COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Substance abuse in Australian communities

FRIDAY, 16 AUGUST 2002

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Friday, 16 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 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 8.30 a.m.

CHAIR—Welcome, and thank you for your attendance this morning at the second day of the roundtable organised by the House of Representatives Family and Community Affairs Committee as part of its inquiry into substance abuse in Australian communities. Before we proceed the committee must attend to some business.

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

That submission No. 226 be accepted as evidence and authorised for publication as part of the inquiry into substance abuse.

CHAIR—During the two days of the roundtable we are addressing all five of the inquiry's terms of reference. Yesterday we dealt with health care, families and workplace safety and productivity. Today we will be hearing from people with experience of the impact of substance abuse on road trauma, crime, violence and law enforcement. The information that we obtain during these two days will help the committee to draw conclusions about substance abuse in Australia and to make recommendations to the government on this topic. Substance abuse is an important issue in today's society because of the social and economic harm it causes. The committee wishes to examine all the arguments for the different options available for dealing with the harms of substance abuse. We want to be able to contribute constructively to building better solutions to the problems that substance abuse present.

Yesterday we heard evidence from tobacco, alcohol and substance experts. We heard from a broad range of speakers on prevention and early intervention, and opinions on treatment options, including the adequacy of current treatment. We also heard the thoughts of consumers on currently funded proposals for needle and syringe programs. School and parental education programs drew interesting debate and opinion that will assist the committee in understanding family support programs, as did the evidence on the issue of controlled heroin trials from an organisation comprising families suffering from the effects of illicit drug use and subsequent deaths from overdose.

Workplace safety and productivity is an area that has had little work or research done in the past. We were indeed fortunate to receive a comprehensive overview from our presenters and I am sure the committee members have a far greater understanding of the challenges, particularly for small business. I am sure that today's presentations will put the finishing touches to a most successful roundtable.

The sessions today will consist of presentations by invited speakers, followed by questioning of the speakers by committee members. All of this is covered by parliamentary privilege and members of the public are here 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 hearing and learning from the participants over the next two days. I welcome you.

There has been a slight change in this morning's program. We have two speakers this morning. I also give the apologies of one of the committee members, Trish Draper, who due to

her ill health is unable to be here for the two-day roundtable. This is session 4, and the first session in the roundtable today deals with the road trauma caused by substance abuse.

[8.38 a.m.]

KING, Mr Mark Johann, Principal Adviser, Road User Policy, Road Safety Policy and Advanced Technology, Land Transport and Safety Division, Queensland Transport

SWANN, Dr Philip David, Manager, Drugs and Fatigue, VicRoads

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

Mr King—I am going to talk about drink- and drug-driving. It is primarily from a Queensland perspective, although I also have some involvement at the national level and I am aware of much of what is going on on that head. I will talk about drink-driving and then drug-driving. I will briefly go over the fundamental approach that we have taken to drink- and drug-driving, pointing out that there are some alternatives and I will also speak briefly about the potential Commonwealth role in the area.

Slides were then shown—

I have not covered statistics in great detail. I had been anticipating that Margaret Smythe would be able to do that, but unfortunately she cannot attend. In Queensland at least, the rate of involvement of alcohol in crashes has been relatively unchanged in recent years. The figure is around 33 per cent in fatal crashes and nine per cent overall. That is higher than in some of the southern states but it is a considerable advance on the situation going back 10 to 20 years. Drink-driving remains the key road safety issue, together with speeding and, to some extent, seatbelts and fatigue. But really alcohol and speeding are the most important issues. Like all states, the main approach that we take in dealing with drink-driving is random breath testing. There has been a considerable body of work to evaluate, finetune and develop best practice. It is a general deterrence approach based on deterring people from drink-driving in the first place, but it is also a technique which needs to be constantly renewed to make sure that it remains effective, otherwise it wears out. We will be reviewing it in the light of a forthcoming Austroads report which focuses in particular on some of the problems in conducting random breath testing in rural areas. It is rather easy to avoid random breath testing as a threat in rural areas where there are a limited number of roads and it is easy to spread the message. We know random breath testing is only effective if it is supported by high-profile, high-impact media campaigns. The two go together. You cannot have an effective police enforcement campaign against drink-driving without good supporting publicity, and publicity about drink-driving is not effective without a good enforcement campaign.

One of the things that we do in Queensland is different to what they do in most of the other states. Victoria has a lot of courses for drink-drivers; we have one main one which is called ‘Under the Limit 1’. It is an intervention for convicted drink-drivers and it is run by the Queensland University of Technology on a user-pays basis. It is a judicial model where people are offered the opportunity to do the course as an alternative to the normal fine. It is done

through probation, which fits with best practice as determined from a meta-analysis conducted worldwide a few years ago. Evaluation of this program shows that it has been effective in reducing subsequent drink-driving. That evaluation was funded by the Australian Transport Safety Bureau. We may need some supporting legislation, and we are proposing to review all of our impaired driving legislation in the near future. We are also trialling alcohol ignition interlocks for convicted drink-drivers. That is being integrated with the 'Under the Limit' program. People do both. The trial is being conducted by the Queensland University of Technology, with the involvement of Queensland Transport, the police and Corrections, as well as some other stakeholders. Once again, it uses a judicial model, administered through the courts or with a probation order, rather than using an administrative model. However, we will be reviewing that again when we look at the review of impaired driving legislation.

We do not have compulsory blood testing of crash casualties for alcohol. It has been considered numerous times since the seventies. In fact we did have legislation which had not been proclaimed for many years and it was finally dropped from the books. We have considered it again recently but we are not planning to introduce it, because of its cost and questions about its cost-effectiveness. Police, however, can request testing of conscious victims at hospital, who can give their consent or not. We have proposed legislation for the testing of unconscious victims as well.

Drug-driving rates in Queensland, as in most places, are difficult to determine, for obvious reasons. The problem of identifying whether a drug is present or not and whether a person is affected by it at the time is fairly large but, to the extent that we can determine it, our drug-driving rates in crashes seem to be comparable to other states and are probably pretty close to New South Wales rates. An important thing about our drug-driving approach, which is shared around Australia, by and large, is that the focus is on the actual behavioural impairment, not on whether or not a drug is present.

Our approach also focuses on the impairment itself, not on whether a licit or illicit drug causes it. Queensland Transport and the Queensland police have been part of the Austroads Drug-Driving Working Group and are also together, as a result of our Travelsafe inquiry, in the Queensland Drug Driving Prevention Working Group. I noted that to make the point that Transport and the police are co-operating as best we can on activities in this area and we are making sure that we link through to the national level; it is not just a state thing.

The Drug Driving Prevention Working Group is developing a field observation report, which is a checklist based assessment of a driver's impairment, similar to the one in New South Wales. The way that that will work is by building on an existing system where, if people are pulled over and are seen to be impaired and that is not accounted for by alcohol, police can request a blood test if they believe there is sufficient justification do so. This has not been very formal in Queensland, whereas it has been quite formal in New South Wales. We are going to trial that. If that is unsatisfactory, we will look at some sort of behavioural roadside test to detect drug impairment. That will not be as complex as Victoria's, which Dr Swann will probably outline for you. We have not actually gone far down the road in developing that because we are waiting to see if the field observation report will be effective.

We are monitoring new technology such as the detection of drugs through saliva and other means, and we are also developing publicity to support what we do. We have conducted

qualitative and quantitative research to give us direction for both our operation and our publicity. CARRS-Q—the Centre for Accident Research and Road Safety, Queensland—has already made a submission to this committee about the changing patterns of drug use and the attitudes of drug users which differs somewhat from the viewpoint that was expressed through the Austroads process, and we are taking that into account in the Drug Driving Prevention Working Group. CARRS-Q has proposed other kinds of research and has some other drug-driving research under way.

The fundamental approach that we have taken to drink-driving and drug-driving is, firstly, that we still believe that drink-driving is more important than drug-driving. It has much more of an impact and in many drug-driving cases alcohol is present in any case. Secondly, our drug-driving legislation is based on road safety considerations rather than health considerations or issues of crime, so from a legislative point of view we are only interested in people driving under the influence of drugs if it is impairing their driving performance. Similarly, our enforcement approach is based on impairment, not on a particular level of a drug or whether or not the drug is present—some impairment has to be demonstrated.

The role of the Commonwealth is relatively limited so far, because we have significant differences between states in legislation and in practice. In particular, I have mentioned alcohol ignition interlocks. They need to operate across borders. We have an administrative issue whereby it is difficult to administer alcohol ignition interlock drivers from one state to another. We have not had a lot of that as yet, because there are not many in the programs. We have different degrees of attractiveness of alcohol ignition interlocks if they are used to trade-off a licence suspension period—Queensland, for instance, has a very low licence suspension period compared to other states—so there may be some role for the Commonwealth in that area. Otherwise, if there were Commonwealth support for research and evaluation and national consistency, which is already occurring through the Austroads process but could perhaps be facilitated for other, broader purposes, that would be of assistance too. That is basically it. Thank you.

CHAIR—Thank you. I now ask Dr Swann to come forward and give his presentation.

Dr Swann—I have taken a slightly different approach from Mark in that I have gone through your first report, and in the 10 minutes that have been allotted to me I would like to put forward a position where I believe the committee can make a real contribution in reducing road deaths and deaths associated with illicit drugs. The philosophical approach that is taken in Victoria is a cost-benefit approach where there are many accident factors. I am sure you are aware of them all, and I am conscious of the time, so I will quickly go through my presentation.

CHAIR—We have a little extra time if you are caught up, so that is fine.

Dr Swann—We look at what percentage of the road toll a particular factor contributes to, what is the accident risk for that particular factor and what are the costs for the countermeasures—not just the technical but all the costs that are associated with implementing the countermeasure. That is basically the approach. I have been in the area for 25 years and cannabis has been with us for a long time. I think an enormous contribution can be made by shifting the focus of the cannabis debate. For example, on the subject of whether or not drugs

cause accidents, your report entitled *Where to next? Inquiry into substance abuse in Australian communities* states:

> Drivers who are cannabis users, and test negative for alcohol, have not been found to have a significantly elevated crash risk.

That is a perfectly accurate statement. One of the definitive benchmark studies was done by the Victorian Institute of Forensic Medicine. It was a five-year study. That has now gone into a 10-year study, which I will refer to quickly. They found, when they used as a measure of accident risk an odds ratio as derived from culpability, that cannabis users had a crash risk of 0.6 compared to drug-free one. So there is no increased risk. This is a traditional approach that has been used throughout the world. When you look at the literature, what they use to measure cannabis by is the relatively easily detected carboxy metabolite THC-COOH. The five-year study shows that your report is absolutely correct.

But I want to go further than that. The traditional analysis looks at THC-COOH—and most culpability studies looking at accident risk for the last 20 years have done this—but it is not the active ingredient. It is not impairing and it remains in the body for several days. In road safety we are concerned about impairment, as Mr King said. We are concerned about drivers who are impaired, not whether drivers have used drugs. The study here shows that cannabis users as a group are not a deviant group in terms of their behaviour on the road. That is because they have used as a measure of cannabis this metabolite that stays in the body for several days, even weeks. The actual impairing ingredient in cannabis is THC, which is delta-9 tetrahydrocannabinol. The reason the debate should be shifted is that when you are talking about cannabis, you can be talking about Mexican marijuana that has no THC at all—and that is what we use in our studies as a placebo. It still has health effects, and the literature shows that for every inhalation of marijuana you are getting more tar and more carcinogens than you are with nicotine cigarettes.

From the point of view of road safety, if you use Mexican marijuana, you are not going to be impaired because it has no THC in it. Clearly, other cigarettes that have up to 10 per cent THC can cause impairment. What we are concerned about is that all psychoactive drugs act on the brain reward system, and what we are looking for is the amount of THC in the brain. For all our psychoactive drugs, the effects depend on the dose. We use blood as our measure because blood is the best measure we have of a pipeline to the brain. It is very difficult to measure drug levels in the brain. I want to take a moment to look at THC, which is where I would like to see the debate shifted, to look at cannabis the way we look at alcoholic beverages. We take into account whether we are drinking light beer or whether, in fact, we are drinking straight glasses of whisky.

We have known for 12,000 years that THC can give a powerful high. For decades, psychopharmacology has shown the dose-related powerful impairment effects of THC during driving tests. One of the best reviews—and it remains one of the best—was done in Germany, and other reviews have substantiated these figures. What you see on the slide, in terms of the skills related to driving, is that a person's tracking skills can be impaired with doses as low as three nanograms per kilogram of body weight (ng/kg).

The other point that I would like to make is that your impairment with THC is very time dependent. What we are concerned about is driving soon after using high doses of THC. We can plot that on a graph. We can see on this slide that as the doses of THC in the blood increase so does your impairment. Taking on board what the literature gives us from academic studies, I would now like to show you what happens in the state of Victoria, where actual THC levels are recorded from the drivers killed. We see on the slide the average THC death. In one of our recent years, the level was 42. Many drivers survive for some hours before they die, and blood samples up to four hours are taken into our database. The THC levels fall very quickly. So when we are looking at the actual levels at the time of the crash, we can get a surrogate measure of that by looking at the top 30 per cent. When we do that, we get the result that appears on the slide, which shows a very marked effect of THC.

Let us look at actual driving accident risk. We have been working with the Victorian Institute of Forensic Medicine. We originally encouraged this institute to look at driving accident risk, because accidents involving drugs require very large numbers in order to get statistical significance, and we encouraged the institute to work with the other Australian states. To my knowledge, the institute is the only government organisation throughout Australia that does this type of research on a consistent basis. The institute has been helped particularly by New South Wales, who have an excellent system in terms of a comprehensive analysis of people who are killed, and Western Australia. We have excluded Queensland and South Australia because the samples from those states are not comprehensive enough to include in the database.

The study that originally showed only five years of accident risk, which I quoted initially, is now up to 10 years. It has a massive 3,398 cases. What I would like to show you is the highlights of that study. The slide shows the breakdown of road deaths according to cars, motorbikes and trucks over the decade of the nineties. The left of the slide shows the percentage that tested positive to alcohol. If we have a look at psychoactive drugs, we can see there the comparison for the three key road user groups. I would like to draw to your attention the percentage of deaths in relation to trucks. We can graph that, and we can see that alcohol has come down initially and then remained reasonably constant while the drugs are going up. That fits with all the other evidence that you have been given in your report on illicit drug use. Do these drugs cause accidents? Again, we go back to the culpability studies. These are the culpability ratios.

Mr CADMAN—Could you explain the ratios?

Dr Swann—The ratio is the per cent culpable, or the per cent of drivers who were responsible or caused their own deaths and tested positive to a drug, compared to the drug-free drivers. That is giving you an indication that the drug may have caused the death.

Mr CADMAN—The higher the figure, the more culpable?

Dr Swann—Yes. When we plot that, we get very high culpability for stimulant drug use in truck drivers; we get very high culpability for THC—greater than five nanograms in drivers. And then we have alcohol and then we have THC, stimulants, drugs, opiates and benzos. How much higher are these top two? The conclusion from the Victorian Institute of Forensic Medicine in their 10-year study is that in drivers with greater than five nanograms per millilitre of THC the odds ratio was statistically highly significant, and was greater than in drivers with a

BAC of .15. When we look at their accident risk, we see no drug and alcohol, 1.0, which is the base; all psychoactive drugs, 1.7; and THC only—and I make the point that Mr King did, that illicit drugs often occur with alcohol. Those results do not have alcohol in them, so that is THC only with all the alcohol taken out. When we look at THC only, again with all the alcohol taken out, it is greater than five nanograms. For truck drivers who tested positive to stimulants, the odds ratio was significant and greater than for drivers with a BAC of 0.05.

Are there enough of these deaths to warrant action? That is the second part of our approach. With truck drivers, 23 per cent of the dead truck drivers test positive to stimulants. There are not lots of truck drivers killed; however, there are lots of other people killed when trucks hit them. Consistently across Australia trucks are associated with 20 per cent of the road toll. So if we are looking at 23 per cent of truck drivers testing positive to stimulants, with a very impairing—in fact grossly impairing—odds ratio, and they are contributing to 20 per cent of the road toll, we can see that we have got potentially 4.6 per cent of the road toll if we could introduce successful deterrents.

With respect to THC, I can speak only for Victoria, but I have no reason to suspect that Victoria is any different to any other state. In fact, an initial paper I presented to a drugs conference concentrated on New South Wales, and we got similar results. But in the year 2000, the per cent of the road toll due to THC positive was 12 per cent; in 2001, it was 13.5 per cent. To put that in perspective, in Victoria illegal alcohol is down to 22 per cent. Is it simply young drivers? Everyone says it is only young people who take cannabis. There is the age distribution of the THC deaths in three-year breaks. You can see that basically it is the 23- to 25-year-olds and the 29- to 31-year-olds; it is not only the 17- to 18-year-olds. You can see it spans from 17- to 49-year olds: it is not confined. Were they grossly impaired? As I have already shown you, 7.8 per cent were grossly impaired. Again, to address the key issue—people say it is alcohol—in 55 per cent of these cases, no alcohol was present. That represents 4.3 per cent of the road toll.

Why that is important, why I think a contribution can be made, is that the debate on cannabis is mixed up by these huge studies that are, firstly, looking at an inactive ingredient—logically you are not going to expect to find impairment if you are looking at an inactive ingredient; it is associated with the active ingredient—and also there is this myth that it is not a problem, it is an alcohol problem. In Victoria, in the year that that was taken, in 2000, we had 4.3 per cent. The other myth about cannabis is that it is a non-addictive drug and it is very safe. With those statistics, it is not. THC is not a safe drug to take if you are intending on driving.

The point I want to make is that stimulants and truck drivers represent occupational drug use. These are not addicts; these are people who take drugs for financial reasons. From a logical point of view, if you had a financial disincentive you could stop it overnight, and it has been suggested in the past that things like vehicle sanctions would be extremely effective. There have no been political decisions to bring such things as vehicle sanctions in. But, from a road safety perspective, if you deregister a truck, even for 24 hours, when the driver tests positive to a stimulant, I believe you would go a very long way to changing this culture of occupational drug use.

Dealing with THC in drivers is slightly harder. It is a recreational drug, but a lot of evidence shows that the majority of people who use cannabis for recreational purposes are not addicts. I

make the point that, compared with the main problem you are dealing with, which is addictive drug use, these behaviours should be relatively easily changed.

The second issue I want to bring to your attention concerns drug testing. One of your conclusions said that there are technological barriers to it. There are not technological barriers if you use GC-MS—gas chromatography-mass spectrometry. That is now down to only about $35 per sample, so it is very cost-effective. But if you do not wish to go along the bloodline, saliva is another option. When you take a drug, it comes out of your body in many different ways, and I want to make the point that hair, sweat and urine can contain detectable drug levels for hours and days after the impairment period. Saliva and blood are more related to whether the driver is actually impaired—and that is presented there in that graphic for you—and highlights what we are concerned about, which is that with impaired drug users blood and saliva are the body fluids that we prefer.

There is a lot of discussion on saliva, and it is clouded by the fact that people want a device they can use instantly to get an accurate result. They forget that if you take it to a lab you can, overnight, get a 100 per cent accurate result with GC-MS. It requires only two drops of saliva—0.3 millilitres. We are not talking about huge amounts. Saliva has the advantage of people being able to collect the sample themselves. They can be observed immediately, with virtually minimum health risks. On the other hand, blood requires skilled collectors, time delays, has health risks and it is hard to get the samples. With THC, which is the one for which I am putting the case forward today, saliva is appropriate, because multiple studies prove it is detectable in the saliva for the first hour, and it is in the first hour that you are particularly impaired. You get maximum impairment in 40 minutes to one hour. Recent use, which is what you pick up with saliva, is very dangerous. With respect to the truck drivers, amphetamines have always been easy to detect in saliva. There is a 10 to one saliva-plasma ratio.

Finally, I want to make the point that the screening devices are not evidentiary standard, where GC-MS is evidentiary standard. The new second generation devices for screening are now being tested. I have brought them along for you. This is the COZART RapiScan device collection equipment, which we are using with the police. This is the new Drugwipe II, and this is the device from Drager, which has not been commercially released at the moment. As I said, you need two drops of saliva, and these devices allow you to collect it relatively quickly. This device has the advantage that in roadside testing you simply wipe it across the tongue or the mouth and, in theory, you get an indication within a few minutes. I am not being derogatory to the company when I say 'in theory' because the devices have not yet been proved by independent testing. We are in the hands of the manufacturers; that is why we are testing them ourselves.

I want to make the point that it does not really matter whether they work because you take it to the laboratory and it gives you 100 per cent accuracy for a relatively low cost. If you set up your arrangements with your laboratory, you can get the results pretty quickly. You could get a general deterrence effect using saliva testing. Why I make that point is that people say, 'No, there are technological disadvantages.' Yes, there are if you want the perfect system—like random breath testing—but we do not have to wait for that. I think I have run out of time.

