. Furthermore, the council has within it a wide range of views which reflect the variety of opinion within both the alcohol and other drug fields and the community generally, so it is a microcosm of the broader community. Also, as with the broader community, I believe, there is a commitment and an agreement on our goals and purposes in reducing this problem in our nation. And, as with the broader community, we agree on 95 per cent of things.

In effect, the ANCD essentially brings the views and experiences of community service organisations to the policy making table, allowing communication between those involved in service delivery and those involved in policy development to occur. Our council has been particularly active on the ground with coalface organisations throughout the nation, in consultation with them in states and territories, inviting comment and feedback, and raising

community awareness of the components of the Tough on Drugs strategy. We recognise that we have a very distinctive position within the advisory structures of government. In reality, the ANCD is an unprecedented attempt to include the non-government sector in policy development by an Australian government. To my knowledge, this is a drug policy development situation that is unique in the world. I am proud and honoured to be the chairman of this council and to represent the very eminent and highly skilled people of which it is composed.

I believe the ANCD has made a very significant contribution to ensuring governments increasingly recognise the innovative and highly effective work being done in the community at a local level to address drug issues. The members of the council are not politicians; we are not elected, nor are we officially tied to any particular government or party. We are members of the council by virtue of our expertise, experiences and, above all, commitment to the alcohol and drug sector. The council is unique because it brings together an alliance of non-political, committed people, some with more than 25-years experience in the field, to examine and advise on drug policy in the national interest.

It is here that the council most notably differs from other advisory bodies or committees responsible for advising government, many of whom are closely tied to government. I believe it is absolutely essential that Australia has an independent council that is not constrained by political processes. Our significant role in the development of the Tough on Drugs strategy and our representation on the various steering committees responsible for developing those many components is also unprecedented for a non-government body.

We have been involved in the development and implementation of a number of initiatives. These include the illicit drug diversion scheme, which is directed towards encouraging people who come to the attention of the law to go into treatment rather than have them caught up in the criminal justice system. We have been involved in the community partnerships initiatives, which has been resourcing and supporting very small community organisations in local areas and a strengthening of family initiatives; the more than $50 million that was given to non-government organisation treatment services; the training of frontline workers, including police, ambulance, pharmacists and those who are working directly in treatment services. We have worked on the matter of communicable diseases and blood borne viruses—AIDS, hepatitis C and those sorts of things. We have been involved in public education campaigns, school-based programs; information services, co-morbidity and the growing problem of mental illness associated with substance use and misuse.

In relation to these initiatives, I would like to highlight the fact that the ANCD remains very concerned at the lack of appropriate services for these people suffering from dual problems of mental health and drug use. It is a group that is unfortunately growing substantially, and it has grown in size over the years. There is a greater awareness of this, but it appears to be resulting in an ever increasing appearance of these people within the prison system. It is an urgent matter, and this is a result that is completely unacceptable.

Finally, I would like to draw the committee's attention to the number of projects that enhance the evidence and information available to decision makers and service planners that the ANCD has commissioned. I believe these could be of help to your committee. I believe each committee member has received copies of the various research projects that the council has commissioned. I hope you have seen the rural and regional reports where we have gone to remote regions of

Australia and had information from people in places as far apart as Broome, Mount Isa and parts of Tasmania.

We have also worked closely with the ATSI population, looking at family history of alcohol and drug use, diversion programs for Aboriginal and Torres Strait Island youth, looking at the matter of supply and demand reduction in prisons. I talked about the rural and regional research. We have study grants that we have given and are continuing to make available every year to people from remote and regional areas of Australia. We are mapping alcohol and drug treatment services to look at where the gaps are. With the national foetal alcohol syndrome, which is a great concern, particularly in some of the remote areas of Australia, we have diversion workshops. There are many projects which the council has undertaken, and which I would commend to you in your work.

Finally, I would like to say that drug problems are diverse in their nature and in their impact on our community. Cooperation and support must be the guiding principle in our work together on this issue. It is very pleasing to see the broad party representation, which is a reflection of the government and opposition party's attitude towards the drug problem in Australia. It is non-party political. The ANCD has a great capacity to harness the wide range of expertise of its membership, to add a unique perspective on the impact of drug policy, and the federal government has shown the required leadership with funding. That is a combination of factors that, with the goodwill of all those working in this area, must surely benefit the community as a whole. Thank you for the opportunity to be here and for your time today. I wish the committee well in the proceedings for the next two days and into the future. I look forward to reading your final report.

CHAIR—Thank you very much, Major Watters.

[8.50 a.m.]

HILL, Professor David John, Director, Cancer Control Research Institute, The Cancer Council Victoria

MATTICK, Professor Richard, Director, National Drug and Alcohol Research Centre, University of New South Wales

PATTON, Professor George, Director, Centre for Adolescent Health

SAUNDERS, Professor John Barrington, Professor of Alcohol and Drug Studies, University of Queensland, and Member, Australian National Council on Drugs

CHAIR—This morning's first session is the health care session, session 1. It deals with the following presenters: Professor David Hill, Professor George Patton, Professor John Saunders, Professor Richard Mattick, Professor Ian Webster, Professor Ann Roche and Ms Annie Madden.

I remind all those participating in this session that the evidence that you give today is considered to be part of the proceedings of parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to contempt of the parliament.

We will deal with health care in two sections, with the first section covering prevention and early intervention and current and new treatment options for drug abuse. With respect to the first part of this session on health care, I invite to come forward Professor David Hill, Professor George Patton, Professor John Saunders and Professor Richard Mattick.

Prof. Hill—Thank you very much for the opportunity to be here. It is a privilege and a great opportunity to speak on the topic which is very dear to my heart—tobacco and tobacco control. It does link to other substance uses as I can point out and other speakers will. I am going to speak to time and will introduce a few things. I do have other information and slides that I could offer if it happens to be appropriate during the discussion later, because I will be making some statements, and some of them do not have all the evidence, but I have some further evidence with me.

I will try to lead you to the conclusion with my argument that you cannot isolate prevention and early intervention from treatment and cessation of the use of tobacco. They do go together and an attempt to isolate prevention and early intervention and ignore the other would be a very flawed approach.

A PowerPoint presentation was then made—

Prof. Hill—What I have done is offer you a framework built around the life stages through to the time when people become adults and those points at which we could intervene and the kind of intervention that would be most appropriate. If we take the unborn baby, obviously, the intervention that is most appropriate is for the parents and particularly the mother to cease

smoking, if they smoke. For infants, we look at the protection from environmental tobacco smoke; in schoolchildren, the possibilities to change influences on the children through parental example, health education, media, comprehensive population programs and youth access, that is, preventing children from buying cigarettes or getting them from other means; also, in mid to late adolescence, the sort of social venues young people go to and the workplace, if they have commenced work.

I am going to go through each of those in order, briefly, and make some further comments. Just to outline the evidence about the effects of smoking during pregnancy—the reproductive outcomes—they really are quite broad and quite devastating. You can see that there are effects even before conception. Smoking makes it harder to become pregnant, if that is what is wanted. Infertility is involved. Loss of a foetus is affected. Difficulties with pregnancy and birth include premature rupture of membranes, abruptio placenti, placenta previa, and there are even more problems with the baby: preterm delivery, low birth weight and small for gestational age. Birth defects do not appear to be affected by smoking but it might affect stillbirth, neonatal deaths, increased perinatal mortality and sudden infant death syndrome. Incidentally, some of the leading work on that has been done in Australia. In a very recent paper published this year, there are some later problems that we can identify. I do have some more information on that if the committee wants to pursue it.

Harmful drug use: a large study was done in Denmark where everybody was registered and followed up meticulously throughout their life. If the mother smoked, 15 to 20 years later the offspring were more likely to be hospitalised for drug use and to become involved with the criminal justice system than if the mother had not smoked.

Infants: this is largely about smoke-free policies in the home or in the car, which is where children mostly spend time with parents and family. This is obviously not an area for government intervention, but it is certainly an area where people can be educated and encouraged. Just to show that this is not a trivial effect, if you collect urinary cotinine samples from children—cotinine is a metabolite of nicotine; it tells you whether a person has been exposed to cigarette smoke—you can see on the slide that very small amounts of this urinary cotinine are found in children who live in a home where there is a complete ban on smoking inside. But as you go through to completely unrestricted smoking in the home, you can find this urinary cotinine. So there is a very immediate, measurable effect on a biomarker, just from children being near smokers, and that of course explains some of the later morbidity and even mortality, down the track, that arises from ETS exposure.

Schoolchildren: we can think about parental example, and I will come back to that in a moment. Health education and media: I wanted to draw the committee's attention to the fact that there is a question mark about how effective those rather obvious interventions are—lessons in schools about smoking, for instance. Personally, I believe they are an important part simply because it would be wrong for a society to allow children to grow up without being educated about the harms of tobacco. But the immediate impact of simply that on smoking behaviour is not very great. Likewise, media campaigns that are naively done, not supported by other interventions and directed at children are unlikely to be very effective.

Although a lot of parents who smoke may not want to know this, parental example is a really important factor. It is one of the strongest predictive factors for uptake of smoking that we

know. I have just given you an example there of some data from a large national study in Australia, and you can see that in this large sample—it happened to be Victoria—if neither parent was a smoker, about 17 per cent of the children had smoked in the past week. This rose to more than double that if both parents were smokers. So this is a very strong relationship and an important point of intervention.

There is good news—or somewhat good news, anyway. Here I have plotted the percentage of adolescents who smoke and the age at which the parents quit smoking, if indeed they did. You can see that if the parent quit smoking early in the child's life, that child was less likely to become a smoker as an adolescent than if the parent did not quit or left it very late to quit. So that is an important message for parents. That is actually why, in a recent campaign that was organised and which has gone national—in fact, it is not a Commonwealth program; it has arisen through a coordinated effort by the states—directing a media campaign at parents smoking is very important, and it is starting to have some effect.

More on schoolchildren: one category of the factors that predict smoking I have called the upstream factors, things like children's commitment to school values, social values and so on. I have a feeling that Professor Patton may mention that, so I am not going to go into that, but there really are very great benefits not only for tobacco use but also for other substance use in addressing those upstream factors.

Comprehensive programs really are important. Perhaps not ironically, programs that target the whole community, from adults through to infants, are effective, and more effective than simply concentrating on young people. I will have a bit of data in a slide in a moment about that. 'Youth access' is about stopping shopkeepers from selling cigarettes to kids. It has great intuitive appeal. It is a great rallying point for communities but, unfortunately, it does not actually appear to be very effective. So it is not enough. Again, it is something we must do because it is logical and laws that exist should not be broken, but we should not put all our money on that one.

Getting back to the comprehensive campaigns, there are some states in the United States that have comprehensive campaigns. These are usually funded by levies from state tobacco taxes that go towards tobacco control activities. Massachusetts is one of those states which, over a decade or so, has had this well-funded, comprehensive program. This slide shows the impact on children. I have taken this from Siegel and Beiner's study, and at first it is a slightly confusing way of presenting the information. It compares Massachusetts, in green, with the rest of the country. You can see a 40 per cent reduction in smoking by eighth graders in Massachusetts between 1996 and 1999, compared with only a 17 per cent drop in the US generally. You can see, in each of these grade levels, that there was a much greater effect in Massachusetts than the rest of the US.

What about mid and late adolescence? The smoke-free workplace is increasingly common. We have had huge advances in the last decade in Australia in moving workplaces from being smoky places to being smoke free. It is a good thing that young people going into workplaces are very often going into smoke-free areas. That is fortunate because some people do not take up smoking while they are still of school age. It is true that most people do but a significant number of people do not. So the workplace is an important intervention point.

The thing that is particularly worrying us at the moment is the nicotine 'classrooms' as we call them—the social venues, the dance places and so on. I will not go into this in detail, but certainly there are people who are going to those sorts of venues who are not yet committed to smoking. All sorts of features of those environments militate towards them taking up smoking, including some fairly subterranean activities to promote tobacco by the tobacco industry.

Then there is binge drinking. I have to acknowledge the work of Professor Annette Dobson and all her colleagues in the Australian longitudinal study on women's health which shows a strong relationship between binge drinking and tobacco smoking in young women. If people do not binge drink, they are very unlikely to be smokers; if they binge drink regularly, they are very likely to be smokers. A lot of that happens in those sorts of venues.

So I ask the question: can we really expect youth smoking to fall if adults do not quit? You will have guessed already that my answer is no; I do not think we can. Again, US data, which is handy because it is such an enormous country with large populations in a number of states, can give us a bit of a clue here. I did not count them, but quite a large number of each point is a state in the United States. For each state in this data here, there is data available for adolescent smoking prevalence and adult smoking prevalence. You can see in this scatter plot a very clear relationship between smoking prevalence in adults. If it is high in adults, it is also high in children; if it is low, it is low in both. You might ask: where is the state that has a prevalence of less than 15 per cent? Would anyone like to guess? Utah, where nearly everybody is a Mormon and the religious tenets preclude smoking.

What about the impact of all this on disease and death? Again I am making the point that, if we attacked only the front end of this and put all our efforts into the early intervention prevention and programs to prevent uptake of smoking in people up to the age of 16 or 18 compared with what would happen if we did nothing, these are the expected deaths with the present trend. That is the straight line. That is the impact that we would have. It would be a mighty long time coming, 25 years or so, and would not be too great too quickly either. However, if we do both, if we reduce use and initiation, we get immediate gains and they are substantial and much bigger 50 years out.

To personalise this a bit, I looked at the number of tobacco related deaths in electorates picked completely at random. These do assume that each electorate is exactly typical for the whole county, which it is not, but it is a fair assumption. It would be very unlikely that any of these would be more than 10 per cent out either way. I thought you would be interested to see the effect that tobacco is having every day. You can see here that, in a typical electorate, there is somebody dying a tobacco death every second day.

Finally, I did want to make a plug for this document, which I would like to leave. You have got the short version in front of you. There is a long version, which the secretariat has. It is called Tobacco control: a blue chip investment in public health. It has been written by the VicHealth Centre for Tobacco Control, which is part of my institution. It has endorsement across a large sector of the public health community. It gives you a great deal of information about the sorts of programs and interventions that will be appropriate for tobacco. Thank you.

CHAIR—I am looking forward to the question and answer segment. You can expand on some of your topics there. I now ask Professor George Patton to present, please.

Prof. Patton—Thank you for the invitation to present here this morning. I head up the Centre for Adolescent Health in Melbourne. It is Australia's leading organisation in terms of the health care of young people of the age from 12 through to 25. The focus of that organisation is very much on developing applied research and programs related to that research. Prevention for us has been a major focus over the last 10 years. We have been very keen to develop some practical approaches that complement other strategies that have been used in the prevention of substance abuse such as the strategies of supply, control and harm minimisation.

Our focus here has been very much on what we can do to prevent the onset of substance use and abuse in young people. In this presentation, I am going to be talking about what are the key steps that we believe are important in practical prevention programs. I will be keeping a very close eye on how substance abuse prevention relates to some of the other important health and social problems that emerged during the teen years, in particular, youth offending, sexual risk behaviour and mental health problems.

My talk is really very simple. It has four steps. I am going to be talking about the four steps that we believe are important in terms of prevention. The steps are shown here.

A PowerPoint presentation was then made—

Prof. Patton—Step 1 is very much defining a problem. David Hill has already done a very good job of defining what the problems are in terms of substance use and abuse. As a broad picture, that includes both licit and illicit drugs. I am not going to spend too much time on that; rather, I am going to be talking about steps 2 to 4.

Step 2 is knowing what the appropriate focus for a prevention program might be. Step 3 is knowing what actually works; what evidence do we have that a particular strategy is effective? Step 4 is knowing how we put it together in a workable format in a particular setting. I turn to look at what the social factors are; if you like, the 'risk' and 'protective' factors. They are technical terms. Risk factors are social factors that increase the risk of substance use and abuse; protective factors are those that protect against it. What social factors do we know to be important in terms of determining substance abuse in young people? The immediate factors relate to three settings: family, school and local neighbourhood. These are the three social contexts that impinge most on the lives of young people, and it is these three settings that are going to be prime targets in terms of prevention programs that will be effective in getting to young people.

Clearly, these systems sit within broader socioeconomic macro influences. They relate to cultural factors and also to the growing role of the media in young people's lives. We must remember that young people are important consumers for industries such as the tobacco industry, the alcohol industry and the illicit drug industry. In terms of thinking about these social influences we need some framework that makes sense to guide our prevention programs—something of a map. The kind of map we think is really important is shown in this slide. It has at its central point the sense of connection, bonding and attachment between a young person and these core institutions of family, school and local neighbourhood. Where a young person is bonded—connected—to adults in that setting they are likely to adopt a set of healthy values and beliefs that, in turn, will lead on to healthy lifestyle choices and behaviours. Where that connection does not exist young people at the margins of school and family are going to connect

to other young people in similar situations, and adopt their values and behaviours. Those are the routes to substance abuse.

What do we need to promote bonding attachment? We think three things are important in terms of prevention. One is to create the opportunities for connection—in our schools, local neighbourhoods and families—with adults. Secondly, we need to promote skills in young people around making those social connections and promote those skills in adults in those settings as well: how to talk to young people. It is about communication. Thirdly, we need to get young people actively involved in their communities, families and schools in a way that is valued and recognised.

Putting that very technically—and I do not want to go into the detail of this slide—there are a whole lot of individual risk factors, some of which David Hill has already mentioned, that relate to substance abuse. But they also relate to antisocial behaviour, school dropout and suicidal behaviour. The hope is that, if we can tackle those risk factors, we will affect not only substance abuse but also these other important social problems affecting young people. This is data from a survey of 10,000 young Victorians carried out by our centre looking at some of these social risk factors and their relationship to alcohol use and abuse, cigarette use, marijuana use and other drug use. You will see here rising rates of those risk factors—rising levels of disconnection—and so too rising rates of substance use. There is a similar pattern for early sexual activity, depressive symptomatology, risk of homelessness and deliberate self-harm. They have the same risk factors.

So what are some of the evidence based intervention strategies that are beginning to show that they work? We have strategies that focus on families, schools and communities that are shown to be effective. Stars here mean evidence of effectiveness. This is a draft document of a review carried out for the Department of Health and Ageing which has comprehensively looked at this range of strategies. This has been carried out by the National Drug Research Institute in Western Australia and the Centre for Adolescent Health, and details what programs and strategies work. The short message is that we now have strategies and an evidence base for prevention that we did not have 15 years ago.

How to put it all together? In the time available, I would like to take the example of one project. Again, it is from our own work at the Centre for Adolescent Health, which was a schools based project—the Gatehouse Project—which has applied these principles in practice. There are three steps to doing this work, as I have already mentioned. The first is to know the social environment in which you are working—know your school and assess risk and protective factors in that local setting.

The second step is building a structure for coordinating activities within that setting. For us it was an adolescent health team within the school. Thirdly, it was to implement strategies that are the best strategies for that school setting, at multiple levels. This is the kind of assessment that we did in schools. We asked students to tell us what their relationship was like with their teachers, the key adults within the school. We asked what their view was of school work and if there were opportunities for them in their school setting. These are the things that make a difference, a connection with school.

For example, in hypothetical school X, a lot of kids are bored. These kids are not connecting with the main task of school. A lot of kids are saying they do not like their teachers; their teachers are not fair. There is something wrong here with the relationship between teachers and students in that school. That is a focus for preventive work.

The strategies used here were some of the traditional strategies we have used. We turned to the curriculum but not just curriculum in health and physical education. We go beyond that to English and to other subjects, dealing with the little problems of life and life skills. We would agree with David Hill that doing curriculum or health education alone does not work if it is simply about providing knowledge. We need to be providing very much more. We need to be providing skills and dealing with the broader setting. We need to be dealing with what is happening in the classroom. We need to be dealing with what is happening at the whole school level: what is happening in the schoolyard and on the sports field. What is happening in the nicotine 'classes' that David Hill mentioned?

Does it work? I cannot tell you the findings; I can just give some illustrations of what we found in relation to smoking. In a randomised control trial of 3,500 kids, the highest level of evaluation looked at what happened with year 8 students, 13 to 14 years of age, two years on from beginning intervention. On the baseline there were no differences in smoking levels. At follow-up, this was the picture in our intervention schools: there were significantly lower rates of regular and experimental smoking compared with comparison schools. This is effective stuff.

In terms of messages for the future, there are a few that I would like to reiterate. In terms of prevention steps, step 1 is to find the problem. Effective prevention is about targeting all forms of substance use, licit and illicit. In step 2 we need good data to drive preventive work. We need that data at all levels. We need good data nationally, at a state level, and at a local level about the social context in which young people are growing up. We do not currently have that data. Step 3 is to implement strategies which are evidence based. We have a growing literature and evidence base that we can implement. But in implementation, we need to be engaging young people actively to make sure that what we do is relevant to them.

Lastly, in terms of program implementation and coordination, reiterating David Hill's message, we need to target whole settings, whole communities, whole neighbourhoods and whole schools. If we do so, we will be more effective. What we do needs to be age appropriate. There is no point in targeting negative attitudes to tobacco use, for example, in primary school. Kids in primary school have negative attitudes. Those attitudes change during their teens.

There is a particular message I want to really drive home, which is that we have got some high-risk marginalised groups of young people who are doing very badly at the moment in all respects, in particular substance use. These are kids in protective care and juvenile offenders. Indigenous youth are in this category as well, as are kids who are dropping out of school. These kids are doing very badly. We need special attention to them. We need to target them early. The last message is really that prevention is about the long term and we need a long-term approach. It is not about the next two years; it is about the next 10 to 20 years.

CHAIR—Thank you very much. I ask Professor John Saunders to make his presentation.

Prof. Saunders—Thank you very much for giving me the opportunity of giving this presentation to members of the committee. I have made available copies of the presentation to each of the committee members. May I also draw your attention to a book that Major Watters mentioned, *Evidence supporting treatment*, which I think members of the committee would find a valuable resource in judging the effectiveness of treatment.

A PowerPoint presentation was then made—

Prof. Saunders—I am going to structure my presentation this morning around the different substance groups which are used and abused in this country. I am going to cover alcohol misuse, smoking, cannabis, heroin, psychostimulant use and inhalant use. There are other ways in which I could have structured this presentation. For example, I could have talked specifically about approaches to treatment in indigenous peoples or approaches to treatment of people in different age groups. But in the time available I thought that as an overview it might be best to structure it according to the particular substance type, recognising of course that many people use multiple substances and may require treatments which span the range of substances or different forms of treatment for different forms of substance abuse.

Before I cover each of the substance categories in turn, I want to ask two fundamental questions. Firstly, what is the goal of treatment? Secondly, how do we judge the effectiveness of treatment? You might think that that first question is a foolish one. What is the goal of treatment? Isn't it obvious? Aren't we trying to reduce substance abuse in our society? Well, it is a little bit more complicated, because we have two potential goals. Is the goal cessation or reduction in substance use or is it reduction in substance related harm? In the United States the goal of treatment and policy in general is the reduction and if possible the cessation of use. All the treatment programs and all the policies in that country are directed to that end. In Australia for the last 17 years we have adopted a more public health approach, which is how do we do the greatest good for the majority of people, in particular how do we reduce deaths from substance use, major morbidity and the major social complications. So the focus over this period of time in Australia has been in the reduction of drug and alcohol related harm, even though the strategies put in place might not lead to a reduction in use. I would put it to members of the committee that that distinction is a very fundamental one.

The second question is how we judge the effectiveness of treatment. Again the answer to this might seem very obvious. You do some studies, you do evaluations. There is certainly a body of research evidence which attests to the effectiveness in controlled scientific trials of various forms of treatment. But there is another very important question, and that is, does it work in practice? Are these practical treatments which can be offered to people with a substance use problem? As scientists, we sometimes have to show some humility because the scientific methods that we put into play often are not appropriate to addressing certain forms of substance misuse treatment. In particular, they are not very good at addressing whether the longer term rehabilitation programs are effective.

This table here gives an at-a-glance overview of where we are at in our knowledge of the effects of different forms of psychoactive substances, whether we have the evidence of effectiveness of treatment and also whether that treatment is widely available throughout the Australian community. I shall deal with each of these in turn.

As you can see, in some areas we are doing very well. For example, we have a tremendous amount of knowledge on the effects of tobacco and nicotine. There is evidence of several forms of effective treatment and treatments are widely available throughout the community. Some forms of nicotine dependence treatments can be obtained as over-the-counter preparations. You do not need to go to a doctor to access these forms of treatment. I would regard this as a tremendous success story. Any time you are feeling a little bit glum about prospects for addressing substance use problems, look at what has been achieved in the tobacco area.

On the other hand, inhalants are an increasing problem, particularly in marginalised and indigenous communities. What do we know? We have some knowledge. Do we have models of effective treatment that are scientifically proven? Essentially, no. Is that treatment available? There is no scientifically valid treatment, so the answer to that is no.

Let me give you a brief tour of the major forms of substance misuse treatment. Brief interventions for hazardous and risky drinking to prevent alcohol-related harm have been shown in many randomised controlled trials to be very effective. They take only a few minutes, but unfortunately they have been taken up little in practice. There is solid evidence for the effectiveness of psychological therapies for risky drinking and alcohol dependence. There is rather limited availability and often people do not persist in these forms of treatment.

Over the last 2½ years, there have been two useful pharmacological treatments for alcohol dependence introduced, namely, acamprosate and naltrexone. There is substantial evidence for their effectiveness but only 1.5 per cent of alcohol dependent people in Australia are being treated with these drugs at any one point in time—98.5 per cent therefore are not. There is limited evidence of effectiveness from scientific studies for rehabilitation and supportive approaches. But please note my earlier caveat. This is the major approach that is offered in practice.

What are some new approaches? We have the techniques and the evidence base for brief interventions. We need to provide incentives for general practitioners and other primary health providers. There is a tremendous opportunity for providing psychological therapies without therapists through the Internet and correspondence programs, which are looking to be extremely promising.

There are great developments in pharmacological treatments and in neuroscientific understanding of alcohol dependence and its treatment. A new generation of pharmacotherapies is becoming available. We need to match that with training and support for general practitioners in particular in this area. In the area of rehabilitation, the challenge is to incorporate these individual treatments into rehabilitation programs.

Moving on to smoking, this is overall a great success story. The forms of treatment include brief advice, often only of a few minutes, with solid evidence for its effectiveness, although the treatment effect is somewhat small. There is solid evidence for the effectiveness of substitution therapies using various forms of nicotine replacement, which are widely available, including many over-the-counter preparations. As for other pharmacological treatments, there is good evidence for bupropion but some limitations because of contra-indications. It is an area of active development and it is one in which I am sure there will be some additional therapies available over the next five years.

Moving on to cannabis, our knowledge base has greatly improved over the last few years. We know a lot about the actions of cannabis. There are receptors in the brain and in many parts of the body which cannabis interacts with. There are endogenous naturally occurring cannabinoid compounds in our bodies, and we know much more about the health effects. I draw the committee's attention to the fact that people are giving themselves much higher doses of cannabis now than they were 20 years ago. One could argue that cannabis use, as practised 20 years ago, was a relatively trivial form of substance abuse—that is not the case now. We are seeing an increasing number of people with cannabis dependence and the severe health effects of cannabis. For psychological therapies for cannabis misuse there is very limited evidence. Pharmacological treatments and trials of cannabis blocking drugs are being undertaken overseas, and also trials of cannabis-like compounds.

What are the challenges and the new approaches? Firstly, we need to disseminate the new knowledge that we have about the effects of cannabis. There is a need, given the impact of cannabis use on people's lives, for there to be Australian based trials of different psychological therapies. Some have been done, but not enough. With pharmacological treatments, I would urge that we collaborate with overseas institutions to examine prospective treatments to see whether they have application in our own country.

On current treatments for heroin dependence, there are three main approaches. Substitution therapy is the benchmark treatment for heroin dependence. That includes methadone and the newly introduced compound buprenorphine. There is sold evidence for the effectiveness of methadone and buprenorphine in reducing harm related to heroin use and deaths. Methadone maintenance reduces the death rate amongst injecting heroin users by 75 per cent. It is a very important treatment.

Antagonist pharmacological treatments produce some superb results in a small number of people. Naltrexone is the principal drug which is used in this regard. It is best for highly motivated clients with very good social support. I would judge that it is appropriate probably for about five to 10 per cent of heroin dependent people at any one time. Rehabilitation and supportive approaches also produce good individual outcomes, but there is a high attrition rate and this approach is unpopular with many people, and therein lies a challenge for rehabilitation.

What are some of the new approaches? We have, in methadone and buprenorphine, two very effective treatments for opiate dependence. They are, though, not directed to complete cessation of all forms of opiate use because they are substitute opiates. Hence my earlier comment. Do we want to reduce opioid use completely, or do we want to reduce harm and deaths? If the latter is the case, then I would urge us all to try to achieve a target of 80 per cent of heroin dependent people in Australia in treatment with these forms of treatment. This has been done in Switzerland and in the Netherlands, and I say that is a challenge for us.

In terms of antagonist treatments, one of the difficulties about the present form of naltrexone treatment is that it is a tablet and a person needs to renew their commitment to use on a day-by-day basis. Often people experience ambivalence about going through with treatment. Naltrexone implants last between two and six months. They provide a promising long-acting form of treatment, using a blocking drug and is designed to help people to become truly opiate free. I would urge a research and development program into these implants and other long acting preparations. With regard to rehabilitation approaches, we would need to look at how we

combine different forms of treatment. Is there an approach for using substitution therapies? Is there any argument for incorporating naltrexone treatment within existing rehabilitation and support programs? My argument is that there is.

This slide summarises the state of our knowledge on treatment for psychostimulant misuse. It is pretty well non-existent, particularly as it relates to amphetamine use. Even the treatment of cocaine dependence, which has been subjected to a huge amount of research funding in the United States, is very difficult. There are a few psychological approaches but, with one slight exception, there is not yet a single pharmacological approach that has been shown to combat cocaine dependence or amphetamine dependence.

What are the challenges in the treatment of psychostimulant misuse? First of all, we have to develop our knowledge base and disseminate that knowledge. It is again an increasing and major form of substance abuse in Australia. We need to trial psychological therapies that have been shown to be useful for other forms of substance misuse. This is happening in a small way. We are conducting a trial collaboratively with some other colleagues, but much more needs to be done in this regard.

With regard to pharmacological treatments, my interpretation of the evidence at the moment is that for the small group of people who are truly amphetamine dependent the best form of strategy is the use of substitution therapy, with a purified form of amphetamine or other synthetic psychostimulants. There is some early work suggesting that this is a promising approach. But again I come back to the issue: this would not be reducing the overall level of use of psychostimulants; this would be a harm reduction approach designed to limit harm, deaths and social problems.

The state of our knowledge of the current treatment of inhalant misuse is summarised appropriately in that blank slide. There is a bit of information about the prevalence of inhalant misuse. We have very little evidence about what treatments apply and we are not even approaching the systematic availability of treatments for inhalant misuse.

I have tried to emphasise that, for the various major types of psychoactive substance abuse that we see in our society, there are some good forms of treatment that are evidence based. There are some forms of treatment that are now increasingly widely available. There are certainly some gaps in our knowledge, in the evidence we have for treatment effectiveness and, certainly, in the dissemination of that information and providing those services so that they are accessible for the whole of the Australian community. Thank you.

Prof. Mattick—Firstly, I would like to take the opportunity to say thank you for being invited to speak here today. I am from the National Drug and Alcohol Research Centre in Sydney. The centre has submitted a report to the inquiry previously. What I would like to do today is to focus on a few controversial areas. I would like to make some statements about treatment, to deal with some of the myths and claims that have been developed over the recent past. Brian Watters commenced by saying that he thought it was very important that there was a non-political approach to drug and alcohol use but, unfortunately, in Australia that has not always been the case, particularly over the recent past. That has been driven by strong advocacy for or against certain forms of intervention.

I would like to walk you through some of the evidence concerning the treatment of illicit drug problems, mainly, and, briefly, alcohol problems—I think John has already touched on this evidence. In the time available, the presentation aims to overview the treatment of alcohol problems through brief interventions, acamprosate and naltrexone, which are new pharmacotherapies. It also aims to overview the treatment of opioid dependence through methadone, buprenorphine, naltrexone and to discuss with you a study which was conducted called the Australian NEPOD project, National Evaluation of Pharmacotherapies for Opioid Dependence. We will talk briefly about amphetamine and cocaine—the problems with treatment and the international literature—and we will provide a summary of the talk.

What I would like to do is to acquaint you with the nature of heroin dependence. In the context of understanding treatment, you need to understand what happens to people who become dependent on opioids. Before I walk you through the slide in detail, I will tell you that, prior to coming into this area, I worked in mental health and I knew that heroin dependence was something that individuals could relatively easily overcome. We did not treat individuals who were heroin dependent. We told them that they should go and overcome their dependency. We would not treat people who were on methadone treatment.

One thing that is not explained to audiences like you is the nature of this problem. Part of the problem which arises in discussing treatment or intervention is that people do not understand what they are facing and, to an extent, that is because we have only had heroin problems relatively recently—for the past 35 or so years. We do not have Australian studies. We have US studies. Of the US population, about 0.04 to 0.07 per cent become heroin dependent. That is similar to Australia. They have about 800,000 or maybe 1 million people who are heroin dependent currently. In the UK, the figures are similar.

The point of this slide is its middle point: that enduring abstinence from heroin is, once the use is established, rare. What you and the public are not usually told is shown by those last points, which relate to follow-up studies of individuals in North America—and there is no reason to believe that those findings would not and do not apply here. Of the individuals who came into treatment and were followed up for 20 years, a third of them died prematurely; a third achieved and maintained abstinence, which is a good outcome—that is what we want, and that is what John Saunders was talking to you about; about a third move through a cycle of treatment, prison and active heroin use into their 40s and 50s.

So when we talk about these problems, we have to talk about management, not cure. That is the kind of terminology which has been put about in the media over the recent past—that we need a cure for these problems. I am sure that others who speak to you will talk to you about the similarity of alcohol and other drug problems to health problems generally, whether asthma, schizophrenia or diabetes. They are chronic relapsing disorders, unfortunately, once they are established.

The treatments for opioid dependence include detoxification, which will achieve short-term abstinence. That point is very important. You will not achieve long-term abstinence with detoxification. The studies internationally are quite clear. Long-term rehabilitation, which John talked about, is an option, but it is not attractive to the vast majority of people who become dependent on drugs. There are pharmacotherapies, including methadone, buprenorphine and naltrexone, recently introduced into Australia—certainly the last two. But counselling and

psychotherapy or psychological approaches on their own are not particularly useful for this problem.

