COMMONWEALTH OF AUSTRALIA

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Reference: Substance abuse in Australian communities

MONDAY, 23 SEPTEMBER 2002

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND COMMUNITY AFFAIRS

Monday, 23 September 2002

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

Members in attendance: Mr Cadman, Mrs Draper, Mr Dutton, Ms George, Mrs Hull, Mr Pearce, Mr Cameron Thompson, Mr Quick and Mr Wakelin

Terms of reference for the inquiry:

To report and recommend on:

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

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

WITNESSES

DRUMMER, Professor Olaf Heino, Head, Scientific Services, Victorian Institute of Forensic Medicine; Adjunct Professor, Department of Forensic Medicine, Monash University 1271

WEATHERBURN, Dr Donald James, Director, New South Wales Bureau of Crime Statistics and Research 1258

Committee met at 10.40 a.m.

CHAIR—I declare open this public hearing of the House of Representatives Standing Committee on Family and Community Affairs and welcome everyone here today. The inquiry into substance abuse was started during the last parliament. A vast amount of information was collected and last September, just before the end of the last parliament, the previous committee tabled a discussion paper that summarised this information. The discussion paper did not contain conclusions, nor did it contain recommendations to the government. This is the task that the new committee formed in this parliament has taken on: to complete this report and to provide to the government and to the Australian community a list and summary of recommendations and a report on substance abuse. Last month, the committee held a very successful roundtable that addressed all of the terms of reference for the inquiry. The speakers at the roundtable have helped us to refine our thinking. Today, we are looking forward to obtaining more information that will assist us to draw our conclusions about substance abuse in Australia and the recommendations that we might make to the government on the way forward.

[10.41 a.m.]

WEATHERBURN, Dr Donald James, Director, New South Wales Bureau of Crime Statistics and Research

CHAIR—I will now move to the procedures for calling witnesses, and I welcome Dr Don Weatherburn. I remind you that evidence you give at this public hearing is considered to be part of the proceedings of parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. Please proceed with your presentation.

Dr Weatherburn—I will not talk for long. I thought it would be better to make myself open to questions at the end of a brief presentation, not to go on at length not knowing precisely what your interests are. You have already had circulated to you the dot points that I am going to speak to and a short document entitled *Reducing illicit drug use and drug-related crime: some issues and misconceptions*. I am happy to answer questions on that document or on the presentation I am going to give you now. I was asked to talk about options for dealing with illicit drug crime, but I have thrown in alcohol, if you do not mind. Since it causes so much grief, I could not resist offering a few words on that subject as well.

Before we begin, I might just address a common question: how much crime is drug related? That seems to be something that generates a great deal of confusion and public misunderstanding. We know that about 50 per cent of assaults are alcohol related—that is to say, in about 50 per cent of assaults either the victim or the offender has been drinking immediately before the assault. In the case of illicit drugs, the best evidence we have in Australia comes to us from the Drug Use Monitoring in Australia program, the DUMA program, which I think you been briefed on already, run by the Australian Institute of Criminology. That program tells us that about 32 per cent of people arrested for property crime—and I include robbery as a property crime—test positive for recent heroin or cocaine use. That is substantially less than popular estimates of up around 60 to 90 per cent.

You need to bear in mind, though, that there are a couple of complications in judging from that statistic how much property crime is drug related. The first complication is that many regular drug users are involved in crime long before they become drug users, and remain involved in crime after they become drug users. The principal effect of drug use on crime seems to be that those who are dependent commit a lot more crime after they become dependent. To illustrate that point, in one survey we conducted of 225 incarcerated property offenders in New South Wales a couple of years ago, we found that burglars who self-reported dependence on heroin were committing about 15 break and enters a month, compared with eight or nine who were committing burglary but were not drug-dependent. The general effect of serious heroin or cocaine drug dependence is to increase the rate at which people offend rather than to draw a lot of otherwise law-abiding people into offending, although of course there would be exceptions.

There are three broad strategies you can use in the management of drug related crime: offender based, offence based and drug market strategies. I am going to say a little bit about each and then I am going to stop and answer any questions you have. In terms of offender based

strategies, the first option is to expand voluntary treatment. In the case of heroin, that means methadone. After four or five years of trying to score heroin and trying to avoid the police, a good many heroin users become very tired in the process—worn down by the stress and strain of trying to raise money to buy heroin. At that point they become quite open to the idea of treatment. In those circumstances it is absolutely crucial that we provide easy pathways into treatment. There is a good deal of evidence that people's offending rates and illicit drug consumption rates decrease when they enter treatment, so voluntary treatment is an important line of defence against drug related crime.