CHAIR—No, you can keep going if you have more to say.

Dr Swann—I just wanted to say that the device that we have bought and are using with the police at the moment in our trials is RapiScan. We have chosen this device because they have claimed 100 per cent improvement in the THC accuracy: the device actually can give you quantitative readings at the roadside and the device is available. It has been used in Britain; more than 5,000 tests have been done with the police. It has a disadvantage in that they are using it there to identify at an early stage whether those people who are alleged to have committed a criminal offence have a drug problem, because then they are separating the treatment options. They have now extended the use of that device.

They have a very detailed protocol. They require you to actually sit there for 10 minutes because your mouth refreshes its saliva every 10 minutes. They want to make absolutely sure that there is no mouth contamination. Then they calibrate it negatively and calibrate it positively, and then they finally do the taking of the saliva. The average person's mouth gives 0.6 millilitres of saliva every minute. It requires one millilitre of saliva, and it is then diluted. It takes about a minute and a half for the average person to give a saliva sample, but these people take 30 minutes in a custody suite to do it because they are using it, essentially, as an evidentiary standard device, even though it is not that accurate.

We have proposed that you could use it at the roadside; you could put it through the window of a car. It would be a political decision whether holding someone up for one and a half minutes to take the sample, on average, and then sending it to a lab to get a 100 per cent accurate result is acceptable or whether, in fact, you would then want to delay them for another 10 minutes while you went through the process of negative-positive calibration and gave them a screening result on the roadside. These are all political issues. What I want to do, though, is make the point that it is not technology that is holding these things up, it is political decisions and cost-effectiveness decisions.

CHAIR—Thank you very much for such a comprehensive presentation. Could I ask if it might be okay if you passed those items around for the committee to have a look at?

Dr Swann—Yes. I will try to open that one up so you can see it. You just wipe that part across your mouth, or under your armpit for sweat.

CHAIR—Would it be possible for the committee to have a copy of your presentation slides?

Dr Swann—Yes.

CHAIR—Also, it appears that the committee does not have the document that you were quoting from.

Dr Swann—The Victorian Institute of Forensic Medicine, which has spent 10 years doing this now, and Professor Drummer, who is the author of this document, would be able to provide you with the 10-year study. It ranks as an outstanding study in terms of what it has found. I would suggest that that would be the document that would be very relevant to your committee.

CHAIR—Thank you, Dr Swann. We will look to getting that and also perhaps having some discussion with the author.

Ms GEORGE—I must say we all found what Dr Swann said quite illuminating because I recall that Peter asked a question on one of our recent visits to Victoria about the issue of the impact of marijuana smoking on driving accident statistics. We were assured then—weren't we, Cameron?—

Mr CAMERON THOMPSON—Yes, we were.

Ms GEORGE—We are all smiling. We were assured that there was no impairment. This did not register with someone like me who has no particular scientific expertise but who would have thought that, if you spend the night smoking joints and then get into a car, it defies all logic to say there are no impairments. Do you know of any studies that have been done on the impact of methadone on driving? I have a number of families that tell me anecdotally that every time their children come back from the methadone clinic, they are more likely than not to have some form of accident driving into a car or having someone drive into them. Has there been any research done into methadone maintenance?

Dr Swann—Yes, there has. The same man who did the major study here on culpability rates has done papers on methadone and has looked at the accident risk of people who are on the methadone program. I am not familiar with, and I would not be confident enough to put into evidence, what those conclusions are, but I would recommend that he be contacted specifically on that issue.

Mr CAMERON THOMPSON—You said that, in the UK, they were using COZART on crime scenes. Sorry to go off into the next segment already, but can it check out other things? Will it give you evidence of heroin in the system? Will it give you evidence of all drugs?

Dr Swann—Yes, it has five panels. I have just picked the two illicit drugs, methamphetamine and THC, but in fact it has got a deamphetamine and it has cross-reactivity with a range of stimulants. All of these devices are immunoassay based and, therefore, they can only be used as a screen, because you do get cross-reactivity with similar compounds. They really are a generic screen. That is their strength in one way—they are not totally specific—but it is also their weakness if you are trying to find fault with the device, because you really need then to go to a laboratory. The strength of the COZART device is that it gives you enough saliva to divide into three: to give one to the person who is being tested, to give one part to test with the device and then to send one part off as an evidentiary standard to the laboratory. The answer is that nearly all the devices are trying to get the five-panel test, which is generic. It is for the opioids, the benzos, the cannabinoids—they cover the whole range of impairment drugs that are important.

Mr CAMERON THOMPSON—Can we get from you the name of the person who did those studies about culpability?

Dr Swann—It is Professor Olaf Drummer.

CHAIR—Good. We will have Professor Drummer come in to the committee.

Mr WAKELIN—Can I take it that a THC level above five was associated with more road deaths than alcohol on a percentage basis?

Dr Swann—No. The figure I gave in my evidence was for THC overall in Victoria in the year that we did the detailed analysis. Roughly, in the last three years, it has been about 12 per cent. But, in terms of greater than 5 nanogram, it was 7.8 per cent. Illegal alcohol, in the same year, would have been about 22 per cent.

Mr WAKELIN—In view of the testing processes and the fact that a number of people—I do not know of any better way of putting this—die some period after 40 minutes to an hour, we just could not be confident that we have an accurate analysis at this point on THC levels in terms of the totality of the road fatalities, could we?

Dr Swann—I would be confident because, although they only report to 1 nanogram, with the GC-MS that they are using, they can get slightly below that. The problem with the THC is that there is very rapid decay. It falls off very quickly.

Mr WAKELIN—Forty minutes to an hour.

Dr Swann—For 40 minutes to an hour, it is detectable by saliva devices. By GC-MS, it is detectable for much longer, for several hours or even days.

Mr WAKELIN—I have to absorb some of this in greater detail and over a longer period. I just want to be reassured that we are getting the appropriate measurement on marijuana impact on road fatalities. Therefore, I want to be reassured that, with the whole process of testing and getting to the sum total of some presumption at the end of the day, we are there now in terms of accurate summation—that is, testing within the 40 minutes to one hour and subsequent blood testing at some later period. I want to be reassured that we have the accurate data there now.

Dr Swann—I can assure you that we have an evidentiary standard, which Mr King referred to, a behavioural testing regime for drugs. The window in which you are liable is three hours, and that is based on THC. Mr King referred to the Victorian system as being very complex, and it is. To actually get charged, you have to satisfy four tests. The last test is that the drug that is detected in your blood has to have the same impairment characteristics as you have shown in the behavioural impairment tests. So my answer to you is, yes, we have an evidentiary standard system that has a window for three hours, and it is based on THC.

Mr WAKELIN—Is that for 99 per cent of the fatal accidents?

Dr Swann—No. Our behavioural one is where the police—if they have reasonable cause—can stop a driver and test them behaviourally. Mr King is right in saying that it is complex, because you have—

Mr WAKELIN—Which, of course, is quite different from a fatal accident.

Dr Swann—Yes, quite different.

Mr WAKELIN—Therefore, we are a way away from—

Dr Swann—But, in fatal accidents, you can use the same analysis system. If you stick with THC, you are on the right track.

Mr CAMERON THOMPSON—Relating to that, is that figure about dead drivers?

Dr Swann—That is only about dead drivers.

Mr CAMERON THOMPSON—So it does not take into account where the driver might have hit someone because they were influenced?

Dr Swann—No, and that was the point of my reference to the truck situation. There are very few dead truck drivers. About 20 per cent of the road toll is due to heavy vehicles.

Mr CAMERON THOMPSON—So that would be a conservative figure.

Mr King—Yes, of the overall injury.

Dr Swann—That represents the number that are killed and test positive. Most studies throughout the world and the literature show that about 20 to 30 per cent of the people in the morgue are innocent victims. The exception is with heavy vehicle accidents. The figures in Victoria show that roughly seven to eight people die for every truck driver who is killed. In terms of culpabilities, you have to look at who was responsible for the accident and we do know that, where we have looked at culpabilities with stimulants in truck drivers, they are invariably responsible for the accident.

Mr EDWARDS—The figure of 20 per cent of deaths associated with trucks is quite frightening. What is the breakdown between country and cities?

Dr Swann—I would have to look that up.

Mr EDWARDS—Would it be possible to have that question taken on notice.

Mrs IRWIN—That was very interesting. How many times have we been on a country road and seen a truck doing 20 or 30 kilometres an hour over the limit. We all say to ourselves, 'My God, where are the police?' You are virtually saying that we should shift that debate to THC. Twenty-three per cent of truck drivers have proved positive to stimulants, and that makes up 20 per cent of the road toll. Are you virtually saying that you would like to see recommendations made by this committee that the states and territories introduce random breath testing?

Mr WAKELIN—Saliva testing.

Mrs IRWIN—We have random testing for alcohol, but you would like to see this incorporated as well?

Dr Swann—Definitely. It appears to me that if you equipped the police task forces with those saliva testing devices and said, 'We want you to test trucks doing interstate trips on the highway,' the impact would be enormous for a very low cost.

Mr WAKELIN—Moving the debate forward: certainly we have the capacity; there is no blockage.

Dr Swann—There is no stopping it at all. With the COZART device you would be stopping the truck for perhaps three or four minutes, on average. The sample would immediately be taken to a laboratory and analysed by GC-MS with 100 per cent accuracy and you would know what the stimulant drug is. If you then had an effective deterrent—I personally believe in a vehicle sanction—if you stopped a truck for 24 hours, you would wipe out the culture of drug-taking.

Mrs IRWIN—Say you go to a weighbridge—which a lot of the truck drivers do; they could most probably do the test when they are having their truck weighted—how long does it take to get the results back? I think you mentioned some time ago that it was about 1½ minutes.

Dr Swann—No, it takes 1½ minutes to take a saliva sample. What I am saying is that you can have a screening device that will give you a reasonable degree of accuracy within 10 minutes at the roadside. You would not ever have a sanction associated with that; you would take the sample to the laboratory and you could have the result within 24 hours. The VIFM, the lab in Victoria, aims for a 24-hour turnaround. It has a seven-day turnaround with our behavioural testing program. Why I think this is so achievable—from a road safety point of view, not from a political point of view—is that the drug use is occupationally driven. They are not addicts; they are doing it for financial reasons.

Mrs IRWIN—That is right; you are correct.

Mr DUTTON—To follow on from that question, when you talk about the evidentiary value of these tests, is it the case at the moment that with the random breath testing devices the police use on the roadside they do not actually carry any evidentiary value in court? The test is taken when the driver is taken back to the police station or wherever the case may be. In Queensland—and Mr King would know better than I do—I think their licence is suspended for 24 hours and their car is parked on the side of the road. When you say that there cannot be any sanction for using the saliva device, couldn't a similar system operate so that if there was a positive saliva swab that came back the driver could be made to park the vehicle or whatever the case may be for 24 hours and then a test would be taken?

Dr Swann—Certainly. I was pre-empting my answer in trying to get a system in that will have as little kickback as possible, because the moment you introduce a sanction based on a non-evidentiary standard device, taking your analogy of if it was proven to be one of the rare false positives or negatives, you would immediately be in a civil situation with prosecutions and all sorts of things.

Mr DUTTON—Conversely, you would be in the same legal situation if you allowed that person to drive and subsequently the test came back positive if that person was involved in an accident—for argument's sake—when they left that scene.

Dr Swann—That is a concern, but at the moment if you have just taken a huge amount of whisky and you have a rising BAC you can test just on the limit and drive down the road and in a matter of minutes be involved in an accident. If you were not killed, and if within the three-hour window they came and did the test, it would show a positive result. So there are situations

and scenarios. The problem is that systems will not move forward and do anything until the rare exception—one in 10,000—is solved. The system I am putting forward does not have that one in 10,000.

Mr EDWARDS—I am just a bit concerned about the way you are heading with a focus on detection. I think if you are going to address the trucking industry you need to address the whole industry. The point was made to us yesterday—and I am not sure yet whether it was tongue-in-cheek—that you may well take the stimulants away from the truck drivers and end up causing more crashes from people going to sleep. That is the point that I am making. It seems to me that if you are going to address the horrific statistic that you have given us then you need to address the whole industry, including the unrealistic demands that are being put on owner-drivers in particular to meet unrealistic deadlines. I just think that, if you are going to address drug abuse in the trucking industry, the whole industry needs to be addressed. If we are going to look at it as a committee, I hope that we will look at those things as well. The other thing I would like to know is: with those crashes involving trucks, is there any statistic you could give us as to whether a crash was caused by a truck driver or by the other person involved in the crash. I am also interested in the breakdown between country and city.

Dr Swann—Basically, the culpability studies that have been done with truck drivers show that in the vast majority of cases the truck driver was highly culpable. There are culpability studies showing differences between trucks and vulnerable road users such as pedestrians or cars, but you have to look at how the study was done. There is one study that the trucking industry quotes, but I think it was done by researchers asking the truck driver who was at fault, and you will not get the right answer.

Mr EDWARDS—Mr King, we have recently had a debate in Western Australia where a proposal was put to raise the speed limit from 110 kilometres per hour to 130 kilometres per hour in remote parts of the far north of the state. Are you aware of the debate and would you have a view on such a move, whether it be in remote parts of Western Australia or remote parts of other regions within Australia?

Mr King—That would be ill-advised. There has been a debate in the speed area for many years—an argument that it is not absolute speed but relative speed which is important. If there is a difference between, for instance, heavy and light vehicles and the speeds that they are doing, the argument is that that is more important than the absolute speed that they are travelling in terms of crash risk. A recent study by the Road Accident Research Unit in South Australia looked at the relationship between crash risk and speed in rural areas, and it quite clearly shows an exponentially rising crash risk with absolute speed. It is a case control study—the sort of thing that established the crash risk and association with the .05 BAC limit.

Dr Swann—I had not finished one part of my answer. You made the point that yesterday you had a witness saying that, if you took away stimulant drugs, you would increase the number of crashes. Of course, that is a political decision; I agree with you. One of the areas that I have been looking at over the last 10 years is microsleeps in truck drivers. Because truck drivers reject the academic studies that show that young drivers have microsleeps, in cooperation with the TWU we have put truck drivers into the sleep laboratory at the Austin Hospital. We measured their microsleeps in three ways. We put them on a driving simulator. We found that truck drivers continue to drive when the microsleeps get up to 50 seconds in total per hour. Drivers are get-

ting the eight key symptoms that we advertise as being the signs for when they should take a break and have a nap or a power nap, which is a non-drug alternative. Fifty seconds an hour is quite frightening in terms of being road user.

To answer your question, if there is a political decision made that nothing will happen because if you take away the stimulant drug use you will increase the crashes, and the committee will do nothing until it looks at that, can I make a plea that the committee look at safer drugs. There are a whole range of new drugs, such as modafinil, that are promoted on the basis that they do not destroy sleep architecture and do not have the addictive effects of the stimulants. They should be looked at. I personally do not support that approach, but if there is an approach that drivers are allowed to do this to meet the economic imperatives then let us put them on safer drugs.

Mr EDWARDS—Would you be adverse to a whole-of-industry approach to this?

Dr Swann—Your whole-of-industry approach is the way to go, but it is a very slow approach.

Mr QUICK—Evidence given to the House of Commons inquiry into basically the same thing that we are looking at said:

... cannabis led to "increased risk for new users or new drivers, for established users/drivers [it] appears to reduce accident risk by improving driver behaviour (slower speeds, larger gap, fewer risky manoeuvres)".

Is there any evidence to support that?

Dr Swann—Addressing that concern was the point I put up before. I will go back to it if you do not mind. The video shows the levels that are given in academic studies. One of the partnerships we have is with Swinburne University of Technology where we are giving THC to students. One of the huge restraints we have is that the highest level that has been safely given in academia is about 300 micrograms per kilogram of body weight. These are the sorts of levels that the academic studies are given. These are the levels that the people who get killed have. At these levels it is very much like saying, 'I'm going to study whether you are a safer driver with 0.01—one or two glasses of light beer.' If you regularly take high levels of alcohol, one or two beers will help you, but if you are taking 0.15 you will be grossly impaired. There is no doubt that, when you look at all the psychomotor skills and all the things that cannabis affects, one of the things that it does is slow you down. In very controlled academic driving studies on restricted open highways in Europe they have found that people do slow down, and speed is a key cause of accidents. So you could interpret that study as saying that they are safer, but my point is that they are very low doses. Also, in those very same studies they did not go ahead with urban driving because they decided it was too dangerous.

Mr QUICK—In all the evidence we have taken not only on this but also on other issues related to health there has been the silo rail gauge mentality of each state doing its own thing. With this evidence, why can't we get a national approach? Is it bloody-mindedness on the part of the states which have their own territorial transport departments and road safety departments? Mr King said that they have alcohol ignition interlocks, and they might be the first state to do that. Victoria has a wonderful reputation for 0.05 and seatbelts—it has led the way with those

sorts of things—but how do we get a national approach? I come from Tasmania, which will probably be the last state to do so because it cannot afford it. The argument will be cost-effectiveness: how we are going to find the money to train the police officers, where we are going to get the additional vans, how we are going to purchase those wonderful little bags of goodies and so on. Would the recommendation be that we should have a national clearinghouse and that the Victorian Institute of Forensic Medicine should be the clearinghouse for all the papers and all the initiatives such as the indigenous health initiative which we set up with Edith Cowan University, where at least you can go and find out what is happening? How will we get a national approach rather than an ad hoc state approach?

Dr Swann—From a parochial point of view, last year Victoria passed interlock legislation and the program has started, but your questions raise a really powerful point. There are social and political issues. What has to be established is a clearinghouse that allows the sharing of information but does not control information or stop new initiatives.

Mr QUICK—I travelled from South Australia to Victoria. The speed limit is 110 kilometres an hour, but when you get near Bordertown it is down to 100. There is no level playing field. We are talking about interstate truck drivers. Would one of your recommendations be that whatever governing body talks to road safety ministers—there are probably many acronyms that cover the different agencies—somebody should bite the bullet at a COAG meeting and say that alcohol ignition locks will be in cars, as they are in America, by 2004, end of story, no discussion and no correspondence will be entered into? Will there be a definite cost benefit to Australian society if we do that?

Mr King—It is not as if states are just going their own way; there is an attempt to try to coordinate them. Is the committee familiar with Austroads?

CHAIR—Yes.

Mr King—Austroads has had a road safety program for a number of years. It commissions various studies. In the ignition interlock area, for instance, they commissioned a couple of reports. One was to look at a recommendation for a national way of approaching interlocks, acknowledging that each state had its own legal framework that it had to fit into. But it was an attempt to do it. In drug-driving, we have the Austroads Drug-Driving Working Group. Again, that is an attempt to make sure that we keep some sort of consistency between the states. In terms of road rules, I first started working in road safety in 1980 and I was told that a change to the Victorian left turn-right turn rule was just around the corner. It took until three years ago, which was a 19-year period, for that to actually happen when there was the introduction of the Australian road rules. The Australian road rules have a lot of areas of commonality; there are areas that are different. They are being worked on, but it is a slow process.

In the area of heavy vehicles, there is the National Road Transport Commission in particular that has done a lot of work to try to get rid of those state issues. They do not go away. The issue of fatigue with truck drivers was mentioned earlier. There are three national programs going on to try to get some coordination. One of them is a fatigue management program, which is being managed by Queensland Transport. The main partners in that are Victoria, New South Wales and Queensland. As part of that, there has been the introduction of chain of responsibility legislation which means that the freight forwarders who put pressure on drivers to meet unrealistic

deadlines, which they can only meet by violating road laws and taking drugs, are now liable. Prosecutions have taken place under that. So there is a bit of divergence among the states, but there are genuine attempts to try to avoid that.

With respect to being able to introduce something uniformly such as ignition interlocks, the issue often comes down to not so much how seriously a particular state government views the issue but other local considerations. If you look at the fines and licence suspension periods that apply in different places, in a high-income state such as New South Wales there tend to be higher fines than in a lower income state such as Queensland. In Queensland a lot of attention is paid to regional issues and the need for people to continue to have a licence whereas in a more urbanised state, where there are fewer distances to travel, there is much more willingness to take people's licences away. Those sorts of differences make it difficult to get national consistency.

Dr Swann—Road safety invariably costs money or costs civil liberties. The people in Treasury or Justice tend to be against road safety for very good reasons—because it costs money or reduces people's civil liberties—irrespective of the road reduction benefits. Therefore, I would oppose having a bureaucratic system of control, because the gains are always made by states actually doing something. It has been my experience that what results from national approaches is the recommendation for more studies and research.

Mr DUTTON—It seems to me that Mr Quick is indicating some sort of abolition of the state governments—of his counterparts there. My question is to Mr King. As a Queenslander, the evidence that we have received from Dr Swann this morning came as some surprise, certainly from my perspective, because the debate has been raging in Queensland in recent months about drug testing for drivers. My understanding of the debate that has occurred in Queensland is that the facilities or the technology were not available for the drug testing. Are you surprised by the evidence that Dr Swann has provided this morning? If not, why has the Queensland state government not moved down the track that Dr Swann thinks is more than feasible?