Methadone is a treatment which has been widely criticised. It is a synthetic opioid receptor. It is like morphine. It replaces heroin. It is presented in a syrup and usually dosed once a day in medically supervised treatment clinics or in accredited GP or community pharmacies. Methadone is the best researched treatment for opioid dependence to date. It lasts about 24 hours; it reduces blood borne viral infections, heroin use, criminal activity and morbidity and mortality, as John pointed out. It is relatively safe in pregnancy and it is inexpensive to the individuals, as it is government subsidised. However, it does maintain opioid dependence and it is difficult to withdraw from. It can cause respiratory depression and overdose fatalities. It is inconvenient, because of daily dosing, and the users, the heroin dependent people, have concerns about ongoing dependence and side effects. It is also highly stigmatised.

Buprenorphine has recently been introduced. Buprenorphine is a pain-killer and it has been used for many years in Australia as a pain-killer. It is an opioid receptor—a partial opioid medication. It gives a mild opiate effect but blocks the effects of additional opioid use. It comes as a tablet in various sizes and it is usually dosed once daily but can be dosed on alternate days because it has got some unique properties. It has been registered for use since October for the management of opioid dependence and detoxification. Buprenorphine has a number of advantages: it has a relatively low level of dependence associated with it; it is relatively safe in overdose, except when combined with alcohol and benzodiazepines; it has a long duration of action of up to 35 or more hours; alternate day dosing is possible; it is safe in higher doses than methadone; and it reduces heroin use and morbidity. There have not been enough studies on mortality to comment about that. However, it is expensive. It costs the federal government 10 times what methadone costs. Slightly fewer patients are retained in treatment, but it is still quite an effective treatment. It takes longer to dose, which seems like a trivial problem but practically, at the interface of providing treatment to individuals in community pharmacies, this becomes potentially a major problem for it. As I have said, there is also a risk of overdose, if it is combined with alcohol and benzodiazepines.

A number of years ago there was a controversy raised concerning naltrexone. There were strong claims made about naltrexone's value. They were driven largely by media, but they were also supported by a number of people nationally—and some internationally. Naltrexone is a long-term—and I emphasise that it is long term—oral opioid receptor blocker. It blocks opioid receptor sites in the brain from the effect of heroin. It comes in 50-milligram tablets and it is usually not supervised after the initial induction period of a week. It has been registered since January 1999 for treatment of opiate dependence. Its advantages are that it is safe and effective while people are in treatment and it results in increased stability, social contacts, employment and lower levels of craving for heroin. It reduces heroin use and morbidity while people are in treatment: that point is very important. The disadvantage is that the patients do not like it: there is poor patient compliance and acceptance, poor retention and there is some evidence of the risk of death increasing when the treatment is ceased. That is not because of the treatment; it is because of cessation of the treatment. The risk of overdose death may increase if individuals are using heroin and naltrexone intermittently.

I will go on to the National Evaluation of Pharmacotherapies for Opioid Dependence. It was a three-year national evaluation of effectiveness, safety, cost and cost effectiveness of

pharmacotherapies for opioid dependence. There were 13 treatment trials in six Australian jurisdictions; there were 1,425 patients; and the treatments examined were methadone, buprenorphine, naltrexone and LAAM. The trials were funded by state governments and the NHMRC. In a sense, this grew out of the debate about the heroin trial. The National Drug and Alcohol Research Centre was responsible for the overall work, and the states and territories funded the trials.

I am going to go straight to the results. I will look at retention in treatment, which is a very good marker of outcome. LAAM is a medication which I will not talk about. It is not currently registered in Australia, but it had relatively good retention. Methadone had retention of about 50 per cent and buprenorphine had about 40 per cent. These figures are not ideal—we would like them to be somewhat higher—but they are not unreasonable, and I will put them in context in a moment. When I presented to the Ministerial Council on Drug Strategy last year, I made the point that nationally we expect treatments like methadone—and we will expect this of buprenorphine—to achieve outcomes which are probably not possible with any treatment. We also expect these treatments to achieve these outcomes with relatively few ancillary services. Methadone and buprenorphine should be provided with more ancillary services than are currently provided by the state governments. That leads the treatments to be somewhat less effective than they might otherwise be, which leads people to criticise them and say that they do not work. If you want these treatments to be effective, they need to be supported adequately in a number of ways, and there is good literature on the nature of the additional interventions rehabilitation that may be effective.

This slide shows the outcome for naltrexone. John Saunders correctly stated that retention in treatment of patients is very low for naltrexone. For many of the treatments, patients drop out within a week or two. I will summarise that on this graph here, which shows results for methadone, buprenorphine and LAAM. With those, retention in treatment is about 50 per cent or 60 per cent at six months. With naltrexone, half the patients leave within a week or two. So the promises that were made to the community, to the parents and to the users about the effectiveness of naltrexone were not realised. These treatments were run across a number of states by different investigators. People were enthusiastic about naltrexone, patients were keen to be in the treatment, and these are the outcomes they got. When people leave treatment they tend to do badly; they relapse—and I take you back to that initial slide about the chronically relapsing nature of heroin dependence. The outcomes were that all the pharmacotherapies reduced heroin use while patients were in treatment. Rapid opioid detox with naltrexone was effective in inducting patients onto naltrexone, but there is no evidence of long-term benefits and there is a large drop-out. Methadone maintenance treatment, buprenorphine and LAAM produced similar benefits; however, LAAM was superior to methadone. LAAM is unfortunately not registered in Australia currently.

I would like to make this a bit more concrete, and I will do this briefly. There was a study conducted in Sweden many years ago. The Swedish government were very critical of methadone. They did not want to introduce it; they did not like the treatment. They grudgingly allowed some investigators to look at 34 individuals who were heroin dependent. In the study, these individuals either received methadone or received no methadone. These individuals also received extensive counselling, rehabilitation and job finding assistance. There was a very high level of intervention. The individuals in the control group could not enter the methadone group for two years, but after that they could. It is not very clear on the slide, but the Us here refer to

individuals. There were 17 who received methadone. There were 17 who were using—that is the U—and receiving no methadone. Two years later, 12 of those who received methadone were abstinent from heroin use; five were not. Of those who did not receive methadone, most were using—that is the U, ongoing daily use—two were dead and one was abstinent. The control group that originally received no methadone were allowed to enter treatment if they wished. Four years later, six of those who had initially received no methadone but who had chosen to enter methadone treatment had become abstinent and two had continued using. Of the control group, among those who did not choose to enter methadone treatment, four were dead, four were using and one was abstinent.

I am not an advocate of methadone. I think it has a lot of problems. But the reality about this treatment has not been made clear to the community or to you, and I think you need to understand that. It is a treatment that has been criticised. It has been criticised by those who support more radical moves like heroin trials or injecting centres, because they have to tell you that the existing treatments, including methadone, are ineffective. It has been criticised by those who do not like the treatment because they think that you should not give drugs to drug dependent people. However, the results of that Swedish study have been replicated in a number of trials internationally at different times, in different settings, with different investigators.

I will briefly go through the amphetamines. Amphetamines are stimulant drugs. They have a pharmacological action that produces a sense of energy and euphoria. The withdrawal is mild and short lived but sufficient to support a chronic, harmful, relapsing condition and dependence in some individuals. Intense craving may be a critical factor leading to amphetamine relapse. There are no specific services or recognised pharmocotherapy treatments for amphetamine withdrawal. John summarised this well. Most of the studies have relied on cocaine treatment research. There are some psychological interventions—cognitive behavioural therapy, therapy to communities and self-help groups—which have been shown to have some success. There has been study of amphetamine replacement therapy—John also mentioned this—and there have been dexamphetamine programs in England and Wales. The notion behind these programs is to take individuals who are injecting illegal amphetamine and give them a pharmaceutically pure form of the drug, try to stabilise their use and draw them into a process of withdrawal. It is not about long-term maintenance. John said there is no evidence there. He is right in a sense. The number of patients who have been studied in dexamphetamine studies internationally is probably about 400. Probably 10,000 or more have been studied in methadone and buprenorphine treatment. The amount of research that has been conducted to date in this area is tiny.

I will finish by just saying that you also need to understand the value of treatment purchase. Studies from the USA—from California—show the cost-benefit ratio for taxpaying citizens. The benefits of treatment outweigh the costs of treatment by ratios of from 4:1 to 12:1, depending on the treatment. The problem with this information is that the money is not returned, necessarily, to the department that expended it. Benefits from health intervention may occur in criminal justice, and they may be long-term benefits which come in the future. But treatment is a good purchase. Put in a different context, there is a different study looking at ways of reducing, in this case, cocaine use in the USA by source country control, interdiction and domestic enforcement or treatment. The cost of reducing consumption by one per cent, if you chose source country control, was $US783 million; interdiction was $366 million; domestic enforcement was $246 million; and treatment was $34 million. It cost 23 times as much to get a

reduction through source country control as through providing treatment. That does not mean that you do not do these other parts of the equation but, again, treatment is an important part of intervention which needs to be understood and supported in Australia.

I have talked to you about methadone, buprenorphine and naltrexone, about amphetamines and not so much about cocaine and cannabis. I have made the point that there are few treatments available for these areas of illicit drug use. There is replacement therapy with dexamphetamine and there are new directions which can be pursued; treatment is a good purchase. Thank you.

CHAIR—Thank you. We will open to questions now. Speakers, please feel free to expand on anything that you might wish to expand on that you were not able to cover in your presentation, as I know that we have kept you relatively short. If you do have papers from your presentation that you would like the secretariat to have, please feel free to give the secretariat a copy of those, and we will have them distributed to the committee members.

Mr EDWARDS—Professor Saunders, you spoke about new approaches to cannabis misuse and you indicated that you thought there was a difference in cannabis today compared with 20 years ago. Could you expand on that?

Prof. Saunders—Twenty and more years ago, most cannabis which was taken was in the form of marijuana leaf. Marijuana leaf is a relatively low potency form of cannabis, and the frequency with which it was used was usually low, and there were few serious health effects. People are now taking a dose of cannabis which is, on average, 3.5 times greater than 20 years ago. People are using the flowering heads of the cannabis plant, which contain a much greater concentration of delta-9-THC—the biologically active cannabinoid. They tend to use water cooled apparatus, and this enables them to take a much bigger dose than used to be the case when marijuana leaf was a predominant form. The evidence we gained 20 and more years ago about the health effects of cannabis and the opinions that people formed 20 or more years ago really have to be rethought, given the fact that the doses are higher and there has also been an accumulation of evidence about the deleterious health effects of cannabis. I do not want to overemphasise this point, because as a harmful substance cannabis does not compare with tobacco or with alcohol. However, it is equally important, I would argue, that we do not write it off as a trivial substance, because it is not.

Mr QUICK—Professor Patton, how do we get over the solo mentality of state and also Commonwealth government agencies when we hope to set up something as radical as these health teams? Are any states or cities or regions doing it any better than anyone else, or is it still rail-gauge mentality and adhocery?

Prof. Patton—I think this is one of the major barriers that we face in doing effective prevention work. The best opportunities for prevention are probably going to come outside the sphere of influence of the health sector. In terms of children and youth, it is going to be the responsibility of other departments; the justice department is going to be important, Family and Community Services and, clearly, education. We need to be doing our research differently, for a start. We have tended to start with developing policies within silos, with doing our research within silos. In our work we have tried very hard to build the links with other sectors that we think are terribly important—links with education, with the community services. I think if we can begin to do our research and our development of program work differently, with common

objectives and common goals, then we can move to some common policies around this. And, moving to common policies across departments, we will then be moving to a situation where we are able to develop the infrastructure we need for doing prevention well.

I do not think any of us has an answer at this stage, but I would note that there are initiatives in the field here. One, for example, is a national alliance which has been established of researchers across these areas of health, education and the social sciences to work together around strategies of prevention. This is the kind of initiative which I think will, in time, lead to a better conjoint approach.

Mr QUICK—Professor Hill has already stated, and Professor Mattick has substantiated, the cost benefit of early intervention. Why isn't it happening, when for $1 in early intervention you save having to spend an additional $US19? The evidence is there; why aren't we doing it? We are losing tens of thousands of people to cigarette and alcohol related deaths and a substantially smaller number to illicit drug deaths. Governments are spending tens of millions of dollars putting pamphlets in people's letterboxes when the evidence is that that is not the way to go. Massachusetts have bitten the bullet. Why aren't other states and countries doing the same thing?

Prof. Hill—I hate to raise this but it involves resources. The 'blue chip' document that I articulated for tobacco—but I am sure the same sort of document could be produced for the other areas—does, I think, make a very compelling case that it is a good investment. Of course, there are gains way down the track, but I think some people are under the misapprehension that even the economic gains are very distant. I have not got slides of the figures here to show you but, in fact, investment in tobacco control starts to return economic benefits quite quickly. Take stroke, for instance, which is a condition most people know about and fear quite deeply: within a year or two, an intervention that converts smokers, who otherwise would have continued smoking, into non-smokers starts to show up in strokes that do not happen that otherwise would have happened. And stroke is a very expensive sort of condition to have, as everybody around the table knows. The big question is why people like us have not been effective enough in selling the message to the community, to the decision makers. That is why we are all so very delighted to have an opportunity to come to this place, where the decisions are really made. I say again: it is a very good investment, in human terms and economically.

Prof. Patton—To reinforce what David is saying, the way in which we configure our health services for young people does not and has not worked. For the younger group there are real issues around the recognition of health problems—cannabis being a good example. I endorse the comments from John Saunders. This has been a problem which we have failed to recognise—and I think young people are failing to recognise—as a significant health problem. These young people are not presenting. That is something to do with the attitudes to cannabis use and cannabis dependence. There is a message there about health literacy—that we are not getting to people—or about the health literacy of young people; but there is also something there about the way in which we are configuring our services. I think we need to be smarter in the way in which we make our services more accessible. Part of that is about the training of health professionals in responding appropriately to this age group. Part of it is also about looking at the way in which our services are structured and at how the younger group get to treatment, because they are not utilising the services as they currently are.

CHAIR—I have a quick follow-on question. Professor Hill, I understand the government is currently negotiating an international framework convention on tobacco control. You are obviously a member of that delegation. How significant do you think such an international treaty will be around the world and do you think it will contribute to programs and policies within Australia?

Prof. Hill—To answer the first part of your question, it will undoubtedly be extremely important around the world. This country has quite a good reputation for tobacco control—that term is perhaps not the best term but it is the term in the field—and that is because of a whole gamut of interventions, such as policy interventions, economic interventions, programs, regulatory means and so on. Many developing countries with new markets are being exploited, most shamelessly, I would say, particularly by Western tobacco companies. This convention will be a way of helping to protect those countries.

I have been to only one of the negotiating sessions in Geneva, but what really struck me most forcibly was that this gathering, which was like a parliament of people talking about tobacco, brought in other parts of government than the health sector. It brought in people from government—not the health sector but trade people, customs people and legal people from the whole range of government. We in health will continue to play our record about the consequences of drug use—we know it all, in that sense—but the important thing is bringing in the other sectors. So the process of creating the framework is very important. That is happening within Australia as well, because we have brought in people. Simply participating in that process means that the Australian government as a whole has to think about tobacco, so that has been good. The actual provisions of what is likely to be the outcome of the convention may not be a great advance on what we already have here. It is an international contribution, but I think the process is really important.

CHAIR—Thank you.

Prof. Mattick—I want to comment on the question of why these interventions are not necessarily as widely used as they could be. I think you need to understand that the drug and alcohol field was largely ignored professionally for many years. It was, to quote an old professor of mine, ‘the refuge of the intellectually destitute’. That was his view. Over the last 20 years, there has been huge investment, nationally and internationally, through a number of initiatives. What you are seeing through the information presented here, and through a lot more information available to you, is the accumulation of that investment over 20 years. You have a good research base from which to move ahead. You should take advantage of that. It has not been available until relatively recently. We did not have good treatments for opioid dependence 20 or 30 years ago; we did not even have good treatments for alcohol dependence. A lot of these interventions are new, and you are in a position to capitalise on that and take it forward. You are in a position to make the point to the government that the huge public health problems associated with illicit and legal drug use can be addressed; there are clear strategies which are well accepted across the board. The controversy that I pointed to has lessened with time, and it has lessened across a range of areas. The work that has been done on tobacco, on alcohol and on opioids really allows you to make some recommendations. I think you also need to think about investing in understanding the management of other problems like cannabis, amphetamine and, increasingly, cocaine dependence.

Mrs IRWIN—Professor Mattick, you are stating that, at this stage, you feel the best treatment in Australia is methadone, but you also commented that you thought—and I hope I have got this right—that LAAM was better than methadone but that it is not available here in Australia. Could you give the committee a brief background on LAAM? I believe that was in the trials. Is that correct?

Prof. Mattick—Yes, LAAM was trialed in two jurisdictions. It is a medication like methadone but it lasts in the body for longer. It is probably more stable in blood levels for the individual so there is less withdrawal or craving, because with any of these substitution therapies you are substituting one opiate for an illegal opiate—the registered pharmaceutical for heroin. LAAM seems to provide a better blood level and more satisfaction for the individual so they do not go into withdrawal as easily. It is not available; it is unlikely that it will be registered unless the company involved were encouraged to do so. I think we would need to do a little bit more work to make sure that the results in this study are replicated. It is relatively expensive, but it could be a part of the overall approach to opioid dependence.

Mrs IRWIN—In the submissions we have received, some groups and individuals stated that they would like us to put recommendations to the government for the trial of heroin on prescription. What are your views on this?

Prof. Mattick—I think that the debate about this is appallingly poor and the discussion is naive. If you speak to those individuals overseas, in countries where this is available, it is a very small treatment option. It is done in countries like Switzerland, where they are trying to penetrate up to 80 per cent of heroin dependent people. So they are taking that last group—the ones who will not come onto methadone or will not come into the other alternatives which the community is more willing to accept—and saying, 'We want you as well.' In Australia, we have probably got about 45 per cent of heroin dependent people in treatment. It may be less than that; we have got a long way to go. We have got two new pharmaceuticals, naltrexone and buprenorphine. I think the investment should be in those; and if we can deal with the demand for those treatments and bring people into treatment, then you may go and take that next step.

The other thing you need to think about if you are going to consider heroin on prescription is that the claims made for it are vastly overstated, in my opinion. Ministers and premiers sometimes make claims that heroin on prescription will remove the black market and will stop deaths. This is nonsense. It is simply impossible. You may bring a small number of individuals into treatment with that, but you are not going to get the vast majority of heroin users coming into treatment for the very simple reason that they will not come into a clinic two or three times a day to inject. They would rather do it in their own way in their own time, without the supervision of health professionals.

The final thing about heroin on prescription—I am not an advocate of it and I am not against it; I think it is an interesting issue—is the cost. We are currently, with our colleagues at the national centre, working up a paper on the economic costs of heroin on prescription, given the recent trials in Europe. It costs at least three times more than the existing treatments. It probably does not get a better outcome. So you have to think of the opportunity cost if you are going to invest in it, and you only invest in it when you have reached the stage where you have dealt with all the demand.

Mrs IRWIN—Professor Saunders, my question follows what Professor Mattick said about naltrexone. I think your overhead showed that 1.5 per cent of people were using naltrexone. Is this because of the cost factor? To go into treatment can cost anything between $3,000 and $6,000, and the tablets can be rather expensive as well.

Prof. Saunders—I was referring to the percentage of alcohol dependent people in Australia who are being treated with any pharmacotherapy—naltrexone or acamprosate—at any one point in time. The reasons why 98.5 per cent of alcohol dependent people are not in treatment are several. They include the fact that many medical practitioners are simply not aware of, or have no experience in the prescription of, these medications and, therefore, the treatment of patients with them. Their expense in the treatment of alcohol dependence is not great because people would only pay $20.60 a month, which is the co-payment. Another factor is that some self-help groups are fundamentally opposed to the use of medication to help people recover from alcohol dependence. Many of the alcohol and drug services are not well linked with general practitioners. I would regard that considerable shortfall as a challenge and, through a variety of strategies like the continuing education of general practitioners, working together with alcohol and drug services and shared care arrangement of patients, we can make some headway.

With regard to the use of naltrexone as a treatment for opiate dependence, that is not subsidised by the Pharmaceutical Benefits Scheme. An opiate dependent person who wanted to be treated with naltrexone would have to pay about $250 a month for that form of treatment. I do want to emphasise though that I regard naltrexone treatment for opiate dependence as a treatment which is appropriate for about five or 10 per cent of all the opiate users. It is a treatment which requires very considerable commitment and effort from themselves, their treating doctors and staff and also from their partners and families.

Could I take the opportunity of endorsing what Richard Mattick has said about heroin trials? I must be one of the few doctors in Australia who has actually prescribed heroin for a small number of heroin addicts. I did that when I was in the United Kingdom 20 years ago. My colleagues in the UK treat about three or four per cent of heroin dependent people with heroin. It is a niche treatment. I am saddened that the debate on what is the most appropriate way forward in the treatment of as many people with heroin dependence as possible has been hijacked by this discussion on heroin prescription.

Mr CAMERON THOMPSON—I wanted to talk a little about something that is raised in this document: price elasticity of cigarettes. I see here policy No. 1 is to continue indexation of tobacco excise regularly by annual increased duty in line with average weekly earnings and to minimise evasion of customs and excise duties. It says as a set these proposals would increase revenue. I think that to an extent governments are as hooked on cigarettes as the people who are hooked on them. Would it not work to just bump up the price of cigarettes to such a point where you get people actually dropping off so that revenue would not increase? Is there not a point behind it on that? Governments continually ramp up the duty on tobacco but it seems designed so that it does not actually affect the revenue? Would it not be a fact that, if we ramped it up a fair bit more, you would get a drop off?

Prof. Hill—Yes. The price elasticity is the relationship between price and consumption. That is a fairly well-known relationship. It is better at reducing the amount of tobacco an individual smoker uses than it is at converting someone who was previously a smoker into a non-smoker.

There is always the risk that a person who is continuing to use tobacco will ramp up their consumption again. Having said that, if you take a population perspective, the more tobacco that is consumed in a country, the greater will be the morbidity and mortality from tobacco. The government is getting about $4.5 billion in tobacco tax. A very tiny fraction of that goes back into interventions of the sort that I would advocate. A linkage between what is taken in tobacco tax and what goes back into prevention would be welcomed very much, by me and everyone else in the field. That is really why places like Massachusetts and California can do so much. One of the very powerful policy levers you can pull in tobacco control is to make the price higher. I would be most in favour of that. Eventually, if we are completely effective, revenue to government will start to fall, and that would be a hard pill to swallow for government. That is inevitable, if we want to control tobacco related disease.

Mr CAMERON THOMPSON—Have there been any examples in which that lever has been pulled, where they have actually tried to ramp the price to the point where people drop off?

Prof. Hill—A big step up? Not really. It is not the way that has been used. When you say 'ramp the price', are you thinking of a 10 or 20 per cent increase?

Mr CAMERON THOMPSON—In your policy proposals, you are telling governments about gradually stepping up the indexation of tobacco and doing those things and aligning your duty to estimates of children's average weekly disposable pocket money, for example. As I said, these proposals would increase revenue. Is that really what we are after? Is it not really about trying to get them to stop smoking?

Prof. Hill—Yes, it is, absolutely.

Mr CAMERON THOMPSON—Has there been a stage where they have gone to the point where they have not put that little rider on the bottom and they have said, 'This will actually reduce revenue because we are going to drive people away from smoking'? Has that been tried?

Prof. Hill—It has not been tried, but it is calculable. You can model the point at which a hike would have such an impact on consumption that it would reduce revenue. This document is intended to be both attractive and valuable, but also politically attractive. You are challenging me to take my reading of the political reality out of it and—

Mr CAMERON THOMPSON—We have had appeals about how it should not be political.

Prof. Hill—I would love that.

Mr PEARCE—Professor Mattick, you made a comment during your presentation that people in the community and people such as ourselves have not been fully informed about the outcomes and the benefits of the methadone treatment program. You suggested that a lot of the people who advocate heroin trials would want that to be the case. Why do you think the broader community and people such as ourselves have not been well informed?

Prof. Mattick—Initially, when methadone was introduced, it was done in a relatively quiet way. There was some controversy about it, but there was not a lot of public discussion. The debate was never really had and, when it was had, it was had in a very polarised environment

where people made strong claims for and against the intervention. Then we started to review the evidence. When I first started in this area I thought that methadone was essentially a wrong way to proceed, but the evidence is quite convincing that it does reduce deaths and that it protects against HIV infection—not so much hepatitis B or C, but certainly HIV—along with other measures. It reduces crime and reduces heroin use.

The other thing that occurred, certainly in New South Wales, was that the Department of Health had no political will to say firmly and clearly to the community, or even within the parliament, that this is an important intervention. The bureaucrats that worked within the department know this information, but it is not put out, because of the controversy which occurs and the political damage which can occur through the debate. That is driven by this broader debate, as John Saunders said, about the value of heroin trials. The collateral damage done by the debate on heroin trials has been quite significant and very substantial. We need to get away from the strong advocacy for and against, and you need to understand that these are minority options and they should not take our attention. We need to keep our attention on how to improve public health generally—and for the individuals who are users. Having the discussion, at least at the state or jurisdiction level, scares governments. They do not like doing it, because of the controversy. It gets in the newspapers. The advocates of naltrexone will say, 'This is the way to go', and it raises a whole mire of problems for them, and so they tend to back away. That is my view of what is going on.

Mr DUTTON—My question is also to Professor Mattick. It relates to methadone and follows on from your comments there. Can you tell me what studies have been done and what evidence we have that points to the long-term use of methadone? Some of the evidence we have taken over recent months has indicated scenarios where people have been on methadone sometimes for 15 or 20 years. What sort of psychological or physical effects does that have on those long-term users?

Prof. Mattick—The studies on long-terms effects of methadone indicate that there are basically no long-term negative physical effects from taking methadone day to day. They have been done by very senior people in the USA and they have been carefully reported. Methadone, taken in therapeutic doses and taken appropriately, is a relatively safe intervention. Psychologically, we know that people who enter methadone treatment are better off when they are in it than when they are out of it. When they are out of it, when they are using heroin, they are chaotic. They commit crime or prostitute themselves or try to obtain money in other ways to buy illicit heroin. That does not mean that methadone is without its negative aspects. It does have a number of side effects. They are not serious, but they are side effects which the users do not like, and they are well documented.

The other thing that you have pointed to in your question is another view in the community which is that people stay on methadone for long periods of time. Some of them do, but most of them do not. If you look at the statistics from the departments of health, individuals will come into these kinds of treatments and stay for relatively short periods.

You have to start considering the nature of the beast, the nature of the individual. Illicit drug users do not like treatment. They do not like health professionals. They do not like being in clinics. They will come in when they are in a time of need, when they need to have some

respite—in this case from heroin use—and they will use what we are prepared to offer them to help them. Often in the past, they left treatment because it was punitive.

Currently it is expensive. We make people pay $2,000 year. They are on marginal incomes. They have to find money to pay for this treatment to go to community pharmacies. They are stigmatised and there are not the supports. There is a notion that people stay on methadone for very long periods. There is a group that does, but it is a relatively small group of about 15 to 20 per cent. Most of the users cycle in and out of treatment when they need it. They do not stay for very long periods; they stay for about six months on average.

Mr DUTTON—I also have a question for Professor Saunders in relation to cannabis use. Obviously, some of the policy direction by some of the state governments is, in actual fact, to legalise cannabis use in differing stages across Australia. In light of the evidence that you have provided today and that is provided more generally now on the effects of cannabis use, do you think the state government should be reviewing that policy and should we be looking at some sort of different direction as part of the education process of the community in relation to cannabis use?

Prof. Saunders—I think it depends very much on how the policy is enforced and whether there are other strategies which are brought to bear to convey information about the health effects of cannabis.

Mr EDWARDS—Yes, but is it actually a case of legalising or—

Prof. Saunders—No. There is no jurisdiction in Australia which is proposing to legalise cannabis use. Some jurisdictions have a policy of decriminalisation of possession of small quantities. For example, in the UK there has been a decision recently by the Home Secretary to move cannabis to a classification which is less serious than the current classification.

I do have concerns about that. I think the impetus of governments to decriminalise cannabis use has been largely driven by the desire not to impose a criminal conviction on somebody whose only offence, as it were, is the possession of a small amount of cannabis. I think that to impose a criminal connection is a rather heavy-handed approach, and involvement in the criminal justice system of a person who has only been using cannabis can have some serious negative consequences. Hence, there is the policy of diversion of people from the criminal justice system to treatment. This has been strongly supported by the present federal government.

I do have concerns about any further liberalisation of the law in general. However, if a decision is made by jurisdiction to decriminalise cannabis use, I would certainly urge that government to put in place measures to prevent the large-scale cultivation and trafficking of cannabis. If there are not those countermeasures, I would have a concern that the overall use of cannabis in society would increase and, particularly given the potency of various forms of cannabis products these days, there would be an increase in harm.

CHAIR—Professor Saunders, do you want to expand on the previous question asked by Mr Dutton with respect to methadone? I note that you were looking at a slide there.

Prof. Saunders—Thank you for that opportunity. I have a table here—which I am very happy to make available to members of the committee—which shows the effect of methadone maintenance in reducing deaths in the injecting drug using population. In essence, the death rate of people who are on methadone maintenance is one-quarter of that of people who are receiving other forms of treatment. Looking at it another way, methadone reduces the death rate by 75 per cent. These are consistent findings from studies that have been undertaken in several parts of the world, including Australia. The follow-up is up to 21 years.

CHAIR—Thank you. We would like to follow up on that and get copies of that slide.

Ms GEORGE—Professor Patton, I turn to what you said about support structures and bonding. Just to simplify my question, your explanation of the association between dependency and high risk, marginalised youth makes sense to me. But I have met young heroin addicts who come from what they tell me are wonderful family backgrounds and who have had the virtues of exclusive private school education. One young woman said to me, 'Ms George, if anything, please tell people that the experts may not have it completely right. I believe that there is something that can be explained as a predisposition, either genetically or in personality terms, to addictive behaviour and drug dependency.' Can the experts make any comment that explains that predisposition even where the bonding and everything else is ideal?

Prof. Patton—Quite clearly, I was not suggesting that this was the only set of factors that was important. Clearly, if you are bonded to a family where the views are that smoking is fine, substance use is fine and cannabis use is fine, you are more likely to take up those values and behaviours. So, in general, bonding is a good thing, but clearly the prevalent attitudes and beliefs within your group—whether that be your family group, your community group or your peer group—are going to be important. And, yes, clearly there are individual factors—personality factors—that are important. 'Sensation seeking' is a term used to describe one individual risk factor which is believed to be important in terms of why people experiment with a whole range of experiences, including drugs. Biological factors are probably very important. Around two-thirds of young people experiment with tobacco. By their mid-twenties only a very small proportion are nicotine dependent. Clearly, there are likely to be biological factors there which determine vulnerability to nicotine dependence and other forms of dependence and relate to the likelihood of ongoing use. So, yes, other factors are important.

Ms GEORGE—Professor Mattick, no-one has made any comment about the outcomes of long-term residential programs like Odyssey House or the Woolshed, which we visited recently. I would be interested in your response to those. You seem to be a strong advocate for pharmacotherapy substitution. I am not really clear about this, but I get the impression that there is a lack of detoxification beds when they are needed. But, on the other hand, my observations lead me to believe that there is, in a sense, a lack of regulation about what happens to those who use detox. There does not seem to be any requirement that it be a precursor to long-term commitment to rehab. When we went to South Australia recently, some of the young people said that detox beds were being used for purposes other than that genuine first step. Could you comment on those issues?

Prof. Mattick—The advocacy is for trying to stay close to the data and giving you data which you can understand and use. Residential rehab is very important. One of the difficulties with it is that it is not necessarily broadly acceptable to individuals who are working or who

have other commitments. They cannot necessarily leave. They usually have to pay for their accommodation in many of these places; if they are paying rent somewhere, they have to pay and they are on marginal incomes. There are a whole lot of structural barriers which prevent people from accessing it, and there is a barrier of not wanting to go into this kind of treatment.

We have done some research on residential rehabs in Australia, and there has been research done internationally. We researched the Woolshed in South Australia, and we found that individuals who entered the Woolshed were worse off than those who were entering methadone generally in Australia. They were at a worse stage of their drug use career, and the Woolshed provided TCs—therapeutic communities—which provided a good treatment for those individuals. There is clear evidence from the American studies, and from our work, that the outcomes are quite good. Acceptability is an issue. If you take the 32,000 individuals who are currently in methadone treatment and try to put them into therapeutic communities, you will have a lot of difficulty: we do not have the resources, and they do not have the desire. So there are a couple of factors there.

On your comments about detox, over the last 20 years there has been a move away from residential treatment and particularly away from detoxification. The first thing you need to understand is that the evidence is quite clear here that detoxification by itself is not a treatment for drug dependency. It does not achieve lasting abstinence. It is like a 6,000 kilometre service: it gives people a bit of time out and it allows them to get their life back together briefly and then re-enter their communities. But do not expect long-term changes in their behaviour. However, it is a moment when you can link them into other treatments, and that is quite important. That is why detox should be supported, to help with the initial health problems, to identify health problems, to stabilise and perhaps reduce tolerance in some individuals, and then link them into treatment.

On the issue you pointed to about detox not being used for detox, detoxification facilities have for many years served a number of purposes—respite humanitarian care, food, shelter and showering. The problem with the changes that the governments have made in Australia in reducing the availability of these treatments is that they say, 'It is not really about detox; that is not the department of health's responsibility. It is a supported accommodation problem.' Some of the funding was removed on that basis. You need to recognise the range of functions that these facilities do provide to this marginalised group—and to the community more broadly—by taking these individuals off the streets and giving them a home for a few nights.

CHAIR—The point that Ms George was making was basically whether detox should be used as just shelter rather than as a step toward the long term—then going toward rehab?

Prof. Mattick—That is an interesting question, and John Saunders might have some views on this as well. It is actually quite important to link people more firmly into treatment, and that has not been done very well by the state and territory governments, in my opinion. Detox tends to be a little bit stand alone; it is not well linked to other parts of the system. That is part of the problem with having controversy and strong views about what is correct treatment and bad treatment in drug and alcohol dependence. A better linkage would certainly be a very sensible thing, and that does not happen particularly well at the moment.