Of course, there are plenty of people who cannot be tempted into voluntary treatment and who will enter treatment only when they see a serious risk of imprisonment. These are predominantly people who are picked up for persistent property crime or violent crime and who are facing their first, second or third prison sentence. At that point they become quite amenable to what you might call coerced treatment—treatment that the court refers them to and which they have to participate in on pain of being sentenced in the usual way and most likely sent to jail. The available evidence suggests that coerced treatment, if properly resourced, is no less effective than voluntary treatment in reducing drug use and drug related crime.

The third option, which is one that the police spend a great deal of time doing—we are talking about reducing property crime here, not drugs—is targeting repeat and high risk offenders. Most of you would know that a small percentage of offenders account for a large percentage of crime in New South Wales. If I can use the phrase, the 'most productive' 10 per cent of offenders are responsible for about 40 per cent of all crime that is dealt with by the local court. It makes good management sense to try and identify these individuals and target them for arrest. That has been happening in New South Wales for a couple of years now. Local area commands have lists of people who they regard as being very active in the area. They deliberately set out to identify and apprehend these people, whether it is for property crime or for any other form of crime. The various methods available include calling in outstanding warrants for fine default and the like. I am rushing fairly quickly over this because I assume it is fairly familiar territory to you.

Targeting receivers is another important way of dealing with drug related crime. As the saying goes, there are no thieves without receivers. In New South Wales, receivers are a very important target for policing operations, because it is in many ways a lot easier to identify and target a receiver than it is to identify a young thief whose risk of apprehension may be quite small. When we interviewed the 200 property offenders I spoke about earlier, we found the No. 1 receivers and the No. 1 means of disposal of stolen goods were drug suppliers. Drug dealers are now, and have been for the last few years, entering into barter arrangements with property offenders. There is no need now to fence the goods, obtain the cash and buy the heroin or cocaine; it is possible to go straight to the drug dealer and swap the goods. This is not backed by any hard evidence at this stage, but there are suggestions that the receivers of those stolen goods then ship them out of the country to South-East Asia and other places where they are resold.

A second major category of receiver—perhaps less important now than they had been a couple of years ago—are pawnbrokers, second-hand dealers and corner stores, which were a major avenue for the disposal of stolen goods at one point. By targeting these sorts of places, you reduce the ease with which stolen goods can be disposed of. That acts to suppress the amount of drug related property crime that occurs. Am I moving too quickly?

CHAIR—No. You are doing fine, thanks.

Dr Weatherburn—On the idea of strengthening non-custodial sanctions, on the way up the ladder of penalties, many drug dependent offenders begin with non-custodial sanctions. I think it is fair to say that in years gone by, in most states, these non-custodial sanctions have not been strongly enforced and have not been as active a level of supervision as one might hope. Penalties for noncompliance with non-custodial sanctions have not always been strict. Clearly, if someone is going to receive a non-custodial sanction and you want to use that as an opportunity to suppress drug related offending, the sanctions have to be properly enforced. It is no good having as your only choice a custodial sentence on the one hand and a non-custodial sentence on the other hand that does not have any material sanctions attached to noncompliance associated with it. Strengthening non-custodial sanctions is important. That, by the way, is something the Home Office is now pushing quite strongly in the United Kingdom: trying to increase the level of supervision of people under non-custodial sanctions.

Another option under the heading of ‘offender based strategies’ is increasing post-release supervision treatment and support. For a long time now, I think one of the weaknesses in Australian criminal justice systems has been to release people from jail without adequate access to treatment and post-release support. In New South Wales, I think it is still true that people who may have a heroin habit and are released from prison have to queue with everybody else to get access to methadone. That is less than ideal because about 60 per cent of those released from jail come back within two years. If you want to reduce that percentage, it is absolutely crucial on the one hand to ensure that those who are drug dependent are provided with the means by which to control their drug dependence, and on the other hand ensure that people who are released on probation or parole realise there is a serious risk of apprehension if they breach the conditions of that probation and parole. You would not call treatment a carrot, but in a sense it is a bit of stick and carrot by ensuring that once people are released from jail you do not just abandon them to the sorts of influences that got them in there in the first place.