Mr King—I was not aware of the most recent five-year data. I believe it has not been published yet.

Dr Swann—It was released in Prague at the International Association of Forensic Toxicology and in publications by the Victorian Institute of Forensic Medicine, but the basic reports have been submitted for journal publication, so you would not be aware of them.

Mr King—Okay. There has been quite a debate. There is actually a strong link between what the Austroads Drug-Driving Working Group has recommended and what Travelsafe has recommended and Queensland is putting into place. One of the things worth mentioning on the technology side is the COZART RapiScan. There are in the vicinity of 30 different devices around. There is the European community project called ROSITA—I am not sure what the acronym stands for—focused on roadside-testing devices such as the COZART RapiScan. We are in contact with them and we contacted them again in July to ask them whether they were aware of the latest claims about the COZART RapiScan, and the people involved were very sceptical about it. Similarly, we have been in touch with people in the UK, once again in July, as we had heard that they were planning to involve the COZART RapiScan in a lot of their road traffic activities and to give it a legal status. Once again, that proved not to be correct.

One of the problems that we have here is that a lot of information that is being disseminated about the devices is coming from the company itself. I think Dr Swann mentioned that many of the research studies put forward to show the accuracy have been conducted by people who are associated with the company itself, so finding some independent assessment of the value is difficult. Another point that I should mention while this slide is up is that, if you look at the bottom line, as Dr Swann mentioned, the levels of THC at which various skills related to driving shows some impairment. I have been involved in laboratory studies looking at the impact of alcohol on various skills like that. The fact of the matter is that you can tailor your results. For instance, if you look at tracking, the first skill on the left in the slide—tracking is some sort of lab test of how well you track a needle or do something on the screen—you can set the difficulty of those sorts of tests so that they will show an effect at almost whatever level you like.

This became an issue when we first looked at the drunk-driving warning system, a sort of interlock, many years ago. The US government had loaned us a piece of equipment which was very sensitive at a 0.10 level, not at 0.05—there were others that were sensitive at 0.05. So you need to take into account that we do not know for sure, for any one of those particular skills, how much a laboratory test relates to how well you are driving on the road and, further, how that relates to your crash risk. Knowing that a particular level of a drug has an impact on a particular test in the lab does not tell you very much about driving and it does not tell you very much about your crashes.

The other point that should be mentioned is the legislative one. Mr Dutton, you asked a question before about the suspension of people for 24 hours. The way that that happens with alcohol is that we use a screening device and that screening device, if somebody is over 0.05, leads to them going to an evidentiary device. The evidentiary device may be at the police station or, if it is a random breath testing device, it may be there at the site. If people are over the limit on that, then their licence is suspended for 24 hours. The only basis for that is that, by failing on the evidentiary device, they have committed an offence. That is without doubt. The problem with doing this at the roadside with something like the COZART RapiScan is that it is only a screening device. It is not the actual evidentiary test. The evidentiary test will take 24 hours through the lab. From a legal point of view, you have to have some good rationale for suspending somebody for an offence that is not yet proven. That relies on how accurate this device is, and there are questions still about that.

The other issue arises if you, for instance, take a fatal crash and you find that somebody has had greater than five nanograms per millilitre of THC present and you find that they were responsible for the crash. Was it a drug-driving crash? At the moment we can say, 'Maybe yes and maybe no.' Another issue to remember here is that the group of people who are more likely to be using cannabis and driving are not going to be the same as the average road user. Are there other characteristics which have contributed to that crash risk? If we had enshrined in legislation a cut-off limit that said that if you are above five nanograms per millilitre of THC then you have committed an offence and it is a drug-driving offence, it would be the same as with alcohol, and we could do that. At the moment we cannot really do that. If you find somebody in a crash with that amount, it is still an open question. I referred to this earlier when I was asked a question about speed. The basis for 0.05 in our legislation is case control studies which show the level of risk of crash rising with an increase in blood alcohol concentration. The way that was done was to take a series of crashes that had occurred where blood samples were taken and then to go

back to the same places and times and pull over drivers as they were driving past. That gave you a base line. From that you can determine, given that this many people were driving around with these levels of BAC but this many people were involved in crashes, a rapidly rising crash risk with BAC. With drugs we do not have that, and maybe developments with the COZART or something similar will help, but unless we can get a good roadside device which can actually tell us how many people are driving around over a certain amount of a drug we will not get that. Unless we have that sort of a solid basis to say that there is this increasing risk with crashes, it is very difficult to justify passing legislation and introducing enforcement.

I realise this is rather a lengthy answer, but these are the sorts of things that we have been thinking about in Queensland, the sorts of reasons why we are not convinced by the technology that is around. I should note that technology of this kind has been around in various forms for more than 20 years, but it has never been of a satisfactory enough level to justify adopting it. Secondly, we would only go this further step if we were convinced that there was a good solid road safety basis on which laws could be passed.

Mr DUTTON—I appreciate your response. If I could quickly follow up, which ties back into some of Dr Swann's advice before: if one of the devices that Dr Swann has presented to us this morning, or something similar, was proven with some sort of independent study to be reliable, not to the evidentiary point but, as Dr Swann says, to a reasonable standard, would you put the recommendation forward to support random saliva testing by police in Queensland similar to that which Dr Swann has spoken about this morning?

Mr King—There are two questions there. Reliability just means that the device provides an accurate measure of the THC in the blood. I have no doubt that we will eventually reach that point.

Mr DUTTON—But, as Dr Swann alluded to, isn't it a deterrent factor as much as anything in the meantime?

Mr King—Yes, but it is a deterrent factor because of the follow-up. If you are pulled over and your saliva is tested and you are over a certain level, it only has some sort of deterrent force if that is an illegal level. For that to be an illegal level, we have to have genuine certainty that there is a road crash risk associated with it. The culpability analyses go some way towards that but they do not go far enough at this stage. I think there are other factors that need to be eliminated. Again, I come back to the issue of whether the group of drug-drivers that we find are different in other ways. For example, are they people who tend to ignore the law in any case?

Mr DUTTON—I am not sure of the response. Despite the fact that it is not up to court standard at this stage, bearing in mind Dr Swann's comments this morning would you support the introduction of random saliva testing by police in Queensland? The end result of that would, I suppose, be deterrence. If you are looking for evidentiary standard then, as Dr Swann has advised us, the saliva sample could be sent away for laboratory testing.

Mr King—I would support it if there were a legislative basis for saying that if you had more than a certain level you were committing an offence, which we do not have now. We would need to get that in place. At the moment we base offences on demonstrated behavioural

impairment rather than on an amount. So, yes, I would support it, but we would need to have legislation that made a particular amount an offence.

Mr DUTTON—So we just need the political will in Queensland.

Mr CAMERON THOMPSON—I want to change the subject altogether. Mr King, a minute ago you were talking about drink-driving or something and you said that there were differences—that in country areas you would sometimes allow people to keep a licence and in other areas you would not. I think that is roughly what you said. There has recently been concern about the level of suicide in rural areas. Quite a lot has been said about that. Anyone can see that loneliness, alcoholism and things happening in a remote setting are factors. Traditionally, people have often sought to overcome that through the support and counselling of their friends, who they encounter in the town. However, we have a very strong regime against drink-driving and, as you know, in Queensland we have mandatory detention in relation to drink-driving. I am concerned about the ramifications of those kinds of harsh penalties that isolate people from their town community by locking them into lonely, isolated situations and not allowing them to seek the counsel and support of their friends. Has that been considered at all? Do you think that might result in further impacts such as increasing suicide rates?

Mr King—Yes, that is a particular problem anywhere in rural areas. Loss of a licence is very significant. One of the things that has been discussed in relation to alcohol ignition interlocks is that, if someone is caught for drink-driving, one alternative might be to allow them to drive with no licence suspension period but with an alcohol ignition interlock. I should say that this has not been seriously proposed in Queensland and there are questions about it because the most effective deterrent to drink-driving is actually the loss of licence, but it is certainly something that could be an option to avoid this isolation.

Mr CAMERON THOMPSON—But in this case, if you have been caught twice the third time you would go to jail, wouldn't you?

Mr King—That is the magistrate's decision. You could go to jail, but that is not necessarily the case.

Mr CAMERON THOMPSON—It is mandatory in Queensland.

Mr DUTTON—If you are caught over 0.15 three times, you go to jail.

Mr King—My understanding is that after three times you can go to jail. The alternative is a large fine; another alternative is that you can be put on a probation order, which will avoid jail. The act under which all of these fall is still subject to the Queensland Penalties and Sentences Act 1992. There are many cases in which the magistrate will have recourse to the Penalties and Sentences Act to impose a bond or probation order rather than proceeding to the penalties set out.

Mr WAKELIN—Dr Swann, you mentioned all those financial costs in road safety. Where would you focus additional resources in road safety if you had them available to you? What would be one or two of your priorities? Is there a possibility of redirecting resources away from

other priorities? If additional finance and additional resources were available, where would you put them?

Dr Swann—As a community we are spending millions of dollars on alcohol. While it is quite right that alcohol is the major problem, when you are looking for balance and at what is being spent on combating the sorts of problems we are looking at with drugs, particularly when we look at the paybacks for the truck drivers—20 per cent of the road toll could be significantly reduced overnight if there were a significant financial deterrent—I think there are huge gains. We really did not make any progress during the 1990s, yet we are doing millions of alcohol tests. So I would be putting resources into drug counter-measures.

As to the whole debate about requiring evidence to introduce legislation, we are talking about two illicit drugs. The drugs are illicit now, and I think that changes the whole complexity of the issue. It is not as if we are saying that we are now going to change your whole perception about a legal drug. We are talking about drugs that are illicit.

Mr WAKELIN—Exactly right. Do you know of any inconsistencies in RBTs across the states? We have had some evidence of totally different methodologies used across the states. Do you know of anything that shows evidence of greater or lesser effectiveness, without getting too much into a states debate?

Dr Swann—It has been pretty much acknowledged for quite a long time that it is hard. What really worked in the 1980s when we introduced it was the perception of being caught, the highly visible policing: the big, highly visible booze bus, all the police on the road in their uniforms and the blue lights flashing. That worked well in urban areas where you had heaps of cars going past the booze buses. But, when we tried to apply that in the country, as soon as the booze bus went up the Hume Highway through every town, it proved that the country network was excellent, and that is not surprising.

Mr WAKELIN—Have many more of our people died because it was not quite as effective?

Dr Swann—I do not know the answer to that.

Ms GEORGE—Dr Swann, could you give me some understanding of how much marijuana would need to have been smoked to produce the kind of THC above five nanograms? Could you describe the amount in a layperson's language?

Dr Swann—My plea was to get the debate focusing on THC, and that is great. The problem with THC is that it is both hydrophobic and very hydrophilic. Once you take it into your body, it goes into your fat and then gets released slowly. So when you take THC—whether you take it in the form of cookies or cigarettes or as a spray for under your tongue like it is medicinally dispensed now—you quickly get a very high peak in the blood. We have measured peaks as high as 70 or 80 nanograms, but it very quickly comes back down and starts to stabilise. The 600 psychomotor tests are all looking at after that peak has gone, so it is a very difficult thing for me to give you an answer, because, if you were smoking a potent THC joint now and we had a cannula in your arm, we would see very high levels. But your impairment actually comes slightly later, so there is a lag in the blood plasma. That is why I made the point before that we would ideally like to measure it in your brain.

There is another problem. I have never taken it and just a little bit would send me off my face, like alcohol used to before I got used to it. Every psychoactive drug is the same: the first few times you take it—

Ms GEORGE—I guess I was trying to get at: can you get that impact after smoking one joint or would it require you to have been smoking five or six, or who knows?

Dr Swann—No. The joints we use in the experiments at Swinburne vary between zero per cent and three per cent THC. We put the people on driving simulators, and they test well into the range up above five nanograms of the THC in their blood.

CHAIR—After how many joints?

Ms GEORGE—Up to three, did you say?

Dr Swann—No, it is a three per cent joint and they only take it for a maximum of eight inhalations. They do not even use the whole joint. But the thing about THC is that it goes relatively quickly compared to alcohol. There are some excellent studies showing THC and alcohol relationships. For instance, even at the very low academic levels that the academics use, it is now recognised that if your alcohol level is 0.04 per cent—which is quite legal—and you have one joint then your impairment is equivalent to a massive 0.14 per cent BAC alochol. To really be 0.14 per cent, I would have to have had 14 standard drinks and then it would take many hours for me to come back below 0.05 per cent, but with THC impairment it falls off much more quickly. Our road safety message is: 'Don't drive after recent use of cannabis.' It is about very recent use.

But the tragedy is—and I want to make this one point—that people do not know that. When we do surveys and we ask females at the university, 'Would you hop in the car with your boyfriend if he was drunk?' They say, 'I certainly wouldn't.' Then you say, 'What if he was smoking a joint?' 'Not a problem.'

Mr CAMERON THOMPSON—In relation to the machine and the saliva tests, can anything be confused for those drugs? We have heard about pseudoephedrine and its relationship with amphetamines.

Dr Swann—You get cross-reactivity within generic groups. That is why you must always use the lab GC-MS. Can I just say that we will never get to a point of implementing anything if we wait for independent academic studies. The Rossiter studies were done in 1999. It is now 2002 and they have not started the next generation. I think they used two or three samples for the COZART evaluation. That is why I am saying: 'Don't let that debate cloud what we should be doing.' We will get huge general deterrents if we say, 'Hey, if you get caught by a laboratory test, there will be a penalty.'

Mr CAMERON THOMPSON—But it cannot be confused—

Dr Swann—The GC-MS cannot be confused. That is why I have cautioned all along about focusing on the screening devices. Every day there will be a new manufacturer bringing one out and saying it is brilliant. We do not know if any of them are, but we do know that there are lots

of ways of collecting saliva. If you take it to a lab, it is 100 per cent accurate and you can go on that.

CHAIR—I would like to thank both presenters this morning—both Mr King and Dr Swann.

Proceedings suspended from 10.15 a.m. to 10.36 a.m.

GRAYCAR, Dr Adam, Director, Australian Institute of Criminology

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

McDEVITT, Mr Ben, General Manager, AFP National Operations, Australian Federal Police

CHAIR—Session 5 of the roundtable deals with crime, violence and law enforcement. We have with us this morning Dr Adam Graycar and Mr Ben McDevitt, and Dr Toni Makkai will assist Dr Graycar with any questions that he might like to refer to her during the question and answer segment. I also 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 parliament.

We will deal with this session on crime, violence and law enforcement in three sections. The first part of this session will cover the prevalence and cost of drug abuse in relation to crime, controlling the supply of illicit drugs and options for dealing with illicit drug crimes. I welcome to the first section of this session on crime, violence and law enforcement Dr Adam Graycar, Mr Ben McDevitt and, as I said, Dr Graycar will and can refer to Dr Toni Makkai for any questions that he feels are appropriate for her to answer. I ask Dr Graycar to start the session for us.

Dr Graycar—Thank you very much for inviting us here today. What we want to talk about today is a project at the Australian Institute of Criminology known as the DUMA project, which stands for 'drug use monitoring in Australia'. In this project we hope to be able to outline some of the relationships between illicit drug use and criminal behaviour. It is a complex area. What we hope to do with all of this is provide good data that will assist policy makers and legislators in being able to understand the complexity of the issues and sort out some practical solutions. I am going to run through a series of slides. I have about 20 slides in my 10 minutes, so cut me off when the time comes and we can talk a bit more in the discussion.

Overhead transparencies were then shown—

By and large I often say there are only really two stories in crime prevention. The first one is how to reduce the supply of motivated offenders and the second is how to make crime harder to commit. To deal with these two things, both drug law enforcement and other harm minimisation interventions have a very significant role to play. If these are our objectives both in crime reduction and in reduction of drug use, how do you make sure there are fewer people who want to do the wrong thing? This is a personal intervention. There are some criminal justice and harm minimisation issues there. The second one is how do you make it harder to do. There are a whole lot of what we call situational crime prevention issues there.

As we are starting to deal with it, essentially, from a policy perspective, there are four different groups that we want to start working with: there are people who possess and use drugs; there are others who sell, produce and traffic drugs; there are those who use drugs and commit crime, and they are the ones that we are going to focus on most; and there are those who commit crime and, in an unrelated fashion, use drugs as well. Each of these has a different policy

response. In the written paper that I submitted to the committee, I have outlined in a bit more detail some of the issues in relation to each of these.

As we are focusing largely on the third one and largely on issues of drug law enforcement, the strategies that we are looking at include issues in relation to deterrents, issues in relation to drug market disruption to disrupt both the supply side and the demand side—and Ben McDevitt is going to talk about these issues—and issues in relation to treatment, particularly coerced treatment, which is the outcome of some of the decisions of drug courts and so on. We thought that Dr Don Weatherburn would end up answering questions or talking about some of the treatment options. It is not an area that I know very much about, and my colleague Dr Toni Makkai, Director of Research at the Australian Institute of Criminology, might be able to assist in discussing some of these issues. While I am mentioning Dr Makkai, the DUMA project is a project that she worked on. While it is linked internationally, she is the one who got it going and put all the rigour into it, and she got some exceptionally good results.

Before I give you some of the results, I will just quickly give you a description of what this project does, because it is a significant project. From a policy point of view, we tried to collect illicit drug prevalence data on all offenders. Our population group, the sample group we have, are offenders. They are people who have been detained by police. Our hypothesis is that the drug use of people detained by police is a very accurate reflection of the drugs that are on the street. We opened the project to improve the quality of data available on illicit drug use in the offender population, to provide early warning systems for changes in patterns of illicit drug use—and we get data back to police in a very timely fashion—and to provide aggregate data.

The long-term goals of the project are to build up trend data over a period of time that will enable law enforcement to determine the changes in patterns of use. I will show you some graphs in a moment that show some quite significant changes at particular periods of time. Other long-term goals are to identify the structures and operations of illicit drug markets, to build in evaluations of local law enforcement initiatives—I just cannot express too strongly the importance of evaluation so that we know what works and what does not, and what is promising and what is not, so that we are not barking up the wrong tree—and to build up a knowledge base of offender decision making processes. We have some interesting data on that.

We collect our data pretty well from around the country. We have just started in South Australia. We have expanded a Queensland site. We are not in Victoria. I do not know whether we have any Victorian members here; we have been in discussion with the Victorian government, but we have not been able to start anything there. As you can see, we are around the country, and in our study we collect two types of data. We collect survey data, which includes associated demographics, arrest and offending indicators, a whole lot of drug and drug market indicators, a whole lot of characteristics of clients' comments and so on. The second type of data we collect is from urine analyses, which is very interesting. At the very beginning we tested urine for the drugs that are listed on this transparency—cannabis, opiates, methadone, amphetamines, benzos and cocaine—and then we did some confirmatory tests on other drugs. We do not do alcohol, and I am always asked why do we not do alcohol. It is too complex. Alcohol is another story and it comes up in the survey.

An American study called the ADAM project, the Arrestee Drug Abuse Monitoring project, has been collecting data for many years in the United States. When my counterpart in the

United States asked whether we would do it Australia, I said, 'What, and get people to pee in a bottle? You have to be joking! Nobody is going to do it.' We ask people whether they will do a survey and 70 per cent to 75 per cent of those who do a survey do give a urine sample. We make sure we give all arrestees and detainees a signed letter from the police commissioner in the jurisdiction, and cosigned by me, saying that the samples will be destroyed, that there is no way they can be traced back to the person, that they are purely for research purposes.

Of the people that we tested during 2001—as you can see there, we did 1,411 cases—we have now built up a database. Dr Makkai will tell me soon exactly how many we have had over the three years since we have been doing it. We are building up a pretty large database—there are 7,053 records on the database, including 5,218 urine samples. As you can see from the associated demographic profile—and I will leave these slides with you later—by and large the people have low educational attainment, many of them are on benefits, and many of them have significant criminal careers. So when we start to look at the associated demographics very often these are not surprising when you look at the prison population and the population of offenders in our community.

When we look at their particular drug market activity, in the first column there we find that about 40 per cent of them have sold drugs and about 30 per cent of the women have sold drugs. When we asked them whether they were seeking drugs at the time of their arrest, the numbers were much smaller—about 10 per cent were looking for drugs and almost half had been taking drugs at the time of their arrest.

I am just going to give you a quick snapshot of the data because I think we have already submitted a DUMA annual report, and there is a lot of material where we can cut the data a thousand different ways. This is what the report looks like. It is full of graphs and pictures by site and by offence—and if any members would like additional copies we would be very happy to supply them. Of all the violent offenders, about a quarter tested positive to amphetamines in the urine, about 57 per cent to cannabis and about 16 per cent to opiates. About 70 per cent of all violent offenders tested positive to any drug—that is, the drugs that we test in the urine sample. Of the people who had been detained by police for a violent offence, about 70 per cent tested positive to any drug, and they are the breakdowns—almost half to drugs excluding cannabis.