Mr WAKELIN—Professor Saunders, in encouraging caution around marijuana—and you mentioned the evidence that has emerged over the last 20 years—do you have very much on issues like cognitive impairment and increasing violence? Could you comment on that?

Prof. Saunders—Yes. There is substantial evidence that cannabis use does cause cognitive impairment. There are two forms: a short-term effect, which is dose related; and also a lingering effect. This typically occurs when people continue using cannabis, but it can occur after people have had periods of abstinence. This accumulating data is part of the information which leads to concern about the health effects of cannabis.

Mr WAKELIN—Could I just ask about the issue of violence?

Prof. Saunders—Cannabis normally induces a state of euphoria, but it is a state of quiet euphoria. However, a proportion of people become violent. Cannabis in high doses has hallucinogenic properties, and people can act out on the basis of the hallucinations and delusions they experience. A proportion of people have an adverse reaction to cannabis and can become quite aggressive. Cannabis is often used together with alcohol, and it seems that the combination of binge drinking plus heavy cannabis use can cause significant acts of violence and indeed has been reported to cause homicide and other forms of severe injury to other people.

Mr WAKELIN—Thank you.

Prof. Patton—My comment relates to our own Australian data on this. We have found that very frequent cannabis use—and around seven per cent of young adults are using cannabis daily in Australia—does predict educational failure at tertiary levels. The other thing that happens with very frequent use is that the risk of dependence becomes very much greater. Some features of dependence are heightened irritability and heightened aggression—verbal at least but potentially physical—during withdrawal from cannabis.

Mr QUICK—Professor Patton, can you tell us a bit more about the Gatehouse Project and this adolescent health team? I am really interested in it, following Professor Hill's alarming statistics about predictability. Is it a one-off? Is it NHMRC funded? Will it build up expectations that it will get results and then will it disappear into the ether or is it a pro forma for other places?

Prof. Patton—Yes, it has been funded by the NHMRC and by a range of other agencies as well. We think it is a new kind of approach. It is cutting edge in the sense that it is the type of thing which is being done in North America, where there has been great investment in prevention strategies of this kind. It is cutting edge in the sense that it goes beyond health education and promoting skills; it goes to working with the setting. It has been designed to be sustainable. I showed you the results of what was happening with subsequent cohorts of students coming through the school. The school has changed. It is a model for how to do this work. In terms of implementing this on a large scale, that depends on the education and health sectors coming together around policies on the social development of young people.

Mr QUICK—But the education department and the health department would say, 'We don't have the money, but it is a good idea.' The Commonwealth Department of Health and Ageing have told us:

In 1992 the tangible and intangible cost of drug abuse was $18.8 billion.

Regarding the amount of revenue we get from cigarettes—as Cameron Thompson said—and compared to what New York State and some of the other states are doing about hiking up the price to $15 a packet, surely some of that excise should be redirected to having thousands of Gatehouse projects, because there is a cost benefit?

Prof. Patton—Having a fund of that kind could certainly be tremendously useful. It needs to be linked to neither education nor health but to exist as a pool which is available to those who will come from health and education to work together. I think that partnership is crucial in doing this kind of work. It needs to be linked to no particular department. The other thing I would say is that this work does not cost; this work saves. Let me give you an example from one school we were working with. This secondary school had 32 different programs around the social development of youth. Nobody had oversight; nobody knew who was doing what. None of it was well resourced. None of it was matched to the particular needs of that school. We reduced the programs at the school to eight, matching those to its social profile. The outcome was far better, and it saved money.

Mr QUICK—So should one of our recommendations be that a percentage of excise from tobacco and alcohol be redirected to additional funding to NHMRC or direct to the education department or to similar projects to this? Obviously there is a cost benefit to society.

Prof. Patton—I would suggest that money be directed toward collaboration across sectors, whether that be research or program development or, ideally, a mixture of both. The money cannot go to just a health person or an education person; we work together in program developments around prevention.

Mr EDWARDS—My question is similar and it is to Professor Patton. It relates to the fact that more children are opting out of sport and recreation and spending more time in front of computers and there are bigger problems with obesity and unhealthy lifestyle choices.

Prof. Patton—Absolutely.

Mr EDWARDS—Is there any evidence to show that physical training and education in primary schools leads to healthier lifestyles, and can you build a case in Australia for there to be a greater emphasis on physical training, physical education, perhaps leading to healthier lifestyle choices, in primary schools?

Prof. Patton—Certainly what happens on the sports field or in the playground is really important in terms of young people. I think there are a number of things that happen there. First, you are engaged in a particular health promoting behaviour. I think that in itself is good in terms of outcomes such as obesity and probably in terms of mental health as well. Secondly, you are engaged with your peers around a health promoting activity, and we know peers to be a crucial influence in terms of the behaviours and lifestyles that young people adopt. Thirdly, it gives you

an opportunity to interact in a positive way with adults who are involved in steering that activity, and that in itself is positive in terms of the values and relationships that are likely to come out of that relationship. So in all of those senses there are good reasons to believe that a sensible approach to promoting physical activity in this social context would be a very beneficial thing. There are other strategies as well that are important.

Mr DUTTON—I have a quick question in relation to amphetamine use, which we touched on before, and the lack of research in that area. Is it the case that a precursor to the manufacturing of amphetamines is a drug called pseudoephedrine? If that is the case, is it true that it is found in drugs such as Sudafed or other tablets which are bought over the counter and that that precursor, that essential element, is derived from those drugs and, without it, amphetamine production would not be possible? Is it within the scope, I suppose, of what we are looking at that we look at some sort of additional regulation in that regard and restriction of the availability of that drug? Some of the evidence we have taken in visiting some of these residential care units is that amphetamine use is obviously as big as heroin, if not bigger, and it is made in the boot of a car with these ingredients. Perhaps Professor Saunders could answer.

Prof. Saunders—The answer to all those questions is yes. Pseudoephedrine, which is the principal ingredient of Sudafed and other proprietary preparations, is a precursor of methylamphetamine. Sudafed is the principal source of the production of illegal methylamphetamines, at least in Queensland, and I do not doubt Australia wide. The pharmacy profession have introduced restrictions on the sale of these preparations, and I think that there is a compelling case for the restriction of this drug. Its therapeutic purpose includes to relieve colds and flu and rhinitis, but there are other pharmaceutical preparations which can do that job equally well. I personally would strongly support a move to further restrict and even ban preparations containing pseudoephedrine.

Mr DUTTON—Is that a realistic expectation? Would they source it from somewhere else? Is it that available, or is it really only available through these drugs?

Prof. Saunders—The criminal marketers show considerable adaptability, so, yes, I think some of the market would be replaced from methylamphetamine which is imported from overseas. For example, there is a very large production system in northern Thailand, in part of what is known as the Golden Triangle. However, it all helps. The pattern of methylamphetamine production and use that we see in Australia is predominantly one of local production in kitchens, garages and car boots, and one where the distribution of methylamphetamine—typically called 'base'—occurs in the immediate neighbourhood. That, of course, is supplemented by other routes. But, given the fact that pseudoephedrine is such an important precursor, if you restricted its availability, then it would at least limit that form of methylamphetamine production.

Ms GEORGE—Professor Mattick, you said that heroin addiction is a chronic disorder, with enduring abstinence being fairly rare. If that is the scientific argument, then I guess it answers Professor Saunders's question about what the goal is, and maybe brings you back to reality about not having expectations that you can forever get these people who are currently heroin dependent totally off the drug. At what point does someone who begins to take heroin face the prospect of being in a chronic disorder pattern? Is there a point of time at which early intervention in the heroin use can have a positive outcome?

Prof. Mattick—That is a hard question to answer. It is probably yes, but people who are in the early stages do not put their hands up to say, 'I would like to enrol in your research studies so I can see whether I get over what I do not think I am going to get anyway,' because these individuals do not believe they will become dependent. About a third of the people who try heroin will become dependent on it. It is a reasonably high rate of induction into dependence. So I think it is important to have a range of treatments available for people who start to get into trouble and for there to be more advertising by departments of health and more outreach to individuals to say, 'If you are starting to have problems, come and see somebody,' to take away the stigma, so that a range of health professionals can be drawn into this. This is a very hard process to put into place and the outcome is very hard to achieve because of the reticence of doctors and other health professionals who have anything to do with injecting drug users. It is quite a difficult thing to get these individuals into treatment. They certainly do not want to go to methadone clinics because they do not identify themselves as dependent, so they will not approach the tertiary or specialist end of the spectrum.

I think the other thing about the nature of heroin dependency is that, to be fair to everybody here and to the scientific community, we have only had heroin as a problem for about 30 to 40 years. We have really only learnt about the nature of heroin dependence relatively recently. That understanding is important, but it is a recent phenomenon that we have had the information available. I think if you were going to advocate earlier intervention you would need to understand the range of structures and processes that state and territory governments would have to put in place to support that, and it would be quite different from the specialist clinics which are currently available.

CHAIR—Thank you very much. Before we take a break, the committee needs to resolve that the document tabled by Professor Hill on tobacco control be treated as exhibit No. 17 and be included in the records of the committee.

Resolved (on motion by **Mr Edwards**):

That *Tobacco control: a blue chip investment in public health—overview document* be treated as exhibit No. 17 and be included in the records of the committee.

Proceedings suspended from 10.54 a.m. to 11.15 a.m.

MADDEN, Ms Annie, Executive Officer, Australian Injecting and Illicit Drug Users League

ROCHE, Professor Ann, Director, National Centre for Education and Training on Addiction, Flinders University of South Australia

WEBSTER, Professor Ian William, President, Alcohol and Other Drugs Council of Australia

CHAIR—Good morning. The second part of our session on health care deals with the adequacy of existing services and the perspective of the service consumers. We will hear from Professor Ian Webster, Professor Ann Roche and Ms Annie Madden. I now invite Professor Webster to begin his presentation.

Prof. Webster—Thanks very much. It has been a privilege to be here this morning and to listen to the evidence given by my colleagues. I think Australia is well blessed with a high standard of very good researchers who are very knowledgeable. I am the President of the Alcohol and Other Drugs Council of Australia, a council that represents non-government but also other organisations in Australia involved in drugs and alcohol. The board of our organisation is elected, and I am the elected president. So it is a representative body, whereas the Australian National Council on Drugs is a body which is appointed by government.

I would like to suggest that there are several areas which will arise out of my talk about which your committee could make recommendations. I am going to talk a lot about the health care system and I would suggest that the committee examine the health care agreements between the Commonwealth and the states with a view to negotiating those so that they include alcohol and drug service performance through the health services, that that links particularly with mental health—I will be making points about mental health—and that, with Commonwealth interest in general practice, general practice funding and incentives for general practice, the Commonwealth show a high interest in engaging general practitioners and those in primary health care in dealing with drug and alcohol problems. The major crisis in the broad non-government treatment sector is having adequate, trained staff and retaining staff; the whole work force environment needs to be attended to. Underpinning all of that, I would like to see a strong emphasis on the combined problems of mental health and substance use disorder. I am proposing to speak to some slides. A lot of what I am going to say, my colleagues have said before me.

Slides were then shown—

Prof. Webster—I am going to start with the medical care system. Most of you would appreciate that managing diabetes, high blood pressure and asthma is done well by the medical care system. I could add to these schizophrenia, rheumatoid arthritis or many other conditions. If you look at this slide, you will see that less than 50 per cent of people with diabetes follow their medication regime; less than 30 per cent, their foot care; and that, in diabetes, relapse occurs in 30 to 50 per cent of cases. The same is true for high blood pressure. For asthma, which is a common problem affecting young people, the relapse rate is 50 to 80 per cent.

What I am trying to demonstrate to you is that, with conditions which you accept, which the public accepts and which doctors are very good at managing—conditions for which you go to doctors for treatment—we get relapsed rates. They are chronic relapsing conditions. If we use the same tests and criteria to judge effectiveness in treating dependents we can see that, with alcohol, the estimated success rate is between 40 per cent and 70 per cent; with opioids, between 50 per cent and 80 per cent; with cocaine, between 50 per cent and 60 per cent; and, with nicotine, between 20 per cent and 40 per cent. They are not my figures; they are figures published recently in the Lancet. So we have this myth in the population that treatment does not work for addiction. It clearly does, and my colleagues have said that. You have already heard from my colleagues about the main treatment strategies. My colleagues have emphasised brief and early intervention, and that is a primary area that we should be focusing on. You have heard about detoxification; there is a whole set of responses to assist people with withdrawal. I may make some comments about therapeutic communities because I noticed some questions were asked about that.

This is reproducing some of the material that has already been given to you. Across the top is from alcohol to tobacco, benzodiazepines, opiates, amphetamine-like substances, cannabis and cocaine. These are various steps in treatment. As you have heard before, where it is blocked out we just do not know; we have no evidence about what works. A lot of that relates to the amphetamines, cannabis and cocaine area. We do know a lot about what works for alcohol, tobacco, benzodiazepines and opiates. You can see that that what works are early intervention and behavioural interventions, which we do not adequately support; they are the sorts of things that Richard Mattick and his group have been working on. Underpinning all of this—every one of those problems—is a mental health approach or ongoing support. We know a lot about what we can treat, but there are some mysteries.

I have picked up alcohol here because I am Chairman of the Alcohol Education and Rehabilitation Foundation. We are currently providing support for people around Australia. Again, the question about alcohol approaches—Is it the public health approach? Is it early intervention? Is it detoxification, treatment and rehabilitation?—meets with a whole string of yeses. They work. But, as you come down the scale, it becomes more difficult. For example, I have said here, in relation to Alcoholics Anonymous, that, yes, it works for some. What about counselling and support? Yes, it works for some. What about mental health treatment? Yes, it is very important—for everybody, I should say. What about pharmacotherapy? It works for some. Residential and therapeutic communities work for people who stay at them. If you go around Australia you will find that this full panoply of interventions is simply not available. In Indigenous communities the response is, predominantly, that community based response. Virtually none of the others are available—except in some communities around Alice Springs, where we recently launched a public health approach to restrict access to alcohol.

I want to talk to you a bit about what goes on in the health care system. This is Liverpool Hospital, which is in south-west Sydney. It has the full panoply of services. Every part of that hospital's work is dependent upon the number of people who present with tobacco, alcohol and other drug problems. It serves a population of about 800,000 people—which is massive—and it is one of the major trauma centres for us in Australia. More road accidents and gunshot injuries come to this place than to most other places. Twenty-three per cent of the people in the intensive care ward of this hospital would not be there if they had not been using a substance of some kind. In the coronary care ward, the figure is 24 per cent. It is difficult to get the estimates, but a

large number of the people using the emergency department are there because of alcohol related violence, some are there due to overdoses from heroin and a large number due to combined mental health and substance use problems. So we have a massive system dealing with these problems. The question in what I am saying to you is: why isn't it dealing more effectively with alcohol and drug problems?

What I should say is that, at that hospital, there is a methadone unit which has got 300 people in it. It is busy all the time but only people who are sick, who are pregnant or who have HIV-AIDS can get onto the program, because it is full. This slide shows a photograph that I have taken of a homeless man who has a mental illness but who came out of hospital not long ago. He had an overdose from heroin and his leg is paralysed, injured and infected because he had a near death experience from an overdose. He had laid still and been injured and the muscles of his legs harmed and he is now permanently incapacitated. That is something we often do not hear about when we talk about overdose.

This slide shows a man attending the outpatient clinic at Liverpool hospital. Notice that he has brought his drink with him. He constantly drinks alcohol and he has a grossly scarred arm which has had massive plastic surgery on repeated occasions because he has been injecting drugs—all sorts of stuff—and he now virtually has no blood supply to that right arm. This next slide is not so clear, but in it he is demonstrating his other arm: he has been injecting into the artery of that arm and the blood supply in it is absolutely compromised. In the health system we are dealing not only with people who present with acute problems but also with the massive disabling and deforming consequences of drug use.

All of these people, incidentally, have agreed to me showing these pictures of them because I use them for demonstration purposes. This slide shows a young woman I know well and have looked after for years. I know her family. She has been on methadone, I recall, for about 10 years, and my colleague Cheryl Wilson, who is the executive CO of ADCA, worked in the program that probably looked after her many years ago. She has been injecting normocin into the vessels of her leg. You can see she has had massive operations; she has nearly died on several occasions and almost lost her legs. While on methadone she had an uncontrollable dependency on injecting normocin—the capsules—which governments have restricted access to. The point about that is that a huge amount of the work of the health system goes into dealing with the consequences, and yet, if you went to most public hospitals, you would find virtually no drug and alcohol unit or not much of a drug and alcohol unit—if there is one, it might be a shed round the back. It goes back to the point that some of my colleagues made that this area of professional development is of poor status, poorly regarded and not regarded as an area that professional people really want to work in.

If you went and looked at the drug clinic at Liverpool hospital or any public hospital and you went to the mental health unit you would find roughly these problems. Of the people with drug problems in treatment, in the methadone program or others, 30 to 80 per cent of them would have associated mental disorders. Conversely if you went to the in-patient psychiatric unit 30 to 80 per cent would have an alcohol or drug problem. Again in this focal point where people present for treatment there is enormous overlap with these problems. One of the things that we must do is to develop a much more systemic response to the double jeopardy people experience when they have mental health and substance use problems. I could show you a slide, but I have not got it here, about the prevalence in the community of these overlapping conditions. There is

good work being done by Richard Mattick's unit on that. But it is very common, it is normal, to have people with drug problems with associated mental health problems.

None of this is surprising—that we see in the health care system such a load of work. The major causes of death in Australia—the things that you and I will die from—are coronary heart disease, cancer, cerebrovascular disease, respiratory disease, injury and suicide. For all of those, a major component of their causation is tobacco, alcohol and, in many circumstances, other drugs. If you just take alcohol as an example, five per cent of all deaths are due to alcohol and 30 per cent of road traffic deaths are due to alcohol—and you will be hearing about that tomorrow. Lots of people who take their own life have been drinking before they suicide. The assaults, the fire injury deaths, the drownings and the head and neck cancers: there are lots of conditions that present in the health care system that you do not think of as being associated with alcohol and alcohol and tobacco. When they are together, there is a double jeopardy. I would like to make another point. The alcohol strategy produced this publication recently and it shows the alcohol caused deaths in Australia between 1990 and 1997. You can see that it is high and that it is declining a bit, but the bit I want to emphasise is the purple bit which represents the alcohol caused suicides. I am re-emphasising that overlap that I was speaking about before. What I am saying is that the public hospital deals with this all the time in the public health system, but we have a low status and half-hearted response to the problems.

The next area of the health care system which engages with this problem is general practice. General practitioners are distributed everywhere in Australia, and there ought to be more of them in some places. Most places want a general practitioner and most communities have primary health care if they do not have a general practitioner. In some ways I am talking about primary health care. A recent study showed that, of people attending the GP, 24 per cent are at-risk drinkers. In other words, they have a substantial consumption of alcohol. It is higher in males than in females. If you look at those who are drinking, they are drinking at a very high level and are also smokers. The questions, though, are: are those people identified and are they picked up with those early interventions which work? It is likely that they are not, but they are to some extent. One of the reasons for this is that doctors and the whole system do not realise that alcohol use disorders predominantly are a problem of young people.

This slide shows the 18- to 34-year-old group and the 35- to 50-year-old group. This is a study done in Australia, again by the people at NDARC and the mental health group; a wonderful study done in 1997. It shows that the people who have what is called alcohol use disorder—and that means they are hooked or behaving in a harmful way; information that comes from the national survey—are younger people. Doctors actually do not think about that with young people. They tend to think that when people present it is the 55-year-old long-term drinker who has the problem with alcohol. We have problems in younger people engaging with our system but not being well identified. The same is true of drug use disorders. They are not so common but, again, they are in a younger age group. The important thing for the health care system is that if we can intervene in the case of young people—most of the diseases we look after in the health care system are in older people, but here are examples of conditions in younger people—we can make gains in life, gains in mental health and so on.

In that study which I referred to—and again this is work by the National Drug and Alcohol Research Centre—the people who said that they had alcohol use disorders were asked if they looked for help. Only 30 per cent of those who had a defined disorder recognised that they had a

problem and sought help. So, first of all, people are not seeking treatment and, when they do seek treatment, predominantly they go to general practitioners; fewer go to specialists and to others. I am emphasising here the importance of primary health care as a point of engagement with people with problems, and I am going back to some of the points that colleagues have made about the importance of early intervention.

When those people presented for treatment—this slide does not tell us a great deal—some of them were given medicines, some of them were told: 'You've got to look after it yourself,' and given help with that and a proportion went to psychological therapy and information. It is very difficult to get psychological interventions anywhere in the health care system, particularly the public system.

CHAIR—Professor Webster, I urge you to wind up a little.

Prof. Webster—Yes, I am winding up now. Since 1995, methadone has become more available. This is a study representing the whole of Australia. We are creating opportunities—and I am just using methadone as a marker here. This slide shows the growth in private and public methadone treatment. As I said before, the major problem in getting access to treatment in the drug and alcohol services is that we do not have sufficient trained staff to man the services.

The evidence for residential programs shows that they do work. They work best for people who complete the treatment, who have been using fewer drugs and who have had fewer crime and more employment opportunities. But the real problem, as Richard Mattick mentioned, is to hold people in treatment. If you go to Indigenous communities, this style of program is the dominant way that they attempt to deal with problems of alcohol and other drugs.

CHAIR—Thank you, Professor Webster. That was very informative. Professor Roche, could you give us your presentation now, please?

Prof. Roche—Breaking with tradition, I do not have any PowerPoint slides; you just get me. I thought it might be useful at this point to try and capture some of the themes that we have been addressing so far this morning. It seems to me that a couple of major themes run through our attempt to grapple with these issues. One is: where are we now in terms of health systems and human services responses to dealing with alcohol and drug problems? I am not going to attempt to recap on the epidemiology or the prevalence or the degree of problems—I think people are reasonably across that—but where are we up to in terms of our ability to respond to those problems? How did we get to the point we are at now? I think it is useful to take a short step back in time, to look at the traditions that have driven the health and human service systems responses, so that we better understand why we are at this point now. What are the limitations and inadequacies of the systems that we have in place and what are some of the things at our very fingertips that we can do to address them? What are the stumbling blocks for us in relation to that?

Before I attempt to cover those things, it is worthwhile re-emphasising that my approach to this is not looking merely at issues around dependence or addiction. It has been heartening, throughout the discussions and presentations so far, to hear that of the whole range, the full gamut, of alcohol and drug related problems, many problems occur in non-dependent individuals. Death and overdose, for instance, can and do occur in non-dependent individuals.

So it is useful to bear that in mind. It is not simply dealing with, managing or treating alcoholics or heroin dependent individuals. Many of the party drugs that create real problems for us in our community are not necessarily associated with dependence, but there are a plethora of other problems that go with it. I think that breadth of perspective is quite useful. The other issue, that David Hill touched on earlier this morning, was in relation to the discontinuity in the notion that there is prevention and there is treatment. These things actually merge, so much of what we do in treatment has a strong preventive component to it as well. Again, we are dealing with continua. They are some prefatory comments about that.

Let me take you back in time. The point that we are at with our treatment systems today grew out of traditions from the 1950s and 1960s. It is important to think about this. In the 1950s and 1960s, if we were dealing with alcohol and drug problems, we were mainly dealing with alcohol problems for older men. The services that were established, and that we still have the remnants of today, grew out of that. It has taken a huge effort on the part of our funders, policy makers and systems providers to come to terms with the rapidity of change that has occurred in our society, particularly over the last 10 years, but over the last 20 years or so. What grew out of that tradition—it was a non-scientific tradition in the fifties and sixties—was dealing with old alcoholic men. The primary modality of treatment was usually in-patient service. The ethos was grounded in the notion that somebody had to hit rock bottom or that there had to be very severe problems before you would intervene. Treatment was very much based on an abstinence model. There were very few pharmacotherapies, with the exception of disulfurim, around in the 1960s. That was the way services were established for a very long period of time, often in large institutions as well.

In the seventies and eighties, we saw some dramatic changes in that. The evidence base started to emerge; more research started to develop in this area and gradually a scientific tradition started to develop. What you saw this morning was our inability, still, to handle the emerging scientific and evidence base in this area because the field grew, to a large extent, out of a non-scientific tradition. Those two traditions still rub together uncomfortably to a very large extent, so that the polemic and the debate that you see is somewhat about that issue. It is important to bear in mind that that is part of the general scenario that we are grappling with.

The other issues around that are that many people who suffer from and experience problems with alcohol or drugs are highly stigmatised as individuals, and the people who treat them are also highly stigmatised. It is not by accident that many of the services that are out there are provided by charitable organisations who are prepared to deal with the stigmatised. Charitable organisations and the non-government sector, which Australia relies on tremendously for the provision of services and support in these areas, are traditionally underfunded. They also rely on staff that they can afford to buy, and they are often not the most well qualified.

So there is a constellation of issues that have developed over the last few decades that bring us to the point we are at now. What has happened in the last decade in particular is that we have seen this rapid change in the pattern of drug use, the types of drugs that are used and the complexity of the problems that we are attempting to encounter. Lay that on top of a health system and human service response system that grew out of a non-scientific and charitable system and you have something that is not well-geared to cope with what we are attempting to cope with at the moment. Today, in 2002, what you are seeing is increasing numbers of young people—now very young people—experiencing problems not just with a particular drug, which

is a challenge from a research perspective, but often with polydrug use. These days, people do not usually present for treatment as heroin users or amphetamine users; people use the full panoply of drugs that are available to them.

In Australia we have very little information about our services. That is the other thing to bear in mind. We do not document this very well; we have few resources available to do this. One of the things that my centre is attempting to do at the moment is to pull this information together. But we have about 550 specialist treatment services around Australia, and we estimate that there are about 8,000 staff within those specialised treatment services. Many of them have minimum qualifications. The evidence presented by my colleagues this morning would suggest that the complexity of what we are dealing with means that it is no longer sufficient to have people who have had previous experience. You really do need to have people who have much more sophisticated levels of understanding and who are more professionally trained and qualified to deal with the complexity of the situation. But we know very little about who provides the services that are out there, so we are attempting to find that out.

We know Australia lags very much behind North America—Canada and the United States. You are not required to have any kind of formal qualifications to work in this area; there is no formal accreditation system as there is for, say, counsellors in the addictions area in the United States. It is difficult to know who is working in the system and what their qualifications are. We have invested relatively little in providing training at the undergraduate and postgraduate level. Although Australia has made great strides forward in the last decade, we still lag substantially behind in the provision of professional training and upskilling in this area. One of the other huge dilemmas for us—and this is true across any of the human services areas where you have this exploding knowledge base, as evidenced this morning—is that there is a major difficulty in how you translate that knowledge base into practice; how you get it into the hands and the minds of the clinicians and the other required workers in the area. We need to apply that. That translation of research into practice is a major dilemma for us.

We have systems that have been set up based on a tradition or pattern of use that is no longer in existence; we have an overly heavy reliance on the non-government sector, who do an excellent job but who are overburdened; we lack an accreditation system, so we cannot guarantee that we provide the best professional staff with the best skills in the area; and we have no way of providing checks and balances or benchmarking. In terms of what needs to happen and needs to be addressed, we need to have a better understanding and a comprehensive overview of what our treatment services actually look like—and it is not just health. I keep emphasising that it is health and human services, because, to return to my point about what we are dealing with now, people are starting this kind of behaviour younger and younger and they have polydrug use problems and, as Professor Webster has pointed out, they often have co-morbidities related to mental health.

Because we are dealing with very young people, where we used to talk about rehabilitation for people with severe drug problems we now talk about ‘habilitation’. Somebody who develops a severe problem with drugs in their very early teens has not yet learnt enough life skills to be ‘rehabilitated’. Often, they have not had the experience of completing their education; Professor Patton highlighted the importance of that this morning. Often they do not have good social skills, are not employable and experience homelessness. Again, this

constellation of problems that we are dealing with is not exclusively in the domain of the drug or the substance; it is about life issues generally for those people.

In terms of a work force response to that, these are complex issues and problems, often for very young people. You need a highly skilled work force to address those; to date, we have not been able to adequately address them. I think that is because the scene has changed very rapidly and it is very difficult, as we know, for services to change in a similarly quick way. We have been caught on the hop to some extent. I think the youth issue is particularly important. Many services do not take people under the age of 18; where do those people go? We know that there is a major gap in our service provision. Many of the people who work in the area—and who do an extremely good job—will say, 'I am not trained to deal with people under the age of 18. I can deal with adults quite well and I think my competence there is quite sound; when it comes to young people I am way out of my depth.' We are seeing—and this is the snapshot I am presenting to you in terms of where we are in 2002 and what I predict is going to happen in the future—that it is young people, and increasingly young people, who present with this very complex array of problems. They need a different kind of system response than we are offering at the moment.

So I think we need to stop, stand back and have a look. I do not think we have actually done that. It is very difficult for me to obtain documentation about what the services that we provide in this area look like, where the gaps are and where the strengths are. We need to monitor those better. We must provide a better accreditation system in Australia so that we catch up with our American colleagues in this area. We must provide better training—and, by training, I do not mean transient roadshows where someone gives a one- or two-hour talk. There is an evidence base in this area, and the evidence tells you that that is not the way you translate research into practice. It is a bit of a feelgood at the time, but it does not change what happens for the practitioner on the ground. So we need to be much more sophisticated in the way we go about doing that.

I think we need to look more into the future, not only in terms of what we are dealing with just at the moment but also in terms of what we are going to be dealing with over the next five years, 10 years and 20 years, because the complexity of it will change. It is young people and it is, increasingly, young women. Again, if you think back to the fifties, we grew out of a system that dealt with middle-aged and older men with alcohol problems. Today, that is not necessarily the case. We are dealing with young people, polydrug use, a vast array of complex problems, young women and, increasingly, young Indigenous people.

Ms Madden—I would like to begin by thanking you for inviting AIVL to present to the committee again and providing us with the opportunity to reiterate any significant ongoing issues and highlight a few issues that have emerged since we last appeared before the committee in May last year. Prior to speaking to a few of those emerging issues I thought that I should briefly outline a little about my personal background and a little about who AIVL is for the benefit of new members of the committee. My personal background—and I think you have a short biography from me—is that I have been a heroin user for over 15 years. I have been on methadone for the past eight, nearly 8½, years. So I suppose in some ways I am certainly living proof of the benefits of long-term drug treatment. I am happy to answer questions in relation to that kind of personal experience after I finish.

Since the meeting with the committee last year AIVL have changed our name from the Australian Intravenous League to the Australian Injecting and Illicit Drug Users League. The main reason we changed our name was so that the organisation's title reflected the fact that, over the past few years, the work of the organisation has broadened considerably to include the perspectives of and the issues that affect illicit drug users broadly, not just injecting drug users. That reflects a lot of the comments that have been made this morning. Of course, given that injecting drug users experience significantly greater health and social harms than other illicit drug users, we have retained and will retain a primary focus on issues for injectors. But we are also increasingly addressing broader issues, such as issues associated with dance drug use, amphetamine and other psychostimulant use, polydrug use et cetera.

For those of you who are not familiar with AIVL's formal role, we are the peak national organisation for drug user organisations at the state and territory level. We have member organisations in every state and territory. Some of those are funded and some are not. We represent illicit drug users at the national level. While AIVL is certainly a unique organisation, we pride ourselves on operating a very professional and accountable organisation. I do encourage members of the committee to utilise the unique and, I believe, very valuable perspective and information that we can offer. There are many knowledgeable organisations and individuals that have and will present to you but as I understand it AIVL is one of the few—perhaps the only—organisation, that can give you the perspective of current drug users.

Regardless of where you stand on the issue of illicit drug use, I hope that you can see how important the perspectives of illicit drug users themselves are in finding solutions to these complex issues. AIVL would like to be viewed as part of the solution, not part of the problem. I hope the committee will allow us to play that role. While there are numerous potential issues I could raise here today, we have selected four main emerging or significant issues that we would like to bring to your attention. Because of the short time I am allowed today I have brought a brief document on each of the issues that I am raising, You can read those later for more information if you want.

The first issue I want to talk about is retractable needles and syringes. Since our submission to the parliamentary inquiry, the federal government has announced their decision to spend $27.5 million over the next four years on the development and introduction of retractable needle and syringe technology. AIVL has a number of serious concerns about this initiative, and I would like to present a few issues and concerns for your consideration. We are very concerned about the potential negative and unintended consequences of retractable needles and syringes for everybody in the community. From our perspective, which is one of having personal experience, and talking to drug users every day on the ground, we believe that it is very likely that injecting drug users will not accept these devices. If that is the case, we believe this could potentially lead to a black market in the current needles and syringes that are available through needle and syringe programs. In the last few years, if needle and syringe programs have even tried to change the brand of needles and syringes, there is often a great deal of difficulty around that; people will not use different syringes. The paper provides some more detail about why that might be the case.

I am sure there are people thinking that injecting drug users should just take what they are given and be happy with that. Regardless of whether you think that or not, the reality is that if these devices are not acceptable to drug users they simply will not use them. If drug users will

not use them then the health and social consequences will affect the whole community: we are talking about increased levels of HIV and hepatitis C transmission through the constant reuse of currently available syringes. We are also talking about other health complications such as abscesses and bacterial infections. Altogether the treatment of those kinds of conditions constitutes a potential increase in health cost to the whole community. You may be aware that the Department of Health and Ageing are in the process of releasing a final report looking at the cost-effectiveness—or cost benefit, if you like—of needle and syringe programs, the return on investment for government. I would encourage the committee, if you were not aware of that research, to have a look at it. It has been done by a well-known health economics company. It is very much an economic study, and it shows the cost-effectiveness and the huge return on investment for the government from both HIV and hepatitis C prevention.

We are also very concerned about the cost of retractable syringes compared with the very cost-effective current needles and syringes available through needle and syringe programs. It is difficult to put an exact number to it because there currently are no retractable devices produced in this country, but on the current available products we are potentially looking at an increase in operating costs for needle and syringe programs of around 700 per cent if we just provide retractable needle and syringe technology at the kinds of costs at which these devices are available when produced overseas.