Let us look at some of the offence based strategies, including proactive patrols in problem locations. The strategies I am highlighting, by the way, are the ones for which we have good evidence of their efficacy. Proactive patrols in problem locations have been found to be a very effective way of reducing drug related property crime. Of course, it is true that drug dependent property offenders can always move into areas where there is a less intensive police presence. However, when studies have been conducted of displacement, by and large, although there is displacement, there is not what is called complete displacement. In other words, there is some attenuation of the drug related property crime, even if it does move into other areas. That is partly because there is a tendency, wrongly, to assume that drug dependent people have a fixed quantity of crime they have to commit to meet their heroin dependence. If the heroin drought has shown us anything, it has shown us that even dependent heroin users can adjust their consumption of heroin to some degree to deal with the circumstances they find themselves in. The price of heroin goes up and, although they still use heroin or shift to cocaine, overall consumption is down.

Reducing repeat victimisation risk is quite important in reducing drug related property crime. Once places have been burgled, the chances of them being burgled again are elevated for about six months after they have been burgled. One very effective strategy for reducing that risk is to increase security in places that have been the target of property crime in the past. That reduces

the perceived ease with which you can access these dwellings and reap the benefits of what the insurance might have provided. Other opportunities controls include publicising risky behaviour and risky places. By risky behaviour I simply mean walking around with your bag under your arm or walking around the streets of Sydney or Melbourne in the early hours of the morning intoxicated—all these sorts of things are open invitations to people who commit crime to do so. So it is very important to try and educate the public not to do silly things that place them at risk of becoming victims of property crime. Property marking is also important. There have been some major technological developments on that front, especially with motor vehicles. You might have seen recent television coverage of spraying identification numbers on body parts of vehicles. None of these things are miracle cures; all of them, though, are quite important devices for reducing the opportunities and increasing the risks associated with property crime.

The last set of strategies that I will talk about before giving you an opportunity to ask me questions is drug market strategies. I cannot resist throwing in strict enforcement of liquor licensing laws. There are, as I have already pointed out, major problems with alcohol related crime and violence. The main line of defence against those problems is enforcement of the liquor laws, particularly laws relating to the responsible service of alcohol. It is very important that those laws be enforced if we are going to minimise alcohol related crime.

The second strategy is to increase the cost of more harmful drugs relative to less harmful drugs. This is a controversial one but, again, one of the things that has been thrown up from the heroin drought is that people who could not get heroin started switching to cocaine. Cocaine is, in many ways, arguably more harmful than heroin. If we had to choose, it would be better if people dependent on heroin or cocaine shifted to cannabis. The prices of these drugs do affect consumption, and the last situation we want to create is one in which the most toxic, most dangerous drugs are actually cheaper than the less toxic, less dangerous drugs. Pushing up the price of heroin is important but it is important to push up the price of cocaine as well if you want to reduce the chances of people moving from one of those drugs to the other—likewise with amphetamines.

In relation to disrupting open drug markets, the Cabramatta experience has shown that you can disrupt open area drug markets and make quite a difference to the amenity of local areas without simply shifting the problem to another area. Of course, the disruption is temporary to some degree. Enforcement of those areas has to go on periodically in order to reduce open drug dealing, but the whole aim of the exercise is to make it difficult, risky and time consuming to score drugs, and that tends to make people consume less than they might otherwise consume where access to drugs is extremely easy and drugs themselves are quite cheap.

Back to alcohol: prohibiting dangerous alcohol marketing strategies is something I will not dwell on but, when I say that, I have in mind—I have forgotten the phrase for them—highly concentrated alcohol that people can take along with beer. I have seen them advertised. I noticed some in the pubs the other day—little schnapps glasses that you can drink alongside beer—which get people intoxicated in a very short space of time and which greatly increase the risks of alcohol related violence. That is all I will talk to. I will open it up to questions. I assume you do not need me to speak on this document which you have already.

CHAIR—No, we already have that document. Thank you, Dr Weatherburn.

Mr DUTTON—Can I ask you to expand a bit more on the claim that only 32 per cent of those people you tested came back heroin or cocaine positive and that that was crime related? Can you flesh that out a bit for us?

Dr Weatherburn—Sorry. I will give you a bit of background on the DUMA program in case people are not familiar with it. Around Australia at various sites, the Australian Institute of Criminology has instituted a program whereby, once every quarter over a two- to three-week period, everybody arrested by police in those stations is interviewed and has, if they agree to it, their urine tested for various drugs. The 32 per cent is the percentage of people arrested by police for property crime whose urine tests positive for heroin or cocaine.