When we get to property offenders the pattern is quite different—and I will show you a graph in a moment that sums it all up. About three-quarters of property offenders tested positive, and we can break it down by site et cetera. Here we have almost a quarter of property offenders testing positive to opiates, which is a higher proportion than violent offenders, and about one-third with amphetamines.

I know you had a presentation earlier this morning on traffic offenders, and we have done some considerable work on traffic offenders and drug-driving. Although we have had a lot of programs on alcohol and traffic offences, about three-quarters of our traffic offenders tested positive to drugs, and this is the breakdown: a third of them to amphetamines, about 57 per cent to cannabis and about 15 per cent to opiates. We also see that there is a lot of multidrug use as well. This is what the picture looks like for these offences. The way to read the graph—this was in the table before—is that 16 per cent of violent offenders tested positive to opiates, 23 per cent of property offenders tested positive to opiates, 17 per cent of drug offenders and 15 per cent of

driving offenders. We see much a higher usage of amphetamines by offence as well. There are the numbers there: a quarter of violent offenders, a third of property offenders and 44 per cent of drug offenders. These are people who have been apprehended for burglaries, car thefts and whatever else, not just drug offenders. Again, as I said earlier, what we are trying to look at is the drug use on the streets for breaches and driving offences.

This driving one is certainly something that we have discussed with the road traffic authorities. We ran a roundtable seminar a couple of months ago and we had both police and road traffic people come and start talking about some very significant dangers on our roads with a third of these people who had been apprehended. If we look at people testing positive to opiates, we can break this down by site or by offence and do the graphs whichever way—the yellow that you cannot read says 'Adelaide'. We have only just started in Elizabeth in Adelaide and in Brisbane. You can see that opiate use has been higher in Parramatta and Bankstown and that these things are going back to the first quarter of 1999—so there is your time series going up till now. The line here is the heroin drought, and you can see that once the heroin drought came into effect it dropped very dramatically in Parramatta. It was on its way down, and it went down, and now opiate use is starting to go up again. We can try to estimate the use by different offence and so on.

This shows that drug markets are local markets. They are very different. If I go onto the next slide you will see cocaine, for example—and I will go back to the previous one shortly. Cocaine use rose when the heroin drought came into play and then it started to fall as heroin started to become more available. Going back to this one here on heroin, one of the questions we asked in the study was how easy it was for people to score. It was very different in different jurisdictions—and we have shared this information with the police. One of the questions was: are you apprehensive of police busting you? In some places they were saying they were and in others they were saying, 'No, it is not a problem at all.' This is information that we can share very positively with police in different jurisdictions. There is the cocaine story.

The amphetamine story is an interesting one. Amphetamine usage has been going up. In our Western Australian study, for example, there was one big jump there in one quarter when it went into a totally new phase. We think—and Ben may be able to comment—that most of it was locally produced, and the police were very interested in those findings. But rather than the ups and downs of the heroin activity, amphetamines have just been on a fairly steady up right around the country. Cannabis has been fairly high and to a very large extent is generally a lifestyle activity of much of this population group. Nevertheless, we see that it is running at around 60 per cent in most jurisdictions.

As well as being able to do it by jurisdiction and by offence, in our study we have done some addendum questions from time to time. It is not just the offences. We have asked people about how they perceive the heroin and the amphetamine markets, where the stolen goods go, whether they carry weapons, whether they drive while under the influence. Furthermore, we have within the questionnaire other interesting things like their gambling activities—that is a standard question; it is not an addendum question—and we talk to the jurisdictions continually about further information they may wish to have that we might add into an addendum.

To finish off, I just want to say, as I did when I started, that when we are dealing with different population groups—those who possess, those who use, those who commit crime et cetera—

by the same token there are different law enforcement approaches. They go from something as broad as border protection through to strategic intelligence systems, integrated street level enforcement, diversion schemes, drug courts and postrelease programs. All of these have a place in different ways. So it is important to make sure you understand very clearly the problem at stake, the population group you are dealing with and the appropriate level of law enforcement to deal with these issues, and provide an opportunity for law enforcement to act in a complementary way with other harm reduction activities, health interventions and so on.

CHAIR—Thank you, Dr Graycar. Mr McDevitt, would you like to present now?

A PowerPoint presentation was then made—

Mr McDevitt—On behalf of the Australian Federal Police I would like to thank you very much for the opportunity to appear before this very important committee. I have been asked to give a short presentation about controlling the supply of illicit drugs. From a policing viewpoint, I can probably bring two separate perspectives to that. One is from my current role as General Manager of National Operations for the Australian Federal Police. In that role I am responsible for the oversight of the work of the AFP's drug strike teams located around the country. Their primary focus is to intercept illicit drugs and to target criminal syndicates involved in the importation of illicit drugs into Australia, many of which are based offshore. That is one perspective. I have only been in this role for about five months and prior to that I was the commander of policing for the Australian Capital Territory. In that role I was involved at the street level—dealing with people with drug issues—and working very closely with Adam Graycar and the AIC in terms of research. One research project involved a profile of an average Canberran burglar and we found some very interesting statistics in relation to the predominant drug problems of people who were committing a range of offences to support drug addictions. So they are the two different perspectives that I can bring to the table.

I have a number of observations. With regard to controlling the supply, I have a short presentation which looks at the sources of illicit drugs, the trends in drug supply, the heroin shortage, control methods, the vexing question of performance data and performance measurement—and how we measure our effectiveness in terms of the quantities of drugs seized at the border and whether that is an effective measure of our performance—and some new initiatives by law enforcement. Then I will look at the future for us. In relation to sources, the illicit drugs consumed in Australia are both produced domestically and imported. Cannabis and methamphetamine are the principal Australian products. The methamphetamine is usually of an inferior quality to its imported equivalent. However, only very recently a facility for making high purity methamphetamine was detected in Queensland and there has been a surge in the numbers of clan labs that have been detected in this country in recent years.

Heroin, cocaine, MDMA and high-purity methamphetamine are imported. Heroin mainly comes from the Golden Triangle, where methamphetamine tablets are also produced. Our cocaine comes predominantly from South America, in particular Colombia. High-purity methamphetamines come in from China. A large percentage of the MDMA, or ecstasy, coming into this country is from Western Europe.

We are seeing a number of trends in drug supply. We are seeing an improved sophistication in crime groups. That is possibly a result of the tightening regime at the border and the opportunity

to conduct increased numbers of inspections and so on. So we are starting to see some very sophisticated concealment methodology being used. One recent example involved the criminal syndicate making moulds of extruded plastic, into which they packed the heroin. These moulds were then slipped into the struts underneath ship containers. That is technically quite a sophisticated method of concealment.

We are also seeing polydrug importations, with groups bringing in different types and quantities of drugs in one shipment. In one instance we had cannabis, cocaine, amphetamines and heroin all coming in in the one lot. That is different to what we used to see. We used to see in years gone by a focus on one particular drug to be brought in. People would tend to specialise—say, compressed cannabis resin might be their speciality. Now we are seeing people starting to become multiskilled. They are working in a market which really is motivated purely by profit. It is about supply and demand, and the type of drug will often change depending on that market if it is readily available. It extends to other crime types as well. We have seen people smugglers also involved in drug smuggling and so on. It comes back to the fact that we are dealing with opportunists who will conduct whatever criminal activity happens to be the best in terms of profit at a particular point in time.

I think the heroin shortage is an incredibly interesting phenomenon, as do most people. We hear a lot of hypotheses put for what the cause might be, what the reasons might be, whether or not it is ending and what the signs are that we are seeing now. From my perspective it is quite difficult to speculate. I think we need to look a little bit more and I think we need to do a fair bit more research in that regard. There is some anecdotal evidence that the shortage of heroin is easing in some cities. Certainly I do not think we could say that its availability has returned to pre-shortage levels. There is also some anecdotal evidence of a displacement effect in terms of preferred importation techniques. We are seeing an increase in individual air passengers bringing in drugs by way of body packs and also drugs coming in through the mail.

This slide shows figures which were presented by Commissioner Matthews and Chief Commissioner Nixon at the second Australasian Conference on Drugs Strategy in Perth in May of this year, showing a reduction in drug overdose deaths in the states of Western Australia and Victoria. We can see dramatic reductions in the last few years. Some of the causal factors of the heroin shortage which have been put forward include the drought in Burma perhaps causing a reduction in production. According to our analysis, that does not actually match the timing of the shortage in Australia. I can go into that later in more detail if you would like. Another theory relates to the Taliban ban on opium in Afghanistan. The reality is that most of our heroin is not sourced from Afghanistan at all. Most of that goes west, across to Europe.

I would like to think that successful law enforcement activity has played a role. It has been a significant contributing factor in two ways. One is in the sheer number of kilograms of drugs seized in recent years by law enforcement in this country. In the last financial year 2001-02, 439 kilograms of amphetamines were seized; over one tonne of cocaine—1,003 kilograms; heroin, 420 kilograms; and MDMA, 154 kilograms. I would not like to start to speculate as to how many individual hits or shots you would get out of that quantity of drugs.

But more important than the quantities seized at the border is the issue of the damage done to criminal syndicates that are very sophisticated organisations. We will talk more about it shortly.

The seizure is one thing but the real impact we can have is in taking out major players, whether they be in Australia or overseas.

There has also been speculation that the shortage may have been the result of a business decision by syndicates to starve the Australian market of heroin and then bring it in at a later time or store it somewhere else and drip-feed the market here. Personally, I think that probably gives too much credit to the level of cooperation that may exist between syndicates out there who are feeding the Australian market. I do not really think that level of cooperation exists. What we tend to find is that it is highly competitive. Cooperation exists where it is mutually beneficial and, to that extent, you will see different syndicates coming together. We will see syndicates coming together who used not to. Groups of people of different ethnic origins who would never have worked together in the past are now doing so, but that is purely because it is mutually beneficial. There is a profit and a market there. That is the only reason they would come together. But to think it was a business decision that caused the shortage gives them too much credit, I think.

The implications or effects of the heroin shortage include some reduction in overdose deaths. We also believe that heroin has become less available to casual and new users. The heroin that is available will tend to go to established customers and markets that are already there rather than to newcomers in the market. There has been an increase in the numbers of people seeking treatment, which I guess you could argue might create a more positive environment for people who may be seeking treatment and education. We have seen some displacement to amphetamines. In saying that, I support Adam in his comment that the amphetamine market is one which was growing anyway. So I guess we need to be cautious there about that particular displacement effect and also the displacement of importation methods. It is certainly not an exhaustive list but a few of the effects that we think we are seeing.

With regard to amphetamine type stimulants, there has been a significant increase in the production, traffic and abuse of ATS in the South-East Asia region. From my perspective, this is probably the most significant threat to us at the moment in terms of the various drug problems we are facing from a law enforcement perspective. The trend is posing a significant threat to Australia. In particular, one of the most challenging aspects of this for the police and for emergency and health workers is the effect of these forms of drugs—as opposed to heroin—on the body. When we are dealing with someone with a heroin addiction, it is my experience that that person is probably at their most dangerous when they are looking to obtain money to buy heroin. However, there is a whole range of effects on a user of ATS including auditory and visual hallucinations, an increase in violence or the potential for aggressive behaviour. In that regard, we need to be very careful because ATS use presents a very different challenge for us and it is an area in which we need to do a lot more research.

With regard to cocaine use and supply, we believe that cocaine production increased fairly significantly during 2000-01. As I said earlier, the majority is being sourced from South America and in particular from Colombia. Cocaine use in Australia has increased, especially in Sydney, and I think we are seeing quite a different user group in relation to cocaine in terms of socioeconomic circumstances and so on. I guess others would be more qualified to comment on that than I am, but it would be fair to say that the target audience is quite different.

Another area of concern for us is GHB. We could discuss GHB for a while because it is of real concern for us. Going back to the ACT policing experience, in recent years we have seen a number of cases of date rape where GHB, which is often referred to liquid ecstasy or fantasy—one of the street names is 'easy lay'—has been used. We are also talking about drugs like Rohypnol which are colourless, odourless and tasteless and which are being slipped into drinks. This causes people to be a lot more vulnerable to types of crime that might include sexual abuse or robbery. Without trying to cause any sort of panic, it is something that we need to recognise does happen. It is there and it is a problem which has been on the increase in the last couple of years. It requires, and is being given, special attention by law enforcement officers and health authorities around the country.

In relation to control methods, the AFP basically treats and attacks criminal syndicates as businesses. They are extremely lucrative businesses and, like any business, they have vulnerabilities and we try to target these vulnerabilities within syndicates. As I said earlier, importation syndicates are amorphous. They develop, merge, segment and reform as circumstances dictate and as opportunities arise, but always central to their existence are people we call 'facilitators.' The investors can come and go, the sources of supply and the commodity can change and the intended international market can change, but the relationship of trust between facilitators and other players involved in the importation process is critical. That is why these facilitators work at the very top end of transnational organised crime.

They are able to test import methods. They are able to test markets. We are aware of them testing the strengths of our border and the integrity of our border. These people are not unlike high level legitimate business brokers in the way that they work and that is why the AFP seeks them out and targets those individuals. That was why I made the point earlier that far beyond the effect of seizing the hundreds of kilos at the border is the impact we can have in terms of taking out facilitators, especially if we can attack the financial base that funds the activity—and it is quite extensive.

CHAIR—Mr McDevitt, I ask that we limit this time so that there can be a little bit more time for questions.

Mr McDevitt—I will not go any more into the vulnerability model, which shows the sorts of players who may be involved. The next issue is that of performance data and performance measurement. I will not go into that but, again, I think we need to be a little wiser. We are trying to look at ways to benchmark our successes against other agencies—overseas agencies—in terms of the drugs that we are seizing at the border, the rates of seizure. We are also looking to better measure the effects we can have offshore. Recently our focus has not been on the border at all; it has been offshore. We have tried to stop the flow upstream, so the seizures are actually being made in countries outside of Australia but, relying on our law enforcement network, we are actually having an impact way offshore and getting seizures long before they get anywhere near Australia. We need to be more effective in the way that we measure that.

In terms of initiatives, we have significantly increased the AFP's liaison officer program. We have now included Phnom Penh, Beirut and Suva. They are either drug transit countries or they are close to drug production areas. We have got trials under way for law enforcement liaison officers from the AFP to be posted to Bali, Belgrade, Chiang Mai, Dubai, Ho Chi Minh City, Mandalay and Pretoria. We will identify the suitability of those areas for further expansion of

the liaison officer network which, for us, is absolutely critical to success in attacking the sorts of syndicates that I have spoken about. The law enforcement cooperation program is significant in terms of training initiatives that we conduct both in Australia and overseas and has paid off in terms of major operations.

Extension of the heroin signature program to cocaine and ATS will, of course, now enable us to be able to identify where these drugs are coming from. We have had significant success in terms of being able to type heroin—where it has come from, where it has been sourced from. We will now be able to do that with other drugs—ATS and cocaine in particular.

In the interests of time, I will not continue, except to say that these are critical issues for us. In terms of the future, we need more research; we need to continue to try to understand the market itself; we need to monitor the displacement factors that we are seeing; and, to us, collaboration is absolutely critical to our success.

CHAIR—Thank you very much, Mr McDevitt. I think you will find that the questions that are posed to you will give you an opportunity to be able to make your points. Mrs Irwin?

Mrs IRWIN—I want to talk about the heroin drought. I am going to refer to an article that was in the Melbourne edition of the *Sun-Herald* on 19 June titled 'Drug gangs' new threat'. There was a comment made by AFP Commissioner Keelty who himself disclosed in June 2001 police intelligence that there had been a business decision by Asian organised crime gangs to switch from heroin production as their major source of income to the making of methamphetamine or, as we know it, speed tablets. He was quoted in the article as saying that 'Their market research ... tells them that these days people are more prepared to pop a pill than inject themselves.' It seems from that statement that Asian organised crime gangs are calling the tune. I want to know what measures of effectiveness of law enforcement are stopping this supply—say, capture rates, even tip-offs, or police activity?

Mr McDevitt—Are you asking what methods we are using at the moment?

Mrs IRWIN—Yes. Because of the comment that Commissioner Keelty made in July 2001 regarding Asian crime gangs—where they are switching from heroin to speed tablets—I want to know what action the Federal Police are taking.

Mr McDevitt—That is correct; the comments Commissioner Keelty made are correct. What we are dealing with is an incredibly active, dynamic, complex marketplace, and we see the commodities changing fairly regularly. As long as a market can be cultivated and as long as there is demand there, we will quickly have people who will step in to fill the void in terms of supply. There are things that we can do. Critical to everything that we do is intelligence, and that is why the AFP invest a high proportion of our resources into gathering intelligence about the market and into gathering intelligence about the particular groups that may be involved—and some of them are Asian and some of them are not. It is always a matter of trying to keep up with the pace.

One of the issues for us is that, if you develop a better mouse trap then the mice will become smarter. They will start to look for different ways to bring drugs in and different methodologies, so we cannot rest for one minute in terms of our vigilance at looking at opportunities for us to

penetrate particular groups. We use a full range of tools. It is commonly known that we engage in physical surveillance and electronic surveillance techniques, and that we utilise informants and undercover operatives. These are all common police tools that are utilised to discover how a syndicate is working, what sorts of commodities it is moving and what its market is to enable us to identify the key players with a view to taking them out of play.

Mrs IRWIN—What is the capture rate of these key players?

Mr McDevitt—I can give you some examples; it might be something that I need to take on notice. I can give you some figures, if you like, in terms of the number of arrests and the quantities of drugs seized if those are the sorts of things that you are looking for. I can give you one quick example: in Operation Logrunner, which was conducted in late 2000, 357 kilograms of heroin were seized in Fiji. This was a culmination of a major investigation which involved six international partners as well as the AFP. The AFP was the primary coordinator of that operation. The prosecutions do not take place in this country; they take place in Fiji. The seizure is made in Fiji. There are no arrest statistics or seizure statistics in Australia that I can give you for that success. However, considerable resources went into that operation which had the sorts of disruption effects and offshore wins that we are after. The ideal situation for us is that no drugs ever make it here because we are so successful that we cut this off as close as possible to source countries.

Another quick example is Operation Natant. In February this year Brazilian police intercepted six kilograms of cocaine concealed inside a computer which was being sent from Brazil to Indonesia. There was a substitution done of those drugs and the shipment was then allowed to continue on to Indonesia, where it was intercepted again. Those drugs were bound to go from Brazil via Indonesia to Australia. We cut them off at Brazil. We took out players in Brazil. We substituted the drugs and let it go on to Indonesia, where our colleagues, the Indonesian national police, with whom we have a good relationship, then intercepted the people at that end. So we can take out those players and nothing arrives in Australia. They are two quick examples of where we can have considerable success but where we cannot count statistics here.

CHAIR—Thank you, Mr McDevitt.

Mr McDevitt—I can make those statistics available to you.

CHAIR—If you would take that on notice, that would be very good, thank you.

Mr DUTTON—Mr McDevitt, I have a couple of questions for you about the domestic supply of amphetamines. We have taken some evidence of there being a dramatic increase in that area. We spoke yesterday about the possibility of recommendations by this committee. Would you support a recommendation for some restriction on the availability to the retail market of, for argument's sake, pseudoephedrine, which is commonly found in Sudafed tablets and which is a precursor for the production of amphetamines within Australia? Would you support a recommendation restricting the availability of that drug, or others like it, to the retail market? It is my understanding that part of the problem in Australia is that amphetamine requires that precursor before it can be produced.

Mr McDevitt—You are exactly right: it does. We have seen increases in seizures of pseudoephedrine. Again, putting my community police officer's hat on, I know we have had operations where we have seen people going from chemist to chemist to chemist to get pseudoephedrine. I think it would be fair to say that most police officers in this country would support that.

Mr DUTTON—With regard to the domestic distribution network of amphetamine in particular, can you advise me as to the involvement of the outlaw motorcycle gangs and what role they now play in that distribution? What sort of legislation can we introduce to curb their activities, if you believe that they have an involvement? It has been suggested that we should have legislation similar to the RICO legislation in the United States, which attacked organised crime in particular. Can you give me your thoughts on that issue?

Mr McDevitt—That is a question which I would like to take on notice so I could come back with some sufficient information to justify a response to such a critical issue.

CHAIR—Okay.

Mr McDevitt—Certainly for a number of years outlaw motorcycle gangs have been known to have had an involvement in the distribution of amphetamines. I think it would be fair to say that goes far beyond just intelligence; that goes to evidence which has been presented at courts around this country. I do not believe there is a stranglehold on that particular drug type and operation and distribution that perhaps existed several years ago through OMCGs when it was predominantly their turf. I do not think that exists now, but I think it would be fair to say that there are still very definite links there. As to the sort of legislation that you are speaking of—the RICO legislation and so on—I would like to take that part of the question in particular on notice, and I will come back as quickly as possible to the committee on that.