I suppose we would question that kind of expenditure when we see the outcome as questionable. I say that the outcome is questionable because we understand that the main reason the government has decided to go down this road is to address the considerable concern in the community about inappropriate disposal of injecting equipment. We acknowledge that that is a major issue, but we do not believe that retractable syringes will in fact address that issue. From our perspective and, I believe, the perspective of a number of other parties, the fact of whether or not a needle and syringe on the ground is retractable is not going to make much or any difference to someone in the community. That is not their concern. Their concern is that needles and syringes are on the ground in the first place; their concern is the potential risk associated with those things. Whether that thing is a retractable syringe or not is quite a complex issue for the community to understand, so I think that having retractable equipment is not really going to address that issue. Potentially also we could find that drug users may see these devices as safer to leave lying in public places, because they are retractable. I am not saying that will happen but there is the potential for that. If that did happen, we could end up with a much bigger public amenity and public health crisis than we have with discarded injecting equipment currently.

AIVL believes that the funding currently being proposed for the development and implementation of retractables could be used far more effectively in reducing publicly discarded injecting equipment by implementing a comprehensive approach to this issue. This approach could include looking at things like a broad community education campaign, which really has never been done on this issue before, and providing funding to develop local community networks to work on this issue. There is lots of evidence around the country where local communities have taken their own initiatives on this issue and have developed partnerships between police, local health care workers, needle and syringe program workers, drug users and the broader community—everyone who is affected—and developed their own local solutions to these issues. In fact, there have been some very positive outcomes from those sorts of approaches. Obviously there also needs to be better and more targeted peer education on this issue for drug users and other users of needles and syringes—and that would include for

diabetics. We believe that there also needs to be a great deal of improvement in public facilities for the safe disposal of injecting equipment.

Over the past 12 months, we have conducted a major national study. We commissioned the study with a reputable research institute in Australia. For the first time ever, they talked to drug users about this issue, about their reasons when they make a decision to inappropriately discard a syringe and about what we might be able to do to remove the barriers to them disposing safely. That research has some very interesting findings, not the least of which is that it showed that the majority of injecting drug users always dispose of their equipment safely—that drug users take this issue extremely seriously. Drug users in that study were very concerned about the possible impact they might have on the rest of the community. In fact, the small number of people who were discarding syringes inappropriately were often doing so because of circumstances out of their control, such as having a change in routine for some reason, injecting somewhere they did not usually inject or with people they did not usually inject with or when there was a police presence in the area.

Once again, regardless of where you stand on the issue of whether people should be injecting in public areas or not, the reality is that it happens and our perspective is, 'Let's look at those issues and try and find solutions for everyone.' So when people were doing things like hiding syringes, tucking them away somewhere, the aim was very much to not expose other people rather than to tuck them away where they could not be found and then have a needle and syringe worker jab themselves on them. I suppose what this showed is that there are more motivations going on than we think. To finish on that issue, we believe that there needs to be a great deal more thought put into this; perhaps the money could be used on safe disposal but in a better way.

Of the three other issues I wanted to look at, one was public liability insurance for needle and syringe programs. I am not sure if committee members are aware, but in the past 12 months non-government organisations that operate needle and syringe programs have been unable to renew their public liability insurance for their needle and syringe programs. This is not based on any actuarial data. To our knowledge—and we have done some research into this—a claim has never been put forward in this area, let alone a case or a payout to anyone. It is a theoretical risk. The basis seems to be fear of needle-stick injury in that environment. But, as I say, there is no actuarial data to back up this being a problem. Quite often this is taking very busy and very popular needle and syringe programs out of operation. Recently a large program has closed on the Gold Coast. Our member group, who runs the biggest program in Perth, has closed, as have a number of major outlets in Sydney and the second largest outlet in Canberra. I have a paper which details this.

The second last issue I wanted to look at is drug treatment options. I do not feel I need to talk about that a great deal—although I am happy to answer questions about it: there has been a lot of talk about drug treatment options already this morning. I would like to restate our support for the availability of as many treatment options as possible for dependent drug users. We believe that this should include heroin maintenance programs and trialing other replacement therapies such as drugs like hydromorphone. We believe there is good evidence from overseas that such programs can be run very successfully. Obviously those sorts of programs are not for everyone, but we believe that there is a group of drug users for whom they could be extremely successful.

They would be a very cost-effective option for the community, and get those people back into effective and meaningful lives.

We desperately need more options and better access to treatment, particularly on issues such as use of psychostimulants, amphetamines and cocaine. As Ian has pointed out, there are very few, if any, options in that area, and we have a growing use of and injecting of amphetamines and other psychostimulants. AIVL does not also believe that the current funding is being directed enough to the places where there is highest demand for treatment—in particular, to methadone programs. We have seen evidence that people are not able to get on to methadone programs. There are huge waiting lists all around the country. In some places, they do not even keep waiting lists any more because they are too demoralising for both the staff and patients.

Finally, the Commonwealth government is currently undertaking a review of the national HIV and national hepatitis strategies. In relation to the HIV strategy, I would like to highlight a couple of points that we made in our submission to the government. We think they are very serious issues indeed. Australia has a fantastic record on HIV prevention amongst injecting drug users. It is internationally known and well deserved. HIV is something that you have to be eternally vigilant about. It does not go away. We do have HIV-positive injecting drug users in this country. They are a small number, but they are there. Once you have any pool of infection, that pool can grow. We know that once HIV gets above a certain critical mass it spreads very quickly among the injecting drug user group. We are very concerned about the changes in the drug market in Australia and changes in the patterns of use—in particular, the shortages of heroin that were occurring 12 to 18 months ago. That led a lot of heroin users to move across to using amphetamines and injecting amphetamines. We also have new users coming in, using and injecting amphetamines. Those users often have not been exposed to some of the HIV prevention material that we were producing and the kind of focus we had on that many years ago. There has not been a major HIV prevention campaign with injecting drug users for many years now. Unfortunately—sadly—when we talk to drug users on the ground they no longer say that HIV is the main health issue they think about, and I think that is a real concern.

We also have an absolutely exploding HIV epidemic on our doorstep. Throughout many countries in Asia, injecting drug use is the driver of their HIV epidemics. I have recently come back from the International AIDS Conference in Barcelona, which was a very depressing affair indeed on a number of levels. Probably one of the most depressing things was to hear that experts are saying that, if things do not change rapidly in a number of countries in Asia very soon, that epidemic will eclipse the African HIV epidemic in 10 years time; that is mind-boggling to think of.

We cannot pretend that would not affect us. We are very much part of the region, and on economic, security, health and all sorts of levels, I think this is an important issue for us, particularly because there is increased mobility in the region. We know that young drug users of Asian background are often sent home for treatment to their countries of origin by their parents. We have recently had statistics from Victoria from the year 2000 that showed a doubling of the HIV infections among injecting drug users. We are still talking about low numbers, but it was a doubling, and we had statistics that had stayed rock solid for the previous five years before that. Those statistics related to some drug users going to Asian countries for treatment, not engaging properly in their treatment—they were using while they were there and not able to get clean needles and syringes—coming back to Australia HIV-positive and then interacting with drug

users here. So there is a real potential there for an increase in our HIV epidemic. With closures of NSPs, as I said, we need to be careful that we do not wait until it is too late and we have an epidemic that is out of control. In Barcelona, we were told that it can take up to 40 years to get control of an HIV epidemic among injecting drug users once it reaches over 15 per cent, so we really need to be careful about that.

Finally, in relation to the national hepatitis C strategy, we wanted to say that, although we have a fantastic national hepatitis C strategy—it is well written and it has some fantastic strategies and ideas in there—it is an unfunded strategy. If we have a great strategy but no funding to implement it, we simply cannot implement the strategy and get the runs on the board in relation to hepatitis C. Hepatitis C is a very serious issue. We have over 250,000 people infected with hepatitis C in Australia. Recently, new infections were at 11,000 every year. In the last two years, they have increased by 16,000 every year, so we have major work to do on that issue, and we cannot do it without adequate funding.

CHAIR—Thank you very much.

Mr DUTTON—I wanted to preface my questions to Annie by saying that I reject or take issue with some of the stories and anecdotes you have provided, particularly in relation to syringe use. I think there is a feeling in the broader community that there needs to be a two-way process. By facilitating retractable syringes, the government is trying to balance the needs of the users and of the broader community, especially regarding needle-stick injuries to children. I think if we are going to approach this by saying that users are of the view that they just will not adopt their use, it is regrettable, to say the least. Somehow, whether it is through an education process—

Mr EDWARDS—Are we having a debate about it, Madam Chair?

Mr DUTTON—We just need to make the comments. The evidence has been given, and I am commenting upon it. I think that point needs to be made because I think the broader community demands higher standards than that. Perhaps we should be looking at a swap scenario for syringes, if these people are as responsible as you say they are.

My question is related more directly to your experiences—we tried to take as much evidence as we could in our dealings with some of the community residential care facilities about how people initially came into contact with heroin. Have you been a user of heroin during your use of methadone? What proportion of people do you think would be using heroin at the same time as they were on the methadone program, and is that the long-term sustainable outcome we are after? Much of the anecdotal evidence that we took from users about methadone is in conflict with some of the medical evidence that is available.

Ms Madden—Professor Webster or others in the room may be able to comment more on the disparity you are saying exists between research evidence and anecdotal evidence. Suffice it to say that research evidence is regarded highly because it is rigorous and it looks at broad samples and the experiences of a range of people. I think it is difficult to draw conclusions from individual experiences or anecdotal evidence from a handful of people in one treatment facility or even a number of treatment facilities. Clearly the benefit of research is that it is rigorous in

that regard and can be done in such a way as to allow us to draw conclusions that are robust and can stand up.

I suppose that prefaces my response to some of the issues that you have raised about my individual experience. I am prepared to talk about my individual experience in the context of how it relates to some of the solutions we might find to this and broad issues. I do not think it is useful for me to talk about whether or not I have used heroin while on methadone. I think we know that people do that; I do not think you need me to say whether or not I personally have for it to make any difference. We know that it happens.

Mr DUTTON—In what proportions though?

Ms Madden—It would be better to ask one of the researchers about that. They would have research that I do not have to hand that might reflect that. Ian, do you know the proportion of people who use heroin while they are on methadone?

Prof. Webster—It varies and changes through time. The real question goes back to points that Richard Mattick and John Saunders made about what we are trying to achieve in treatment. We are trying to achieve an outcome where someone is socially functioning; we are trying to get them back to work and, presumably, back to their families; we are trying to achieve an outcome where the person is healthy and has fewer medical problems—particularly HIV infection and the like—and is using drugs in a less chaotic way. Just as I was showing pictures about the different criteria you might want to use when you judge the outcome of a diabetes program, there are sets of criteria which are used to judge the outcomes of an intervention in addiction.

In a number of cases, we would accept that a person's social functioning—in getting back to work, having fewer health problems, less depression and so on—is a measure of improvement; we do not necessarily use absolute abstinence from illicit drug use as the only measure. However, if you recall the figures that Richard Mattick showed us, there was an absolute reduction of heroin use in those who were on the methadone program. So in the early stages of a methadone program something like 15 per cent of people may intermittently use heroin, perhaps once a week. That would gradually decline. They are certainly not using it three or four times a day and getting into a lot of trouble for it.

Mr CADMAN—Are there statistics or studies on this issue?

Prof. Webster—Yes, there are plenty of studies on that, but I do not have them in front of me.

Ms Madden—One of the issues I want to comment on is the importance of providing people with long-term treatment, particularly in terms of methadone. We have heard evidence from numerous people this morning about it being a chronic condition. It is really important that people are supported to get to that point where they can start making improvements in their lives. We can as a community wash our hands of people, I suppose, but that does not benefit anyone, least of all those individuals. It also does not benefit the broader community. We do not get those people playing a positive role in the community. They do not contribute in terms of employment or anything else. Also, it is not a very cost-effective way to deal with health issues. There are lots of reasons why you might provide long-term treatment. I am not saying that it is

ideal that that has to happen, but it is the reality. There are lots of people who demonstrate the importance of that and are success stories in every way based on that—even if you include total abstinence from illicit drugs other than methadone.

Prof. Webster—I just want to respond to Mr Dutton's point about interviewing people in residential programs. That is a select group of people who have opted for that form of treatment; they would not represent the views of all the people who get treatment.

Mr DUTTON—My experience also extends to my former life in the police force, where I have dealt with drug users for the last 10 years and those who are on the methadone programs. I take anecdotal evidence from both those categories of people as well as those we have come across quite deliberately as part of this process.

Mrs IRWIN—Professor Roche, you stated that younger and younger people are using a variety of substances and that there are not many services that cater for or take people under the age of 18. What type of service would you like to see? What should government be looking at?

Prof. Roche—One of my first points was about the continuity of services that we need to be offering—not drawing a hard and fast line between treatment or management of problems but also looking at prevention. There is excellent research work that now underpins early intervention programs so that we can identify people who are particularly at risk: people who are relatively young, at primary school age and between 10 and 14 years of age. It is not an argument to target those individuals, but knowing the factors that contribute to their being at risk means that we can actually implement a whole range of strategies around youth that will provide a preventative barrier, if you like, to not necessarily using drugs but developing problematic drug use. I think that is a fine but important distinction to make.

There is a whole range of strategies that communities can put in place to ensure that there are facilities for young people. One of the complaints you will hear in rural and remote areas and some outer suburban areas of most metropolitan cities is that young people have nowhere to go, that they do not have sufficient things to do and that they do not have enough supervision. A point was raised this morning about the value of sporting activities or any activities that will keep young people purposefully engaged in a safe environment under the supervision of older people, either responsible young adults or adults that they can bond with or form meaningful relationships with. We know—the evidence tells us—that those things provide a tremendous protection against a range of things including alcohol and other drugs but also juvenile crime and dropping out of school.

Mrs IRWIN—I have just a quick question for Professor Webster. It was so disappointing to hear you say that there are not many drug and alcohol units in our public hospital system, but I know it is true. What would a dream unit be—or do we have one? What would you like to see?

Prof. Webster—Every public hospital should have a group of people who specialise in drugs and alcohol. They should have the same standing as a professor of medicine. They should be running formal outpatient clinics, like the professor of surgery does, and they should be running a full, comprehensive pharmacotherapy program, which would include most of the medications we have talked about today, with students being taught and research being done. It should also have a very strong network of related community based services. I am talking about a

hospital—in some ways, I am using it as a symbol of the health care system, because that is where status is reflected—but I really think that we ought to be doing this at a primary health care level in community settings. We ought to have a much more accessible full range of interventions in community settings where they are linked with mental health responses and general health responses. Increasingly, the health care system is having to move towards a much more primary health care structure. Our problem at present is that, in the city, everybody who has a major problem or thinks they have a major problem goes to the emergency department of a hospital, which is becoming a bottleneck. It is a very cramped, hectic, difficult place. We should create other environments that are accessible to a whole range of people—by linking up with the police service, for example.

One of the things I am reflecting is that the field of dealing with drug and alcohol problems is very comprehensive. Every physical health problem that I listed on the board is related to it, so you have to be expert and knowledgeable about them all. It also intersects with mental health. That is an area that the physical side of medicine does not understand particularly well. It also relates to these public health ideas we are talking about. How do you prevent things from happening in the first place? Where are the best points to intervene to prevent things from developing? What interests me is: why do people not find that an exciting and fascinating area to work in? They do not.

Mr WAKELIN—Professor Roche, I would like to ask a little further about this—as you described it—rather poor interface between the old tradition of unscientific methodology and the perhaps more enlightened emerging approach to this issue. Could you try to isolate—you probably did, but could you then reinforce this—the areas from that tradition that are impeding us? For example, what is the NHMRC view on this? What goes on in the labyrinth of the NHMRC? What effort goes on there? What are the main impediments in this rough interface where we are trying to emerge, if you like, from the tradition?

Prof. Roche—I would not presume to speak on behalf of the labyrinth of the NHMRC. The NHMRC recently made a very useful contribution to this area by funding a number of specific research projects around illicit drugs. We will be presenting on them at a conference later this year. They have recognised the need to expand and consolidate the evidence base, and have directed funds to that. So I think that places the imprimatur of the NHMRC very clearly on that particular approach.

But your initial question is the important one and that is: what do you do about the interface and how can you address that issue? To a large extent it goes back to basics. Unless you incorporate, within your fundamental professional, initial, pre-professional and post-professional training programs—from police through to physicians—a clearly consolidated knowledge base around this area it becomes very difficult for people to acquire it later in their professional lives. As you can appreciate, this is a complex area. It is a diverse area. It is coloured by ideology and personal perspective to a large extent. So it is very difficult for people to sift their way through this amazing array of conflicting things. The way people do that—whether they are engineers or cancer specialists—is by having a very good grounding in critiquing and reading the literature in their field. But, unless they have that grounding, it is very difficult to do it later. So I think you go back to basics and build it in at that level.

Then you also build in infrastructure around the systems you have in place at the moment, to say, 'We value the ongoing acquisition of knowledge, and we are going to assist you to synthesise this new and expanding knowledge base'—which is often not easy to synthesise because it is often full of conflict. But you need the skills to do that, and we need to fold that in to the services we provide. As I said, it is not about having a little, transient, one-hour or two-hour seminar here or there; that is not going to scratch the surface of it.

Prof. Webster—I would like to respond to Mr Wakelin, too, if I might. I do not know that we ought to present it as a conflict, because in fact it will be a melding of the different paradigms. I think that lots of people who are addicted have to learn to become a different person, because the whole of their structures, relationships, thinking, focus and ambition in life has been affected by their drug use. Becoming a different person takes a long time. Quite a lot of people who are very disorganised and damaged by what has happened to them have to go to a community which will nurture and support them.

That is one of the particular values of residential communities, because people are really learning to be a new type of person—or recapturing what they had before—and developing relationships. In Indigenous communities the thinking about the nature of these problems is quite different from ours. They see alcohol use, drug use, mental health and suicide risks as part of a whole continuum, which they describe sometimes as social and emotional wellbeing. Their response to these things is very much a family or community response. I think it is a melding of the paradigms—but giving emphasis to the evidence that, where you use that nurturing approach, it actually works. You have to demonstrate that it is an effective approach.

Mr WAKELIN—Professor Webster, you have touched on Indigenous issues concerning inhalants. Do we have anything there giving us any indication of the way ahead?

Prof. Webster—As I mentioned before, I am the chair of the Alcohol Education and Rehabilitation Foundation and one of its terms of reference is to provide funding to do with inhalant risk. There are some good programs in your own state, South Australia, which have been developed by the Aboriginal Drug and Alcohol Council which consist of resource materials presented in Aboriginal paradigms which they can understand about the effect of petrol and related substances which are inhaled. It is a learning process which you take the whole community through, the elders and so on. It is not a treatment of the individual at this stage. There may be some treatments in the future which will work. It is really about the development of that community and its response to the needs of young people, again acknowledging that petrol sniffing does have very harmful effects. Aboriginal people need to appreciate that in their terms.

Mr WAKELIN—I would like to ask one quick question of Annie Madden.

CHAIR—Could we have a fairly succinct response to the question?

Mr WAKELIN—In terms of abstinence efforts in order to bring people off methadone, people in the program have said to me that there is not the emphasis there that perhaps they would like to see. Can you give me some indication of what is occurring in that capacity to build into programs the abstinence effort, to say, 'Let's come off it at some point'?

Ms Madden—I think this is a really important issue. While saying that people can stay on as long as they need to is important, so equally is making sure that programs are really focused on the needs of each individual. One of the things that I have been disappointed about in relation to my own treatment, and I know that it is an issue for others, is never having had a treatment plan developed for me. I have just continued on and I happen to have the wherewithal to be able to make my own decisions now. I certainly would not necessarily have said that when I first went on the program, but I could just have easily have got lost in it all and I know people do. It saddens me a great deal to see people turning up and going each day when no-one connects with them. I think there is so much lost potential there. I need to say there are some programs that are really much better than others and I am not suggesting all programs are like that. Sometimes some of the really big programs can have difficulty giving that attention one on one to people, because the resources are really limited, as we have already heard, and there are the training issues and all of that. I do think that there should be more of an overall approach that involves things like education opportunities, assistance with training and employment and all those kinds of things. People are coming in regularly. They are there are all the time, even down to things like looking at treating hepatitis C issues. There is a whole range of things that we could do better if there were more resources.

Mr PEARCE—Professor Roche, I was interested in the comments that you made about professional training and development. I think that you said that we are lagging in that area. I presume that means in comparison to other countries. How far are we lagging? How far behind are we in the professional training and development of people to be able to manage these areas?

Prof. Roche—My specific comment about lagging behind other countries was in relation to the lack of formal accreditation. America has a system of formal accreditation for counsellors in this area, which allows them to do a variety of things. It allows them to benchmark and set minimum standards of competence, et cetera, but it also allows them to have some indication of what their work force looks like. We do not even have that as a basic working tool to develop our services. That is a problem for us. In that sense, we lag.

As I also said, we have made great progress in the last decade around Australia in terms of most of the larger universities providing some degree of training. The emergence of RTOs—registered training organisations—has also been a real boon, particularly to the non-government sector. We have made a lot of progress there. There are a range of certificate courses as well. We have been able to establish essentially bridging courses to upskill people professionally. If they want to go further in their professional development, they can do that. The other important development that has just occurred this year is in relation to what is called a Chapter of Addiction Medicine within the Royal Australasian College of Physicians. For medical practitioners wanting to have some kind of recognition for their specialised work—and recognition occurs in a variety of ways—that is a major step forward. So we do lag in a number of areas, but we have achieved some really significant progress.

I will pick up on the point that one of the things that it is incredibly important to recognise is that not only are people with drug use problems stigmatised but also the workers and professionals who work with them in the area are similarly stigmatised. There is an international nursing shortage and there has been a campaign on television recently trying to recruit more nurses. The campaign has been using nurses to say how rewarding they find working in the area. People who work in the alcohol and drug area do so because they find it particularly

rewarding. The treatment works. One of the things we do is undersell the efficacy of treatment. People have tried to underscore how treatment is quite effective in this area, in spite of an impression to the contrary. We undersell it, there is a strong stigma attached to workers and then we wonder why we are having difficulty recruiting people into the field. I think a simple and straightforward thing that can be done to improve recruitment is to give reward and recognition to people who work in the field, to say that they do a damn good job that is highly valuable to the community and that they work in area with treatments and interventions that are efficacious and that work. We do not have to have new evidence to do any of this; this is at our fingertips. We do not reward the people who are out there doing the hard yards, often with minimal resources around them.

Mr QUICK—Professor Webster, you mentioned health care agreements between the states and the Commonwealth. I ask a question in light of the House of Commons Home Affairs third report on drugs. They state that they had a national strategy in 1998 called Tackling Drugs to Build a Better Britain, where they set out the following four aims:

Young People—To Help Young People Resist Drug Misuse ...

Communities—To Protect our Communities from Drug-Related Anti-Social and Criminal Behaviour.

Treatment—To Enable People With Drug Problems to Overcome Them ...

Availability—To Stifle the Availability of ... Drugs ...

They actually set targets to reduce it by a certain amount. Home Affairs now state the following recommendation:

We believe it is unwise, not to say self-defeating, to set targets which have no earthly chance of success. We recommend (1) that the Government distinguishes explicitly between aspirational and measurable targets; (2) that it focuses on outcomes rather than processes as indicators of success and that where a process is intended to lead to a particular outcome, the basis for expecting this be explained, with evidence; and (3) that baselines are established as soon as possible for all targets.

In light of that British recommendation, how do we go about setting health care agreements? As Professor Patton said today, there is this adhocery—some states are doing it and others are not. There are no sanctions at all in any Commonwealth or state health agreements.

Prof. Webster—There was a fashion 20, 15 or 10 years ago to define goals and targets for the nation. We do not quite do that. When the council I am president of, ADCA, has made its submissions to the government, it has always put targets in about what we expect to happen, but virtually no government document in this area has defined targets for the future. On the other hand, I think there should be targets put in place. In health care agreements you could put in expectations of performance and achievements that you would mark. For example, you could include the access of people with drug and alcohol problems to an appropriate level of services or you could ensure that a public hospital provided appropriate detoxification facilities. You could examine the extent to which—as Professor Roche has been speaking about—the proper standards of professional practice are incorporated into the work force. They are all intermediate and process targets. It is still, nevertheless, proper for government to have broad aspirational targets, even though you may not put a number on them.

In the mental health area, the Commonwealth's involvement had a dramatic effect right across Australia. There was the first mental health plan and then the second mental health plan. There were standards set in those plans about what states should perform to in the provision of quite basic services. Ministers at state level have been prepared to accept that their performance is being tested against it. I know New South Wales accepted that it was not doing very well against those mental health standards. So I think it is possible to go part of that way, if not fully to those outcomes that you were describing earlier. The health care agreements originally arose out of agreements between the Commonwealth and the states to fund hospitals. We must see that they are also agreements to ensure that there are services outside the hospital system—in general practice and in the mental health and drug and alcohol services that I have been speaking about.

Mr QUICK—I have another question on the issue of privacy. We are becoming almost paranoid about the issue of privacy and the collection of data. At what stage do we say enough is enough about privacy, that privacy is a secondary issue in a national strategy to deal with these issues and that outcomes are of paramount importance?

Prof. Webster—I absolutely agree with you: privacy is inhibiting the delivery of proper health care in this field and most other fields. There are requirements. For example, you would expect that a public hospital should communicate openly with the local general practitioner. With these new EPC, expanded primary care, items which the Commonwealth has introduced where the GP is expected to negotiate with other health care providers like social workers and allied health professionals of various sorts, in many circumstances—this may not be what the rules say—most of the doctors feel that they have to get a sign-off of permission to do every one of those things.

Similarly, people in the hospital believe that they have to get agreement by contacting the GP about everything. When you make things so difficult because of privacy provisions, people do not get involved in doing proper coordinated care. After all, in the health system, and through the conversations we have had today, we are trying to build a system which interacts and supports each element rather than dividing us into little pieces. So I agree with you on the issue of privacy. Although it is very important and people should still have the option to make statements that they want things kept private, we should assume that when people are dealing with a person's health they also have a duty to communicate. That should be the emphasis.

Mr CADMAN—How is the dual problem of mental health and drug dependency dealt with in Australia?

Prof. Webster—Very poorly, but it is dealt with very poorly in most countries. That is partly because the specialised systems that we have built have grown apart, although I should say that the drug and alcohol services in Britain are run within the mental health services and the people who specialise in that tell me that even inside that system there is poor communication. The Burdekin report of some 10 years ago into discrimination against people with mental illness has a whole chapter on the conflicting paradigms between the way mental health people and drug and alcohol people view their roles. In the mental health field, the idea is that—and we have to do a lot better; we are not doing it very well—we ought to be focusing on care in the community, following up people who do not keep appointments, following up inquiries assertively and making sure we are helping people who have great difficulties with their lives.

The tradition in drug and alcohol work has been that nobody will change unless they are motivated. The attitude is that, if person does not come back, you do not follow that up—that is a test of their motivation. If a person tries to get detoxification anywhere in Australia, they are expected to ring every day, or something like that, to get access. That is a test of their motivation. I must say that there are some examples where people are now saying, 'Well, if a person has not contacted us, we ought to follow them up.' But there are these awful traditions of in a sense blaming the person for not getting involved because of their addiction.

I think the principal way in which this can be dealt with, apart from putting that system together better, is to think about what is happening at the primary health care level—general practice in community settings, where we do not divide people up. If people knock on the door of a general practitioner for help, he does not say, 'Have you got a mental health problem, a drug problem or diabetes?' before he lets them in; the door is open for all those problems. We need many more open doors through which people can engage, rather than dividing it up in the way that we do.

Prof. Roche—I will just comment on that quickly. One of the encouraging things that has happened around Australia in the last two years in particular is that there has been quite a lot of attention focused on the area of dual diagnoses or co-morbidity, call it what you will. There are now a number of pilot projects under way, looking at how you can alter the systems we have in place. As Professor Webster correctly points out—

Mr CADMAN—Would you give us a list of those, please?

Prof. Roche—I can give you a number of them. I am not sure that I know all of them, but I know of a number of them that are occurring.

Ms Madden—We will take that on notice.

Prof. Roche—People were experiencing difficulties because the tradition had been that if you had a mental problem you would not get into a drug and alcohol program and vice versa. So we are trying to break that down. People are now saying, 'Let us bring the two teams together who would traditionally manage such people in isolation. Let us share case notes and develop management plans.' We are trying to train each other in terms of what the key issues are. So there is some very important work going on in Australia in that regard, and it is quite encouraging.

Mr CADMAN—I would like to follow up briefly on that. We have been given evidence that the greatest number of tobacco caused deaths in the electorates of a small sample of those around the room occurred in Canberra, but Canberra has the highest disposable income of any area in Australia. Would you like to offer any observation on that?

Prof. Roche—I think they were absolute deaths and not rates. Weren't they just deaths?

Mr CADMAN—They are tobacco caused deaths by electorate.

Prof. Roche—Yes, but they were deaths; they were not rates.

Prof. Webster—It would depend on the size of the electorate how many were identified.

Mr CADMAN—The electorates are roughly equal, by law.

Prof. Webster—I think it is an interesting question because tobacco smoking is, unfortunately, more common in people who are less well off and they spend their income on tobacco.

Mr CADMAN—I was just asking for an observation. Canberra's population tends to be better off.

Prof. Roche—Is the population here slightly older? You die from tobacco related diseases later in life, so the population profile might be skewed?

Ms GEORGE—We visited the Aboriginal Health Service in Victoria, and it was clear that Indigenous communities were not accessing mainstream detox and rehabilitation services. That is a problem, I think, for urban Indigenous communities. From what little I know, on the ground in remote Indigenous communities, the services are probably even less plentiful. Not long before his death Fred Hollows talked about the possibility of a very serious outbreak of HIV/AIDS infection in Indigenous communities. I wonder whether there has been any data or research done that particularly focuses on the hepatitis C issue and HIV/AIDS in both urban and non-urban settings? Annie, you might have something to say about that?

Prof. Webster—There are probably a number of us who could comment on that. It is true that Indigenous people make poor contact with the non-Indigenous based drug and alcohol services, as they do with mental health services and many other services. They do have their own way of thinking about drug and alcohol problems. I think it is important to work through Aboriginal based organisations in developing a more appropriate response, but experts like the people you have met this morning ought to be facilitating that, rather than taking it over. In terms of alcohol problems, you know the evidence—it is massive. Petrol sniffing occurs sporadically in different communities. In some communities it is extraordinarily high. Injecting drug use is high in numerous Indigenous communities, particularly in urban areas. In the ACT, there is a very high level of intravenous drug use among Aboriginal people who live in this environment. Two weeks ago, the national conference of the National Indigenous Substance Misuse Council was held in Adelaide. There are some excellent Aboriginal organisations. It is estimated that there are 250 Aboriginal based organisations dealing with substance abuse, and my thinking is that we have got to work with them and through them in developing appropriate responses.

Prof. Roche—May I add to that? You asked for some data. Two studies have recently been released. One was conducted in Adelaide and Murray Bridge, indicating an increasingly high level of injecting drug use among Aborigines and an exceptionally high level of hepatitis C. That is part of a study which is parallel to one not long completed in Western Australia. If you want that data, it is available.

Ms GEORGE—That would be very useful.

Ms Madden—There is also a national strategy that has been developed on Indigenous sexual health by the Office of Aboriginal and Torres Strait Islander Health, OATSIH. They are starting to implement that, but it is a really big issue because there are so many health priorities for Aboriginal communities. To place HIV and hepatitis C at the top of that list is sometimes quite complex in terms of resources. But a concerted effort is starting to be made on those issues.

Mr EDWARDS—Thank you very much, Ms Madden, for your excellent presentation this morning. You touched on an issue which should be of incredible concern to us all but which I have not heard mentioned much in health areas. It is the issue of the explosion of HIV in South-East Asia, which is now mostly being transmitted by dirty needles. I have also had that concern about the needles issue in Australia raised with me in Perth by some NGOs. How widespread is that concern among other NGOs? Is the concern being picked up and shared by any other health experts in Australia, to your knowledge? How do you overcome this issue of what many people in the community would see as a good initiative by the government in providing these retractable needles, as compared to the fact that many people who inject just do not want to use them?

Ms Madden—Probably the issues are a bit separate. We do have low rates of HIV in Australia, but I do think we have a changing environment. I am not sure if members are aware that the HIV rate among injectors here is less than five per cent. A few years ago in Vancouver, we were shown that they had the same level of HIV infection—less than five per cent—among their injectors. However, a number of things changed including a change in drug patterns. They had cocaine come into the environment in a much bigger way; they had a restriction on access to needles and syringes; and we saw that their HIV rate went from less than five per cent to almost 30 per cent in 12 months. That is an environment that is very similar to ours; it is not a developing country environment. It shows that we can never have too much HIV education; we can never drop the ball on this, because it explodes very quickly in the injector community if we do not keep eternal vigilance. Obviously the key ingredients are good access to clean needles and syringes—as much as we can possibly resource—and good prevention education so that people are knowledgeable about what they should be doing with that equipment. I understand that needle exchanges are a delicate political issue, but that has meant that we have lost some major outlets in the last couple of years, reducing access. On the other hand, we have not had a big HIV-AIDS campaign focused just on injectors for some time now.

Our organisation does not get a lot of resources. We are resourced for hepatitis C education, not HIV. All we can do is piggyback HIV-AIDS messages on our hepatitis C education resources, which does not say to drug users that this is a priority issue. So there are problems there. We need to refocus. I think we have gone from having a very strategic approach on this issue to having one that is no longer that strategic. I am not sure that we know what we are doing with injectors on this issue right now. We are just hoping that it stays the same, and I do not think hope is enough.

Mr EDWARDS—Professor Webster, do you have any views on this?

Prof. Webster—You asked a question before about non-government organisations. Certainly the non-government organisations that are linked in the drug and alcohol area are very concerned about the issues that you have raised. A number of members of groups at an international level—I meet with other NGOs in neighbouring countries—are becoming

profoundly concerned about the HIV epidemic, and it is influencing their attitudes. You will know that a lot of these Moslem countries strongly reject drug use of any kind. They are very concerned about harm reduction as an idea, but they are accepting that it has to be something that they adopt now in the face of the risk of a massive epidemic of HIV-AIDS.

Mr CAMERON THOMPSON—In our travels around the place, we get different perspectives from time to time about the value of services which tailor their activities to either intravenous drug users or alcoholics—whether there should be a mix. Is there a real perspective as to how that should be? I would appreciate Annie's view on this, as well as Professor Webster's. There seem to be particular services which, for example, Indigenous people are accessing, while other services say, 'No, we never get any of those people in here.' Is it a good thing that services are separated?

Prof. Webster—From a professional technical point of view and in government policy, we have put them all together. The great virtue of Australia's drug policy is that we did not focus just on heroin way back then in 1985; we said all drugs—alcohol, tobacco, legal drugs and prescribed drugs. Where you are dealing with a person's health problems, you have to deal with them all at once. You might have some special interests but, as we have heard, people switch their use of drugs and you have to have a comprehensive approach to that. In any case, just with the use of resources, in a highly costly health care system, you could not afford to have people specialising only in alcohol, because almost everybody in the hospital has some problem related to alcohol. I think it is different when you look at it with a community focus, because communities form around different issues, and this is perhaps where Annie ought to comment.

Ms Madden—I think it is quite tricky. With generalist services, one of the things that users often talk about is being thrown from pillar to post: for every single different health issue they have, they need to go to a different service. That can be really difficult if you are having difficulty with your life and in getting things together. Services that can take a comprehensive approach can be very useful. Having said that, when you are talking about different population groups, as opposed to health issues, the issue of more tailored servicing becomes really important. We know that young Asian drug users, for example, are not accessing mainstream services. They can sometimes have issues about going to services run by their own community, because of confidentiality issues. I think those can be addressed while still providing a culturally specific service. It is the same for Indigenous users as well. I know that it is not necessarily seen as a cost-effective way to approach it but, if we can have a sort of generalist approach to health issues and provide specialist population based services where they seem to be specifically needed, I think that is probably a better approach.

Prof. Roche—I think the integrated services work really well, particularly in a health care setting, but where you have young people, women and specific ethnic groups, particularly Indigenous groups, they often have very specific needs and services need to be tailored to them. If you are looking at a residential in-patient or long-term treatment service like a therapeutic community, there are arguments there to have those tailored in some way. We know that the services say that older men with alcohol problems really do not want to go and spend three months with young people addicted to heroin. So I think there needs to be some kind of tailoring of that. But having some kind of integrated service certainly makes sense in the first instance.

I would like to make one quick final comment in response to the issue of retractable needles. There is no evidence internationally to indicate transmission of HIV through discarded needles, none whatsoever. So introducing retractable needles means spending a lot of money to make the public feel more comfortable when there is no evidence for it at all. I think what Annie has highlighted is the potential for an unintended but really severe public health consequence from this policy which has been made in an evidence free zone.

Ms Madden—Actually there is no documented case internationally of HIV, hep C or hep B being transmitted from a publicly discarded syringe. I am not talking about health care settings; that is a different matter.

CHAIR—Thank you. That wraps up this morning's session.

Resolved (on motion by **Mrs Irwin**):

That the following documents titled: *Issues relating to retractable needles and syringes*; *Public liability insurance and needle and syringe programs*; *Hydromorphone trial;* AIVL's submission to the review of the fourth national HIV-AIDS strategy; and AIVL's submission to the review of the first national hepatitis C strategy, presented by Ms Annie Madden, be treated as exhibit No. 18 and included in the committee's records.

Proceedings suspended from 12.57 p.m. to 1.29 p.m.

BRESSINGTON, Ms Ann Marie, Chief Executive Officer, DrugBeat, South Australia

HANBURY, Ms Julie Tasma, Coordinator, HELP (Helping Empower Local Parents), Local Drug Action Groups Inc.

MUNRO, Mr Geoffrey, Director, Centre for Youth Drug Studies

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

WILLIAMS, Mr Glenn Allan, Founder and Chief Executive Officer, Focus on the Family Australia

CHAIR—This session of the roundtable will deal with families. We will be hearing how families can be assisted to avoid drug abuse and how families with drug addicted members can be supported. Our presenters for this afternoon are Mr Geoff Munro, Ms Julie Hanbury, Mr Glenn Williams, Mr Tony Trimingham and Ms Ann Bressington. I welcome you as presenters for this afternoon's session and I invite Mr Munro to start the session for us.

Mr Munro—I am delighted to have the opportunity to address the committee and I thank you for inviting me. I will begin by emphasising that, for the past couple of years, the Centre for Youth Drug Studies at the Australian Drug Foundation has been engaged on two projects funded by the Department of Education, Science and Training looking at the current practice of school based drug education. In the two of them, we conducted an investigation, along with the National Drug Research Institute in Perth, into a review of the national school drug education principles. We were asked to look at the principles and see whether they were still appropriate and to advise on whether any changes were recommended. Secondly, last year we undertook a scoping study looking at how schools across Australia are dealing with the issue of illicit drugs—to what degree they are including education on illicit drugs in the curriculum and how well they are coping with the demand for it. At the moment, together with the Centre for Adolescent Health, we are undertaking a small study for the education department in Victoria looking at how schools might begin to evaluate their drug education programs.

I do not have a presentation for you. I thought I would speak for about 10 minutes and skate over a number of issues and then leave it to committee members to pick up on those issues that they are most interested in. I would like to begin by pointing out that, in my opinion, drug education in schools has been both oversold and undersold. Drug education is a central component of every government drug strategy, whether at the Commonwealth, state or territory level. There are good reasons for that, but, in the past, I think drug education in schools has almost been treated as a potential solution to drug use. There has been a sense that all we need to do is educate young people about drugs and that would solve the problem. We have discovered—not just in Australia but internationally—that that is a very naive view. I am sure the committee has heard, not just today but on many occasions, that there are very powerful impulses in society for drug use, and it is not just a matter of 'let's educate young people and solve the problem'. In the health and education fields in the past two decades, that has caused something of a loss of support for drug education in schools. I think the emphasis on schools educating young people out of drug use has actually obscured the potential difference that

schools can make in reducing drug abuse. I note that that is the question I was asked to address in the committee's papers.

I would like to point out that schools address drug issues in several domains within their school setting. One is through the curriculum—the formal study that students undertake. That is clearly where educating young people about drugs takes place. That is the most obvious form of drug education, and that is the form we most think of whenever we hear the term 'drug education'. But schools also provide places where young people can achieve success, can develop their self-esteem and can develop self-respect and—I am sure that Professor Patton talked about it this morning—protective factors. We know that young people who do not feel successful and do not like themselves very much are at much greater risk of not only using drugs but developing drug problems. Thirdly, there is a very important domain which I think we are just beginning to come to terms with. Before lunch, there was a discussion about early intervention. Schools have a very important role to play in the way in which they respond to young people when they identify them as having used a drug. Traditionally, schools have responded to young people using drugs with expulsion, and that is a response that has had a lot of support in the community. It sometimes goes under the name of zero tolerance: 'We will take a strong stand and, if you do the wrong thing, you will suffer the ultimate penalty.'

We are coming to the conclusion that that is not the recommended action for schools. The young person who comes to the attention of a school for using drugs gives the school a very good opportunity to address the drug use by that young person. In some cases, it may be experimental drug use, in which case the young person has simply used a drug to try it out for the first or second time, much as many people try alcohol, tobacco, cannabis and other substances. It may not be a mark of a problem; it may be just a marker that that person is an adolescent and is wanting to experiment in the world. On the other hand, it may be a sign that the young person is at risk of developing a serious drug problem. That may be the case if they are already taking that drug in relation to stress. There may be severe conflict at home or they may have a more personal emotional problem or even a mental health problem. The health field and the drug field are now turning to try to address the notion of identifying people who are at risk of developing drug problems, and intervening before they develop a full-blown problem, before they need long-term detoxification, before they need the long-term treatment that is so expensive and so difficult to deal with.

What we need to be doing is finding ways in the community to help young people prevent drug use. But given that some young people will use drugs—sometimes in response to very severe personal problems—we need to find ways to short-circuit them from potentially developing drug problems. If schools do not expel students but actually treat an incidence of drug use as an opportunity to address that drug use and to find out what is behind the drug use, they can retain the young person at school and give them appropriate attention. I suspect Professor Patton might have referred to the fact that we know that one of the worst things that can happen to young people is to leave school early. Young people who leave school early—that is, before they have completed year 12—are at a much higher risk of acquiring not only drug problems but a whole host of other problems. It certainly can reduce their life chances; it reduces their chance of getting a decent job, having a career and going on to tertiary education.

I would also like to mention that the most recent research into the drug outcomes of drug education suggests that formal drug education through the classroom can impact positively on

young people's drug use. Drug education can reduce young people's drug use; it can offset drug use or it can delay the initiation of drug use by young people and it can also reduce the amount of drug use that the person who is using drugs actually undertakes.

A problem for drug education in schools is that it has traditionally been judged—and, I think, is still judged—on whether it prevents drug use totally. What we have not yet tested is whether drug education in schools can reduce the harm that taking drugs causes. It is easier for schools to deal with tobacco and alcohol, of course, because they are both legal and they are found in many homes. From our research in the past couple of years undertaken for the Department of Education, Science and Training, schools find it much more difficult to address illicit drug use, partly because of the stigma that was referred to earlier today and also because that stigma may be attached to the school that is either providing the drug education or is responding in a positive way to a student who is identified as using a drug. Schools are often too worried about their image or fearful of what the community might think, so they are sometimes reluctant to provide the drug education or they might be reluctant to admit that they are dealing with instances of drug use. But I think we can all be assured that there is not a school in Australia that does not have to respond to drug use among the students at some stage, almost every year.

CHAIR—Thank you very much, Mr Munro. I now ask Ms Hanbury to give her presentation.

A PowerPoint presentation was then made—

Ms Hanbury—Thank you very much for inviting me. I am from Western Australia and I am based in Perth. I work with Local Drug Action Groups and I am a volunteer parent with the Parent Drug Information Service. I am also on the Australian National Council on Drugs. I want to talk about parent drug education and how it all fits in, to give you a picture of where parents get support. Alcohol and drugs are a community issue and families play an influential and pivotal role. By increasing access to information and support, it is possible to have a positive impact in the prevention and intervention of drug related harm. Families want to support their children the best that they can. They want to help them grow into healthy and happy adults or at least help them to get there in one piece.

Research shows that there are crucial points in a child's life where positive intervention can be most effective. Starting primary school is one of these points and parents help their babies prepare for this. It can be an anxious time for little children as well as for their parents. They worry about whether they will fit in and make friends, whether they will be happy and whether there is anything that they can do to help. These are simple but important concerns. The transition from primary to high school is similar but more complicated. Adolescence is a potentially scary time for young people and their families. With the increased availability of alcohol and drugs, parents and families are often keen to find out more about them and perhaps prepare themselves a little just in case something goes wrong.

So what sort of information do parents want? Educating the parents of school-aged children can assist the curriculum based education by endorsing the same message at home that the children are learning at school. However, not only do parents want to know what their children are learning; they also have needs of their own. They want to know about drugs—what they look like, what they smell like, how they are used, what their effects are and why young people use them. They also want to know how to discuss drugs and alcohol with their children with

confidence and credibility. They want to know how they can help protect them and where they can go to for help, should they need it. It is suggested that what they want is guidance, not just about what to say but also about how to say it. So where do families get this information and support? Well, that is the question. The response can be haphazard depending on where they live, the resources that are available to them and whether those resources are relevant to the families' values, are culturally appropriate and are in the right language and also whether they meet the demands of changing family structures and busy working lives.

Another important factor that is sometimes a barrier to families seeking help is that, if the family is seen to be concerned with drug and alcohol issues, others in the community may think they already have a problem. Stigma and family privacy are concerns that are widespread. All of these things are relevant not only to families of young adolescents starting high school but also to those families whose children may already be exposed to drugs and alcohol. Research indicates that, when families are involved and they are given the appropriate information and support, the outcomes for the young person are more likely to be successful.

How can we help our families access this information and support that they want? This triangle on the slide I am showing gives you an idea of the targeted approaches to family support. The first level is mass media: information directed to all families via media campaigns—so it is a blanket response. The drug awareness level introduces families of late primary and early high school kids to alcohol and drug issues, raises their awareness about risk and protective factors and offers practical strategies for everyday life and for where to go for help. Research indicates that family-focused programs targeting the school years increase family protective factors in relation to illicit drug use by, for example, increasing parental confidence, parenting skills and communication about drug and alcohol use. At the level of selected targeting are more intensive programs about drug and alcohol use, adolescent development, communication skills and support services. The treatment level shows that treatment is available through specialist services, and often includes therapeutic counselling and support to families whose child is often involved in chronic use. These levels are interactive and each builds upon the previous one.

What can this look like? Because I come from Perth, all I can do is give you a snapshot of what is happening in Perth and in Western Australia. Around Australia, it can be different—there is not an overall approach, but the basic framework is similar. Level 1 is a drug aware public education campaign targeting parents with a drug aware booklet and advertising. In the national campaign that went out last year, there was advertising in the booklet to every parent in the country.

Helping empower local parents is associated with local drug action groups. We train volunteers to organise drug awareness events for families in local areas. These events are interactive, relative to the family and solution focused. They utilise the knowledge and skills of professionals, and strive to enhance the innate wisdom of the families: they know their children best. The professionals involved in facilitating the events are often community drug service teams—the alcohol and drug agencies, the Parent Drug Information Service, local GPs, police, school nurses and other staff—professional people in their community that have something to offer. Local drug action groups are fairly unique to Western Australia. There are now 80 local drug action groups around the state; they are all volunteer and community based groups set up to look at local drug and alcohol issues and at what they can do in their local areas. Their

activities are around community information, parent education, family support groups and youth messages and activities as alternatives to drug use. Increasingly, there are more youth-initiated groups and Indigenous youth groups.

The School Drug Education Project has take-home information and assists staff to address alcohol and drug issues; the information is not directed towards parents but more towards school based learning for kids and reinforcement. The Life Education van is at parent information evenings, again basically directed towards the kids' learning.

The Parent Drug Information Service is a 24-hour telephone service and referral. It is staffed with professional counsellors and volunteer parents with personal experience. It is for any parent along the drug continuum, whether they suspect tobacco use, whether they have found a bong in their child's school bag or whether they are coping with their child's long-term chronic use—any family concern.

Educational programs are for high schools to increase knowledge, skills and support. They are often more intense and usually run over a number of weeks, offering families a greater depth of understanding. They are sometimes held in the AOD agencies or through programs such as Drugs in Perspective and How to Drug Proof Your Kids.

This slide shows intervention and treatment for families that have significant problems. There are structured support groups for families and one-to-one and family group counselling offered through community drug service teams and other agencies. Family Sensitive Practice Development offers training and support for agencies to encourage them to include and consider families throughout treatment.

All this looks impressive and in many ways it is fabulous. However, in my experience in drug education it is still very haphazard, relying on the enthusiasm and generosity of volunteers and staff that are already stretched. From the communications that I have had with people around Australia about drug education for families, there are many great things happening with a lot of very dedicated and enthusiastic people behind them. But, as in WA, they have similar concerns. We need support from the top to make it readily available for your average everyday families wanting a bit of support and guidance.

This slide shows some suggestions for the way forward. We need support from the top and family education. We need support to be built into policies and drug strategies. We need ongoing commitment: there are always children coming through and always families there to deal with them. There needs to be support by existing infrastructure so that family education is something that is built in and it is not just one-off, with things happening here and there. It must be adequately resourced and serviced, have a flexible framework for regional, cultural and language differences and also time demands on busy people with changing family structures and also work in collaboration with families.

Mr Williams—Thank you very much for the opportunity to present this afternoon. What I am going to focus on this afternoon are the key issues in the prevention of drug abuse for families; not so much looking at the actual content, but looking at some of those indicators that actually influence or have an impact on the delivery of that content.

Overhead transparencies were then shown—

One of the key issues I have been invited to present on this afternoon is the results that we have experienced through the parenting program How to Drug Proof Your Kids, which was launched in March 1999 in Victoria. There have been tremendous results with that program since that time. Primarily, what motivated the program was the parent demand for resources, for assistance, for empowerment. A lot of parents were feeling right out of their depth and saying: 'What can I do as a parent? I am afraid my child might be using drugs or is using drugs,' or 'I want to try and prevent my child from being hurt by drug use. What can I do to prevent that?' They were wanting to be empowered, equipped and skilled in that area. The other thing was to try and look at overcoming the ignorance and misunderstanding that many parents had—and still have—parental fear and anxiety, and a lack of skills, which often leads to an inappropriate response.

As I said earlier, I would like to address some of the issues that impact on the delivery of content for parents—I have placed these issues under the headings of 'Community ownership' and 'Community participation'—and then look at the prevention strategies. I will start by talking about community ownership. Compared to three years ago, when the program How to Drug Proof Your Kids was launched, we believe that there have been enormous gains in the area of organisations within local communities working together and acknowledging that there must be an appropriate response from that community to the needs of that community. Although it was only a few years ago, it was not unusual to hear from school principals, church ministers or even local councillors that drugs were not an issue. This message was sometimes supported and reinforced by well-meaning parents who did not want to acknowledge the reality of drug use because (1) it is a reflection of their 'poor parenting', (2) they are afraid of what others will think, (3) they simply do not know what to do or where to go to get help in addressing the issue, and (4) they have an inherent belief in the goodness of their children. These responses have not been dissimilar to those of organisations like churches and schools. Church leaders, principals and school teachers want to believe that, because of their work and their relationships with families and students, young people will have no need to get involved in drugs. They are also concerned about the reputation of their institution or organisation. Unfortunately, like parents who ignore the fact that drugs can be an issue, organisations who do not adequately address issues related to the prevention of drug abuse are more likely to become damaged by it.

In the last three years, our experience of seeing more than 23,000 parents attend 1,480 programs of How to Drug Proof Your Kids, which each consist of six, normally weekly, two-hour sessions, recognises that the first step in helping parents is to let them know that, no matter how good they may be as parents or how good their children may be, drugs are a reality in their community. The second step is that, no matter what the nature of the program on offer to that community, or the resources communicated through that program, there has to be a healthy level of ownership of that program and its objectives by prospective stakeholders.

In the case of How to Drug Proof your Kids, we knew that we would only have very limited opportunities to impact parents in different communities if the facilitation of that program revolved around the presence of our own professionally trained staff. But by empowering and equipping key influencers in those communities—these key influencers represent, for example, school teachers, doctors, nurses, social workers, police officers, paramedics, drug and alcohol workers, church leaders and counsellors—to deliver the program to parents, not only do you get

a greater level of buy-in from those key influencers but you also achieve a much higher success rate in attracting parents who in many cases already have an existing relationship or credibility with those influencers. What has made it possible for Focus on the Family in Australia to train more than 23,000 parents is the careful selection, training and supporting of 1,427 program facilitators to date, as of yesterday. Local ownership, therefore, is critical to the success of any drug prevention program or strategy in helping parents.

Community participation is the next key area. On the surface it looks the same as community ownership, but the two are different. Ownership essentially identifies the need and the fact that a response to that need is necessary. Participation is all about determining how that response should be developed and what strategy needs to be deployed to maintain a commitment to its continuity, quality and integrity. This can only happen via the participation of members of the community at all levels. Significant change in a positive direction for a community can only happen when that community senses that there is energy and momentum for change. This is why Focus on the Family in Australia trains facilitators not only in the delivery of the program but also in how to engage more widely with members of the community.

Examples of how this has been done include leaflets being distributed through McDonald's drive-through outlets; local, state and federal members of government advertising and supporting local programs through their own newsletters; doctors and medical centres promoting the program directly to patients; having local businesses sponsor parents, venues, refreshments and advertising; engaging local media and newspapers—and also community radio has been very effective. Adopting the facilitator model that fosters community ownership and participation has, in effect, led to 8,900 individual How to Drug Proof Your Kids workshops in just over three years, understanding that there are 1,480 programs, made up of six modules.

We have faced perhaps three major challenges in working towards the goal of community ownership and participation. These are: (1), the selection of prospective program facilitators; (2), the resources needed to motivate and support trained facilitators; and, (3), the lack of tolerance towards programs with a different approach. First I will look at the selection of prospective program facilitators. No-one can deny that debate on strategies for drug and alcohol education, prevention, intervention and treatment leads to an outpouring of emotion in amazing proportions in various sectors of the community. Influenced by—and, sadly, even sometimes blinded by—ideology, religion, race, personal opinion and personal experience, different approaches are often frowned upon and even, in some cases, vehemently attacked. The question has to be asked: is there a way to rise above this?

Again we believe that, by carefully selecting and training key influencers in local communities, a common message or denominator can be supported. For this prevention program it is, quite simply, that parents need to be encouraged, equipped and empowered to know how to respond, no matter where their children lie in the continuum of drug use: abstinence, experimentation, casual use or being a dependent user. We believe that it is possible to maintain the integrity of this message even when individual facilitators share different beliefs and attitudes, and to this end we are committed. With the fact that there are many people who feel quite passionate about drug education and prevention and about families, implementing reliable selection criteria has helped us to walk a line of balance. In all things, however, scrutiny has not always achieved the desired result.

The second challenge is that of the resources needed to motivate and support trained facilitators. One thing is true: since launching the How to Drug Proof your Kids program in March 1999, we have totally underestimated the response from the public. Our initial goal of training 250 facilitators, which was then revised to 600, in the first 12 months was exceeded. Our goal of impacting 5,000 parents was also soon reached. Although we were excited and humbled by the response to this program, an obvious problem soon emerged. We believed that we had the resources and personnel to support 250 facilitators—but more than 1,400? This remains our biggest challenge: motivating and supporting facilitators to continue to present this program to parents in their local community, when they have little support or help around them. Moral support and funding support from local, state and federal government would contribute greatly towards overcoming some of these hurdles.

The third key challenge is that of the lack of tolerance towards programs with a different approach. Clearly there is no one simple solution when dealing with drug abuse in our society, nor will every person or organisation working in the area of drug and alcohol education agree on every strategy, methodology, concept, interpretation of available evidence or even use of semantics. Even the very use of the word 'abuse' in the terms of reference provided by this committee is not appreciated by some working in the field. Like any other field of discipline, there is a cautiousness taken to adopting a program created by another, no matter how effective; there is a reluctance to be seen as supporting another organisation for fear that others will misinterpret or dislike the relationship; and, sadly, as has been our experience, deliberate attempts have been made to discredit the program. Misinformation breeds misunderstanding. Unfortunately, until organisations that work in this area can tolerate different approaches to drug education, not seek to cast aspersions on a program because of its effectiveness and not see other well intentioned organisations as being a threat to their funding base or territory, we will be not as effective as we would like and, because of this, many families will suffer.

Again I refer to my earlier submission to the committee that supports the adoption of a national evaluation criteria. This could be used by governments and agencies to provide objective comment on certain aspects of a program without having to endorse or support a particular program that may clearly have considerable merit in certain aspects while being inadequate in others.

Let me look at some of the prevention strategies for parents. There is a considerable body of evidence indicating that, where parents are aware, appropriately informed and active in communicating with their children about drug issues, their children are more likely not to experience harm.

Again, as I outlined in my earlier submission to the committee, there is a need for programs to incorporate a multifaceted approach whereby risk factors and protective factors are addressed because they are present in the various life domains in which social interactions occur. This is why, in the context of How to Drug Proof Your Kids, we address the following issues for parents: setting healthy boundaries that will reward positive behaviour; building a healthy self-esteem; improving communication techniques with parent-child interactions and responding to peer pressure; and identifying conflicting messages through parent behaviour—for example, the way that parents use their own prescription medications, the context in which those things are used and the message that that conveys to their children. There is also the issue of understanding the different reasons why children take drugs. If you talk to parents, many

parents think that it is just because they are available or because of the peer pressure, but there are certainly many, many other issues and reasons as well. We also help them to recognise symptoms of drug use and to know what local resources are available. Trained local facilitators are responsible for collating resources and information on services and other resources available within that local community so that parents who attend that local program then have far greater awareness of and access to those resources and programs in that area.

Let me just very quickly run through this. We look at why kids take drugs and how to educate kids to make good choices. Again, this is in the context of the parenting program. There are some very practical skilling areas here for parents. There are prevention tools for parents. Again, we help them to look at conflicting messages that the children may be receiving. There is learning to intervene and where to get help. Again, we understand that you may find a parent who, at the time of doing a program, may not have a child involved in drug use, but who at a later time may. Therefore, in a very proactive way, helping a parent understand what they can do if that were to occur is very, very helpful. There is also a parents guide to handling relapses. We heard this morning on a number of occasions that relapse is just part of the journey; it is often something that keeps recurring. Often parents wear an awful lot of guilt and shame and feel that they are a great failure in this regard. We help the parents to identify those emotions and how to deal with those emotions in that context.

What has happened in the two years since our original submission? I think the preliminary findings that we have do show some very good results. First of all, 97 per cent of the respondents were married and/or with children, and 63 per cent of respondents were between the ages of 35 and 44. Fifty-six per cent of respondents first heard about How to Drug Proof your Kids through a local school; the next highest category was through a church, with only 15 per cent. Of the total number of children in these families, 64 per cent were below the age of 12 years.

In relation to levels of family communication, before the program 39 per cent thought that they were good, but after the program 54 per cent saw them as being very good. Even in the space of that six weeks, with parents being able to implement change and work on their communication with their children, there was increased effectiveness. Forty-nine per cent agreed that they had an important role in influencing their child's understanding of drugs and alcohol. After the program, this had both moved up the scale to 'strongly agree' and increased to 75 per cent, showing that the increase in awareness was achieved. Forty-seven per cent were uncertain as to where to go for help if they were to find their kids on drugs; yet after the program, 75 per cent agreed that they would now know where to go to get help. Fifty-one per cent agreed that it was important for their kids to participate in family activities; after the program this had both moved up the scale to 'strongly agree' and increased to 69 per cent, showing that parents became more aware of the importance of family time and family activity.

Furthermore, in the last two years, in response to feedback from parents, facilitators and professionals, we have completed three more major additions of How to Drug Proof Your Kids. We certainly have been committed to continual improvement. The number of trained facilitators has grown from 750 to 1,427. The number of parent programs has grown from 300 to 1,480. The number of parent participants has grown from 6,000 to nearly 23,000. The program has been adapted and now launched in Canada; it is being translated into French for France and also

for Quebec in Canada; and it is due to be launched in New Zealand and also in the UK in February 2003.

In conclusion, we believe that, if we are to help families prevent drug abuse among their members, we must address some of the fundamental issues that are preventing those families from having the information that they need and also make sure that they get the right messages. We must identify a common set of core values and principles to undergird any particular approach that has as its goal the reduction of the tragic effects in our society related to drug abuse. These could be incorporated within the national review criteria suggested earlier.

Mr Trimingham—I notice that the membership of the committee has changed since I last presented, and I welcome the new members and would ask if they would mind referring back to evidence that our organisation presented at Fairfield, particularly the personal stories of families who were affected. As part of my evidence today, I would like to table some documents to support my submission: statistics from our national telephone line comparing calls over the last four years; a draft copy of our Commonwealth funded guide to coping kit, which outlines the issues that families affected by drugs face and some constructive strategies to help them cope; and, finally, a total of 339 personal petitions to the federal government collected from our membership asking for, and giving personal reasons why we need, a heroin trial.

Families with drug users bear the brunt of the impact of drugs, and I make the point that the constituents I represent are those for whom prevention is not a factor. They are the ones who have problems; the people who contact our telephone line and attend our meetings have got fairly severe problems when they first make contact. While everyone in the community is affected by drug abuse, it is the family that on a day-to-day basis has to deal with the ongoing trials and trauma. They face health issues, they face communication issues, they face conflict and even violence issues within the home. They face lack of trust and, on top of that, they face the ever-present prospect of the criminal justice system and its impact.

It is true that, if left unsupported, families who have members who are involved in drugs will disintegrate and over time disconnect from drug users. That is generally what happens. At the same time, human beings and families can be incredibly resilient. We have seen evidence over the five years of our organisation's existence—and this does not just come from FDS; it comes from other organisations that support families too—that, if given support, awareness and education, families not only survive but become vital and important tools for working towards successful outcomes, and over the five years we have seen many success stories. We are pleased to see that government treatment services and non-government organisations are finally realising this. The gaps that we saw for families five years ago are starting to be filled. If anybody was to ask me what was the major change I have seen over the five years, my answer would be that it is this attitude towards the value of supporting families.

The statistics from our telephone line show incredible results and trends. We have seen a shortage of heroin over the last 18 months, and that has had an incredibly pleasing impact in some areas. There has been a massive reduction in deaths reported by coroners, and we have also seen the percentage of calls to our line about heroin drop from 49 per cent in 1999 to 16 per cent in the year ended June 2002. Having said that, I also have to say that over the last two months we have seen a rapid rise again. Over the period of probably the last 12 to 18 months, we have seen these glitches where obviously supply has returned. There is a concern at the

moment that the current return of supply is more than a glitch and may well be a move back to the trend that we saw three or four years ago. Another significant stat that needs emphasis is that most drug users called about are very much connected to their families—65 per cent still live at home—and most are in employment. Females call the line most frequently—they represent 77 per cent of all callers—and, of course, the majority of those callers are mothers.

Whilst the news on heroin has been good over the last 12 months, there are other notes of caution that we need to take into account. All experts believe that one of the impacts of the shortage has been a move to other drugs. We have seen an incredible response regarding stimulants. We have seen evidence that families who actually could cope quite easily with a dependent heroin user are now facing far more problems with stimulant use, particularly amphetamines, than they ever encountered with heroin. We have seen increases in cocaine from two per cent in 1999 to five per cent this year. Most worryingly, though, amphetamines have gone from eight per cent in 1999 up to 18 per cent this year and are rising. We have seen newer variants and types of amphetamines, and they are creating havoc with their potency. Aggression, abuse and violence are reported widely. One of the things that I cannot emphasise enough to this committee is the speed problem that we are encountering. We are still only at the start of it, and I believe we are going to see far more problems before we start to see some control of that.

Family Drug Support supports a continuum of services to address drug issues. We believe very much in prevention, education, treatment and harm reduction, and we believe that these services require equal value in resourcing and support. We need honest and open factual information—that is the key to good education. Protective and risk factors need to be built in to assist prevention. I would add one note, though—and without wanting to downplay my colleague on my right's notes about prevention—that all studies show that most nine- to 12-year-olds are vehemently anti-drug, and that is regardless of what sorts of prevention strategies or education they have faced; it is also true that many of those nine- to 12-year-olds who are vehemently anti-drug will themselves be experimenting within a few years. The other thing that I also need to note when it comes to parents and prevention is that there is in fact something that prevents parents from taking advantage of prevention—and that is a thing called denial. I can assure you that virtually all of the families that we talk to have said that there was a time when they believed it would never happen to them and therefore they did not take advantage of prevention type programs.

We believe that treatment is the best antidote to crime, disease and death. We support evidence based treatment which allows for innovation under clinical trial and evaluation safeguards. Again, though, whilst we believe that most people would see it as the ultimate goal, we do not see abstinence as the only measure of success. Most treatment services—whoever they are, wherever they are and whatever they say—achieve about five per cent abstinence but, at the same time, they are very successful in helping people to control, reduce and take respite from the impact of drugs.

We believe that there is a need in Australia for day treatment: multidimensional services that take people wherever they are on the spectrum of need—and that includes families. This type of service would have assessment, pharmicotherapies, detox, rehab, counselling, dual diagnosis, impact on housing, child care, employment preparation, leisure, life skills—the lot, including clean needles. Moving people back to their own family on a daily basis, rather than taking up expensive residential beds, would be very cost effective. This system is widely used overseas,

particularly in the United Kingdom, and I think it is something that we should be addressing locally.

Another urgent matter that distresses Family Drug Support members is the continual discrimination faced by not only drug users but their families, which leads to shame, stigma and isolation and, as has already been noted this afternoon, prevents people from taking a lot of the action that they could take. We blame certain sections of media for fuelling these impacts and would urge political bipartisanship in supporting the Alcohol and Other Drugs Council of Australia's efforts to promote standards in reporting drug matters. I was fortunate to be at the Ted Noffs awards last night and was pleased to see ADCA introduce a media award, and that went to a local newspaper in the Penrith area for a very good campaign that they ran over two weeks about a local methadone program.

I mentioned further urgent needs in a recent written submission that we made to the committee. I would just say that we emphasise, as well as everything else on the continuum, the need for life maintenance strategies. For this reason we support needle and syringe programs, we support the value of injecting rooms and we still see the need for a trial of prescription heroin. It is interesting to note the recent Dutch results. People on that program were using a combination of heroin and methadone. As compared to people receiving only methadone, there was an additional 25 per cent effectiveness in keeping them within treatment. I think that is an important statistic.

The 339 petitions here urge the Prime Minister and federal government to think again on the issue of heroin trials. Despite the fact that heroin shortages have reduced its impact, there are still tens of thousands of heroin dependants in Australia. People are still dying from its effects. The shortage will end at some point and problems will arise again. We urge that people remain open to the benefits of opiates as treatment and we also say that, if Mr Howard is unable to back down on his stand against heroin trials, then at least consider the substance hydromorphone as a possible alternative. Hydromorphone is a schedule 8 drug currently legally available for pain relief and it could easily be reclassified in a trial for dependants.

Australia is a drug-using country. We only have to look at all forms of media to see how we are continually urged to use all sorts of substances to make us feel better, look better or improve our performance. It is interesting that on our web site the page that gets most visits is the page about steroids, yet we receive hardly any calls at all about steroids to our telephone line, which suggests to me that a lot of people are using them but not many people are having problems with them. Moderation is not the Australian way. As a community and historically we applaud risk taking and larrikinism. Our history is full of tales of rebellion. We have also always had a moral and a religious component to society. Temperance movements have been present. Recent multiculturalism has added colour, vitality and other culturally divergent elements. Attitudes to drugs and drug taking are influenced by all of these factors.

Anybody who says that we can implant another country's system into Australia is ignoring the facts of history and our particular way of life. Bingeing is seen as an acceptable activity in Australian society, particularly by young men. Young people are confronted with pressures to succeed. That produces depression, unemployment, suicide and mental illness as well as substance abuse. For most of these young people, problematic drug use will be a chaotic and traumatic stage that they will get over. Others, however, will get stuck in dependency and may

have long-term problems. The reality is that a dependent heroin user is, on average—and this is backed by research—in a cycle that takes 15 years and requires 12 to 15 attempts at treatment before problems are overcome. For the sake and sanity of families affected, let us please keep talking about the issues and working on sustainable long-term strategies to ease the anxieties and concerns of these families. Let us also remember that people who use drugs are much more than the drugs they use. Let us value them just as we would value other people with other health problems and disabilities. Thank you.