CHAIR—Yes, thank you. That is fine, Mr McDevitt. We can have you take that on notice.

Mr EDWARDS—I would like to ask Agent McDevitt a couple of questions. One of them flows on from the quote given by Julia Irwin relating to one of the possible reasons for the heroin drought being a decision taken by crime syndicates, particularly the Asian crime syndicates, to push amphetamine like drugs for a number of reasons, including the fact that they do not have to depend on climatic conditions to produce them, and I think you have indicated that in your own presentation, Mr McDevitt. I can recall Commissioner Keelty saying that the drought factor was a part of the reason for the heroin drought in Australia. I also understand that about 80 per cent of heroin and amphetamines come in from Burma.

During my time on the Joint Committee on the National Crime Authority, the figures we were given showed that we intercept as little as two per cent of the drugs that are being imported into Australia. My concern is this: has there been a deliberate market shift away from heroin to amphetamines, given the marked decrease in heroin and the very marked increase in amphetamines? If so, because of that, do we need to change our focus to the increased use of amphetamines?

Mr McDevitt—You make a lot of very valid points. We need to focus on ATS—amphetamine type stimulants. It presents the greatest challenge for us at the moment. You are right: producers do not have the difficult issues of drought, climate and so on, and that may be a

contributing factor. There is not one single factor; there is a range of impacts. There is no doubt about that. If you are asking whether the focus should be on ATS, I think it should, but you cannot focus purely on that. You cannot let go of the other ball as well. It is difficult; there are new drugs becoming available. The synthetics are ever increasing. That is why I made the point about GHB—there is another issue for us. I am not sure whether I am answering your question properly, sir, or to the extent that you want.

These groups may well be making a business decision to change to amphetamine type stimulants because they may see that penetration of the market is easier or that there is a gap that they can fill. It may be easier for them to produce the product locally. They may think it is easier to move it. They may think the market is more ready. A range of factors is involved. You are certainly right: we need to have a real focus on ATS, but at the same time we need to constantly scan the horizon to see what other threats are emerging and we still need to monitor, obviously, the flow of other illicits.

Mr EDWARDS—In three months time we could easily find ourselves back in a very serious heroin situation with another market share?

Mr McDevitt—It would be a big call to say that that might not be a likely scenario. We try to study the market as best we can all the time, together with factors like availability, crop production and so on, but it is difficult, particularly when we start thinking about perhaps massive amounts of heroin that may be stockpiled and our not knowing the specific locations of those stockpiles. If such stockpiles exist and if in three months time ways are found to bring them into the country, you will find the uptake that you speak of.

Mr QUICK—On the links between drug taking and crime, not all drug takers commit crimes, apart from breaking the law when taking something that is illegal. Are there statistics on the links between property crime, domestic violence, child abuse and drug taking? I would like to think that most of this is because of problematic drug users, not just recreational users. What evidence do you have to support some of those assertions?

Dr Graycar—Thank you for that question. I might ask my colleague, Dr Makkai, to join me. At the moment, Dr Makkai is the director of research at the Australian Institute of Criminology and looks after all of our drug programs. But the long and the short of it is that, first of all, in the DUMA study, we are dealing with people who have committed offences and been detained by police. The data in that study give us an indication of what is out and about and on the street. As you quite correctly pointed out, there are many people who take drugs who do not commit crime.

On the other hand, we have a second study, called the DUCO study, the Drug Use Careers of Offenders study. We are not able to release any results from it yet because we still have not gone through all of the details. It is a different type of study; we have been talking to people in prison—again, people who have broken the law and been convicted—and looking at their whole drug use careers. The preliminary data that have come out of that have shown two quite interesting things. There is a pattern of considerable disadvantage among the people who have responded, and their criminal careers and their drug-taking careers are very complex. The first preliminary finding—and we think it is in an important finding out of all this, but we have to confirm it—is that, of people who take drugs and commit criminal offences, most were com-

mitting criminal offences before they started taking drugs. So people who committed a criminal offence took drugs casually and certainly had established a criminal career before they had established a drug-taking career.

The whole history of who takes drugs, and where, when and how is of course complex. People throughout history have used mind-altering substances. This is not a new phenomenon, but what we are really wanting to look at is the intersection of mind-altering phenomena, as Ben McDevitt was saying, business opportunities to expand markets and then the effects on the communities when people who use mind-altering substances break the law. In the DUMA data, we can certainly pull down data relating to offences, age, demographics, drug use and location—we can do all those things and start to answer those questions in that way. But it is the longer-term data that are really important. Toni has done work on the types of people who use drugs.

Dr Makkai—In terms of your question about looking at the broader community, you could look at data from the National Household Survey which has recently been released. That is done by the Australian Institute of Health and Welfare. That is the Commonwealth department of health side. At the institute, we do not focus on that end of our analysis. We have been concentrating on people who have come into contact with the criminal justice system.

Mr QUICK—The reason I asked that question is that I have in front of me the British House of Commons home affairs report. There are moves in some suburbs of London to decriminalise—I suppose that is the easy word—marijuana. I have been reading the police reports about that. There is the whole issue of cost-effectiveness of law enforcement. We have the AFP and state and territory jurisdictions. In South Australia you can possess so many marijuana plants, and in the ACT you can too, but in other states you cannot. There is the perception by the great unwashed out there that drug takers are a hard kernel. Our evidence has shown that there is a wide range of people.

CHAIR—Is that your question?

Mr QUICK—The question is: what evidence is available to us if we are making recommendations about the cost-effectiveness of policing? Is it working? What new trends would you suggest? You are obviously providing this information to all commissioners of police. Are there changes in the wind? Are we getting the best bang for the buck?

Dr Graycar—This is not a cop-out: there is no simple answer. You will recall that at the beginning of my presentation I talked about the different user groups that one deals with in different ways. There is a significant difference between a 15-year-old kid smoking a joint and the sorts of people whom Ben McDevitt was talking about—people who are bringing drugs into the community—and they require different responses. The 15-year-old kid does not require a law enforcement response; health and education responses would probably be the most appropriate. The people whom Ben McDevitt has been talking about require a different response. The complexity involves looking at the harms and the potential harms that are done, both to the people who use and to the people with whom they deal. Clearly, law enforcement responses are very appropriate in some circumstances, health responses are appropriate in other circumstances, and diversion approaches are appropriate in other circumstances. The complexity of all drug policy is that there is no ‘one size fits all’. The problem we are dealing with has to be attacked and has

to be dealt with in the most effective and cost-effective way. There is the old saying that if the only tool you have is a hammer then every problem looks like a nail. We have many tools but we also have many problems.

CHAIR—Mr McDevitt, following on from Mr Quick's question stating that you are able to have so many marijuana plants in South Australia, it is my understanding that it is illegal in every state in Australia to have any plants—

Mr EDWARDS—It is still illegal.

CHAIR—and that the penalties for the possession of plants are different in different states. Can I have clarification of that, please?

Mr McDevitt—My understanding is that what you are saying is correct. But could I take that on notice, because it will involve a quick check of each of the jurisdictions?

CHAIR—I would certainly appreciate that, because it continually comes up that you can have so many plants in each state. It is my understanding that it is illegal in every single state and that different penalties apply. So if you could take that on notice and come back with some information, that would be extremely helpful.

Mr McDevitt—Sure.

Mr CAMERON THOMPSON—Mr McDevitt, one of your slides had a list of things that you did. It started with border protection and went through a list of different actions that you took. In terms of the allocation of resources to those various areas, in which area would you say we are most efficient at the moment and why?

CHAIR—You are able to take that on notice, if you would like to.

Mr McDevitt—Yes. It is a difficult question. Really it comes back to the bang-for-the-buck question. As Adam said, this is about law enforcement options, treatment options, prevention options and education options, and what is the best mix of those strategies. It is about the timing of those strategies. Perhaps if we see a brand new synthetic drug coming on board, law enforcement might be a great option at that point, where we could dedicate significant resources or whatever, whereas at another point it might not be the best option to get the most value for the dollar. So I guess it is the mix of strategies. For law enforcement, our constant challenge is: within the range of tools that we have in our tool bag, what is the very best one at this point in time?

We are finding that one of our very best tools is the international liaison network. We are getting significant results from having that and so we are investing more into expanding that network into other countries that are closer to source countries and so on. In terms of preventing supply to our borders, we are finding that that is one of our most effective strategies at the moment. We are finding that the Law Enforcement Cooperation Program, where we are involved actively in training ventures with other law enforcement agencies and assisting them with building their own capacity, is very effective. We believe we are getting real value for the dollar out of that as a strategy. I am not sure whether that goes to the heart of your question.

Mr CAMERON THOMPSON—I did not want the answer on notice; I was trying to figure out whether Mr McDevitt had something on his mind that was agitating his concern. That was the purpose of the question, so I do not need to follow on with it.

Mr WAKELIN—Dr Graycar, there is a perception in the community that the link between illicit drug use and crime is overstated. I understand that you believe that it is overstated. Why do you believe that?

Dr Graycar—In the data we have—this goes back to something I was saying before—our population group is people who commit offences. You can start to cut the analysis many ways. We do know that, apart from drug offences—taking drugs that are illegal—the majority of people who use illicit drugs do not commit other offences. In our DUMA and DUCO studies we are dealing with people who, by and large, have committed other offences. These people have used drugs and in many cases have drug dependency. We certainly know that there are people who commit offences to support drug habits. We have analysed the data and found that this is not the sole reason people commit offences.

We have some data—I do not know whether we have it with us—from our DUMA questionnaire. We asked: When you committed the offence were you high? Were you looking for drugs? Were you looking for money to support a habit? The answers show that people were not doing it primarily to support a drug habit. There is no doubt that there is a link between illicit drug use and criminal offence. Not all drug takers commit crimes; most people who commit crimes are also drug users. That has come through in the graphs that we have shown. The relationship is complex. It is always hard in research to develop a very clear cause and effect.

Mr WAKELIN—I hoped I had asked about community perception. It is more difficult because we are dealing with perceptions and not something that is scientifically or statistically based. I would appreciate your attempting to answer the difference between community perception and the actual situation.

Dr Graycar—It is a hard one because at the Australian Institute of Criminology we try to deal with data. We do not try to work out what is in people's minds. We do not do public opinion research at the AIC. Certainly in all areas of criminal behaviour and criminal activity people in the community have very strong views, and they hold those views very firmly.

Mr WAKELIN—In other words, we do not have that data. Mr McDevitt, could you comment on Commonwealth-state relations at an operational level and the reliance on, and significant investment in, technology, computers or other new crime fighting aids? How is that information linked through? I am aware of the international delays in work et cetera, but it seems to be working very well. Can you make some comments about that relationship and about the new era, if I can put it that way, of high tech and the investment in high tech equipment?

Mr McDevitt—The relationship with state and territory policing jurisdictions is absolutely critical to the AFP. I said this at what we call an Australasian crime commissioners forum, which has on it assistant commissioners for crime from every jurisdiction in Australia and New Zealand. We sit around a table quite frequently and discuss a whole range of issues. We have cross-border initiatives, we have plans for running operations across borders and we work on

joint task forces quite frequently on a whole series of crime problems, not just drugs. We have a great example in Sydney of one of our Avian strike teams being a joint team with the New South Wales police and the National Crime Authority. It is a joint Asian crime strike team, with very good results. We find that the best results are when there is active collaboration and cooperation between agencies. The AFP could not do it alone—there is no doubt about that at all. We have a very good and strong relationship with Customs; they are absolutely critical to our success. We have a very good relationship with the Australian Bureau of Criminal Intelligence, and contribute to shared databases, most of which are administered through them. Intelligence is absolutely critical to all of us. I think there is a hell of a lot more sharing of intelligence and information between law enforcement agencies, both at a national level and at a Commonwealth level, than we have ever seen in the past.

You are right about the investment in technology: it is a massive investment when you are putting money into technology. We need to constantly be searching for interoperability with our systems so that we can share data. It goes beyond law enforcement—this is across the criminal justice system. We are seeing offenders coming onto police databases who will then disappear because they have gone into the court database, then they disappear again because they have gone into the corrections database, and suddenly they will appear again on the police database. You need to get a lot more cohesion. I think the best way to get success is to have performance measures which assess things like collaboration and cooperation between individual agencies.

CHAIR—Thank you, Mr McDevitt.

Ms GEORGE—I want to ask about the obvious increase in the use of psychostimulants. I would imagine that it is not beyond the capacity of our domestic manufacturers to manufacture the ecstasy that is being brought in, I think you said predominantly from Holland. Are you aware that in terms of treatment, specifically for the drug diversion programs, we were told by Professor Saunders the other day that our progress as a nation in developing treatment for psychostimulant use, under the heading 'Evidence of effective treatment', was zero, and under 'Widespread availability of treatment', it was also zero? I think it should be a great concern to everybody that, while we are all forecasting substantial growth in the use of psychostimulants, we do not have evidence of effective treatment. What is your response to that, and what do you see could be done?

Mr McDevitt—The point you made about local production is correct: we are seeing a definite surge in local production, in the last couple of years in particular. It is not of the quality that is coming in from Western Europe in particular, and I think it is probably a quality issue that is the reason for the large proportion coming in. Eventually, you may see some change in the quality and then the market will change and probably more will be produced here. We need to be really aware of that and very focused on that. I do not think I am really qualified enough to talk about the treatment options. It is probably a question better directed to someone else.

Ms GEORGE—I raise that because of the important role that the policing agencies supposedly have in drug diversion. If the experts are telling us that as a nation we do not really know what provides for the most effective treatment of people who are dependent on psychostimulants, it is a worry I think. The other point I want to make concerns the liaison officers and where they are placed. Do we put a lot of effort into the Pacific countries? I raise that because many of them are in a state of economic collapse and a number of them are tax

havens, which I think would be pretty fertile ground close to our borders for people involved in illicit drug trafficking to make those countries their base. Could you comment on that?

Mr McDevitt—Again, I think your observation is correct. Where you have a disrupted state you have a great opportunity for organised crime, and you will see organised crime very quickly take the sorts of opportunities that present themselves in a fractured state, if you like. We invest quite heavily in the Pacific. We have recently increased the numbers of liaison officers posted over there. We have officers dedicated to training in the Pacific. I spent time in the Solomon Islands and in Bougainville in the late nineties doing that sort of job. The Pacific is critical to us because, purely from a selfish point of view, it is a transit route. It is in our interest for law enforcement there to be strong and vigilant. So from that perspective we actively play a role in trying to build capacity, infrastructure, intelligence sharing, awareness and all that sort of thing. You are right—it is a really important area for us and, yes, we are focused on it.

Mr DUTTON—I understand that one of the major indicators of success in battling organised crime is asset confiscation. Can you tell me how the AFP has performed in that area in recent years and whether or not you are satisfied with the current legislation that is in place to allow you to strip the assets of these organised crime structures.

Mr McDevitt—As you would no doubt be aware, we are active proponents of a regime of civil forfeiture with substantially enhanced investigative tools. We believe that a conviction based scheme is one which is not effective and which has not netted the sorts of results that we need. We think that unless we have the tools to attack the financial base then whatever we are going to do will be limited in terms of its real impact on the sorts of businesses that we are targeting—lucrative businesses, with multimillions of dollars. Unless you can actually hit them in the pocket, you are not going to have the sort of impact that you need to effectively dismantle those syndicates. So, yes, the AFP actively supports a civil forfeiture, non-conviction based regime.

Mr QUICK—With all the research that has been undertaken, have we been able to quantify the number of problematic drug users in Australia? I ask that question in relation to a statement by the House of Commons report that states:

> We believe that drugs policy should primarily be addressed to dealing with the 250,000 problematic drug users rather than towards the large numbers whose drug use poses no serious threat either to their own well-being or to that of others.

Can we quantify the number of Australian problematic drug users?

Dr Graycar—I have just been advised that there have been estimates of dependent heroin users in that Professor Wayne Hall did some estimates when he was at NDARC at the University of New South Wales, but they were not sufficiently broadly based. I do not know whether Dr Makkai has anything to add to that.

Dr Makkai—As far as I am aware, no-one in Australia has tried to come up with a number like that.

CHAIR—We will now take a break for lunch.

Proceedings suspended from 12.00 p.m. to 12.36 p.m.

MATTHEWS, Dr Richard John, Chief Executive Officer, New South Wales Corrections Health Service

CHAIR—We will now start with the second part of our session on crime, violence and law enforcement. This session will deal with drug abuse in prison.

Dr Matthews—Thank you very much for inviting me. The Corrections Health Service in New South Wales provides health services to all the people in correctional centres and police cells. In New South Wales, health services are provided and funded by New South Wales Health. That is not the case with the provision of health services in other jurisdictions. They are commonly provided by the justice arm. In my 10 minutes I am hoping to give you some information on who actually comes to jail, where they come from, what their socioeconomic group is, what drugs they use before they come to jail, what—most importantly—their co-morbidity is, what the outcomes of sending them to jail are and then perhaps to suggest what we ought to do about it.

Before I start on that, I would like you to reflect on why we send people to jail. There are four reasons I can think of. Retribution is relatively straightforward; it is easy to measure, we are quite good at it and not many people escape. I am going to try and convince you that rehabilitation, although a laudable aim, is not logistically possible in the correctional setting. As for deterrence, my personal view is that it works extremely well for people who do not commit crime, but recidivism rates would suggest that it does not work very well for those who do. Incapacitation is the curious American notion that, if you lock up enough people who commit crime for long enough, you will reduce the crime rate. That is true but, unfortunately, the numbers of people that you need to lock up to achieve that aim are so great that the Americans now have two per cent of their population in jail. California spends more on corrections than it does on either health or education.

In New South Wales we have now reached about 8,000 as a census figure. However, a further 16,000 people come through the front door each year. That is projected to rise quite sharply this year because of changes to the Bail Act. The really important fact to understand about the prison system is that it is a ‘flies in the bottle’ system. There are 146,000 internal movements in New South Wales every year, so people do not stay in one place for very long. The entire system is court driven, because the equivalent of the entire population has to go out to court each month. And, of course, 94 per cent are male.

Again, there are a lot of misconceptions about how long people stay in jail. Of the 16,000 people who hit the front door, because 70 per cent are on remand, 27 per cent are in custody between zero and eight days and 17 per cent are in custody between eight and 30 days. In New South Wales only 10 per cent of those who walk through the front door are continuously in custody for six months. I am going to present an argument—I hope—that that is really the minimum time you need to make much change to the lives of this particular group of people.

We did a very comprehensive inmate health survey. This slide shows their socioeconomic status—before I move on to discussing their health. Seventeen per cent were Indigenous. In New South Wales less than two per cent in the broad community identify themselves as

Indigenous. Twenty-three per cent have a language other than English as their first language. You can see on this figure that the unemployment rates are high, and you would have guessed that. Significantly, half of both sexes left school before the school certificate, whereas I think about 75 per cent of students in Australia get to year 12. If you roll all of that up into an EDOCC score—a Bureau of Statistics score of socioeconomic status of education, occupation et cetera—then you get 790. The state average is 1,000. The lowest local government area in the state is 890. So what we are doing is concentrating people of the lowest socioeconomic groups in correctional centres.

Before I talk about what drugs they are using, I want to present this slide, which is the result of research done on alcohol in the United States but I believe that it holds good for other drugs as well. It looks complicated but it is not. It shows that, if you look at the population using a particular drug, the top 10 per cent of users account for 50 per cent of consumption and the top 20 per cent of users account for 80 per cent of consumption. So you can divide the drug using group into what we might call the 'dabblers' or 'experimenters', the 'accelerators' and the 'heavily dependent'. It is the heavily dependent, because they have a desperate need for money, who commit more visible crime and who come to jail. That is illustrated by three separate studies; two were done in the community and the one on the right of this slide was done in jail. If you focus on the bottom line of this slide, you will see that almost 80 per cent of the intravenous drug users who came to jail were using more than three times a day in the month prior to their incarceration whereas, if you turn up at needle and syringe exchanges across New South Wales, you get a much different distribution of patterns of use. It is the heavily dependent who commit the greatest amount of crime and who come to jail.

This next slide looks busy too, but it is actually not that busy. There is a thing called a national mental health interview. It is being conducted across the country on 13,000 Australians, about six and a half thousand of each gender. Part of it is about drugs and alcohol. If you look at the figure for women on the right of this slide and you look at opioids, you see that about 0.2 per cent of the Australian female population is dependent on opioids. On reception to jail, it is 53.4 per cent, so you get an odds ratio of about 292 to one. If you look at stimulants, which we are also interested in today—stimulants being largely amphetamine—and you look at the figure for women, you see that the figure is 0.1 per cent in the community and 47.8 per cent on reception to jail. The figures are slightly less in men but still of major significance. The odds ratios are extremely high. This survey was done at the height of the heroin drought and you will see that the percentages dependent on amphetamines on reception to jail are extremely high, much higher than you would have expected, and the percentages dependent on opioids have dropped from some of our previous surveys.

I believe there is considerable evidence for a switch from one kind of injecting to another, particularly amongst the heavy drug users. The rates of dependence for the legal drug, alcohol, are also extremely high. You can see there is a big difference between the community rate of dependence for males and for females, 5.2 to 1.8, but in terms of incarceration there is very little difference. We are quite good at locking up people who are drug dependent.

I now come to the co-morbidity of this group, which I think is extremely important. The same interview, the national mental health interview, looked at mental disorder categories. If you look at positive screening for psychosis in the community, the rates of male and female are 0.43 and 0.41—about half a per cent. On reception to jail, the figures are 15 per cent for women and 10.7

for men. That is an odds ratio of about 34 to one for women with psychosis. If you look at the percentage of people with any mental disorder, it is 90 per cent for women who come to jail and 78 per cent for men who come to jail. Personality disorders are more common—but they are also more common in the community. The odds ratios for personality disorders are less than they are for psychosis.

We also did a screen for intellectual disability. Of the 882 people we screened, one-quarter failed the screener and they were all referred for intelligence testing by psychologists. We lost some to follow-up but you can see that of those we assessed one-quarter of the quarter were assessed as having an IQ of less than 75. We need to interpret this data with some care, because as well as doing the intelligence testing the psychologists normally do adaptive tests to see how well people cope. When they used the standard community instruments they just did not work, because they asked the inmates, 'How do you go catching a bus?' The inmates laughed and said, 'Well, there are no buses in here, mate; what sort of stupid questions are you asking me?' So we were unable to do the adaptive tests that go with the IQ tests, because there is no instrument that works in a correctional centre. Nevertheless, these figures are extremely disturbing.

You have marching through the front door people with significant mental illness who are not only drug dependent but are polydrug users who are using very heavily. Essentially, they are using what they can get their hands on. You can sit them down—as I have been doing for 20 years—and say, 'The heroin, speed, coke, alcohol and marijuana are all here on the table; which one are you going to pick?' You almost always get the same answer: heroin. But heroin is not always available and, when heroin is not available, this group will switch to whatever is available. If things get desperate they switch to prescription drugs, which have the virtue of being incredibly cheap.

My next slide is a bit of a shocker. I am warning you about that ahead of time. Again, I am very interested in the co-morbidity and the holistic package. We looked at oral health in this group: 40 per cent had never been to a dentist and two-thirds had lost a tooth by the time they were 20. This young lady is 20 and you can see that she needed to have all her teeth removed. The point of this slide is not just to shock you but to show that if you are serious about rehabilitation, whatever you think about the virtues of spending taxpayers' money on oral health, you will not get this young lady to give up the best analgesic on the planet until you remove her dental pain. It simply will not happen. So she had all her teeth removed and has now got false teeth.

There are a significant number of deaths by overdose in correctional centres. You can see the numbers each year: six, five, four, four, three. In the last two years, you see only one and one. What is the message here? I think the message is—and I will show you the curve indicating the number of people on methadone maintenance—that it has been steadily rising over the years and now just over 1,000 of the 8,000 people on any given day in New South Wales correctional centres are on a methadone maintenance program.

What are the outcomes of putting all these people in jail? Death is a pretty poor outcome in health terms. Between 1991 and 1998 the overdose rate in correctional centres, matched for age and sex, was 19 times greater than in the community. About the most dangerous thing that you can do for an injector, in terms of mortality, is to release them from jail, because large numbers

resume injecting. They are socially isolated, they go to Cabramatta, they score, they are on their own and most importantly their incarceration has rendered them opiate naive.

A very good study was done in Oxford in England that looked at post-release all over the UK. The post-release death rate was 63 per 1,000 in the first 12 weeks. If you want to put that into perspective, the mortality rate of untreated heroin use—when you just let people go along and use it—is about 20 per 1,000 per year. It is three times in 12 weeks what the untreated death rate is in a year. In terms of seroconversion, we have lost the battle with hepatitis C. The latest survey shows that 40 per cent of males and about 66 per cent of females are now hepatitis C positive in New South Wales correctional centres. The experts still differ on what percentage of these people will go on to get liver failure and hepatomas. You can be certain that those percentages will be considerable and that the dollar costs over the next 10 to 50 years will be enormous.

I have referred to HIV in my presentation, and it is negligible. This is a critical point. Throughout the nineties, at any one time we only had about 25 to 30 HIV positive people in prison in New South Wales. Why was that? It is because we introduced needle and syringe exchange into the community in this country very early, around 1985, and Alex might correct me if I am wrong there. Before that, as Alex said, it was pre-legal. In other words, there were needle and syringe exchange programs operating before it was legal. I worked in Kings Cross in the 1970s where at least three pharmacies were selling needles to addicts for profit because addicts were worried about hepatitis B. Other countries that were much slower in introducing needle and syringe exchange got a significant amount of the disease into their injecting drug population. They now have rates on reception to jail of up to 40 per cent. In some places in Spain, it is 40 per cent and the Spaniards are now leapfrogging us because needle and syringe exchange is to be introduced into every Spanish correctional centre in the next 12 months.

Some fairly serious outcomes arise from locking up this particular group of people. I wanted to talk to you briefly about research, and particularly about methadone because New South Wales has, in terms of size, a very advanced methadone maintenance program that has been operating in correctional centres since 1986. I have been involved with it since its inception. In partnership with the National Drug and Alcohol Research Centre, we have done a considerable amount of research to try and prove that methadone makes a difference. As you would probably be aware, in lots of places methadone is somewhat on the nose.

In the first study, methadone treatment was associated with reduced injecting in prison, provided you received more than 60 milligrams of methadone and provided you received it for the entire period of incarceration. The second study that Dr Dolan and Alex did is an extremely important study. It is the only randomised control trial of methadone in a correctional setting in the world. Almost 400 people were recruited. They were assessed as suitable for methadone. They were randomised into the methadone and the non-methadone group. Hair analysis was used to determine the frequency of injecting. There is a significant reduction in the frequency of injecting in the methadone group.

Follow-up studies on those people after they left jail are being carried out to look at mortality, hepatitis C seroconversion and recidivism. The research is very early. It is not published or fully analysed. Nevertheless, Kate wanted me to put some of it forward here today because, in all three of those parameters at this stage, there is a significant difference showing. The mortality is

showing about half—it is small numbers yet—and there are a small number of people who are still seronegative for hepatitis C. The seroconversion at this stage for small numbers is about half and there is a significant difference in the amount of time that people are coming back and spending in jail after release, providing they remain on methadone maintenance. I believe the message is that, providing you are on a sufficient dose and providing you remain on methadone, if your outcomes are reduced mortality, reduced seroconversion and reduced recidivism, then methadone works. I think it is a really important message.

I will whiz through the slides that cover what I just said because I am conscious that I have used up more than my 10 minutes. At this stage, in the last two months, you can see that, for those who are out, half self-report heroin or any drug. That will be confirmed or otherwise by the hair analysis. This is our methadone slide. In 1986, we started a pilot pre-release program. As I said, we now dose just over a thousand people every day. I believe that the slow increase in the number of people on methadone has led to the reduced number of overdose deaths, inside and out. I always end with Oscar because, a hundred years ago, Oscar was incarcerated for something which is no longer a crime. He was sentenced to hard labour and spent 23 hours a day locked in his cell picking oakum, and the experience ultimately killed him. I guess my message is that, maybe in a hundred years from now, people will look back at what is happening now with much the same feelings as we have towards Oscar.

CHAIR—Thank you very much, Dr Matthews.

Mrs IRWIN—You were saying that you are treating a thousand patients a day in the New South Wales jail system. Is that correct?

Dr Matthews—We are dosing a thousand people a day.

Mrs IRWIN—What sort of counselling do they get in jails?

Dr Matthews—You will remember the turnover figures—many of those people are in for only three or four days on remand. They receive a risk assessment, a confirmation of their dose and dosing. The counselling services kick in when they are sentenced or when they spend a long period in jail. There are about 85 drug and alcohol workers employed by the Department of Corrective Services. Our nursing service provides counselling. There are also about 120 psychologists in the system. There are support programs for people on methadone and they are conducted in every correctional centre. I guess the answer is that the counselling is appropriate to the needs of the individual within the time frame allowed.

Mrs IRWIN—The reason why I asked you that question is that, in the last parliament, some of the members of this committee spent quite a few hours at Goulburn jail. We had the chance to talk to a lot of inmates, which we could do privately without the guards being present. For one particular gentleman I spoke to it was his second time in Goulburn jail. The reason why he was back in there was that he had committed a crime: stealing for his drug addiction. It was a pretty horrendous crime. I said to him, 'Is that the reason: you were drug dependent; you needed money to buy your heroin?' He said, 'That is correct.' Then he told me the story about when he was in jail for his first stint. He said it went well; he was on the methadone program. He felt that there was not enough counselling, but he stated that the downfall was when the gates opened. He was just pushed out; he was given a piece of paper to fill out and was told where his local

Centrelink office was. There was no follow-up program. The problem was that his parents had turned against him because of his addiction. The only source he had was to go back to his friends who were in the Cabramatta area—an electorate that I represent here in the federal parliament—and he got back into the drug scene. Hence, he was back in jail.

I want to know what system is in place in New South Wales once they come out of the jail system. He was telling me that there needs to be a mechanism in place for those who do not have a family unit to go home to, where they could go to, say, a place in the country and spend a number of weeks getting counselling, assistance to fill out forms and to find affordable housing, and to get into a retraining program. He feels that, while the system is in place in the jails—with methadone and some counselling—there is nothing in place once they come out.

Dr Matthews—That is a very complicated question. You are right; correctional centres have tended to operate as islands within the state. People go in, disappear, and then, after a period, come out. Firstly, the numbers swamp us, because there are 16,000 going in and about the same number going out. Secondly, with people on remand, we do not always know when they are getting out because they go to court, get bail and are released from the court. It is impossible to make arrangements for people when you do not know that they are getting out although, for those on methadone, we always get them a place to be dosed. This is the other advantage of the methadone maintenance program: for every person who leaves jail on methadone, we arrange a dosing point which might be back where they came from, or it might be a pharmacy. Where I work my weekend job, at Rankin Court at St Vincent's, we get a lot of people coming out of jail. They get a caseworker. They also get a welfare officer who helps them with those very things that you mentioned. Ironically in a way, methadone is really the one treatment modality where you can be guaranteed at least some community treatment link. You are quite correct that lots of people do leave without any link at all, and we need to work hard to improve our post release treatment. It is probably our area of biggest weakness.

Mrs IRWIN—To follow up on that, we virtually get back that prisons are the responsibility of the states and territories. Correct; we all know that. What role, if any, do you feel that the Commonwealth government could look at in this particular area that we were just discussing?

Dr Matthews—I believe it is section 120 of the Constitution that says prisons are a state responsibility, which means that prisoners do not have access to Medicare. Under the legislation in which the Health Insurance Commission was set up, prisoners are specifically excluded.

Mrs IRWIN—I was not aware of that.

Dr Matthews—It is also important to know that, in New South Wales, there are 500 sentenced prisoners who are federal prisoners, in that they have committed offences—mostly drug importation and social security fraud—where they have been convicted before the federal courts. If I had a wish, it would be that the Commonwealth would take the leadership in establishing the minimum standards for health care for people in custody across the country and an ideal framework by which those services should be delivered. As I say, in some jurisdictions, health services are delivered either directly or by contract by the justice arm. My personal view—and I speak personally now, not as a public servant—is that health services should be under the umbrella of health. The government's role should be one of leadership in the area of minimum standards.

Mrs IRWIN—Thank you very much for that.

Mr WAKELIN—Mrs Irwin has touched on exactly the subject I wanted to start off with, because I did not understand why and by what decree the Commonwealth did not accept the responsibility for the health care of prisoners in jail. Do you know the basis of that?

Dr Matthews—As I say, when the Constitution was drafted—and I believe it is section 120—it specifically stated that prisoners and correctional centres are the responsibility of the states and territory so, in Australia, unlike other countries, there are no federal prisons. Again, my understanding is that when the Health Insurance Commission legislation was framed, because of that section of the Constitution, people in custody were specifically excluded from access to Medicare.

Mr WAKELIN—I accept your suggestion about the Constitution, but it surprised me that that would be sufficient. I can understand that the HIC legislation may be sufficient, and that is where we may look. I will certainly look there first. On some of the statistics, 10 per cent of your population remains in prison after six months. The issue is with recidivism. How many of those do how many lots of six months, if you get my drift?

Dr Matthews—I do.

Mr WAKELIN—Do we know how many people are just repeating?

Dr Matthews—When people first come to their first adult incarceration, 60 per cent of them have been in the care of the Department of Juvenile Justice. For many people in fact the problems start in early childhood or indeed in the womb. The rate of recidivism is extremely high. If you take injectors who commit property offences, I think you will find about 50 per cent are back in jail within 12 months after release on each occasion.

Mr WAKELIN—You made the point that you cannot do a lot in rehabilitation for the 90 per cent that are there under six months, even taking into account their recidivism and that in the general anecdotal evidence to the committee in the last parliament certainly the evidence clearly staring us in the face was that for many of these people prison was the main place in their lives where they were stabilised, got better and were healthier. My question is related to the same 50 per cent that are recidivists. Where would you put your main focus to get the jurisdictions to try to deal with the issue of substance abuse? Perhaps I can add a couple of quick things. The database seems to be all over the place from the court system through to the jail system. Mrs Irwin has touched on the fact that there is no support once they get out. The counselling, education and literacy services are not as society would probably like to see them. Where would you like to put your efforts to begin with? So it is back to Oscar.

Dr Matthews—The first thing you want to aim to do is to reduce the incarceration rate. So the first question is: why is the rate of incarceration per 100,000 people in New South Wales, for instance, double that of Victoria? It is roughly 120 versus 60. The crime rates are not all that different. So if we put up another slide and sorted all those drug users by minor to serious offence categories, you would find that, on the basis of the particular offence, around 50 per cent are divertible. In other words, it is relatively minor, possibly repetitive, but potentially a magistrate has the ability to divert.

Before I go on to the solution, the other important point is that many of these people have never accessed treatment services in the community. One of the things we found with the drug court was that with really heavy users—an average of six previous incarcerations—40 per cent had never accessed any drug treatment services in the community except for ambulance services and casualty departments. So it is not only that they are not getting treatment when they go out; a lot of them have not had it despite the fact that their habit is entrenched before they have come in. So, firstly, divert with appropriate assessment into appropriate treatment programs. Secondly, use the point of incarceration opportunistically to access and get into treatment people who do not access treatment services in the community. The same thing applies for mental illness and lots of other things around incarceration. For those who do come, you perversely use it as an opportunity, and you have strong links with the community, you have preserved places for people to go to which are appropriate, and you have the appropriate range of pharmacotherapies available, not just methadone but buprenorphine or naltrexone—all of them—because this group, the most entrenched group, will have the greatest percentage when assessed and will need a pharmacotherapy. There is a big gap. There are no residential programs that accept people on pharmacotherapies.

Ms GEORGE—I must say that, having seen the statistics, I find it amazing that 10 per cent stay longer than six months, particularly in view of recent announcements about the building of more prisons. Is the methadone maintenance program within the New South Wales jails undertaken on a voluntary or mandatory basis?

Dr Matthews—Voluntary.

Ms GEORGE—Is there an argument for mandatory methadone maintenance programs within the prison system?

Dr Matthews—I do not believe so, but you are probably asking someone with a bias as a doctor who treats people. I think that commencing any medication, particularly an S8 medication to which people get dependent, needs to be a decision made between a doctor and a patient, with all the options considered and entered into voluntarily.

Ms GEORGE—In terms of the comments you made about the possibilities for diversionary programs, are the dealings of the drug court mainly focused on young offenders or can anybody of any age with any degree of drug dependency be heard and dealt with through the drug courts?

Dr Matthews—There are two in New South Wales. The first was the adult drug court, which concentrated very heavily on this end group that I have been talking about. There is a separate youth drug court which deals with young offenders, and there is now a third program, which was borrowed from Victoria, called MERIT—or Magistrates Early Referral into Treatment—which is the adult arm that focuses on people who are less entrenched.

Mr QUICK—Firstly, who pays the cost of the methadone—Health or Corrective Services? I have a second question. In New Zealand, they have a drug prison where you are tested and, if you actually register, you are back into the hard stuff. Do we have anything in New South Wales resembling that, is it mooted or is it too hard?

Dr Matthews—In answer to the first question: Health pays. The Commonwealth government provides the drug free of charge, but Health pays. The second question is a complicated one. Drug dependence is a relapsing disease. The idea that, if you relapse, we are going to hoick you out and punish you is not something that we would accept in the treatment of, say, diabetes. If you do not manage your diabetes properly, do not take your insulin, collapse and get taken to casualty, we do not punish you by taking you out of treatment; we educate you and modify your treatment. We need to take drug dependence out of the basket it is in, which is the 'moral' basket, and put it in the 'illness treatment' basket. The idea that 'one strike and you're back to max' is terribly counterproductive.

CHAIR—Thank you very much, Dr Matthews; that was very informative.

[1.13 p.m.]

WATTERS, Major Brian Fletcher (Private capacity)

WODAK, Dr Alexander David, Director, Alcohol and Drug Service, Australian Drug Law Reform Foundation

CHAIR—We move on to the final part of our session on crime, violence and law enforcement. The last part of the roundtable addresses the issue of drug law reform. Major Watters, can I ask you to commence the address with your views on drug law reform please.

Major Watters—I must say I feel somewhat depressed after that last presentation. The bit of light relief about the opera about how to catch the bus reminded me of my prison chaplaincy days, when I invited a singer into the prison. He sang *Bless this House*. When he got to, 'Bless these walls so firm and stout, keeping want and trouble out,' the prisoners really cracked up!

If I had a title for this paper, it would be 'Drug law reform reform'. Laws were reformed in the early 20th century, and I believe those who are now calling for reform are really calling for a repeal of what are actually reformed drug laws. I would like to acknowledge the contribution that has been made to my presentation by Magistrate Craig Thompson. He is a member of the ANCD and was originally to do this presentation but, because of his responsibilities on the bench, he could not come.

What is said to us very often is that the problem is not in the drugs but in the laws. So I see the extension of that as saying that reform is a code for the acceptance, the normalisation or even the legalisation of illicit drugs. But we are told that it is not for the supply of the drugs, which I find a bit oxymoronic. I was in Amsterdam recently, and it is still the law there that in the coffee shops they can sell marijuana to people but they are not able to buy it in. It is against the law for them to receive the supplies. So it is a bit of a ludicrous situation.

It is not true that it is not the drugs. The truth is that the majority of the currently illicit drugs were once legally available in Australia in some form. Often they were in proprietary medications or prepared by the local chemist. Amphetamines and barbiturates, which used to be called uppers and downers, and various forms of opium were in appetite suppressants, sleep inducing or resisting tablets, cough remedies and anti-diarrhoea products. It is probably well known—though it probably was not true in Australia—that in the early days Coca-Cola took its name from the fact that it had a component of cocaine within it.

The reason these things are not legally available today, the reason the restrictions were imposed, was because of the abuse of the substances and the problems they caused. Today we are very familiar with it. On a number of occasions we have heard of the problems of the misuse of certain medications with pseudoephedrine in them, and they are being collected and manufactured to produce speed. I would like to pass on a little of what Magistrate Thompson has written on these matters. He said that the argument is mounted increasingly that drug use should be a health and not a legal matter. The inference is that there is no place for laws to deter the use of substances. Rather, we should permit possession and use legally, perhaps on a

regulated basis, while maintaining our legal constraints against supply. This sort of model appears attractive but ignores several matters. The very reason we prohibit drugs is because it encourages demand through ready availability of the particular drug or drugs. On the other hand, demand encourages supply. If we had no users, there would be no supply. With prohibition of alcohol in the USA, only manufacture and interstate transport was prohibited, which is not often understood by people in Australia. There was a huge legal using market, which encouraged bootlegging and the like to cater to the market. It was not illegal to drink the alcohol; it was illegal to manufacture or transport it.

The introduction into society of psychoactive drugs such as opium and cocaine on an uncontrolled basis has caused enormous problems. The legal use of opium by China, forced upon them by Britain during the opium wars, caused enormous addiction, as it did when forced upon Manchuria during World War II. Over one-third of the population became addicted. Thompson is not saying that they were forced to use the substance but that legal availability was forced. Over 400,000 soldiers became addicted to morphine used as a pain-killer during the American Civil War. Heroin seemed to be the answer to that but as a short-acting opiate caused even greater problems. So too with cocaine, which merely added to their problems. There were 50 distributing houses established throughout the United States, which were later closed. Contrary to what is often said, the laws against many of these drugs were not some sort of a conspiracy on the part of the United States, and that is particularly so with cannabis. The truth is that, before the League of Nations in the 1920s, Brazil, Greece, Turkey and, very prominently, Egypt demanded that cannabis be made illegal because of the problems it was causing in their countries. The United States, I understand, did not prohibit marijuana production and use until the Marihuana Tax Act 10 years after that.