Ms Bressington—Thank you for the opportunity to present to you today. For the past eight years, I have been involved in the area of substance abuse on some level or another. My initial interest was raised because of my daughter's drug use and eventual heroin addiction, which led to her death in August 1998 at the age of 22. During those eight years I devoted many hours to researching various approaches that I believed may have been of use to my daughter. I had no preference at the time of starting my research as to what end of the scale would assist her and what would not, so I was pretty open-minded when I went into it. My main concern was to learn about the hows, whats, wheres, whens and whys of drug use while continuing to maintain a healthy and open relationship with my daughter. Non-judgment of her choices was a priority, and total acceptance of what was gradually came as I moved through the various stages of my own recovery from the terror. That does not mean, however, that I slipped into apathy and gave up.

As every parent is, I was a victim of the experience, and it became my personal mission to find out as much as I could. In that time, I have had a number of professionals from the area of human services—social workers who have been involved for 20 years or more in long-term recidivism, in corrections, in drug abuse—assist me in putting together what I believe to be a very good program. I am going to discuss with you here today observations that we have been able to make over the past three years since we have been funded by the state government. These are up for evaluation, and I have presented to you an evaluation that was done by the stakeholders at the University of SA of our program last year.

Families dealing with a drug addict are split. Mothers want to protect, fathers often react with anger, which is fear based, siblings want to ignore the problem and extended family members distance themselves because they are unable to relate to the pain and heartache that that particular family is experiencing. These reactions exist in a majority of cases and, by the time the family is faced with the reality that one or more of their children have developed a problematic pattern of drug use, a great deal of damage has already occurred. Parents suffer from mixed emotions: fear of losing their child, fear of being judged as bad parents by other members of the community and extended family members, grief over lost dreams and expectations, and anger. This anger is often directed at the system, the government and, eventually, their drug addicted child. The lack of support for parents and family members does little to correct the anger, and often drug users are thrown out of home because parents are at a loss as to what else they can do or how to cope with the behaviour.

Many parents find themselves caring for their grandchildren on a permanent basis, and others are the victims of domestic violence perpetrated by their own children. This brings about a situation in which parents believe they deserve this treatment because they have failed their child or children. The verbal abuse that goes with physical abuse sinks in, as it does with any other form of domestic violence. Providing information and support to groups with such deep-

seated shame and guilt requires care, because they are as vulnerable as the drug users themselves, if not more so, because they are actually living the effects of the substance abuse.

There is a natural process involved when any change, good or bad, occurs in life, and parents especially need to be given good support to allow them to move through this process and not become stuck in being the victim of the experience. If parents are able to move forward by gaining confidence in their rights and responsibilities to parent, they are more able to hold the family together, to be clear on the difference between supportive behaviour and enabling behaviour, to cope with daily living and not allow their full focus to be consumed with rescuing a child who may not be ready to be rescued and to develop strategies to change behaviour patterns that have existed within the family unit long before drug use became a problem. Of the 230 parents who access our program regularly, there has not been one case where it was not believed that, if the child was just to stop using drugs, the family problems would be over. There is also no thought of the damage that has been done to the interfamilial relationships nor of the fact that, should their child recover, she or he will not be the same child that they remember before drugs.

Supporting families does not necessarily mean that someone, anyone, takes on the task of curing the addiction of the child. Most often, parents who approach our organisation for support just want the problem to go away, and that is not going to happen overnight; moreover, it may never happen at all. Our organisation works with families to gain insight into the effects that mind altering substances have on the individual and then begins working on the origins of behaviour. That also falls into line with what Professor David Hill and Professor Patton said about bonding in those early years.

Our program came across what we considered to be a vital piece of information in 1999 from the Australian Institute on Drugs which indicated that the child who crossed over from experimentation to addiction may have made a subconscious choice by the age of five years old to seek an alternative reality. This does not necessarily mean that little Johnnie was sitting under the apple tree at the age of three and decided that by the time he was 15 he was going to be a drug addict. What it did mean was that there was something going on in his environment that he found unacceptable that made his reality not acceptable to him. What has become obvious from the work that we have done with this is that we have been able to track back with most of our clients, and our parents working with the clients, and we have actually been able to identify that early childhood period and get to the origin of the problem, and behaviours and situations that have eventuated from that, and basically resolve the original problem. We found that, once you have parents and children working on the same reality and they are seeing things in the same light, rather than everybody being everybody's victim, you are actually able to progress the drug user as well as the parents and stop that cycle of behaviour that goes around and around.

One example of that 'before the age of five' issue was that one of our clients was an only child for about three years of her life, and mummy all of a sudden arrived home with a newborn. This child was not prepared for the arrival of the newborn in the family and was not prepared to relinquish her spot as an only child, and that created a lot of problems. Although as she got older she was able to rationalise and put it into perspective, those original emotions that were stirred up were never resolved. That was the beginning of that child's lack of trust with her parents—a lack of being able to trust them to provide her with what she believed was her right to safety and security as an only child. It is a complex issue, and it does go back a long way.

In the beginning, family members are the victims of their children, and the children are victims of their parents. There are underlying and often unidentified feelings of anger and resentment from both sides and, because neither the parents nor the drug users have been guided to reach a point of understanding, blame and shame have been thrown around back and forth and no-one moves past being the victim. The most useful way to solve conflict is to gain a common reality on what the problem really is. Parents believe that their child is just adventurous or stupid and got caught up in drugs, and drug addicts believe that they just use drugs because they like them. Little or no attention is paid to the emotional baggage, and therefore the core problem is rarely identified.

This may all sound like very hard work, and it is. For the counsellor, the parents and the drug user there are basically a lifetime of events that need to be identified and resolved. Providing counselling and family therapy is an important aspect of support that is now being identified as an essential part of the recovery process—broken people, broken lives and broken families need to be mended. It is irresponsible to ignore the fact that emotions play an integral part in breakdown of such magnitude.

Education and information for parents on the physical, psychological and emotional effects that mind altering substances have on an individual are also vital, because they need to understand fully that cessation of drug use does not necessarily mean recovery; it simply means a break in the cycle of one behaviour pattern that has been adopted as a coping mechanism. Once a substance abuse has ceased or decreased, other behaviours will surface that were present prior to the drug use but went unnoticed. Just as recovery is a process, and not an event, so too is addiction. No drug users start out as addicts; it is a gradual progression with each drug use filling an emotional gap that exists to mimic a desired feeling or response. For example, through observation of approximately 1,000 drug users, we believe that relapse occurs not because a drug user wants to relive the experience of addiction but because situations arise that they were unable to cope with and that require them to feel, and they are not actually familiar with how to feel.

Relapse back to heroin or other depressants is a sign that change is happening too fast and that too much is expected of the person in recovery. In other words, parents may see that their child has been clear of drugs for about two months and believe the battle is over and now it is time to get a real job. Two months clear of drugs does not indicate that recovery has been achieved; it simply indicates that progression is occurring—but those underlying issues have not even been touched on. We believe that it takes a drug user approximately six months to even acknowledge that there are underlying emotional issues and what has been achieved is that immediate behaviours that cause friction have changed enough to allow for existence in a comfort zone.

We also now confidently identify that relapse back to speed or other stimulants is an indication that parents and family members are not adjusting fast enough or that change is not occurring at the same rate as personal growth of the drug user. Some parents want to continue to protect their child from experiencing life in the outside world and are reluctant to allow any level of freedom or independence. It may also mean that the recovering addict has done more work than the parents and is being exposed to old behaviours based on fear and insecurity that surface. A common behaviour of parents who are enjoying a relatively good relationship with their children after many years of dysfunction is sabotage. Oddly enough, they miss the drama.

Life has been chaotic for a very long time and that chaos has become expected and accepted. These parents, often unknowingly, sabotage the child's recovery, with a number of different behaviours. Humans do like to have drama in their lives, because the opposite of drama is perceived to be boredom. Many parents are so preoccupied with waiting for their balloon to burst that they act out their fears and then, basically, realise those fears. This does contribute to the relapse of drug use.

Teaching families to work to a plan is very important, because often situations may arise that can be volatile, and they require care and thought to avoid a bad outcome. Parents are asked to keep a daily diary, and at the beginning of each day they are asked to answer three simple questions: how can I make my day today as good as yesterday or better, what is my desired outcome for today and what can I do today that I did not do yesterday? This approach has proven to be effective in changing behaviour patterns on a conscious level on a permanent basis and works well in conjunction with the weekly workshops. We have some parents who have been attending the program now for two years, and they are able to manage situations instantaneously. This outcome, of course, is one of the objectives of the program—that is, to develop strategies to change destructive behaviour patterns.

This level of involvement in the lives of people who are literally dealing with life and death situations on a daily basis is not taken lightly and requires 24/7 availability of counsellors in the early stages. It also requires the absolute understanding that, as a counsellor, you are training parents to be effective counsellors in their own families and not encouraging or developing a dependence upon an outside influence to solve problems. Providing parents with the skills to cope is giving them back their personal power and releases them from that hopelessness and helplessness that brought them to us in the first place.

As you can imagine, it takes a great deal of time and work to deal with people going through this kind of trauma when there is no sign of relief. We are finding more and more that parents are becoming disillusioned because the external environment actually does not support their children to become drug free. Parents and drug users are caught on a bad merry-go-round. Those parents who are now raising their grandchildren are provided with no respite nor any support for the children of the drug users. These children have been traumatised and exhibit behavioural problems. Many of them have seen their mothers savagely beaten, have seen both parents overdose on numerous occasions and have also witnessed the IV drug use of their parents. These children require specialised counselling, and our organisation also works with the domestic violence unit in our area to run specialised groups for these children to receive the specific counselling and group work that they need.

If we do not do something seriously, if we do not look at the way that the funding rounds are allocated and if we do not look at the way that treatment rehabilitation centres and counselling services are funded, we are still going to be asking these questions in 20 years time and giving evidence to committees such as yours. This is not about a lack of funding; it is about how the funding is actually allocated and spent. I believe that everybody across the board, as Tony said, requires equal amounts of funding to be able to do the work that they are doing, because basically it all works. It is different strokes for different folks. Thank you very much.

Mr PEARCE—Mr Munro, I was interested in the comments that you made regarding education and educating our children within schools about drugs. Would you like to comment

on some of the programs—for example, the Life Education program—that exist today throughout Australia? Do you have any comments on those styles of programs? What do you feel about their usefulness?

Mr Munro—I think programs external to schools can be a useful adjunct to existing school programs, but research from around the world, as well as in Australia, indicates that the most effective drug education programs are those that are conducted by the teachers in the class—the teachers with whom the students have an ongoing relationship, the teachers with whom the students can return to for clarification and the teachers who know the students very well, know their emotional make-up, know their parents and know their families.

Many schools call on Life Education or other people in the community—whether they be GPs, local police officers or drug workers—to come in and talk through issues with the students. I think there is absolutely no doubt that the most effective drug education programs in schools are those which are run by the schools. What we know about drug education and prevention as a whole is that a single program is really not going to do the trick. Drug education programs need to be located in a broader context. In schools they are health programs. The school programs are most effective in communities that are taking some concerted action as well. We need to see drug prevention as a fairly holistic exercise and not see a single intervention as being the answer. But certainly external agencies should be seen as adjuncts to be used within a broader program.

Mr DUTTON—My question is to Mr Williams. Thank you very much for your presentation; I appreciated it. In addition to that, I certainly saw the virtues of your program through my friend Mr Pearce, who I understand had some involvement in its formative stages. How easy is it to replicate your program, say, in my electorate or elsewhere in Australia? How difficult is it to facilitate that and what exactly is involved? How lengthy is the process and what sorts of costs are involved in set-up?

Mr Williams—First and foremost, it is really a matter of identifying the appropriate people to facilitate that program to local groups of parents. Again, we do have in place a set of selection criteria for that, which includes a letter of commendation from that person's supporting or host organisation or agency. It might be a school, a community group or a church. We need to know that this person is highly regarded or regarded to be fit to be a facilitator or educator. We also ask for a number of references, which we do follow through and check, to ensure that this person has the appropriate skills and persona to deliver that program. How we go about training facilitators is to promote facilitator training events. There is one coming up in South Sydney, for example, in a couple of weeks time. Invariably, what we find is that organisations approach us and say, 'We've got one or two people that we'd like trained. Can we send them along to you to be trained?' We train them and then we support those facilitators as they go back into their respective communities, who then provide the programs to those groups of parents.

Mr QUICK—I have a couple of questions to any members of the panel. By placing the onus on schools to provide drug education, aren't we allowing parents to opt out? As a teacher of 23 years, I ask: how well do our teachers really understand the families and how they function?

Mr Munro—I might begin by pointing out that I do not think the intention is to let parents off the hook, but schools are an effective setting to educate virtually all young people, because they are a captive audience and education is the core business of schools. No drug educator would suggest that it is the schools' responsibility alone. Nearly every school across Australia endeavours to include parents in the drug education exercise. I think they do struggle in that regard. I think it is very hard for schools to include parents in programs, despite their best efforts. Often, the parents who do attend are not the ones the school would like to see there—as you probably know, being an ex-teacher. We are not suggesting that parents are off the hook. Clearly, parents have a very important role to play in drug education. As some of the speakers have said as well, some of the most effective drug education takes place in the home, where the children are merely observing their parents' use of prescription drugs, tobacco and alcohol. I hope that is good news for most parents, but it may not be of course.

Mr Trimingham—I have spoken at community forums the length and breadth of Australia, and of course there are many other forums held. It is always a struggle to get community members to these events. If you get 60, you are doing well. When I get invited into a school to speak—which is not part of our core business, but I do get invited from time to time—we automatically have an audience of up to 600 or 700. I believe that is quite effective, in that it does give us the opportunity to reach many people in one sitting. I personally do not believe that schools should take over the role of parenting, but I do believe that they provide opportunities that sometimes the home does not provide.

Mr QUICK—Apart from congratulating Glenn Williams on the How to Drug Proof Your Kids program, which I know is working pretty well in my electorate, I want to ask about Centrelink's understanding of families—that is, the issue of benefits and the flexibility and understanding of Centrelink when families are going through this process, with the dysfunctionality of families and people coming in and out of the system. How well are Centrelink doing this? Are they still being prescriptive rather than understanding when it comes to benefits?

Mr Trimingham—My experience of the people who work at Centrelink and DOCS and in other community services is that they do their best, but they are stretched to the limit. Individuals are worn out and burnt out with trying to cope and there are a great many problems. Rather than criticising them and saying that they do not understand, I think they try their best to understand, but it is a question of resourcing and a question of massive problems.

Mr QUICK—The reason I asked is that we have to come up with a series of recommendations. I know there is flexibility within the system for additional payments or special payments and the like; you are dealing with lots of families.

Mr Trimingham—Yes, I believe there is no one formula. Every family is different and every individual circumstance is different and that is what makes it difficult when you are trying to put a set of rules together that will affect every family or every potential person who needs help.

Ms Bressington—In our area we have actually set up a good relationship with one particular person that we work with in that office; he is basically the liaison officer between Centrelink and our program. That works excellently, because we can talk to him about what a client's needs are and also let him know if that client is abusing the system or what is happening. So there is a

good exchange of information there. If we could set that up in offices so that programs have a liaison officer who is familiar with how the program works and what is expected of the clients it would make Centrelink's job much easier. It would also make our job a lot easier by preventing EBT cards being done and stopping clients being given extra cash when they do not really need it and that sort of stuff. To educate one person in a local office on what your program offers and what it does about substance abuse as well, because there is a great deal of ignorance there about substance abuse, and get one person that you can contact and be in contact with all the time is very useful.

Mr QUICK—So how do we set that up? For example, I am dealing with a young heroin addict at the moment. The letters from Centrelink keep coming but he is never there and there is no money in the family—you do not have it there, because it is going to be knocked off. How do you put the safety net there to support not only him but also the parents and the other siblings so that you do not jeopardise them and put them in an even greater hole?

Ms Bressington—We actually organised with our officer in Elizabeth to bring the parents of one family in and sit down and talk to the social workers about what that family's specific problems were—if their son was to get extra payments, whether those payments could be diverted into his mother's account. That was arranged—he signed a release stating that it was okay to do so; that he did not have full control of his money. There are a number of things you can do if you can set up that relationship with your office and one person—if you explain the situation fully and you have got the parents that will go in there and actually talk about the problems that they are having. You probably break a few rules, but if you have got the consent of the client and the family cooperation to do it then it works wonders.

Ms GEORGE—Tony, in terms of the records of the telephone calls, of people ringing in, and the drop in the level of heroin related problems, that accorded with what we were finding as we travelled around and spoke to a number of young people with quite high levels of amphetamine dependency—they were even injecting things like normocin. Do you think this is a result of the shortage of heroin and just a short-term phenomenon so that when heroin is back on the market it might revert, or is it part of a new cultural dimension to the party drugs and that kind of scene?

Mr Trimingham—This is the great big unknown, and this is where all the fears come from. I believe the heroin shortage has changed the population of speed users. Previously you could fairly well identify whether it was the recreational party drug users or the people who were using speed for a particular purpose—to drive, to study or to focus for a while. Now we are seeing former injecting heroin users using it; we are seeing young people, particularly, moving into the wide use of amphetamines. Not only do we see an explosion of home produced amphetamines; one of the consequences of the heroin shortage—which I believe is driven by the Hong Kong cartels, who have basically swapped one substance for another—is that we have seen the importation now of potent pills and new forms of crystal meth. Instead of one or two fairly easily identified populations we now have a massive population. If heroin returns to the scene, does that mean that some will revert? Probably, but I still think we are going to be left with a speed problem, and that problem is going to increase before it gets better.

Ms GEORGE—Professor Saunders said this morning that we do not have any evidence of effective treatment or widespread availability of treatment for the use of psychostimulants and

inhalants. You are saying we are going to face this massive explosion, and it seems that the research is lagging behind this phenomenon on our doorstep.

Mr Trimingham—Absolutely. The other thing we have to consider is that, whilst seizures of heroin by police indicates we collect maybe 15 per cent of what is out there, seizures of stimulants are probably more like two per cent. A huge amount is not being picked up, despite the fact that Federal Police and state police are picking up more than they have ever picked up before. It is a frightening scenario.

Mr CAMERON THOMPSON—Thank you for some of the comments you made, Ann; I want to pick up on some of those. You spoke about the core problems and issues which you seem to see as being psychological type things. Certainly, in our travels about, we heard a lot about poor self-esteem. In fact, one person said that some 80 per cent of female heroin addicts would have some sexual abuse in their background. Do you see that as being a major thing? If so, are those personal psychological issues receiving enough attention from people such as the presenters we heard from earlier this morning, who are focusing very much on the health angles?

Ms Bressington—I can only speak on behalf of our program and on the breakdown for our program. Only 35 per cent of females who have presented through our program have been sexually abused. When I say 'only' 35 per cent, that is still a huge amount. What we are finding is that somewhere along the way as adults we forgot that children see life differently to adults. We forgot that children do not tend to express how they are feeling all that well. They may act that out in bad behaviour. We are tracking back to that first five-year period. Some are quite serious situations; some are not. It is a matter of what that child, at that time and depending on their emotional status, perceives is going on around them—whether they are feeling well or not, whether they are happy or not. All of those contributing factors change their perception of how serious situations are in the family. As I said, coming home with another child was seen by one person as a huge trauma in her life, but that was never identified and never resolved—until here she is, 10 years down the track, a heroin user.

Sexual abuse, neglect and all that sort of stuff contributes, and we cannot deny that, but there are still other factors there. It is about how parents communicate with their children and how they bond with their children in those early developmental years. We are missing that because so many parents are working full-time. Children are at the babysitters, preschool or whatever and are missing that interaction.

Mr CAMERON THOMPSON—Do you think that aspect of it is receiving enough attention?

Ms Bressington—No, not at all. I think we have professionals who are doing an excellent job in the research of pharmacotherapies and are starting to identify that therapeutic communities are useful but, as far as dealing with the emotions, that is still considered to be a bit 'out there'. Not half enough work is being done that should be done on that.

Mr CAMERON THOMPSON—Tony, you mentioned two things that I did not hear about in our discussions this morning: a steroid drug and something called hydromorphone treatment.

Neither of those things got a guernsey in any of the health discussions this morning; why is that?

Mr Trimingham—The point I was making about steroids is that a lot of people access that page on our web site, which suggests to me that a lot of people are interested in them and use them. But our statistics show that it never comes up as a problem. An incidence of violence as a result of steroid abuse is very rare. I just gave that as an example of a drug that a lot of people use and are interested in but which does not cause problems, except if you are an elite athlete and you get caught with it.

Hydromorphone is a legal opioid. Professor Wayne Hall put out a paper late last year suggesting that we could use it to get over the impasse of the problem that people have with heroin trials. It is currently used as a treatment for pain relief. It is similar to morphine, if you like, and it is similar to heroin. It is injected and it is a possible alternative to heroin. It is already listed as schedule 8, so that means you can prescribe it. It also means that you would have to change the scheduling so that it could be prescribed as a treatment for opiate abuse as well as for pain relief. There is some scientific information I can give the committee if that would be of value.

Mrs IRWIN—I want to talk about supported accommodation services for drug addicted parents and their children. There is some accommodation available where parents can go with their children, but a complaint I have been getting from people within the area I represent is that they feel there is a need for it but that there is not enough of it. What is your view on supported accommodation for drug addicted parents and their children? Do you support that?

Mr Trimingham—Absolutely, but I think it is like everything else: there is a need for a lot of things but there are not the resources, and there is not the willingness or the political will to provide all the resources we need. I think it is arguable whether supported accommodation is needed more than something else. We need all of these things. As everybody on this panel has said, there is no one simple solution. We need to attack the whole continuum, from start to finish, and try to apply resources equally along the continuum. So I would certainly say that we need them and I would support them, but whether we can take the pot from somewhere else and put it there is arguable.

Mrs IRWIN—Another complaint I have received is from parents in my electorate. Once a child who is over the age of 18 is receiving treatment for their drug addiction, the service providers do not want to know the parents. They do not want to let the parents know how their child is coping with rehabilitation. Not enough counselling is given to parents on how to cope with the situation once their child is back in the community. Do you find that this is a big drawback and big a complaint from parents?

Mr Trimingham—Yes. But it is better than it was five years ago. Five years ago, that was the impact everywhere you went. I believe that confidentiality was used as an excuse. I believe the real reason was that those services were already stretched to their limits and that the last thing they wanted was an emotional and volatile parent to deal with as well as the chaotic drug user. I think that is the area that has changed for the better but, of course, it is still a long way from ideal. We find that programs like WHOS and Odyssey and all sorts of treatment services are opening their doors to parents and including them in the process. I think they have found

that, once they have done that, they have a tool to help them to their business better. But, yes, I agree that it is still there and there are still a lot of places who are not opening up.

Ms Bressington—We had to develop our own confidentiality agreement for clients who come in. They read it and sign it if they agree to allow parents access to information that is passed on in individual counselling sessions and in groups, if it is seen to be of use in a family therapy session. You would be surprised at the number of addicts who were keen and eager to sign that part of the agreement that would allow the passing on of information to their family members, in order for their family members to gain an understanding. So we have developed our own confidentiality agreement and we have got legal advice on that. Clients sign off on it. Of course, if they do not sign off on it, we cannot do it, but we have not had anyone refuse yet.

Mrs IRWIN—And it is working?

Ms Bressington—Yes, and it makes parents feel very much included.

Mr DUTTON—My question is probably best directed to Mr Munro. We have taken some evidence recently that it is almost too late for drug messages to be delivered to children of high school age—that children need to be targeted in the latter years of primary school. Would you agree with that comment? Also related to that is the argument in society today about where rights and responsibilities start and stop, particularly for parents. Do you think there is any argument, if the resources were available, for a prescriptive method of education for parents? Do parents who have children at primary school need to attend an education process—maybe something similar to what Mr Williams offers? Would that make a substantive difference?

Mr Munro—I do not know whether I would support it being prescriptive; I do not know how that could be practically implemented. But there is certainly some evidence in the research literature to suggest that programs for parents, particularly those parents who are regarded as being in difficult circumstances—if you like, at risk parents—can be or ought to be an efficient and efficacious way of short-circuiting the potential for drug problems in their children. There has certainly been some good evidence in the United States around parent programs. But I do not see how it could be prescriptive. If people are dragged along to something, I suspect they are not going to be very willing participants. It is much better to have volunteers attending programs. Within the health field, parents who might benefit from such assistance will come to attention. I think GPs or nurses—people in the medical profession or health professions—can probably direct parents to some assistance. But more work does need to be done in providing support to parents who find themselves in difficult circumstances.

In terms of drug education in schools, I think there is a flaw in the notion that secondary schooling is too late for drug education because some children do start using drugs like tobacco and alcohol, and increasingly cannabis, in late primary school. There is certainly an argument for some drug education in primary school. Some children begin to experiment in secondary school and right through secondary school. Some young people who do not touch drugs in secondary school do so after they have left school—at university or when they join the work force. So I do not think there is a magical time, but I think the evidence also does indicate that it is best to provide some education before behavioural patterns are established. It is probably not too late after a young person has experimented, but you might want to intervene or provide education before they become established in their drug use. Having said that, we also need to

educate people to manage drug use, because a lot of drug use is legal, and the biggest drug problems in Australia, I would argue, are still tobacco and alcohol. Most young people, most adults, do drink alcohol, even if only a minority now smoke tobacco. We should not just see drug education as aiming to prevent drug use; it has to also provide assistance to help people use their drugs in the lowest risk manner. There is no safe level of drug use, but there is low risk and high risk.

What schools really cannot do now is provide that harm reduction education for young people who are using cannabis or who are going to use cannabis—to take the most likely illicit drug. A total of 40 per cent of our year 11 students have used cannabis and nearly 50 per cent have used it by the time they leave year 12. But at the moment, because it is illegal and because schools are very nervous about providing any education about cannabis, our students are leaving school without getting much help at school about that drug. I do not think it is too late, but I do think we need to be much more supportive of schools, teachers and parents in grappling with these issues. As we have heard from, I think, all the speakers, the stigma that is attached to this issue, both in schools and in families, does enormous damage.

Ms Hanbury—Just in response to that, I have seen, in Perth, where sometimes you have parent nights and maybe 10 people attend. I think the key to something successful is often a working partnership between the schools and the communities that is ongoing—not demanding that parents go along to a parent evening but more or less encouraging them that there is something good to be got out of this. That message is passed down from year to year to the parents. It is more like a community thing rather than somebody demanding that parents attend. The more interesting and relevant it is, the more parents will come along.

We know many parents have busy lives—that is just a reality now. There are also a lot of single parent families that cannot get out at night whenever they want to to go along to a parent evening or whatever there is. There is an opportunity here to develop take-home information—perhaps videos and things like that—that parents can look at at their own leisure and so not have to face those stigma related problems. Perhaps they are in the country and they are aware of these things. There are opportunities to broaden our scope to parents—to broaden our resources to them and bring them in in that way.

Mr EDWARDS—I have a question for Tony and it relates to the issue of the heroin trial—and I might say, Tony, that I still try to keep an open mind on it, but I do not support it. Should this be a question for the states or should it be a question for the federal government? If you were going to set up a heroin trial, where in Australia would you set it up, how could you possibly make it relevant to the whole of Australia and how could you secure it so that it was relevant to a certain part? And isn't the question of a heroin trial one that is now superseded by other issues?

Mr Trimingham—I believe that heroin prescription will only ever impact on a minority of people—even a minority of heroin dependent people—so I do not think we are talking about heroin trials as solving the heroin problem, solving the drug problem and being a panacea. We still need all of the other forms of treatment—all of the other forms of pharmacotherapy. Heroin prescription would never be as successful as methadone or any of the other newer pharmacotherapies. So I am talking about a heroin prescription trial that, from the evidence overseas, works for people for whom continued attempts at treatment with other forms of

therapy have failed—for people whose lives are pretty miserable; who are in fact at the bottom of the barrel. On the question of where it should be: we already had a trial ready to go ahead which was going to emanate from the Australian Capital Territory and then move into two or three other capital cities in states where there was a willingness to run those trials.

So, yes, definitely it is a state issue rather than a federal issue. Unfortunately, federal law intervenes in the ability of states to run a trial. As I said in my submission, the people who want this trial from our organisation are people whose kids are heroin affected. Not all of them would see heroin prescription as appropriate for their children, but they would all know people for whom it is appropriate. It is a last-ditch effort to keep people alive.

The whole point about my son is that he died before he reached any point of being able to make a decision to give up drugs. At the time that he died he certainly would not have been a candidate for a heroin trial, nor would I have wanted him to be, but at some point later on he may have been. There are other things that would have helped him—possibly injecting facilities. I do not think the statistics—the shortages in heroin over the last 18 months, the fact that we are doing well in other areas—supersede the fact that for the minimum number of people we should disallow them the opportunity to get treatment and to have some form of value in their life.

If we look at the benefits that have been achieved in heroin trials overseas, it is not just that it keeps them alive: it improves their general health; it improves their housing; it improves their employment; it reduces the crime that they are involved in and it actually reduces the amount of drug that they use—it certainly keeps them out of the criminal justice system. It is for those reasons that the majority of our organisation's members would still advocate for a continuing need for a heroin trial, and we may well see a time come again when we have a real heroin problem and it becomes even more pressing. I think the great sadness about Australia is that, if it had gone ahead, we would have had the evaluation of the trial that was proposed in 1997 and we would know by now, instead of still second-guessing, whether it is appropriate for Australia.

Mr CADMAN—Julie and Glenn, from the two parent groups, I know that it is easy to come up to Canberra and say, 'Give us more dough and we can fix the problem.' But in your experience, having dealt with parents and observed the whole system from top to bottom, where do you think resources could be better allocated? I am not talking about more resources. Do you see a more appropriate manner of allocation of resources?

Ms Hanbury—Are you just talking about prevention, or parent education, or the whole lot?

Mr CADMAN—Prevention, education and all through the system.

Ms Hanbury—It is needed in every place. I gave that inverted triangle example before. There are parents at each level who need support in their own ways. There are many more parents of young adolescents than the ones in the apex of the triangle, but that does not mean that they are any more or any less deserving. As Tony said before, the issue is how the money is used and how efficiently it is used.

CHAIR—I think that is what Mr Cadman is leading to. On the reallocation, is there any area that you see that is currently being delivered funds that you think is not as effective as another area into which those funds could be delivered?

Mr CADMAN—If you had the same amount of money that is being putting there now and you had the sole role to distribute it, would you do it exactly the same or would you vary the allocation?

Ms Hanbury—I cannot say I am privy to exactly how the money is distributed.

Mr CADMAN—All I want is for you to speak from your experience. I do not care whether it is wrong or right in anybody else's eyes.

Ms Hanbury—Okay. First of all, I would like the parents that are really having a lot of difficulties to be supported in the best way they possibly can be, because they are the ones that are dealing with this day to day at the coalface, and that is the hardest thing you could ever possibly experience. From there, I would like the money perhaps to support a range of therapies or services to parents, perhaps like the parent education. Parents of the kids that are coming through do not have any idea of what they are heading for and they do not know where to go to for help. The basic task of getting information out to the wide spread of parents in schools is really important because the confidence and knowledge that they get are passed to their children. So, first of all, make sure that the parents who are really in need are fine, then look to the wider community. But that is my opinion.

Mr Williams—I am sure, as with most other organisations, there is a cost of implementing a strategy, there is a cost of creating and delivering a program, and there is also a cost of promoting that in order to achieve as much access as possible for the greatest number of parents.

Mr CADMAN—You haven't had much money from government at all, have you?

Mr Williams—Our organisation was successful in getting some funds from the third round. We get $40,000 per year for two years, which, as I am sure most other organisations here would say, does not go too far. From our point of view as to the use of funds, we could use funds more effectively in the area of supporting key influencers in local communities who are already working in a wide range of different areas, not just in the area of drug and alcohol education or counselling. But the key influencers that we seem to be training for in the facilitation of this program go across every field or discipline, whether it is a social worker, a policeman, a schoolteacher, a church minister or whatever. This is an area that still requires lots of support, and we find that that tends to chew up lots of resources to drive it.

The second area where I think we would utilise those funds more effectively if there were more available would be in the area of trying to give greater access to parents to attend a program. There is a cost for parents to attend that program. Not all parents are in a position to pay to attend a program. We try to short-circuit that by giving an undertaking to facilitators that, if we are in a position to offer a free place, then we will cover the cost of that parent to attend. Again, we are a not-for-profit organisation and most of our funds are generated from donations

and from the sale or delivery of programs. It is unfortunate to have to turn parents away when they really want that information.

Ms Hanbury—Our program is run by volunteers. Our parent education program in schools is mainly run by volunteers with people presenting from schools and other parent drug information services in other areas that offer their time, basically. They get paid through their own agencies; we do not pay them. It is free for parents to come along, but, to coordinate all volunteers is a huge job if you are looking at it widespread, so we can only do it in tiny pockets. We did get one grant of $42,000 for two years, and we got another one this year of $30,000 for a year. You cannot do much on that.

Mr Trimingham—I guess I would support what Glenn and Julie have said. Certainly I would advocate for community and volunteer groups to receive more resourcing. I have already said that I think we should have more resources across the board. However, I think we should be looking at evidence-based approaches, and every single person who gets funding should be accountable for the funding that they get. One of the problems in Australia at the moment is that not all funded organisations are held accountable. Not enough evidence is gathered on the effectiveness of their programs and there is, unfortunately, lots of money wasted. I am not saying where that money is wasted; I am not pointing the finger at any particular organisation or program, but I think a more efficient use of funds might make it lots easier for organisations that are poorly resourced to get more.

Mr PEARCE—To follow on from the previous question, I note that both Julie and Ann are on the ANCD, which we are told is the most important and influential body in Australia.

Ms Bressington—I would not agree with that.

Mr PEARCE—Don't you argue these issues within that body, and don't you have influence on the decision making process, and doesn't that decision at the end of the day have some influence on government direction on these issues?

Mr CADMAN—If they are worried about how the money is being spent, they ought to bring up accountability themselves.

Ms Hanbury—We do sit on community partnerships initiatives which give out funding to small community groups for the different projects that they do. We do not have the power to tell the government how much money they should give the drug and alcohol area.

Mr EDWARDS—But you do have influence in relation to the amount that is provided?

CHAIR—There is a list of people who have been waiting patiently to ask their questions, Mr Edwards.

Mr EDWARDS—That is fine. I was just following up the question and now I ask whether it would be possible to have an answer.

CHAIR—Yes, but please stick to a succinct question. Others have follow-up questions and, in order to get through the list, I have held them over so that people could get an opportunity.

Mr EDWARDS—I will just get an answer to that and I will not ask any more.

Ms Hanbury—The community partnerships initiatives are small grants for communities to apply for. There is a new round of those coming out within the next few months. I think there is $14 million for community groups' projects. On the ANCD, we do not have the power to tell the government how much money we want, unfortunately.

Mr PEARCE—I would like to ask Ms Bressington a question based on her experience. At the end of the day, one of the key objectives of this inquiry is to come up with a series of recommendations about how governments at all levels in this country might make some improvements and changes in this area. Without revealing my personal position—in other words, my position or how I think about this—we hear sometimes that there are not a lot of services in the community for actual users and families. On the other hand, it seems to me that you open up some community directories and there is a plethora of organisations available. For example, you can look through some and there are umpteen foundations and councils et cetera. Through your experience, do you think there is a lot of misallocation of funds—a lot of wastage and potential duplication? I am interested in your comments as a parent. Also, if a parent were to come to you and say, 'I have a 22-year-old daughter who I am worried about,' what single bit of advice would you give to the 22-year-old user and the parent or parents? I am trying to be sensitive. In other words, if you had your time over again, what advice would you have heeded the greatest?

Ms Bressington—I do not think that there is one piece of advice that you could give a 22-year-old person using drugs and a parent because there are just so many different contributing factors to every individual case. That is a little bit like saying, 'A 22-year-old heroin addict behaves like this' and, therefore, 'Parents can be told this to deal with them.' It does not happen like that. What we try to do when we get parents of 22-year-old drug users is to get them to come in first, on their own. We give them an opportunity to tell their sad story and get that grief, fear and all of that out on the table. We then start to develop a strategic plan for how they are going to manage their life, because they are not going to change the direction of their child's life.

Probably the hardest thing for every parent to come to terms with is that, as much as a parent wants a child to change, they will not do it just because the parent wants them to. They will do it because they go through some sort of physical or emotional need that indicates to them there is a need for change. We teach parents to deal with their life, manage their life, solve their problems and get their life as much under control as they possibly can while supporting their child. Then, if we are lucky enough and the child decides that they want a piece of that information too, we bring the child in and we give them the same sort of information: 'How do you manage your life better, how do you have less of an impact on your family, what is it that you need to do?' and we do a plan for them. Whether or not they stick to that is another thing.

What we believe is good support to parents and drug users is good information and then assistance to achieve the direction and guidance that they have been given. You can't do any more than that. If they don't want it, they don't want it. But parents can make a huge impact on changing the pattern of their child's drug use just by changing the way they interact with their child and the expectations they have for that child. So it is about reality check, reality based stuff, really.

As for the duplication of services, I don't believe there can be a duplication of services in this country because nobody can agree on what are the desired outcomes for any service. If you go to a drug and alcohol services counsellor and ask what their desired outcome is for their clients, it is completely different to the desired outcomes of a counsellor of an abstinence based program. Maybe looking from the outside in, there would appear to be a duplication of services but, certainly from my experience, because there are so many personal opinions and personal viewpoints that come into this, duplication is not very common.

CHAIR—Mr Dutton, you wanted to ask a follow-up question on the heroin trials?

Mr DUTTON—Yes, I have a follow-up question to ask Tony following some of his earlier evidence. It is probably appropriate for me to declare first of all that—like, I think, the vast majority of Australians—I am completely opposed to heroin prescription or in fact trialing heroin injection rooms. If I were a heroin user, what incentive would there be for me to stay on the methadone program or to find a way out if what was being offered was prescription heroin? What incentive would there be for people to make that break, to try to find some sort of resolve? Bear in mind that it all needs to be put into context: you are dealing with people who are essentially in the darkest hour of their lives.

Mr Trimingham—Not necessarily. Not everybody on the methadone program is in the darkest hour of their lives. Certainly an injecting heroin user may be. He may not be. I think one of the myths about heroin dependence is that those taking heroin are in the gutter and they are wasted and scruffy and dirty and commit crime and live lives that are not worth living. The reality is that 97 per cent of people who use heroin don't fit that stereotype at all. They look after themselves quite well.

Mr DUTTON—I accept that.

Mr Trimingham—I also would differ with you in the belief that the vast majority of people are anti heroin trials and anti injecting rooms. The polls do not in fact have that outcome, but you are right in saying that more oppose them than support them.

Mr DUTTON—Absolutely.

Mr Trimingham—Putting that to one side, I guess I come back to what I said earlier: heroin prescription is for a minority. It is for a minority of people who have failed repeatedly other treatments, including methadone. So it is not a question of somebody on a methadone program leaping off the methadone program and being accepted into a heroin program. There would be checks and balances and everybody would be recorded and there would be hoops that people would have to go through to be accepted on that trial. So I do not think the analogy that you raise is really an issue. The other thing that I would also say is that heroin prescription trials are also a different beast to an injecting facility.

My son, on the night that he died, travelled from Katoomba to central Sydney by train. He walked five kilometres to Taylor Square to buy his needle fits and then he walked another kilometre to where he used his last dose of heroin. The location where he used his last dose of heroin was about half a kilometre from where the injecting facility now stands. I do not know

whether he would have walked that extra half a kilometre, but to my mind there is no reason that he wouldn't have.

I do not stand here saying that I want heroin trials and injecting rooms because I think they are a good thing and people should be allowed to use them and use whatever they want. I hate heroin: it killed my son. The reality is, I would rather have him alive now and using those facilities. I have to say to you that if you talk to the majority of parents of heroin dependents, whilst they would also say that the thing that they want most is for their kids to be drug free, they also would like to know that there are safety nets and that, if their kids are going to use, they are going to use a clean needle in a safe place with a safe substance.

Mr CAMERON THOMPSON—Mr Munro, you made the comment that the best way to do some of these things would be in schools with their teachers, and yet we have got these community and volunteer groups, some of them represented here, stepping into the breach. Is it because the schools do not want to be associated with drugs, do not want to know anything about drugs, do not want to have it presented that they have a drug clientele in the school, that they are not doing sufficient, and these community and volunteer groups are stepping into the breach? If that is so, should we really cause an upheaval in that and try to transfer it from the community and volunteer sector to the professional school sector?

Mr Munro—Thank you for that question; it is a very good one. It is not true to say that schools are not doing drug education because our survey of 150 schools across Australia shows that they are. What would surprise many people is the number of primary schools who are explicitly addressing drugs like amphetamines and heroin in their curriculum—not because they believe the students in primary schools are using those drugs, but because the drugs are featured in the media almost every day and children naturally bring questions and comments to school about what is on the news. Also, some parents are using those drugs, and I suppose we are at a new phase in our history. When I was a child at school, the only drugs my parents could use were prescription drugs or alcohol and tobacco, if they chose to, but we have now got children in our schools who go home and watch mum and dad smoke cannabis, shoot up heroin, use cocaine or other drugs. Some parents are growing cannabis in their backyards and, in some jurisdictions, it is legal to do that—or it is decriminalised.

Children are much more exposed to drugs, and most schools are providing some education, even primary schools. But they still struggle, partly because the teachers are not trained in this area. We do lag in providing professional development for teachers. If we want really good drug education programs in schools, we need to have good policies promoting drug education and to give schools permission to do it. At the moment, many of them feel quite nervous about providing extensive drug education programs. Many of them feel very nervous about admitting that they sometimes have to deal with students who use drugs because they fear that parents will take their children out of the school if the parents know.

I hope I have not given the impression that schools are not doing drug education—they certainly are. But I think that, if we want them to do it better—and there is a lot of improvement to be made—we need to support them with appropriate policies and tell them it is a good thing to do it. We also have an education program for parents. We are quite good at providing materials, although we do need more about illicit drugs. Where we fall down is in giving teachers the training. Many teachers feel ignorant and that these are very personal issues that

they do not want to get involved in. I think from a government view down, we do need to be providing more support for teachers. That is a Commonwealth and state responsibility.

Mr CAMERON THOMPSON—You seemed to be indicating by your previous comments that there should be a reallocation of resources to do that because a volunteer or community group would only show up once in a while, do their thing and disappear, and that teachers were there all the time so they are a better conduit. Do you believe that we should be transferring resources from out of those areas where they appear and disappear every now and then, into the thing that is there all the time—the schools?

Mr Munro—I would certainly advocate that. I do not know where it ought to be taken from but I can use the example of schools in Victoria. Victorian schools are now quite well resourced in terms of drug education because they have had an enormous injection, if that is the right word, of funding through the Turning the Tide initiative, going back to 1997. The education department was guaranteed $4 million per year for four years, which is not a lot of money but in terms of drug education in schools that was like nirvana.

The history we face in Australia is one of stop-start where a scare will occur in one state and then there will be money going in to drug education for one or two years. Just at the time when teachers have some decent training the tap will be turned off for three or four years. In three or four years time it will be turned on again. By that time the teachers who have been trained in drug education have stopped doing it or they have left. What we have done in Victoria over 15 years is that every six years we turn the tap on and we train regional drug education coordinators to support schools. After three years, just when they understand their job, they know what the issues are and what materials are available and they have got some expertise, we stop the program because it is a three-year program. But three years later another scandal occurs and we start the process again.

I am certainly a very strong advocate for permanently funding schools for drug education because then we will find out if schools are the place where we can reduce and prevent drug problems. At the moment we do it in a very half-hearted manner. We do understand, I suppose, the enormous calls on government for funding but we ought to fund drug education in schools for a 10-year period and then evaluate it. Give it a go. Do not fund it for one, two or three years and think we can then evaluate it because you are not evaluating anything at all.

CHAIR—Mr Williams, you wanted to comment on funding allocations. It is probably very appropriate that you are given the opportunity now.

Mr Williams—There have been some questions regarding how funds are allocated and I would like to pick up on a point that Tony made. Funds need to be appropriately allocated to evidence based programs where there are measurable outcomes. That also does, however, present a real challenge. Most community organisations do not have the resources to effectively and externally have their programs evaluated. It is a substantial cost. One example of that is that we have endeavoured to process and evaluate as many of the returned parent and facilitator surveys as we can but for a relatively small organisation that is making a big impact we are stretched far beyond our capacity. We would have something like 15,000 surveys sitting there waiting to be evaluated. As Tony has mentioned I think it is worthwhile saying that because at the end of the day we do not just want to be part of a program that makes parents go away for a

week and feel really good. We also want a program that is going to be long-lasting and is going to lead to attitudinal and behavioural change over a period of time.

Ms GEORGE—Tony and Ann, we have talked a lot this afternoon about strengthening and involving families. Yet the two families in my electorate that I have had some first-hand experience with say to me that it gets to a stage when the dependency is so bad that one thing the family can do to keep itself together is to disengage with love and walk away from it, not wanting to know any more about it. How do you reconcile what you are saying about involving families with what I perceive is a natural reaction at the end of a long line of difficulty for the parents to say, 'That is it'?

Mr Trimingham—I am sure Ann will add to this and she has already indicated that her program encompasses some of what I am going to say. If families are unempowered, left in isolation, without support and without awareness and education, they will get to that point of disengagement. We have found—and it is quite magical—that any time that the family gets those things, things start to change. Their goal might be a drug-free child. Success, in my view, is not necessarily achieving that goal, although we certainly do not take that goal away.

I believe we have empower them to have coping strategies that are effective; to have the ability not to put up with abuse, violence, having everything in the family stolen and relationships breaking down. We encourage families to look after themselves and their own emotional, physical and spiritual wellbeing. We believe that they need to know what the substances are that their kids are using, what they do and how best to reduce harm—for both the user and the family. And we encourage good communication. It is often just a simple matter of giving them a few communication skills, particularly listening skills. I am sure it is in Glenn's program. I am sure Ann does it with families too. It is just a matter of engaging families. Once you start to engage families, they get a sense of empowerment, they get a sense of coping, they get a sense of collecting wisdom, they get a sense of being able to survive, and they develop resilience.

There are some situations where family members have to leave home; that can be one of the situations you get to. It is a question of how that family member leaves home. Are they cast out, thrown out and abandoned and never spoken to again, or are they sent out with love, saying, 'We really care about you, we really love you, we want to stay connected to you, but we are not going to tolerate this behaviour any more within our four walls'? It is that kind of thing. It is giving them empowerment by helping them with support and education.

Ms Bressington—A lot of parents do get to that point where it is just all too hard, and the drug user is not changing their bad behaviours, so there has got to be some sort of agreement on what is best for them. If this happens to occur, one of the coping strategies that we give to our parents, and we also give it to the drug users, is letter writing. I know that sounds very simple, but you can stay in touch and put what you are feeling and thinking on a piece of paper, and you know that the anger is not there and this is all about wanting to offer support. Send your kid a card once a fortnight, send your kid a letter once a fortnight. Do not ever lose contact completely, but let them know that there are boundaries as to what you will and what you will not put up with in your home. Always keep that door of communication open, always let them know that you love them no matter what. That in itself does tend to change the behaviour and the perspective of the drug user. A level of cooperation does eventually start to develop where

they can see that their behaviour is affecting their family, and they do take a bit of responsibility for that.

Mr PEARCE—Mr Trimingham, I have a question based on what is clearly a great deal of experience that you have. Rather than understand your view on heroin and heroin trials, I would like to go back to the question: if I were a heroin user, what would motivate me to go into some sort of alternative treatment, if heroin was available? Can you give us any insight into that?

Mr Trimingham—I guess one of the things that your question supposes is that heroin users enjoy being heroin dependent.

Mr PEARCE—With respect, it does not suppose anything, because I do not know. I am asking you for your experience.

Mr Trimingham—My belief, and this comes from talking to thousands of families and drug users, is that the majority of heroin dependent people—or people who are dependent on any substance, for that matter—lead pretty miserable lives. They are not happy using the substance. They do not use the substance for the reasons they first used it. Drug users go through a stage when they first use where they only see benefits: they feel invulnerable, they are able to cope with all the challenges. Gradually problems develop. Once they have become dependent, they actually have a lack of choice. So I do not even think that the question would arise. I can only say that from my personal perspective; you would have to go and ask some drug users about that, but certainly I believe that most people would not view it as: 'Now I can get my drugs for the rest of my life freely without having to worry about it.' There may be some people who would think that way—and they would probably need to get their supply like that, because there is no way out for them. The majority of people who are dependent on heroin want to get out of the dependency, do not want to be confined to the lifetime of misery that it brings.

Mr PEARCE—Are you saying that you cannot give me a clear answer to that question?

Mr Trimingham—I thought I had given you as reasonably clear an answer as I could.

CHAIR—I thank the presenters, particularly for their patience and certainly for their presentations—they were all excellent presentations.

Resolved (on motion by **Mr Cameron Thompson**):

That the following documents presented by Mr Tony Trimingham be included in the committee's records as exhibits: as exhibit No. 19, 'Family Drug Support telephone statistics: a comparison of call patterns over the last four years'; as exhibit No. 20, the draft paper to the Commonwealth, 'Family Drug Support: a guide to coping with problematic drug use'; and as exhibit No. 21, 339 personal petitions on the question 'Do you agree with a heroin trial?' and their reasons for supporting a heroin trial.

CHAIR—Again, I thank the witnesses for their very intensive and extensive presentations.

Proceedings suspended from 3.46 p.m. to 4.06 p.m.

ALLSOP, Associate Professor Steven John, Acting Director, Practice Development, Drug and Alcohol Office Western Australia

GARDNER, Dr Ian Robert, Immediate Past President and Councillor, Australasian Faculty of Occupational Medicine

SHARP, Mr Trevor James, National Coordinator, The Building Trades Group of Unions Drug and Alcohol Committee

CHAIR—Good afternoon again, ladies and gentlemen. This afternoon's session is on workplace safety and productivity. This session of the roundtable deals with workplace safety and productivity with the following presenters: Dr Steve Allsop, Dr Ian Gardner and Mr Trevor Sharp. I remind all those participating in this session that the evidence that you give today is considered to be part of the proceedings of parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. I welcome the speakers for this session and I invite Dr Allsop to start with his presentation.

Prof. Allsop—Thank you. I was asked to address the issues of prevalence and cost. I will commence by saying that my conclusion is that we know very little; we certainly do not know enough. Essentially it is important to stress that, as in other areas, the relationship between drug use and work is complex. It is evident that drug use can affect work conditions and work outcomes but it is also evident that the workplace itself can affect drug use and similarly work outcomes can affect drug use. Unfortunately, within that context of complexity there is much opinion and rhetoric and little valid and reliable evidence that is available to actually make sound judgments on the best approaches to take to drugs in the workplace.

One investigation that was funded by the Commonwealth looked at all published and unpublished literature, over 400 pieces of literature, between 1980 and 1996. We found that there was very little scientific literature available. The majority of it was opinion, reviews and summaries of work in other countries. In that period there were 41 studies available, looking specifically at prevalence, that had some sound scientific basis. Fourteen of those studies were only on tobacco, 14 were only on alcohol, seven were on other drugs and the rest of the studies were a combination. So in terms of available information in Australia we actually have a dearth of information on which to judge the best approaches that we can take, whether or not there is a problem and what responses we should actually make.

We can make a broad assumption and that is that the majority of people who experience problems with drugs are actually in employment. There can be some assumption that the prevalence of drug use in the work force is likely to be similar to that in the general community; not excluding the fact that if particular workplaces recruit from particular populations, that may affect prevalence in the workplace. For example, if you recruit young males from the north-west of Western Australia, you are much more likely to recruit a heavier drinking work force than if you recruited from the south-east of Australia. So obviously local conditions are going to have a very important impact on the level of harm. If we look at National Health and Medical Research Council guidelines and the available evidence on alcohol consumption in the workplace, we see

the evidence suggests that about seven per cent of the work force drink at harmful levels and about 15 per cent of the work force drink at above low risk levels. There is some range around that. For example, the mean of 15 per cent is in a range of 10 to 24.

Unfortunately, most of the studies that look at hazardous alcohol consumption in the work force very rarely look at whether or not that translates to problems in the workplace. For example, someone may drink very heavily on Friday and Saturday nights and therefore drink above the National Health and Medical Research Council guidelines, but whether or not that translates to problems in the workplace on Monday or Tuesday mornings is another matter. Unfortunately, very few studies examine that. Of the series of studies that I have mentioned, in Australia only one study looked at that issue.

In terms of drugs other than alcohol, including prescribed drugs and illegal drugs, there is even less data available. Those data are rarely adjusted for age, for example; the sample sizes are very small; they are done in one or two industries; and there is often under-reporting because of the very nature of illegal drug use—people are not going to be forward in giving information about an illegal activity which may have negative consequences for them in general and, in particular, in the workplace. The evidence that we have available again says that prevalence rates within the workplace vary by occupational group but tend to be similar in range to the general population. As I have already stressed, even hazardous consumption at home or in the broad community may not necessarily translate into harm at work. In fact, we have very little evidence on which to make judgments about that.

If we look at fatal injury, most of the evidence that is available internationally comes from the US. There is very little information in the Australasian region that can guide us, and most of that evidence is to do with alcohol. Looking at some of the more carefully conducted studies, we can assess that about 4.3 per cent of the risk of a fatal accident can be directly attributed to blood alcohol levels of above 0.1ng per cent. Two things are of concern about that. One is that that level of alcohol is very high. We know that, for example, with road safety, the accident risk begins to increase at above 0.03ng per cent and increases substantially at above 0.05ng per cent. The other thing is that we have to be cautious as the report makes assumptions that do not necessarily translate to the real world. There are assumptions in coming to that figure—for example, there is an assumption that there is a random selection of fatal accidents, and that is not necessarily true.

Some of the best available evidence in Australia comes from a report by the National Occupational Health and Safety Commission. It was published in 1998, but it is important to recognise that it relies on data from 1989 to 1992 and that it is quite evident that patterns of drug use have changed quite substantially in that time. Therefore, we are relying on data that are over 10 years old. My best guess is that the figures we report here are either similar or may well have increased. For example, we have had an increase in heroin use notwithstanding the last two-year shortage and we have had an increase in amphetamine use. From those studies, we are able to conclude that a raised blood alcohol level appears to contribute to at least four per cent of all working deaths, and alcohol was consumed in the workplace in 39 per cent of those cases. It is estimated that drugs contribute to about two per cent of all deaths but, unfortunately, information was only available for a third of all deaths.

There is a wide variation in figures from the various jurisdictions. One of the reasons for this is that, in many jurisdictions, they will only look for drugs if they suspect there was a drug contribution—so it may well overestimate or underestimate the number of deaths that occur. The majority of the single causes of deaths in relation to illegal drugs relate to amphetamine type stimulants and road accidents—remembering that this is on 1989 to 1992 data, so we cannot make comment on data subsequent to that date. We can assume that at least five per cent of all deaths in the workplace are associated with alcohol and other drugs but, as I said, there is substantial variation by jurisdiction.

In terms of combining that with non-fatal injury, a study by English and Holman in Australia looked at pooled risk of fatal and non-fatal injury, and the estimate was about seven per cent. Based on data from the Industry Commission—and again this is using data that goes back to the beginning of the nineties, so its current application is unknown—if we assume conservatively that five per cent of fatal and lost work injuries are alcohol related and that two per cent are drug related then we can make an estimate that the overall injury related costs are $1.35 billion to industry and to the community. That does not include other costs, for example, in terms of absenteeism or drug related crime. There is some evidence again that heavy drinkers are somewhat more likely to be absent for ill health than are people who are not heavy drinkers.

You will see that some of these figures are substantially lower than some of the estimates that have been quoted elsewhere. For example, I have seen the International Labour Organisation figures that were quoted in the document. I had quite a bit to do with the establishment of those figures and that was the best available evidence on data available in the 1980s. On the basis of available evidence now, we would question the accuracy of those figures. They were the best available estimates at the time. I think the evidence that we have now is much stronger but still insufficient.

There is some evidence that risk factors are brought to work. Some people have alcohol and drug problems that have developed as a result of lifestyle, of community factors. What happens in the broad community can have an impact on work. This was most notably enlisted by the British during World War I when they brought in legislation to control the availability of alcohol because of the impact it had on the workplace. So what happens in the broad community can impact on work. People who have marital problems and drug problems may sometimes bring those problems into the workplace.

But there is also some evidence that suggests that drug problems are not evenly distributed amongst workplaces and a variety of factors have contributed to that: the level of supervision, the quality of occupational health and safety procedures, alienation, stress, boredom, particular work cultures, people's working conditions—all of these have been identified as having some impact. Some people will bring problems into work but some work conditions will contribute to the development of drug related problems.

Drug problems do occur in Australian workplaces, but to what extent? We know a little but we do not know enough. We do not have good data to make bold conclusions about the level of harm across Australian workplaces. Under what circumstances? We know there are a number of contributing individual factors—things to do with the availability of the drug and the environment both within and outside the workplace. What is the best response? We know some

things that can be helpful, but the evidence base is limited. We know some things not to do but, again, we should not be making bold conclusions.

The evidence suggests that strategies that simply focus on the individual employee are unlikely to have impact and may contribute to harm. This is tantamount to the example of trying to detect the accident-prone worker rather than trying to find all the conditions that might contribute to accidents. A simple example of that: if we came up with a strategy to stop truck drivers using amphetamines, one consequence of that might be an increase in accidents on the road as drivers fall asleep at the wheel. We have to find strategies that deal with the structures that make amphetamines a valid option for some people who wish to stay awake. So it is about tackling amphetamine use but it is also about tackling the conditions that mean that some people will take risks by driving when they are sleepy.

The link between drug use, employment and work behaviour has not been well explored, and it needs to be. We need to have clarification and definitions of drug related harm at work. Just because an employee drinks heavily at the weekend may mean that that harm translates to the workplace but it may not. People may keep their lives compartmentalised. So we should not make assumptions that heavy heroin or alcohol use will necessarily translate to the workplace.

We need carefully conducted investigations into the prevalence of hazards and drug harm in the context of the workplace and we should detect impairment, not just the presence of drug metabolites. Far too much decision making is based on detecting the metabolites of drug use rather than the hazards and harms that might occur in the workplace. We need to identify the factors that contribute to harm and also recognise that there are a number of industries that are well protected from harm. We can learn a lot by looking at those industries that have low levels of harm and by finding out why that is. I suspect we will find that those companies that have good occupational health and safety, good levels of supervision and good safety records are likely to be the industries that have lower levels of alcohol and drug related harm. We need to identify effective interventions and avoid the lure of masterstrokes. There are far too many people selling a single answer to a complex problem.

CHAIR—Thank you very much. I now ask Dr Ian Gardner to make his presentation.

Dr Gardner—Chair and committee members, I am not exactly sure where the invitation to address your committee came from. Officially I believe that I was recommended through the National Occupational Health and Safety Commission, but the actual invitation came very shortly after I talked to the Hon. Alan Cadman, member for Mitchell, on a recent flight from Canberra to Sydney. However, thank you for the opportunity to address the inquiry.

I am speaking today both in a private capacity and as a representative of the Australasian Faculty of Occupational Medicine. AFOM is one of the four faculties of the College of Physicians in Australia and New Zealand, and occupational medicine physicians are those medical specialists who basically work in the area of the effects of health on work and work on health. The discipline is mainly preventive in focus and can be seen as the medical side of occupational health and safety. I have been a fellow of this organisation since 1982 and of its predecessor body, and my recent presidential term expired in May this year. The majority of my professional medical career has been in the management of medical, safety, health and environment issues in major multinational corporations, predominantly US based, such as IBM

and Alcoa. I have therefore seen at close hand the social, political, legal and economic factors which have led US corporations down what I believe is a flawed path in relation to the management of substance abuse in the workplace.

I have been asked to brief the committee, in 10 minutes, on current policies and programs with respect to drug abuse in the workplace. Today I only have time to focus on the abuse and use of illicit drugs. Therefore I will not cover the use of alcohol or tobacco, nor the use or abuse of prescribed or over-the-counter medications. In reality, this limits the field to marijuana, cocaine and amphetamines. I have been asked to address three issues: one, the main issues; two, current approaches; and, three, suggestions for the future. Given the limited time, I will predominantly focus on the third.

What are the main issues? I believe these issues have been very conclusively and well addressed by the National Occupational Health and Safety Commission in the July 2002 background briefing paper which they provided to the committee. They highlight that there is very little objective evidence in relation to the contribution of drugs to workplace accidents, other than with the exception of traumatic fatalities. There is scant evidence that drug testing relates to worker impairment and, even more worryingly, as summarised by the American Civil Liberties Union, drug tests may actually miss drug users who are under the influence at the time the test is given.

NOHSC also states that the national and international agencies all support the development of programs to address drug and alcohol issues in the workplace via a consultative model between workers and employers, backed up by clearly laid out policy. While many employers claim that the law requires them to implement a drug testing program to meet the legislative requirements and their duty of care issues, there is concern from many that drug testing is an invasion of privacy. It is fraught with interpretational difficulties, chain of custody issues, consequences of false positive tests and a lack of focus on other more significant issues such as workplace design, systems of work, including the hours of and the necessity for shift work, as well as fatigue and the effects of chronic ill health, family worries and what I call polypharmacy. The current use of devices, often based on computer screen tests, to allegedly measure impairment is widespread in sections of Australian industry, particularly in the mining industry. However, there are no large-scale published studies that support the efficacy of these measures as predictors of workplace safety.

What about the evidence related to drug use and employment outcomes? Still the best international study is that of James Ryan and Craig Zwerling, with whom I have corresponded in preparing this paper. Their 1990 paper in the Journal of the American Medical Association showed a study of a large US postal worker cohort. They looked for drug use on pre-employment testing. In particular, they found that use of marijuana was associated with higher, statistically significant labour turnover, accidents and injuries, absenteeism and discipline problems. However, the data for cocaine users did not support any strong association with accidents or injuries. They comment that the level of risk is much less than previously estimated and that their finding has important implications for the social, legal and economic arguments in relation to drug screening.

The claimed adverse effects of the use or abuse of drugs on workplace productivity are even more uncertain than the evidence in relation to accidents. Certainly the easy indicators of

absenteeism show a correlation with drug use, but our national statistics and the corporate records do not distinguish between absenteeism due to the ill effects of drugs and that due to personal injuries or illness. Even in the case of workplace accidents, as will be discussed later, the widespread use of safety incentive schemes and standardised recording systems for classifying these accidents actually means that the possible contribution of drugs to industrial accidents is probably underestimated.

The US Substance Abuse and Mental Health Services Administration also highlights the problem that drug use appears to be more common in small workplaces and that these workplaces also tend to be the ones with higher accident rates and without drug testing programs in place. This does not logically mean that there is a cause and effect relationship between drug use and poor work accident outcomes. However, it does highlight the need in all future research to ensure that surveys focus not only on the worker but also on workplace characteristics.

In Australia, the previously reported 1993 study done by John Sargaison when he was working with the Queensland Mining Council focused on alcohol, not on drugs. Recent discussions with him by phone in preparation for this meeting have highlighted the fact that there have been no major follow-ups at an industry wide level in Queensland since his 1993 report. Other experts, such as Brad Strahan, disclose that there are multiple, but unpublished, small-scale studies from a number of sites which have inquired into drug use. They are all self-reported questionnaires and they disclose a pattern of off-site drug use in one to two per cent of respondents. He believes that there is limited evidence to support an association between sleepiness on the job and some types of accidents. However, until this evidence can be aggregated and properly matched, it will not have widespread acceptance.

The Australian Coal Association research program study dated April 2001, entitled ‘Scoping study—fitness for duty, issues and research’, provides some of the only recent high quality, industry wide Australian data. This study was done over a six-month period and involved some 80 interviews as well as an extensive literature search. Their conclusions are comprehensive. Amongst others, they cite the fact that the root cause of accidents is only rarely investigated and that there are few education and awareness programs aimed at helping employees and supervisors to better manage the consequences of injuries and illness.

They also highlight the fact that there is no proven link between the presence of a drug and impairment and, most importantly, that post accident the presence of a drug should not be assumed to be the root cause of the accident without significant further evaluation. They also provide useful comments on the issues surrounding fatigue, especially in relation to safety performance and the impact of shift design and rostering. There is also a plaintive cry for proper validation to be undertaken of the fitness for duty testing devices which are being widely used in the mining industry as a means of allegedly testing workplace impairment.

Finally, in this section, the issue of employee assistance programs should be briefly addressed. As documented in the Australasian Faculty of Occupational Medicine’s 1999 publication entitled Workplace Attendance and Absenteeism, most employee assistance programs in Australia draw from the old alcohol and drugs model. Potentially this model can work, but the uptake of the services is limited by the industrial environment in which they operate, underpromotion, lack of referral, sometimes high costs, attractiveness of the program,

union and management support and whether the employees are willing to participate. Overseas developments, particularly those in relation to greater acceptance and success rates of union-controlled EAP programs should be viewed with interest.

I will not go into current approaches in great detail. In summary—and I have provided a copy of the full paper to the secretariat—there are basically seven areas. They revolve around legislative compliance, fitness for duty testing, employee and supervisor education, provision of EAP-style in-company programs, residential treatment facilities, performance appraisal and counselling, and disciplinary proceedings including dismissal. Each of these does require consideration in its own right, and I suggest that they be followed up in future submissions.

The third section of my talk is related to options and suggested future approaches. Clearly, I believe there is a limited place for continued drug screening in Australia in relation to safety critical jobs, even if only for meeting duty of care requirements on workers and employers. However, I stress again that there is minimal evidence relating the presence of a drug in blood, urine or saliva to impairment. For alcohol, the evidence is clear on the levels at which impairment becomes significant and has been exhaustively studied, especially in relation to aviation and driving of vehicles. However, in relation to drug abuse, what is needed is a better understanding of the real prevalence rates of drug use in the employee population and properly designed studies that will help to elucidate the link, if any, between consumption of illicit drugs and the impact on safety and productivity. This will require significant investment from the federal government. The NOHSC, in spite of significant budget cuts, can still bring its considerable expertise and moral authority to bear in helping to address this issue. Additional funding would be required, with input from states, unions and employers. Professional groups such as occupational physicians and other OH&S experts, as represented by the Congress of Occupational Safety and Health Association Presidents, known as COSHAP, would be delighted to assist in developing this consensus.

I have six practical suggestions to offer. Firstly, I believe that two one-day national summits/workshops should be held in Canberra, with possibly up to 100 invited attendees representing governments, employers, unions and the OH&S professions. The ministers for health and for employment relations should be involved. High profile national and international speakers would be invited, including people from the US from Substance Abuse and Mental Health Services Admin; from the United Kingdom from the Health and Safety Executive; and our own trans-Tasman colleagues from the Accident Compensation Corporation in New Zealand. The first workshop should focus on input from the committee's two reports and input from the invited speakers on the way forward. A second meeting, perhaps a month later, could then focus specifically on how to implement the suggested changes. This might lead to requests for funding for studies on safety and productivity and the impacts of substance abuse, controlled trials in relation to intervention studies and possible changes to state and federal legislation, with adequate privacy safeguards, allowing full investigation and drug and alcohol screening following injuries et cetera. Also foreshadowed would be the need to look at the Australian standards definitions in relation to lost time accidents, which I will mention soon.

Secondly, we should have a targeted study, preferably coordinated by NOHSC, to better understand the true prevalence rates of substance abuse in employed persons and their impact on OH&S and productivity. This study should not just focus on drug testing but also attempt to quantify the impact on the employees of the working environment, workplace stressors,

shiftwork rosters, fatigue, excessive driving times, non-occupational factors such as mental ill health, prescription drug use and chronic medical conditions such as hypertension, diabetes and obesity. There is also a need for properly validated studies of the workplace based devices which claim to measure performance detriment of alcohol and other drugs.

Thirdly, the health aspects of occupational health do not necessarily fit in well with the industrial relations model of OH&S, which is predominant at this time in all Western democracies. Whilst there are both health and industrial issues surrounding the impact of substance abuse in the workplace, some would argue that the workplace is really just a subset of the wider community and that community based responses are the best treatment options for people with significant workplace substance abuse problems. However, as mentioned earlier, some of the evidence coming out of the United States shows that EAP style counselling and treatment programs work much better when fully integrated into the workplace setting and with significant input from peers and other counsellors who really know and understand that specific workplace and its problems. As far as I know, there are no large-scale quality Australian trials in this area, and certainly none published in the peer reviewed literature. This should be a high priority for funding, with adequate resources committed by both health and employment relations ministries. I believe this would be a likely outcome from the national summit that I propose in recommendation 1.