After World War II, these substances came under the control of the United Nations aided by the World Health Organisation. You probably know that we have a number of conventions to which we are signatories and the narcotics, drugs and psychotropic substances convention limits the cultivation and possession of illicit drugs for personal consumption and can be made prosecutable by criminal offences.

I often hear people say that it is no place for the laws and, with respect, I heard something of that in the previous speaker's presentation. I think it is oversimplistic to say that this is only a health problem, just as it would be wrong and oversimplistic to say that it is only a legal problem. This is a compound and complex problem which impacts on many parts of our society and many parts of the individual. It is a moral problem in that we expect people to be able to support and contribute and accept their responsibilities as part of our community. There is an ethical problem and the question of whether we allow people to do harm to themselves and have access and availability without any restrictions to those things that would harm them. There is, I believe, a spiritual dimension to this. We are increasingly seeing young people and not-so-young people who seem to be adrift in a sea of shifting values, with no sense of purpose or anchors to their direction and values in life—those things which can be considered to be of more than passing import and value. However you interpret spirituality, I believe that is one of them.

I have had significant involvement with the criminal justice applications in my court work and in three years as a prison chaplain. You will find that I have never, at any time, advocated that people who have a drug abuse problem should be incarcerated. I think that is barbaric at the

very least. But when I was running Salvation Army centres many people came to us for treatment, sent there by the courts, who otherwise would not have come, and who went on to achieve drug free status and a fulfilled and meaningful lifestyle. Just a few weeks ago I was in Brisbane. I went to a Salvation Army detox centre and was speaking to a young man who had been admitted just two days before. I asked him his story. He said, 'I was sent here by the police.' I said, 'What was happening to you? How do you feel about that?' He said, 'I feel good. I was totally out of control. I was shooting up and sniffing and swallowing anything I could get my hands on and there was nobody amongst my friends or associates I would listen to. That policeman saved my life.'

I was visiting a compulsory treatment centre in Sweden for young people just two weeks ago. One section of the facility that I went to was for young women, girls with an average age of 16 or 17. I said, 'How do you feel about being here?' One girl said, 'The first three months I absolutely hated it; the next three months, I began to realise I need it; I have been here six months now and I am so glad. I think they have saved my life.' So there is an argument for the deterrent effect of the law and of the police, and of the value of the intervention of somebody with some authority for the very best of purposes, that of saving these people's lives, turning them around and helping them to get the sort of treatment that, in their addicted state, they are incapable of making a rational judgment and decision about.

So many times, people—especially young people—have been sent to us or have come to us at a point of crisis and, after two or three days when they start to feel better and have been detoxed, have decided to leave, and I have had the families plead with me: 'Please don't let them go. They will go out there and get back into this and they are going to die.' In some instances, they have. I have been distressed along with the parents, as a parent and a grandparent myself. We did not have the means, and it was not our role, to incarcerate people and prevent them from leaving. But if there was some way that they could have been contained and constrained until they had gone through that further process of detoxification—and begun to be capable of thinking rationally and normally, begun to get some hope and to recognise that they are not bad people and that they are not useless and worthless people, begun to build up some of that sense of self-esteem, and, in the group work, begun to realise that they are not alone and that there are other people who are struggling with this and there are underlying issues we can help them with if we can get them through that early stage—then the possibility of their going on to successful completion of the program and remaining in a drug free state would be very high.

Our research shows that about a third of the people who come to us remain completely abstinent—of alcohol as well as other drugs. About a third, in the term that is popular today, very significantly reduce the harm that they have been doing to themselves. They begin to contribute to the community and make less demands upon social services and the health system, and they avoid impacting upon the criminal justice system. About a third are no better or worse; in some cases they are in prison or have died.

We need to be very careful that we do not accept the suggestion that if, somehow or other, these substances were available it would solve the problem. In our recent national household survey we saw that there has been a significant downturn in the use of illicit substances. The one substance that is of great concern to us, and which has been recognised here in the last two days as the greatest cause of social dysfunction and disruption, is alcohol. It is legally available

in pharmaceutically pure and measured quantities, with no criminality necessarily involved. We know that, particularly amongst young people, there has been ever-increasing usage and a move towards binge drinking and very serious harm to themselves as well as the community.

Thank God we have grasped the nettle and responded to the tragic consequences of smoking and tobacco in our country. With over 18,000 deaths a year, it is a tragedy not only for those who have died but for those who loved them and for those who have been robbed of those they love. There is also an economic cost in both the medical treatment and the lost opportunity to contribute to society. We cannot make this thing illegal, because we made it legal years ago. But we have taken a very clear, unambiguous line that smoking kills, smoking is bad for you and there is no such thing as safe smoking. We are leading the world in the reduction of smoking and we believe in its impact, as we heard from Professor David Hill yesterday.

One of the most deceptive lines that is being spread and promoted in our society is the idea that somehow marijuana is a relatively innocuous and harmless substance. My council conducted regional workshops and community organisation seminars in regional and remote parts of Australia last year. Time after time in these communities they said to us, 'We have got two problems. We are not so worried about heroin here, and there is a bit of amphetamine use around, but the things that are killing us and our kids and disrupting our community are firstly alcohol and secondly marijuana.' They said to us, 'Why don't you make sure that somebody gets up and tells the truth about this substance and what it does. We want to stop hearing it being talked about as recreational, as if it were tennis, cricket, swimming or something. Don't talk about it being soft; it softens brains.' And they told us about the impact on their young people.

There is a place for police, and as we have just heard about from Adam Graycar and Dr Matthews, the relationship between drug use and crime is very interesting. The research that I conducted in our services maybe 10 years ago showed that more than 60 per cent of those with criminal records in relation to drugs had been committing crimes before they ever used drugs, and that was confirmed by Dr Graycar this morning, when he said that the majority had criminal records before they began to use drugs. What that tells me is that we have people—and this has been emphasised by the presentation earlier—who have got dysfunctional lives, who come from dysfunctional backgrounds and who have chaos in their lifestyles. Often there are very low levels of literacy and self-esteem and a lack of a sense of hope or purpose in their living, and they are involved in antisocial activities. It is almost inevitable that they are going to get caught up, for a number of reasons, in substance abuse.

We can use our police and our laws to try and intervene in a positive way to turn these things around. I have seen it happen; I know it can happen. I am a supporter of compulsory treatment. I have seen centres in other countries where this has been introduced and they are getting good results. The other thing we need to remember is that there is not only drug related crime but there are also drug induced crimes. In the Sydney papers on Monday morning there were reports of the horrendous murder of a woman by her husband and her two children, and in the reports in the paper on Monday it related to the fact that these people were suffering from marijuana drug induced psychosis amongst other problems. People using drugs, especially the amphetamines and psychostimulants, have the capacity, because of the availability of the drugs and the use of the drugs, to do things that in their normal state they would not do.

CHAIR—Major Watters, you have been speaking now for 15 minutes. May I ask you to draw to a conclusion.

Major Watters—Certainly. One of the big lies is that nothing is working. We heard yesterday from Professors Mattick and Saunders that there are good things happening and some things are turning around. We have introduced diversion programs that are designed to intervene in people's lives. They are designed not to direct people into the criminal justice system but to direct them towards treatment. We need the cooperation of police, treatment services and education services. We need the multifaceted approach.

I have seen a tremendous development in the last five years, in particular in the attitude of police towards drug users and drug offenders. There are humane laws being enacted across the country. I think we do have to ask ourselves: what are our goals and our purposes? I think we are at a watershed. This is a seminal moment in our history. We can make a decision—as we heard yesterday—to accept the normalisation of drug use; we can say, 'We'll try and contain this and contain the harms'; or we can have the goal of trying to eliminate this thing as much as possible and not accepting the use of drugs as normal and inevitable in our society.

We have to look to the wellbeing of our kids and our society. We have to look to the challenge to our beliefs and values. We have to ask ourselves whether our respect for the quality of life as well as for the length of life will allow us to minimise the effects these drugs are having. We have to accept the challenge of the right and the capacity of people to live fulfilled lives, the challenge for our young people to accept the opportunities to fulfil their dreams and the dreams of those who love them. We have to recognise that, if we allow these substances to be normalised and accepted in our society and if we remove the restraints that the law can bring, we will have a great deal to answer for in the future. I earnestly plead that this committee carefully consider the implications for the future of Australia in the recommendations you make to the Australian parliament.

CHAIR—Thank you very much, Major Watters. Dr Wodak, if you would present for 15 minutes with a three-minute summation at the conclusion, that will see us with the final presentation and then we will open for questions and answers.

Dr Wodak—Madam Chair, members of the committee, ladies and gentlemen: thank you for the invitation to appear before this committee. I am going to comment on three aspects: firstly, the drug policy debate itself; secondly, how to get better outcomes from drug policy; and, thirdly, what voters around the world are now saying about drug policy.

Firstly, the drug policy debate is over. The reform side has won. Drug policy has been vigorously debated for decades. Some argued that drugs were primarily a criminal justice problem and therefore needed basically a law enforcement response. Others noted that policy based on trying to reduce drug supply was expensive, relatively ineffective and quite often counterproductive, while health and social interventions were usually more effective and less expensive. This debate is now over. The reform argument has won. Drugs are now recognised to be primarily a health and social issue. Support for this view is increasing around the world. In western Europe, harm reduction is the mainstream, while zero tolerance has marginal support.

Most experts and more and more community members recognise that drug policy should be based on science, public health and human rights, not fear campaigns and simplistic one-liners. It will still take some time for this change to work its way through the political process. Nor is it yet clear exactly what system will replace global drug prohibition. Of course, law enforcement will always and should always play an important role in any new arrangements, as it does today with legal drugs like alcohol and tobacco. No-one, including drug law reform supporters like me, wants to see one-kilogram bags of 100 per cent pure heroin or crack cocaine sold at supermarket checkout counters.

What are the major problems with a criminal justice based approach? Firstly, despite valiant attempts over several decades, prohibition has not worked in the vast majority of countries; secondly, prohibition is very expensive; thirdly, we do not know accurately even what the financial costs of prohibition are; fourthly, it is difficult to identify certain or even probable benefits of prohibition; and, fifthly, prohibition often produces very serious unintended negative consequences such as police corruption. In addition, it is now clear that drug prohibition was adopted half a century ago, when little was known about illegal drugs, when the costs and benefits of prohibition were not carefully considered and when the costs and benefits of alternative options were also not carefully considered. Moreover, in most countries, drugs cannot even be kept out of maximum security prisons. Alcohol prohibition in the United States in the 1920s is the model for what happens when demand remains strong and substantial supply reduction cannot be achieved. Drug prohibition is likely to be even less effective in a world increasingly adapted to globalisation.

Global drug prohibition and communism, the two major utopian movements of the 20th century, began about the same time. Both movements ignored powerful market forces. Communist economies, denying a role for the profit motive, were unable to deliver prosperity. Communism collapsed in the early 1990s. The Achilles heel of prohibition is also a denial of the importance of profits. The harder law enforcement authorities try to eradicate the supply of a strongly demanded drug by increasing the risk of detection, or the severity of punishment, the higher the price of drugs and, therefore, the more lucrative drug trafficking then becomes. How can supply control ever be effective when the price of a kilogram of heroin increases more than two hundredfold when transported from Bangkok to Kings Cross? If authorities increase the risk of detection, or the severity of punishment, the price and therefore the profit will increase even more. While ever demand remains strong, there will always be some people who are so ruthless or so desperate that they will accept the increased risk in the hope that they will get the increased profit. As communism showed, policy based on voodoo economics does not work.

Research from the prestigious RAND Corporation in the United States showed that drug treatment for cocaine users is 50 times more effective than eradicating the coca plant in South America, it is 23 times more cost effective than trying to intercept the transport of cocaine from South America to North America, it is 14 times more cost effective than investing in US police and customs, and three times more effective than drug education in trying to reduce the social costs of cocaine to the United States citizens. Yet the US government allocated 93 per cent of resources for cocaine to law enforcement and only seven per cent to treatment.

Some will say, ‘What about the heroin drought in Australia?’ That was five minutes of supply reduction sunshine in over 30 years of rain and flood. The recent shortage of heroin in Australia raises, in my opinion, three important questions: what caused it, how sustainable is it and what

were the net benefits and costs? Several senior law enforcement leaders have cast doubt on the contribution of improvements in domestic law enforcement to the heroin shortage, so we should be cautious about attributing the cause just to law enforcement. Eighteen months after the shortage started the availability of heroin has increased, but it is not yet back to the original levels. The 24 per cent reduction of drug overdose deaths in 2000 was very welcome, although overdose deaths had increased 30 per cent in the previous year and there had been a one-hundred-and-tenfold increase in the 34 years to 1998. We also have to remember that there were more deaths from drug overdose in Australia in the four years up to 2000 than occurred in the World Trade Centre last September. Many injecting drug users switched from heroin to amphetamine or cocaine during the heroin shortage. This switch is a serious threat to our national efforts to control HIV infection. So I am not certain about the cause, I am not sure about the duration of the shortage and I am uncertain about the net benefits and costs.

While recognising the huge and welcome benefit in having fewer drug overdose deaths, we have to remember how high these had climbed before they started to fall a bit. We must remember the threat to HIV control from the switch to cocaine and amphetamine. The parliamentary Joint Committee on the National Crime Authority said in 1989:

> Over the past two decades in Australia we have devoted increased resources to drug law enforcement, we have increased the penalties for drug trafficking, and we have accepted increasing inroads on our civil liberties as part of the battle to curb the drug trade. All the evidence shows, however, not only that our law enforcement agencies have not succeeded in preventing the supply of illicit drugs to Australian markets, but that it is unrealistic to expect them to do so.

Since 1989, that evidence has become even clearer. I now turn to the second question: how should we respond to illicit drugs to get better outcomes? First, I believe we should focus on getting better outcomes. This means especially reducing deaths, disease, crime and corruption. Achieving better outcomes is far more important than sending moral messages. Reducing drug consumption is important, but it is a means to an end; it is not an end in itself.

Second, we need to increase funding for health and social interventions to the level of law enforcement. In response to illicit drugs, the Commonwealth and state governments in Australia in 1992 spent an estimated $451 million of which 84 per cent was allocated to supply control, six per cent to treatment and 10 per cent to prevention and research. Switzerland abandoned a harsh law enforcement approach in the early 1990s when it was obvious that this had failed. Switzerland now has a balanced approach, spending about $A500 million each year on supply control and the same amount on health and social interventions. Outcomes have improved dramatically, and the new approach has massive community and political support.

Third, as the use of illicit drugs is likely to continue for the foreseeable future in Australia with only limited impact from efforts to reduce demand or supply, Australia should put the main focus on doing what we can do well: reducing the harm that drugs cause. We must at all costs maintain HIV under control. In the year 2000, there were 15 new AIDS cases in the USA for every 100,000 Americans compared with one new AIDS case for every 100,000 people here in Australia. Australia officially adopted harm minimisation in 1985 while the United States still explicitly rejects harm minimisation. Injecting drug users account for more than a third of new AIDS cases in the US compared with less than five per cent in Australia.

Fourth, drug treatment works but is grossly underfunded. We should expand the range of choices, increase the capacity of the system and improve the quality of treatment. Treatment

should be based solidly on research evidence rather than on whims and fancies or historical ways of doing things.

Fifth, we need to identify the least worst way for cannabis demand and cannabis supply to meet. In the next year, 3 million Australians will spend $5 billion—one per cent of GDP—getting relaxed and comfortable with cannabis. If there is no taxed and regulated source, cannabis consumers will spend $5 billion purchasing cannabis untaxed and unregulated from criminals, corrupt police or organised motorcycle gangs. This happens by choice not chance. Why preserve a $5 billion a year monopoly for these criminals?

Sixth, Australia has to try promising new interventions in health, social and law enforcement areas—provided that any evaluation will be rigorous. In the recent Netherlands' scientific randomised control trial of heroin assisted treatment for severely dependent heroin users who had not responded to any previous treatment, 56 per cent of those receiving heroin prescription improved compared with 32 per cent of those receiving methadone. Statistically, this was a highly significant result.

Heroin assisted treatment is only needed for a small minority. Just five per cent of those in drug treatment in Switzerland receive heroin assisted treatment. But it is critical that this small minority who consume vast quantities of heroin, as you heard from the previous paper from Dr Richard Matthews, are attracted to and retained in treatment. They account for a disproportionate share of the crime and probably also for a disproportionate share of the recruitment of new initiates. An Australian heroin trial is now inevitable. Why should the Australian people be deprived of the benefits of a promising intervention that might help to reduce the misery resulting from heroin use?

What are voters around the world saying about drug policy? On 7 November 2000, 61 per cent of voters in the state of California, the most populous state in the United States, supported a proposition to shift US$120 million from drug law enforcement to drug treatment. This was, I should add, against the implacable opposition of the entire political establishment of California, all the major newspapers and media in California, and all the district attorneys bar one. Majorities have supported reform proposals in 17 out of the 19 citizen initiated drug policy ballot initiatives in the United States since 1996. In 1997, 71 per cent of voters in a national referendum in Switzerland supported maintenance of heroin assisted treatment. According to Newspoll, support for a heroin trial in Australia increased from 38 per cent to 45 per cent in recent years while opposition fell from 55 per cent to 47 per cent. Around the world more and more voters are telling politicians that they no longer support policies based on the criminal justice approach. They want policies that reduce death, disease, crime and corruption. More and more governments around the world are now responding. It is time that we recognised that people with a drug problem need our help, not punishment. If our children had a drug problem we would want our kids to be helped rather than punished. Why treat the neighbours' kids any differently.

I have tried to put forward three propositions to you. The first proposition is that the drug law reform debate is over; the reform side has won. The second proposition is that the most fundamental decision we have to make is to switch from a policy that is based almost entirely on law enforcement to one based on both law enforcement and health and social initiatives where health and social initiatives receive equal funding with law enforcement. Thirdly, I have put to

you some examples of cases around the world which show that voters are telling the politicians that they want the kind of policies that I have been advocating. Thank you very much.

CHAIR—Thank you, Dr Wodak.

Mr DUTTON—My question is to Dr Wodak. I note that you are the President of the International Harm Reduction Association. Where does that body receive its funding from and what is the purpose of that body?

Dr Wodak—I must say that I am staggered that you ask such a question. Frankly, I do not see what relevance it has. But if you want to know, we receive money from UNAIDS, which is a branch of the United Nations system. It helps us run our conferences. We receive funding from a variety of organisations around the world. We make a little bit of money sometimes at our conferences. The organisation has six or seven regional networks around the world, which receive funding from people like the European Union. It is a complicated question and I do not have the answers right here in front of me. I could get the answers for you. I could ask you where you get your funding from.

Mr DUTTON—We get it from the Australian taxpayers. I might say that the reason I am in this place is because I represent the people of Dickson. Let me provide you with an assurance that there is overwhelming opposition to a heroin trial in Australia, certainly from my electorate's perspective. I think it is ill-conceived to suggest that a heroin trial in Australia is inevitable. Thank you.

Mr QUICK—On the whole issue of early intervention, having worked in my previous life as an educationalist in disadvantaged areas, I can see where both of you are coming from and I can see a commonality—I guess it is an ideological difference. How do we have a meeting of the ways? To my mind we have created industries, and those industries, whether law enforcement or drug reform, have particular agendas. As federal members we see the people who knock on our electorate office doors when the system has failed them. We have heard evidence over the last 18 months of poor coordination between the Commonwealth, state and local governments. How do we get rid of the ideological arguments and get back down to the people that Dr Matthews sees in jail? I can still identify them when I visit kindergartens in my electorate. We cannot get the resources; we cannot get the support for families. We are dealing with the end of the tunnel. How do we intervene? We are pouring hundreds of millions of dollars into law enforcement and intervention, but nothing seems to be working.

Dr Wodak—Thank you for the question. We are both going to answer it. If I may, I do not accept that the differences between Major Watters and me are ideological. I think the difference between us is basically one of evidence. I submit that the arguments I am putting to you are all based on evidence, and if you want to know where any of this evidence comes from I can tell you precisely where it comes from.

To answer the other part of your question about early intervention, it is a very important question. I think it is long overdue that Australia put much more emphasis on early intervention and I am delighted that that is now starting to happen right across the country. The evidence is overwhelming that early intervention is cost effective and that the benefits span a wide range of different health and social outcomes including marriage, crime, drug use and employment—it

really is quite staggering how many areas are benefited by it. History will not look kindly at us and how we have behaved over the last two or three decades in terms of starving the area of early intervention of much needed funding. It is basically a funding question. I hope we do further research in this area to make sure we get even better outcomes. There are very few people these days who are opposed to it.