Fourthly, there is evidence—much of it anecdotal—that the major impact of substance abuse is not in accidents but in lost productivity. Lost productivity includes not only absenteeism but also poor morale affecting both the drug using person and his or her co-workers as well as persons whom I term as being 'absent at work'. In relation to productivity, I know of only one health and safety executive who has in his title 'Vice-President, Health, Safety and Productivity'. His name is Bill Bunn and he is a Vice-President of Navistar Corporation based in Chicago, Illinois. His work within the corporation has already led to major improvements in productivity, with a significant improvement in health and safety. He sees organised labour representatives and, in particular, those from the UAW, as key players in the development of industry based substance abuse management programs which benefit all participants. If committee members were planning study trips to the United States, I would strongly suggest that Dr Bunn should be consulted.

Mrs IRWIN—It is not likely.

Dr Gardner—He has a unique perspective, with doctoral degrees in medicine, public health and law and a distinguished record in research and publications. He is also one of the senior editors of a textbook we produced in 1998 entitled *International Occupational and Environmental Medicine*. I can provide his contact details to the committee at a future stage.

Fifthly, and coming to the end, the newly installed President of the American College of Occupational and Environmental Medicine, Dr Ed Bernacki, in his inaugural address at Chicago in May this year, specifically highlighted the impact of ill health, including that due to substance abuse, on productivity of the American work force. Better management of substance abuse and its mental and physical health consequences can be seen as a significant means of improving the international competitiveness of our industries. However, in Australia, as in much of the world, the true impact of drug abuse's impact on productivity and, to some extent, accident statistics, is hidden in the artificial systems that we use to record workplace accidents.

The primary problem is the slavish adherence, based on definitions in the Australian and other international standards, around what is a 'lost time' injury. Every OH&S practitioner that I have spoken can tell of examples where injured workers are inappropriately brought back to work just so their injury does not show up as an LTI—a lost time injury. This is not only bad safety practice, but is also bad for the proper medical treatment and rehabilitation of the ill or injured worker. It also means that, in those cases where drug abuse might have been a factor in the underlying accident, this accident is not properly recorded, and since it is not an LTI, the amount of investigation is limited.

At a national level, therefore, I believe there is probable underreporting of the true impact on safety and productivity of accidents and incidents due to drug abuse in the workplace. However, to put it in perspective, I still believe that it is tiny compared with the contributions made by poor training, inadequately maintained work equipment, failure to adequately control workplace risks and failure to implement safe systems of work. I strongly recommend that the federal government inquire into these unintended consequences of the Australian standards on the recording of workplace accidents and their causes.

Finally, the most contentious issue is that of drug testing—whether pre-employment, post-accident or random. Legislation in many Australian states and, in particular, in the mining industry, requires employers to have a drug—and alcohol—testing regime in place as part of a fitness for duty standard and to ensure the OH&S of all persons that work in a defined hazardous industry. The evidence base on which these requirements are formed is flimsy, to say the least. The much quoted ILO statement referred to by a previous speaker which claims that 'in many workplaces, 20 to 25 per cent of accidents at work involve intoxicated people injuring themselves and innocent victims' is not backed up by facts. A visit to the ILO web site shows no supporting reference studies for this statement. Unfortunately, this flawed evidence was recently provided to the previous committee. The NOHSC, in its background briefing paper, specifically comments on this issue. The US National Research Council and Institute of Medicine's report to the Committee on Drug Use in the Workplace stated:

> It is difficult, given the current research base, to make definitive statements regarding the magnitude of the impact of alcohol and other drug use at work. Many of the effects found, although statistically significant, are small to moderate. Indeed, the available research, taken as a whole, should soften the concern about employee alcohol and other drug use often found in the popular media.

Whilst I do not advocate a soft on drugs mentality, we should not victimise an already socially isolated and disadvantaged group—for example, recreational drug users—who, based on characteristics with not much more scientific validity than their handedness or the colour of their hair or eyes, are seen as a scapegoats in a workplace safety agenda. This issue requires significant national study.

At this point in time, I urge governments and employers not to require the implementation of drug screening programs as part of any fitness for duty requirement. The research base does not support this agenda at present. There may be valid reasons for requiring people to be drug free at work, but I am not convinced, except in rare circumstances of overriding public safety—for example, airline pilots or heavy vehicle drivers—that there is any realistic need for routine drug screening amongst employed persons in Australia. An adequate research agenda to address this issue would be a significant step forward for our nation as well as a significant contribution to the global issues surrounding improvements in OH&S.

CHAIR—Thank you very much. Did you indicate that you had a paper that was more comprehensive?

Dr Gardner—I have a paper that is a tiny bit more comprehensive, but it is 90 per cent there. The other version includes the full list of references, so that is on the submitted diskette copy.

CHAIR—I will ask the secretariat to get that paper from you. Mr Sharp, would you like to make a presentation.

Mr Sharp—The presentation I will do today will include very little references to research and statistics. It will mainly focus on a program that we have been putting into place in the construction industry for about the past 13 years. We have taken it very seriously and have had full-time workers involved in it for 10 years. The program is the Building Trades Group Drug and Alcohol Safety and Rehabilitation Program. It is a workplace drug and alcohol safety and education program run by the Building Trades Group of Unions Drug and Alcohol Committee. It promotes awareness and workplace safety through drug and alcohol education as well as linking workers with problems to appropriate treatment services.

The program has been successful in four states. It was implemented nationally after being trialled in a pilot program nationally and has succeeded in having full-time employees in Sydney, the ACT, Melbourne and Adelaide on an ongoing basis for several years now. Most of the work was developed in Sydney. It was formed in Sydney in 1989 out of meetings with workers and union officials. They were concerned that the abuse of alcohol and other drugs in the building and construction industry was not being confronted and was leading to accidents and unsafe workplaces. The committee met regularly with rank and file building workers on construction sites. After much discussion, drafting and re-drafting a program and workplace policy for the building and construction industry was developed. I think it is very important to understand exactly what that means: it means that the program was developed by workers for workers. This is a program that has been developed from the bottom up and has not been implemented from the top down.

The three main stakeholders in the construction industry are the workers themselves, the employers and the unions. All three have different economic, political and ethical interests and agendas. This program's success lies in its ability to continually and effectively meet the needs of all three groups. An interesting by-line to that is that in the developmental stages of this program the employers were not consulted. The employers came on board to support this program after it had been developed and implemented and they recognised that it could meet a need that they could not meet themselves.

The aim of the program is to improve safety on building sites by teaching workers to take responsibility for their own safety and that of their fellow workers in relation to drug and alcohol use and to inform workers with drug and alcohol problems of available treatment options. This is achieved in several ways. Firstly, it is achieved by raising awareness of safety and health issues related to the use of alcohol and other drugs. Workers are addressed at site meetings and shown the video Not at Work, Mate. The program's messages are promoted on-site by posters, stickers T-shirts, leaflets, fliers et cetera. On appropriate sites the program is now having its messages included in on-site induction training for all workers.

The program's aims are also achieved by increasing workers' commitment to alcohol and drug safety by seeking to have the policy endorsed on all sites. On all sites on which the policy is endorsed, a vote is taken after the awareness session that workers will have the program implemented on their site. This gives the workers ownership of the solution as well as the problem. It involves training safety committee members, delegates and workers on how to implement the program and how to intervene when a worker is unsafe or has problems. The program does this through a specially designed alcohol and other drugs safety in the workplace training course, which incorporates the program's video Not at Work, Mate—available for purchase! It is included in general safety committee training, and it is also being presented to construction industry apprentices in TAFE colleges.

In summary, the key features of the program are: it has been developed by workers for workers; it uses peer education strategies where fellow workers, site safety committees and other nominated peers undertake intervention; and it employs a harm reduction approach that focuses on safety and emphasises the impact on all workers of unsafe behaviour caused by alcohol and other drugs. The components of the program are: a 45-minute address to workers on sites, including a screening of the video Not at Work, Mate; a two-hour drug and alcohol safety in the workplace training course designed especially for and presented to safety committee members; and a version of the two-hour drug and alcohol safety in the workplace training course, especially modified to suit the needs of young persons and apprentices, presented to apprentices in TAFE colleges.

In relation to the reach of the program, these figures are from New South Wales only. They do not refer to the results of the other three states that have effectively implemented the program. Over the past 10 years in New South Wales alone, 55,565 workers received the 45-minute address and awareness session in on-site meetings; 1,263 safety committee members received the two-hour drug and alcohol safety in the workplace training courses in 130 sessions; and 12,925 apprentices received the two-hour drug and alcohol safety in the workplace course in 1,154 sessions. That equates to a total of 69,753 workers being personally addressed for a minimum of 45 minutes over the past 10 years. I believe they are quite amazing statistics.

The program has achieved great recognition both within Australia and internationally. In its most recent recognition, it was selected as one of 15 programs to be promoted and upheld as a best practice model by the United Nations Drugs Program Committee. It has since been distributed internationally to practitioners and policy makers. It is quite amazing that a program that developed from such roots as it did finished up with an award like that.

We look now at the provision of treatment services. Although the program has been successful in many areas, the program has been, however, restricted in its potential to provide a comprehensive service by the lack of treatment facilities that are easily accessible to the target group. Availability of treatment places has always been a problem, with waiting lists of up to six weeks to enter a treatment not uncommon. In 1997, Peter Connie of the Network of Alcohol and Drug Agencies in New South Wales surveyed 14 non-government organisations and residential drug and alcohol agencies, and he found that 1,287 people sought admission for the survey period, 1,023 were assessed by the participating agency, 415 were admitted and 551 were declined admission. The principal reason for being declined admission—that is, for 261 or 47 per cent of those who sought admission but were declined—was the lack of an available bed.

Connie concluded that the demand for places in residential drug and alcohol treatment centres currently exceeds supply by 300 per cent.

This final statistic provides a compelling argument for the development of carefully targeted and appropriate residential and outpatient drug and alcohol treatment facilities for problematic or severely dependent drug and alcohol users and abusers within the workplace. All available evidence supports a comprehensive view that a comprehensive residential and outpatient treatment facility is the most appropriate venue for the provision of these services. Evidence also exists that a significant number of admissions to residential drug and alcohol treatment centres are employed in the construction industry. An informal survey of detox units in Sydney for the period 1995-96 revealed that 16 per cent of all male admissions were employed in the building and construction industry.

To address these problems, the construction industry in New South Wales collectively established a fundraising organisation in 1994 called the Construction Industry Drug and Alcohol Foundation. The foundation is a registered charity bound by the rules of the NSW Charitable Fundraising Act. It has recently been granted public benevolent institution status by the tax department. It is a nonprofit organisation with the general purpose of raising funds to support the services of the building trades group program and to provide treatment options for workers who have difficulty in identifying access through the public health system. The foundation's fundraising campaign aims to raise funds to establish a specialist building workers drug and alcohol treatment facility similar to the construction industry rehabilitation plan, a highly successful, industry-administered treatment centre for construction workers in Vancouver, Canada. We sought out a model to work off and that was the only one we could identify anywhere in the world.

The fundraising campaign was launched in 1996 by Dr Andrew Refshauge, the then Deputy Premier and Minister for Health and Aboriginal Affairs. As a result of a successful fundraising campaign and unprecedented industry support, Foundation House, the Construction Industry Drug and Alcohol Foundation treatment centre, was established and officially opened by the Premier of New South Wales, Mr Bob Carr, in July 2000. It is a 14-bed unit, staffed 24 hours a day, located—there is a bit of a blurb here!—in a tranquil waterfront setting in the grounds of Rozelle Hospital provided by the health department. The facility offers a broad range of services specifically designed around the needs of construction industry personnel and their families. Those services include a residential program, outpatient counselling, after-care and support, relapse prevention groups and family support programs.

That is basically our program. It started off with a workers compensation officer sitting in an office and thinking: 'We have to do something about the problem in the construction industry.' With no research, no data, no evaluation—just a gut feeling that things were wrong—we started off, and we have come to where we are today. We have come to where we are today with commitment and dedication and a refusal to accept no for an answer. If I can say anything about what is needed it is more commitment and less interest. Everyone you speak to about this situation will tell you, 'Yes, I am interested in it.' If you ask any number of people, 'Okay, when I go back to where I come from today, how committed are you to stay here today and start doing some work in this area?' they will tell you they are pretty busy. It is about commitment and getting on with the job.

Ms GEORGE—In terms of the people that are referred on, is it a mixture of alcohol and drugs? What are the main drug dependency statistics?

Mr Sharp—You usually find it is about a 60-40 split between alcohol and other drug problems, 60 per cent being alcohol. While a few years ago the most common hard drug would have been heroin, there is a shift towards amphetamines these days. You may need to ask my colleagues about that.

Mr EDWARDS—Setting aside the issue of workplace accidents, there is an issue which relates to the fly-in, fly-out situation, which does not impact on workplace accidents. But I hear anecdotal stories from time to time, particularly in Western Australia where there are a number of fly-in, fly-out operations, about people working 12-hour shifts, knocking off, going down to the boozer, spending as much time as they can there, going to bed, grabbing what sleep they can and then going to work. That might not impact on accidents, but surely it must impact on lifestyle. To your knowledge, is this a problem? What are industry, employers and employee groups doing to address this sort of lifestyle situation?

Prof. Allsop—Again, we have got some information that can lead us to be concerned but we do not have a solid base on which to make decisions. Yes, the workplace can influence patterns of drug use, just as people's patterns of drug use can influence the workplace. If we look at some of the international studies we can quite readily see that certain occupational groups are more at risk of particular drug related harm than others. The obvious one being people working in the alcohol industry who have been much more prone to cirrhosis of the liver than people working in other industries. We have sufficient evidence to say that it appears that some workplace factors do contribute to drug use which may not necessarily have an impact on the workplace but may have an impact on an individual's lifestyle.

We have many reports—you can go into those sorts of situations and observe it for yourself—but we do not have good evidence with which to inform our decisions. I would also say that my experience, not evidence, has been that some mining industries—and it is not just mining—manage it very well and other industries seem to manage it much less well. I have observed that those who seem to manage it well are mining industries that have a fairly stable work force, that have perhaps grown up and grown older with the company. The workplace attends well to occupational health and safety practices, and the workers have good access to recreational facilities when people are not working. A company that provides alternatives to heavy alcohol consumption seems to have less of a problem than companies that have very little in the way of good occupational health and safety, poor supervisory practices and poor access to recreation. It is not just that remote area mining is higher risk than other industries; there is some reason to believe that some remote area mining industries actually do a better job of reducing the risks than others do. I think there is good reason to believe that the conditions under which people work are likely to have an impact on an individual's lifestyle, which in turn can become a cost to the community. Unfortunately again, we have a very limited evidence base to actually make bold conclusions.

Mr QUICK—In our briefing papers it says:

It is impossible to quantify the impact of absenteeism and reduced productivity but it could have been $9.2 billion for 1992.

It also states that there were:

... 1,761 workplace deaths between 1989 and 1992.

And it also states:

Workplace alcohol and drug issues are generally not addressed specifically in principal occupational health and safety legislation in Australia other than in Tasmania and South Australia.

There is all this ad hockery. At what stage does someone intervene? The building industry has said enough is enough. Who is responsible? Is it the states, the federal government or industry? It costs $9.2 billion; 1,700 and something people die; who grasps the nettle and says enough is enough?

Prof. Allsop—I think it is a combination of all. Dr Gardner and Mr Sharp have said that what we need to do is to bring the relevant stakeholders together. Some industries do appear to attempt to address the issue well. Some states have taken some steps but at the end of the day in terms of federal, state, and employer and employee groups there is an uneven distribution of the effort that has gone into responding. Some areas are served well. I think the building industry has been served better than other industries; some mining companies have taken laudable steps to prevent drug-related harm whereas other industries have not taken any serious consideration of the issue.

Mr Sharp—Part of the problem here is that drug and alcohol issues are not the core business of industry. I know it must seem amazing that you look at that figure and say, 'If they are losing that much money they should be looking at the bottom line and doing something about it.'

Mr QUICK—That is right. We are talking about 1,700 workers in a three-year period.

Mr Sharp—It is absolutely amazing. It is spread out over such a vast area and it may be only one person in this workplace, but it is not until you get the figures put together like this that it makes the disastrous appeal to us that it does. I think one of the solutions is to rope in mechanisms that must be included in tender processes and must be included in legislation. I can speak only for the construction industry, and if an organisation wants to successfully tender for work in the construction industry, it must be able to provide documentation about workers compensation, superannuation, long service leave and a whole range of other entitlements for workers that are found in legislation. If something were put in those tender processes that organisations must have a drug and alcohol policy and process in place—that is, you must be providing education or you will not be considered for this tender—perhaps something could be achieved.

Mr QUICK—But we have states competing against each other to get infrastructure development within their states. They tend to offer taxation subsidies and a lot of other things, and for the average punter it is business in confidence so we do not know the details. Only South Australia and Tasmania have some of this written in their legislation. Where is onus on government to say, 'We really care about our workers'? If the road toll suddenly jumped up by another 1,700 people—we have breathalysers, speed cameras, reduced speed limits and a requirement to wear seat belts, and there are other things, but we have this other problem that is drug and alcohol related.

Dr Gardner—I would like to briefly comment on that. I would caution about the interpretation of the numbers of deaths and things. I have a strong feeling that the numbers are soft. I am not saying they are zero. We have seen other evidence of this—for example, in relation to the impact of occupational cancer-causing agents and what percentage of all cancer deaths in Australia are due to occupation. It is very difficult to be sure.

The short answer to your earlier question is that, clearly, the states have prime responsibility for this. Yes, it may be true that only two states have current legislation that specifies drug and alcohol programs; however, in supporting legislation and, in particular, in regulations—for example, under the coal mining acts and regulations in multiple states there is a requirement that says, 'Anyone who enters a mine site must ...' and it lists all of the things, including drug and alcohol testing. All the states also have in their occupational health and safety legislation requirements on employers to provide a workplace that is safe and without risk to health. Based on legal advice, some employers interpret that as saying, 'We must also provide alcohol and other screening programs to meet that standard,' even though it is not actually spelled out. I see the Commonwealth as having a leadership role here even though it does not have primacy in this area. Certainly we have federal bodies—we have the National Occupational Health and Safety Commission—we have an opportunity to influence the development of state legislation and state based practices.

CHAIR—Dr Gardner, we have talked about small business and large business and we have talked about state legislation and federal legislation. How does the small business person come to terms with the onerous responsibilities continually placed upon them in a workplace where, sometimes, there may be only one or two employees, or maybe three to 10 employees or maybe more? They are governed by OH&S standards and they provide goggles, masks, overalls, coverage, sunscreen, and a whole host of additives that are generally hanging up on walls. They have to continually police that employee in order to ensure they cover themselves all the time and the employee is not really keen to work under all the areas of occupational health and safety that perhaps they should, and now we want to introduce some sort of requirement with respect to drug and alcohol testing. So the responsibility continually comes back to the small business employer. How do we assist them across this hurdle, and when does accountability have to be distributed to the worker as well? We are always looking after the worker, but what about the small business employers who find themselves having to continually comply with a rigorous amount of legislation? What should be put in place to assist them to get through this?

Dr Gardner—This is a very good question. Nobody in Australia—or anywhere else in the world that I am aware of—has a good answer as to how to get quality occupational health and safety information, advice and support to small employers. In New South Wales—the state that I know best because I am the minister's medical representative in that state on the workers compensation and occupational health and safety council in New South Wales—if we look for a small employer, defined in workers compensation terms as someone who pays less than $5,000 a year in workers compensation premiums, they can expect not a fatality but a lost time accident once every 9.7 years. What I am really saying is that, although we think they are big at a national level, when it comes to small employers accidents are actually very rare events, luckily. The other side of that is that, because they are small employers and things are uncommon, they do not get the visits and the support from the state WorkCover authorities. Again it takes more than 10 years, unless you have a particularly horrible, nasty, crushing, blood-on-the-floor, front-page newspaper type accident, to trigger a visit by a WorkCover inspector in New South Wales.

In the recent changes to the workers compensation legislation in New South Wales there has been money specifically put aside for education programs support through unions and through the employer organisations, but by and large it is only the larger employers that are members and get maximum value from those bodies. There is a huge amount of material available on the Internet that is industry specific. In New South Wales again there are industry reference groups set up within the WorkCover authority—I think there are 13 from memory. That has huge input from employers, but again relatively small input from small employers. What I am saying is that I do not know the answer to your question. There is a lot of goodwill out there and there is certainly a lot of intent to try and improve, but it is a very difficult area.

Prof. Allsop—In the mid-nineties the Commonwealth actually funded Dr Robert Bush, who was then at the National Centre for Education and Training on Addiction, to develop resources specifically for small business. Small business was involved in developing those resources, and substantial quantities of those kits were distributed around the country at the time with some evaluation component. The important part of it was that small business people actually took part in the design and development of the resources and, as such, that contributed to their good reception. It may be appropriate to review those items and look at perhaps making them more widely available through distribution on the Internet. The resources are there. They may need some updating, but at the time they were developed electronic means of distribution was not as widely available as it is now.

CHAIR—Following on from that, particularly in small business there is a workplace culture of drinks on Friday afternoon. You are trying to overcome an indoctrinated practice of being one of the boys—there is very little difference between the employer and the employee because they work side by side. There is not a basic employer-employee relationship; rather there is a side-by-side workplace practice that means they then down tools on Friday afternoon and have a beer. How do you cut across that mentality? That does not just happen in workplaces with only one or two people; that probably happens even more so in workplaces with up to 17 people. After that it pretty much gets too expensive for employers to do that.

Prof. Allsop—It is not necessarily a bad thing. Again, the issue is having checks and balances and, again, there is no single response. There is no evidence that can guide us in this, but I have seen some examples of good practice in industry. One company invited family members, and what they found was that having partners and children there actually reduced heavy consumption of alcohol. I am not suggesting that there is an evidential base, but that it is useful sometimes to think a bit laterally about whether there are ways in which we can have a convivial evening at the end of the week and whether there are ways in which we can reduce risk. Some companies have said, 'Okay, we will have alcohol available, but we will make sure it is low-alcohol beverage. We will have food available. We will have somebody take responsibility so that somebody doesn't get in their car and drive intoxicated.' It is about looking at each individual situation and trying to find ways in which you can actually reduce the risk. It is the same way you would approach any risk situation: identify what the risks are and come up with a variety of different strategies to respond to those risks.

Dr Gardner—In my experience in IBM Corporation, where I was director of health, safety and environment for about 13 years, the global policy, which had a very strong puritan streak in it, was that alcohol was not allowed on any corporate premises globally. It was a sackable

offence, regardless of one's level, to have alcohol on any IBM facility. Mini bar expenses on trips were not deductible in any way; you could not claim them.

CHAIR—A good idea.

Dr Gardner—Alcohol could not be served at company functions without prior approval by the highest-level executive in that country. In relation to customer events, normally the alcohol would not be an allowable deduction and you could not claim it if you used it at dinner. There was a strong culture message right from the very top to the very lowest that said alcohol was not part of the way that IBM did business.

Mr Sharp—I think this culture you are talking about is very negative but it does present us with the opportunity to change. Within our industry, we have reversed a lot of that negative culture into positive culture. We have developed guidelines for the responsible serving of alcohol at company functions. We have developed a lot of guidelines around that. We address the peer pressure elements in all training courses that we do. So it is not only negative; we can reverse it to make it positive and to achieve some healthy outcomes for us as well.

Mrs IRWIN—I have to congratulate the construction industry for the program that you have in place. I think it is absolutely fantastic. We are all aware that there are few programs that address the hazards of substance abuse in the workplace. Who do you feel should address these problems? Should it be the states and territories individually, or should the federal government work with the state and territory governments in developing national guidelines and legislation?

Mr Sharp—It must come from the federal government. The states follow it and it filters down to the various industries and levels. There needs to be plenty of scope in there because not all the problems are the same and not all industries are the same. I have said—and Steve has said something similar—that it is a strange thing that for 10 years I have done nothing but work in workplace drug and alcohol programs and yet I continually say drugs and alcohol are not a workplace problem. Drugs and alcohol are a people problem. People go to the workplace five days a week. That presents us with an ideal opportunity. We have them there for 40 hours a week. Politics and ideology aside, the trade union movement and other organisations are great presenters of educational information. If we translate that into the workplace, we have a great possibility to conduct a lot of effective education and changes.

Mrs IRWIN—Thank you for that. My last question is to Dr Steve Allsop. It concerned me—and I know what you stated is correct—that there is a lack of research and data on drug abuse, workplace health and safety, and productivity. What do you feel are the priority areas for future research?

Prof. Allsop—There are particular methodological challenges that we face. Each of the areas of data that we might search carries particular weaknesses. First and foremost, we actually have to get some agreement on sound methodology. Dr Gardner gave some indication of how that might be done. We have to inculcate some sense of caution about the best possible data that we can gain, because there are always going to be limitations to that data for simple, practical reasons and for the fact that we are talking about hidden behaviours. We need to have some agreed methodology and I do not think that would be too difficult. We need some simple application of the levels of evidence. If we applied levels of evidence to the quality of evidence

that we have at the moment, most of it would be level D. We have to agree on some sound methodologies, and then we have to examine the databases that we have. We have a number of databases that we can explore to give us more routine information.

For example, simply waiting on somebody to presume that drugs may have contributed to an accident and then using that as the basis for making a judgment about the prevalence of drug use in fatalities gives us, by definition, biased data and gives us what we have, which is huge variation across the jurisdictions. So we need to have a consistent approach to how we gather data. I do not think that is necessarily an expensive task.

I also think we need to have some consistent methodologies and approaches to evaluating interventions. We need to recognise that, as in all other areas of health—not only the drug area—we need a variety of different interventions; we need a variety of different approaches. No single approach will be sufficient. But we need to have a standard methodology to evaluate the impact of those. I think we do need to pay particular attention to small and medium sized enterprises because, where effort has been made, it has tended to be led either by large interested organisations such as union groups or by large employers.

We need to have some way of helping to translate this into small enterprises and of recognising that in small business, in particular, it is not just an issue of resourcing. We often find that we are talking about people who come from the same family, and tackling some of these issues is a particularly sensitive problem. If there is a family culture where drug use is a problem, as you heard in the previous session, that can be translated into the workplace.

So I think we need sound methodologies and up-to-date information. As you saw, I was relying on 1989-1992 data, which does not tell us very much about what is going on now. We need a methodology that allows us access to recent information, which I think we could achieve if we addressed some of the issues that Dr Gardner touched on.

Mr QUICK—Following on from Julia Irwin and Professor Allsop, when the issue of suicide was studied by this committee, state coroners did not have a standard agreed understanding and format in methodology. Why has it taken so long? What needs to happen? Does the Commonwealth need to belt the states around the ears and say, 'You people need to have a national approach to this issue'? We are talking about large numbers of people. Dr Gardner said the figures are soft—for instance, when it comes to suicide and road accident, where that is unclear. It is the same with industrial accidents and absenteeism. We are talking about huge amounts of money. We need a supporting regime that covers everything. And there is admission to hospital—even the hospitals cannot agree on a standard regime.

Prof. Allsop—Science in this field is a relatively new partner. We have relied much on moral persuasion and belief. Science has begun to have an impact. When you think about where we are now compared to where we were 15 years ago, we are in a substantially better place. It is not necessarily about the Commonwealth clipping some people around the ears, but I think it is about the Commonwealth perhaps providing that leadership role, in partnership with the states and territories.

I think the time is ripe. We have far more interest from state governments, employers, coroners and the union membership about this issue than we have ever had in the past. I think

there is a good window of opportunity to help us get better information but also to recognise some of the challenges that exist. For example, in the case of trying to detect blood alcohol levels in someone who has drowned or been underground for a long time, you are not going to get valid information no matter how well you approach the issue.

It is about being bold in what we try and—unfortunately, something that is not always listened to in this field—about being cautious in what is claimed. I think the biggest problem that I am concerned about now is the lack of caution about what is claimed. I think we can substantially improve the science that we use, but we have to be very cautious in what is claimed. Unfortunately, some of the rhetoric is incautious in its claims.

Mr QUICK—Is this the result of a fear of insurance and liability, that we do not want to affect our claims and have a perception that we are an unsafe workplace? I have been around dozens of places that have a big sign up that says that there have been so many days since there was an accident. God help us with what is happening with the insurance industry, but was that one of the contributing things, to say, 'We'll just keep it all hazy and, hopefully, no-one will take any notice'?

Prof. Allsop—I think it is a factor, that it is an illegal behaviour or it is a behaviour that is frowned on or it is a behaviour that is specifically legislated against, so obviously that is going to have an impact. I also think it is to do with the uninformed way in which data are interpreted. For example, the presence of a drug is not necessarily indicative of cause but, unfortunately, is frequently interpreted as such. So it is a combination of anxiety with poor science, and with much supposition.

Mr QUICK—Every time I get on a plane at Canberra airport to go home, I hope that the airline pilots are adhering to their alcohol free requirement. What industries apart from the airline industry have this requirement of zero tolerance? One would assume that, when I had my heart operation, the surgeon was calm, cool and collected and substance free.

Dr Gardner—There is no legislative requirement on your surgeon to be substance free.

Mr QUICK—Just on the airline pilot?

Dr Gardner—In the rail transportation industry and in underground mining there is a requirement. I do not know of any others off the top of my head.

CHAIR—You might take that on notice and let us know if there are further professions that you think might have that requirement.

Mr QUICK—And how they got over the privacy stuff?

Ms GEORGE—The National Occupational Health and Safety Commission, which gets funding from the federal government—and probably not enough—deals with standards on a whole range of issues. It has a research arm. Why isn't it more interventionist in this area which has such a profound impact on both economic outcomes and the lives of people? Is there an answer to that? Is there something this committee might do to jog them along?

Dr Gardner—Yes, there is. The fact is that, even though the NOHSC was set up with a research intent, and with the original intent to have a national institute to do this, that has never been delivered. The funding for NOHSC has been slashed repeatedly over the years. There is an absolute inability to do quality research in house. The small amounts of research funding that it has available are farmed out to be done externally. That has a valid role, but, by world standards, the funding of occupational health and safety research in Australia is extremely small.

One of the specific problems in Australia is that, in the past, the National Health and Medical Research Council did have funding and did sponsor major studies in OH&S in Australia. With the establishment of the commission, all that disappeared and supposedly went to the commission. In fact, it has disappeared entirely. In particular, with OH&S being split—with the 'H' partly coming under the ministry for health and everything else coming under Employment and Workplace Relations—it is not clear to the man or woman on the street who owns what and who funds it, and you get the answer: 'Well, it's not actually in my budget.' The short answer is, yes, NOHSC requires significant additional funding to allow it to do what it was legislated to do, but at the moment, unfortunately, it cannot deliver.

Mr WAKELIN—Dr Gardner, I confess that I thought some of the things you were saying were slightly schizophrenic.

Dr Gardner—I will talk to my mental health adviser!

Mr WAKELIN—I think I heard you say that substance abuse really was not the key issue in the workplace.

Dr Gardner—Is not a key issue?

Mr WAKELIN—It is not the key issue.

Dr Gardner—Correct.

Mr WAKELIN—And you said that there are a whole lot of other issues. You touched on your experience at IBM in that there was a very strong ethic of no encouragement, of zero tolerance. In that sense, what I am to draw from that? For example, are IBM doing a lot of other things right? What are you saying about IBM's very strong discouragement of substance abuse or even of substances?

CHAIR—Substance 'use'.

Dr Gardner—Can I go back? I did preface my earlier discussions by saying I was only talking about drugs.

Mr WAKELIN—Yes.

Dr Gardner—Certainly alcohol abuse is a significant problem in Australian workplaces and is a substantial core contributor to occupational accidents and definitely to fatalities. The

evidence for drugs, though, is much less clear. It is probably unfair to apply the standards of global Fortune 10 companies to the small employer in western Sydney or the outskirts in Queanbeyan. Also, by and large, the workplaces are extremely highly engineered and have extremely good standards of safety, not only because of the culture but because the products made and the chemicals and processes used are extremely hazardous. The employees are highly educated—the average person would have at least a four-year post-secondary degree to get in the door. And, of course, there is this culture: I mentioned, semi-jokingly, the puritan ethic, but clearly, if you look into the US corporations, when you go right back, there is that strong streak in them.

Mr WAKELIN—Forgive my tongue-in-cheek comment at the beginning. Really, what you—all three of you—did for me was most valuable in the sense of saying, 'Don't just focus on substance abuse, focus on the whole picture.'

Dr Gardner—The big picture.

Mr WAKELIN—That is what we have got to try and capture in our report if we are to do justice to what you are saying today; certainly it is part of it, but it is very much part of a whole picture. As Trevor said, it is an opportunity to improve behaviour. And, as I understood it, Steve said we have come a long way, so there are a whole lot of things.

Prof. Allsop—In terms of what you are saying, a useful model was developed by an individual named Zinberg: individual factors, drug factors and environmental factors all contribute to the experience of drug use and drug harm, and therefore any strategy that is going to be effective also has to address all three domains. That applies in the workplace. If you only address worker knowledge or try and control employees and do not do anything about the environment that might be conducive to drug use, you are going to have limited or perhaps no impact.

Mr WAKELIN—Thank you.

CHAIR—There being no further questions, I thank our three presenters for their excellent contribution. We have all gained a lot of benefit and knowledge from this. It is one of the areas of the report that we had been a little bit light on and we needed to skill-up on it to ensure that we covered it adequately. You have provided us with some significant information to move forward on. I thank my committee members, and the public and the gallery for hanging in with us all day.

Resolved (on motion by **Mrs Irwin**, seconded by **Mr Wakelin**):

That the document tabled by Mrs Bressington, 'A stakeholder's view: evaluation of the Drug Beat of South Australia Program', be treated as exhibit No.22 and be included in the records of the committee.

Resolved (on motion by **Mr Thompson**):

That this committee authorises publication, including publication on the parliamentary database, of the proof transcript of the evidence given before it at public hearing this day.

Committee adjourned at 5.29 p.m.