There was an excellent publication that was commissioned and published by the Australian National Council on Drugs called *Structural determinants of youth drug use* that goes some lengths into this area and points out that we really need to embrace the area of early intervention in a much broader field. It is too complex to summarise very briefly here, but the basic argument of this publication is that early intervention is really only part of a new way we need to look at things like drug use. That includes things like, for example, town planning, where we have to get around to the idea that our cities and major towns have to have areas in their design where it is legitimate for young people to hang out and do their thing. It is a very important question, and I thank you for it.

Major Watters—I have to say that I think there are some ideological differences between us. We have shared platforms before. On the matter of evidence, I am somewhat surprised at what has been presented here today that I believe there is no evidential base for. We are a Commonwealth body, and there is no question that the Tough on Drugs strategy that has been implemented in Australia since 1998 has roughly equal amounts of money directed towards law enforcement, treatment, education, family focused efforts, the diversion program and public education programs—it is wide ranging but it is balanced.

There is very strong evidence—and we have heard it today—that the interdictions that have occurred have reduced the availability of heroin on our streets. I think it was sad to hear Dr Wodak say that the deaths have dropped a bit. It was not a bit. In Victoria, as we saw in the figures here, they dropped from 300 in one year to 50. That is a very significant drop. I estimate that there were, conservatively, 800 to 900 people who sat down to Christmas dinner with their families last year who otherwise would have been dead, from the way the movements were occurring. We have made a very significant impact. Deaths are only one measure; there are other things that occur in a society as a result of the availability of heroin. Contrary to what we were just told, the supply has decreased and the cost has increased. And we have not increased the problems; we have reduced the usage of heroin. The national drug survey, which has just been released, shows that there was a drop from 22 per cent use of any illicit drug in 1998 to 16.9 per cent. Heroin has dropped from 0.8 to 0.2—that is a fourfold drop. These are very significant figures. I am troubled when I hear people say that nothing is working. It is working; there are things working. We are not going to turn it around overnight.

I want to say this: I am a great supporter of harm reduction strategies. I believe that methadone and needle exchanges have their place, but I believe that the concept is being used to cover too many things that are not truly harm reduction. If we are talking about the evidence of prohibition over the last 20 years, the problems it has caused and the increase in deaths, have a look at the changes in the levels of drug use, deaths and infections that have occurred over the last 15 years under what has been called ‘harm reduction’. It is, what, a four- or fivefold increase in deaths. What have we got: 90-plus per cent of people who are injecting drug users infected with hepatitis C. What harms have we reduced? The reason for that is that we have tended to take a mechanical or pharmacological approach to this problem. Everybody who goes to receive sy-

ringes should be given the opportunity of counsel and support and psychosocial support, even as happens with the methadone programs.

We saw yesterday the very dramatic results that are occurring in methadone programs in Sweden. What was not spelt out for us is that it is a reducing regime with accompanying psychosocial support. That does not happen in Australia. Early intervention is absolutely essential. But, fundamentally, we are not dealing with a substance abuse problem; we are dealing with people problems, societal problems, deeper issues in families, underprivilege and lack of employment—all of those things that some of us grew up with and know a lot about in our own personal lives. Any compassionate society and nation is going to give those things due credence. I would like to see a lot more money directed to those things. But I do not believe that we should just accept that there is a huge imbalance, certainly at the federal level, towards law enforcement. That is just not true.

Ms GEORGE—I was pleased that Major Watters indicated his view that incarceration of people with a drug dependency is barbaric. I agree with you, and I think most people would see the treatment of drug dependency as a medical and social matter. My concern as a member of parliament and my perception is that there is a maldistribution of places in detox and rehabilitation. I come from the Wollongong area which has very few places, so that people who want to break their dependency do not always have access to a facility. Yet, on the other hand, on visiting a detox centre in Adelaide, I was told anecdotally by some of the younger people who have been through it that you could now virtually work the system and, if you wanted to, get a detox bed if your money was running short for the purchase of heroin. How can we act compassionately but in a way that at least regulates the public provision that is made to ensure the outcome that is there? How do we get a snapshot of the failure, in many places of need, for the services to be there? For example, the Aboriginal people tell me that they do not use mainstream treatment facilities. That is surely a major issue of concern. I am interested in how one focuses on treatment in a way that does not leave it totally open-ended and where there is some kind of regulation for a productive outcome.

Major Watters—I am very aware of what is and is not available in the Illawarra, and it has been a concern to me for many years. In my previous life as an active Salvation Army officer I made numerous approaches to the state government to try and expand services. Through the Tough on Drugs strategy we were able to give some money to the crisis centre down there, and there is a women's program that we are able to give some money to. At the moment a street-front counselling service is being opened by the Salvation Army in the Shoalhaven area. I know that is not your electorate, but it is a similar general problem area. There was a place called Oolong House at Nowra that particularly served Indigenous and Aboriginal people with what was quite a good program. I believe it has gone through some difficult stages. All of us would like to see a lot more available. I have always had the dream that people could find help and treatment as easily as they could find the dealer. That is the sort of commitment that we need in Australia—we need to see the priority of this thing.

Detox is important. Dr Wodak and I were both running detox units within reasonable proximity of each other. His had a different approach. Ours was the first stage of entrance into a rehabilitation program, so people had to show some sort of determination to do something constructive about their drug problem. At the same time, the sort of service that is provided as an adjunct to St Vincent's Hospital is very important for people who are beyond their capacity to

cope with their life at that point and gives them a chance to withdraw enough to begin to make some reasonable decisions about their life. Certainly, Dr Wodak would be as aware as I am that there are people who will try and use the system to go into treatment, as they call it, or certainly into detox, for long enough to withdraw to a degree where their tolerance has dropped enough that they can go out and use drugs again without having to spend so much money. It is a fairly cynical exercise. I am a little Pollyanna in that I hope that at some point in their drug using career they are going to listen and respond, even if they have used us a few times in the meantime. I hope that answers your questions.

CHAIR—Dr Wodak, would you like to comment?

Dr Wodak—Let me respond by commenting in two ways. Firstly, the overall problem is a mismatch between the demand and supply of detoxification across the country. There may be a few areas in the country that are lucky enough to have enough capacity for detoxification for their local areas. The area that I work in in eastern Sydney is unfortunately nothing like that, and I do not know any part of New South Wales that is privileged enough to have enough local capacity to meet the demand for detoxification. The basic problem is that we do not have enough supply. Secondly, the nub of your question was: 'How do you eradicate misuse of the facilities?' My answer is that you cannot; not completely. You can try and minimise it—and we do try and minimise it—but the only way you could eradicate misuse of any of the resources would be to close the facilities down. You would be eradicating all misuse, but you would be forgoing a lot of benefit.

Thirdly, it is important that we look at detoxification for what it is; it is part of a much larger system. We should not look at detoxification in a very short-sighted, simplistic way—in a cost-benefit way—because detoxification has a different function. The way detoxification functions, in my view, as part of a larger system is a little like the loss leader in the supermarket. As you are aware, to draw customers in from the street, supermarkets sell nylon stockings for 99c or something like that, at a considerable loss. Customers come into the shop and buy nylon stockings, but they also buy cereals, bread, eggs and bacon. They walk out of the shop having spent $80 and having bought some stockings which they got at below cost price. In a sense the stallholder lost on the stockings but gained much more on all the other things. Detoxification has that important role as well. It is bringing people into alcohol and drug treatment who are not yet ready at this stage in their lives to make a commitment where they are prepared to put more of themselves into the treatment, but they are prepared to make a little bit of commitment to get a little bit back.

What I hope is that, when they have had a couple of experiences of detoxification, they might be prepared to do something that is a little more serious. That might be going to a self-help group, some form of drug-free treatment, some religious based treatment or pharmacologically based treatment. Personally, I do not have any problems whatsoever with anybody achieving their objectives by whatever means. When it comes to drug treatment, I have to confess that I am utterly shameless. If a drug treatment works for somebody and they get their objectives, I am for that treatment. But, at the same time, I have to recognise that the treatments that are most effective in attracting people and in retaining people for decent lengths of time, and that are best supported by evidence that they have important benefits across a range of health and social domains, are invariably pharmacological. I believe in letting 100 flowers bloom and 1,000 schools

of thought contend in drug treatment, but at the same time I have to recognise that pharmacological treatments are the ones that are best supported by evidence.

Mrs IRWIN—Thank you, Dr Wodak; that was an excellent presentation. I have had the pleasure of going to St Vincent's Hospital and to your detox clinic. You are definitely saving lives, and it is a pity that you do not get more funding for the great work that you are doing. My views are a bit different from those of the member for Dickson. I have people within my electorate who would like to see the trial of heroin on prescription; their attitudes have changed over a number of years since I got into federal parliament in 1998. The ACT, I believe, was going to trial heroin on prescription but unfortunately the federal government stopped that. If there were recommendations in place where the federal government supported the trial of heroin on prescription within our states or territories, how would you actually start that particular trial? I think this is where people in the general public are getting a bit confused. They think that anyone who is on heroin could virtually go to the doctor and say, 'I'm going to have heroin on prescription.' If you were given that funding, how would you start that trial?

Dr Wodak—All of this was mapped out and presented to the Ministerial Council on Drug Strategy on 31 July 1997. You may be aware that the 18 ministers who met that day voted 6-3 in favour of the heroin trial. The whole program was mapped out with two or three stages, starting off with a smaller stage—a pilot stage—and then going on to later stages. As you are aware, that was passed 6-3, approved by the members that day including the two Commonwealth delegates. But Mr Howard overruled that on 19 August when the federal cabinet met. My guess is that when this is finally approved, later on in this parliament or in the 41st Parliament, we would go back to those plans and we would see what has happened in the light of developments around the world.

Since the 1997 plans were drawn up, the heroin trial in the Netherlands has concluded very satisfactorily. It has been an astonishing success. The kind of success that was reported for the Netherlands—and it was a very rigorous scientific trial—was such that, had this been a drug that was marketed for a common condition, such as peptic ulcer or high blood pressure or diabetes, the company responsible for that drug would get a 10 or 15 per cent rise in their sharemarket price. A very substantial benefit was shown in the Netherlands, so we would look at the results of what has happened in the Netherlands, depending on how the other trials were proceeding. There is a trial proceeding in Germany. There is one about to start in Spain in a year or so, and Canada has recently approved a trial. It would depend on what we have learnt from all those trials, because we would need to modify those plans in the light of new knowledge.

I might point out that the Canadian trial was funded by the national medical research organisation equivalent to our NHMRC. It went into competition with 71 other research studies spanning the whole field of medical research, so cancer, diabetes, heart disease, kidney disease—the lot. Out of the 72 it was judged third best, and the funding body did not have the funding required to support the application—$8 million was requested—but they thought the study was so important and so good scientifically that they went out and found the $8 million to fund the study. So that study will be going ahead in Canada and, depending on when the Australian study starts, we will learn from all the other international studies.

Mr WAKELIN—Australia should be grateful that it has been able to listen to the debate and discussions overseas. I have a statement and a question. It seems that our main responsibility—

given our general agreement on this—concerns the harm that drugs, whether legal or illegal, do. It seems that should be our main focus, and certainly as a legislator that is my responsibility. What would your main single message be to our national community over the general substance abuse issue? I suppose I will confuse it a little by asking how you feel about the amount of knowledge on access to treatment. What is the main message to our substantial community? How do you feel about the knowledge of our community and the knowledge of our national community about access to treatment?

Major Watters—The message I would want to give is that this committee, the nation and the national parliament do not surrender. It is not inevitable that we are going to have an escalating and continuing drug problem and that it has to be part and parcel of our culture. That is not necessarily so. There will always be some drug problem, just the same as there will be other social dysfunctions and crime occurrences. We are never going to eliminate them; we are never going to live in that utopia. That would be very nice but it is not going to happen. But we will compound the problem immeasurably if we follow this line that somehow or other if we make these things more available and accessible and more acceptable and cheaper we are going to reduce the problem. We have the message of the current legal drugs to tell us what the problems are and how they will impact on our society.

On the day I was leaving England two weeks ago, on the front page of the *Daily Express*—I think it was—there were great headlines: 'We've halved the price of ecstasy and doubled the deaths in 12 months.' That is very telling. I went and visited that facility in Amsterdam just two weeks ago. I spoke to the medical director there. I have not received the official reports, but what she said to me and the member of the Prime Minister's department who was with me was a lot more ambivalent than that. I talked to her last year and she was very enthusiastic.

It is very difficult to translate these things. The fact is that heroin is not a popular drug in Holland. I would also say to our nation, 'Don't get sidetracked by heroin.' They tell us in Holland, 'It is yesterday's drug; it is a loser's and an oldie's drug,' and we have heard it here time and again. The epidemic, in some ways, has passed and other things are coming up. I cannot understand why we would want to put our resources and energies into heroin trials when we all know that amphetamines and other psychostimulants are the things that are impacting now.

Regarding knowledge and access to treatment, there is not enough access. We disagree on some things, but we do agree that there should be a wide range of pharmacological treatments, abstinence based treatments and all manner of things—horses for courses. We need to have a wide range of treatments to meet the needs of the individual. The other thing we need to do is get the knowledge out in the community that there are treatments that work. We do not have to surrender our people and our kids to a lifetime of substance abuse.

Dr Wodak—I think the crunch point is always whether we couch it in terms of a law enforcement problem or a health problem. We should resist the temptation to couch it in terms of a war, being tough on drugs and tougher than other people. If I may, I refer you to the *Hansard* of Tuesday 28 May 2002, page 2,455, where the Prime Minister said:

I also believe we have a war against the scourge of illicit drugs in our community, and I want to see that prosecuted with the same zeal ...

The word ‘same’ refers to the war against terrorism. I do not wish to address this to one side of politics, so it is most important that all members of parliament get away from that language and that sort of moral view. This is much better approached as a health issue and a social issue. The conclusion of the Mullin report from the House of Commons stated:

> If there is any single lesson from the experience of the last 30 years, it is that policies based wholly or mainly on enforcement are destined to fail. It remains an unhappy fact that the best efforts of police and Customs have had little, if any, impact on the availability of illegal drugs and this is reflected in the prices.

Committee after committee around the world is coming to that kind of a conclusion, so we have to go where the evidence is. In terms of treatment, what do we need to do? As I said in my talk, we need to increase choice, capacity and quality. Why choice? Because, if you are selling toothpaste, it helps not just to sell white toothpaste but to sell toothpaste that has green stripes in it, pink stripes in it and all sorts of stripes so that you can get as many people as possible in Australia using different kinds of toothpaste to increase the market. We should be getting people into treatments for three reasons: it helps them, it helps their families and it helps the community. We all lose if they are on the streets using street drugs, and we all benefit if they are in treatment—‘we’ meaning people who own property, pay taxes or pay insurance, just looking at it in those mercenary terms.

In terms of capacity, the system at the moment cannot meet the demands of all the drug users in Australia, were they all to put their hand up and say they wanted to go into treatment. We cannot even meet the demand that exists today. I am ashamed to sit here before you and tell you that I am responsible for a methadone program that has a waiting list. The methadone program has existed for 16 years and for all but six months of those 16 years we have had a waiting list. I am ashamed about that. I would love us not to have a waiting list—I would love all methadone and drug treatment units not to have a waiting list. There is a waiting list basically because there aren’t enough units. There aren’t enough trained people and there isn’t enough money going to them. It is as simple as that.

There are some complexities. If you gave us more money right now, we could not expand the treatment system fast enough, for your liking and my liking, because we do not have enough trained people. We do not have enough trained people—it is all very circular—because very few people have been attracted to this area. It is very stigmatised, and it is stigmatised because the users are stigmatised, and the users are stigmatised because they are regarded as criminal scumbags. They are not criminal scumbags; they are people with a health and social problem. A tremendous number of them have terrible histories going back to their early years.

Finally, I want to say something about quality of treatment. We have to get our drug treatment systems to be accommodated in buildings that are no better and no worse than the buildings we use to treat diabetes, heart disease, kidney disease or anything else. I do not want them better than those; I want them just the same. Likewise, I want the quality of our staff to be as good as the quality of other staff and to get the same rates of pay as the other people. It is not all that complicated really, and it basically comes down to money, and the reason the money is not provided is the skewed distribution, most of it going to law enforcement.

CHAIR—Thank you. I need to wind up, but I need to indulge myself in a question—I have refrained from doing that for most of the two days. I will try to put my question as succinctly as possible, and if I can get as succinct an answer as possible that would be really good. In all of

our programs, it does not matter whether they are drug programs or telecommunications programs, we have an industry that builds upon researching, understanding, getting out there and doing lots of paperwork and lots of investigating, but when we get to the delivery side of it, out of the entire budget there has been this much spent on researching, running out, inquiring and investigating and this much on the actual delivery. Why is it that we should be looking at heroin trials when we have not even considered removing the paperwork war, the research and the whole host of investigative material out of the debate and putting the funding directly into on ground delivery of services and actually delivering to the people? How would heroin trials reduce, with respect, the methadone waiting lists? Would we not just be transferring to people on a heroin waiting list?

Major Watters—Briefly, in answer to the first question, I want to do a plug for the Australian National Council on Drugs. We have advocated and we have received the funding now to set up a national magazine which will act as a conduit from the heady world of research to the coalface. There is wonderful research being conducted that is gathering dust on university and other shelves. We have wonderful researchers in Australia. Yesterday morning I was absolutely in awe of the things that were presented to us. There are wonderful researchers at places like NDARC, Dr Graycar's centre and others, but it does not get down, as you rightly said. We are establishing this magazine, which will go to the treatment services. In our future research project contracts through our council we will require that the people do a simple English precis of what they have accomplished and how it can be applied. We hope to get it down there to the people who are doing it, and to make it useful.

It is no secret that I very seriously question the value of heroin trials and I will be very surprised if they ever occur. At the Ministerial Council on Drug Strategy last year, after listening to Professor Mattick's presentation, which we heard yesterday, the Minister for Health, who voted for the heroin trial two or three years before, stood up and said, and it was agreed to by most there, that if we had had this information in Cairns two or three years ago we would have come to a different conclusion. The only other thing I want to say is that this focus on heroin is unfortunate. The medical director of the heroin trial in Amsterdam told me that 92 per cent of her clients were also using street cocaine.

CHAIR—Thank you. Dr Wodak, do you have a response?

Dr Wodak—Yes. Let me summarise your question. The first part was: what is the relative proportion of spending on research and on service provision? I do not have the exact figures available to me, but the proportion is predominantly weighted to service provision by a large factor of 40:1 or 50:1—it is of that order. We do need research because we need to keep investing in what we should be doing in five, 10 and 15 years time. Also, we need research because, frankly, we do not have answers to problems that are very big issues now and that are looming—such as the increasing use of amphetamines in Australia.

In answer to your second question about why do a heroin trial, let me put it succinctly like this: in my vision of how things should proceed in the future, we will end up with everyone who wants to get into treatment for all drugs getting into treatment. That means that we have to have treatment that is attractive and diverse, which also means that we should particularly focus on a tiny proportion—those whom Richard Matthews talked about—who are going in and out of prison, causing a lot of crime and probably doing a lot of recruitment. They are that five per

cent of heroin users who are using maybe 20 or 30 per cent of all the heroin used in the community. We do not have these figures—I am just guessing them, because we cannot get the figures directly as the area is illegal and highly stigmatised—but they would be of that order.

Getting that last five per cent into treatment is even more important than the five per cent who are just starting to dabble, because many of those who are just dabbling will probably give up on their own or with minimal treatment. We are talking about those five per cent who are not going into treatment at the moment—if they were they would not be turning up in Richard Matthews's hands. We need to get them into treatment and as much as possible keep them in treatment for everybody's benefit—theirs, their families' and the community's benefit. The experience of the Netherlands trial is so overwhelmingly positive I would have to ask you: why would you not want this available in Australia? It costs more money to do a trial than it does to provide the treatment. This would probably be a more expensive treatment than the methadone treatment but it would be reserved for people who cause a tremendous amount of damage in the community. Investing in a more expensive treatment for them is for the benefit of everyone.

CHAIR—Thank you very much. I conclude by thanking all the people who have provided information to the roundtable over the past two very informative days. I congratulate all speakers on their discipline in their presentations. I also congratulate all committee members on their discipline. A lot of discipline has been shown by everybody over the past two days.

On behalf of the committee, I thank the committee secretariat—Sarah, Margaret, Bev, Debbie, Jill and Rebecca. Everybody takes for granted that these roundtables just come into being. It takes an enormous amount of organisational work and knowledge to have a very balanced two days of presentations. I congratulate the committee secretariat on the time and effort that they have put into achieving an extraordinary exchange over two days that will assist this committee to come to resolutions, hopefully by the end of the year; it may be a little later.

I would also like to thank the audience in the gallery for their patience and their attendance. I thank the Hansard staff for their diligence over the past two days. It has been very much appreciated.

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

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 2.29 p.m.