Mr CADMAN—Is that figure of 32 per cent for New South Wales or is it national?

Dr Weatherburn—Those are figures drawn from Parramatta and Bankstown. I would imagine that they are as high as they get. They are probably somewhat lower in other parts of the country.

Mr CADMAN—Could you let us have some of the background details of those?

Mr DUTTON—Following on from that, I would be interested to know if you included amphetamines and perhaps cannabis as well.

Dr Weatherburn—It does not include cannabis. A much higher percentage would fall into the category of testing positive if you included cannabis. There is not a lot of evidence that people commit crime to raise money to buy cannabis, although we did find some evidence of that some years back with young kids in custody. We have not found much evidence of that amongst the adults. When I say only 32 per cent test positive, that does not mean that only 32 per cent of crime is drug related. I might have moved too quickly over that issue. My point was that, although 32 per cent test positive for heroin or cocaine, that group will be committing more offences than the group that does not test positive. Remember, I said that heroin dependent people in prison were committing about 14 break and enters per month compared with nine or so for others. It is the difficulty of trying to work out what their contribution to the total crime rate is that makes it difficult to put a figure on the total amount of drug related crime.

Mr DUTTON—So that I am clear, have you included amphetamines in that category?

Dr Weatherburn—That would not make much difference.

Mr DUTTON—Really?

Dr Weatherburn—No. What would make a difference is including cannabis. If you want the up to date figures on that I am happy to provide them.

Mr DUTTON—Thank you.

Dr Weatherburn—For the country as a whole, I would advise you to go to the Australian Institute of Criminology, which actually runs the program.

Mr DUTTON—We have taken some evidence on that.

Mr CADMAN—The New South Wales figures would be pretty helpful.

Dr Weatherburn—Yes, I would expect those of New South Wales to be amongst the highest around the country. I would not be as familiar with drug markets in other states as I am with those of New South Wales. But there are reports available in the public domain about these things and you can get complete breakdowns of the figures.

CHAIR—Thank you, Dr Weatherburn. We will seek to get those figures.

Mr PEARCE—Dr Weatherburn, with the last slide your were talking about drug market strategies. One strategy was to increase the cost of more harmful drugs relative to the cost of less harmful drugs. How do you do that? How could you implement such a strategy?

Dr Weatherburn—A great deal depends upon where police focus their efforts. Say police were to concentrate all their efforts on cannabis—crop eradication and attempting to identify people who are involved in the importation of cannabis and the like—and genuinely succeeded in creating a scarcity so that the price of cannabis rose higher than, for example, the price of cocaine or amphetamines or heroin. What worries me about that situation is that people may shift from cannabis to the cheaper drugs. There are plenty of people out there who are polydrug users, and they will simply use whatever drug is available and relatively inexpensive to obtain. Sure, there is some personal preference involved but cost is an important factor. So the short answer to your question is that the way in which police influence drug prices is determined by what sorts of drugs and drug trafficking they target.

Mr QUICK—On that issue, what are more harmful drugs? We have heard evidence from Collins and Lapsley about the cost to Australian society. To my mind tobacco and alcohol are more harmful in terms of death, lack of productivity and a whole lot of other issues. Are we just talking about illicit harmful drugs?

Dr Weatherburn—I have thrown in alcohol, which I thought was perhaps going outside the terms of reference. This question of which drugs cause the most harm is more complicated than it looks. It is certainly true that tobacco and alcohol cause a lot more harm than illicit drugs. But it is also true that that is because tobacco and alcohol are a lot more prevalent than most illicit drugs. It is fair to say that, if we were to see an increase in, say, heroin or amphetamine or cocaine use on the scale of the current levels of alcohol and cigarette use, I am sure illicit drug related harm would go up accordingly, so in some ways it is a little unfair to say which drugs cause the most harm. We have chosen to live with certain drugs, their prevalence is high and it is not surprising that as a result the harm they cause is high. The sixty-four thousand dollar question is: if we allow the prevalence of cocaine, heroin and amphetamine use to grow, would the harm associated with those drugs go up commensurately?

Mr QUICK—What correlation is there between drug use and law enforcement in light of the fact that we have different tolerances within the states—for example, South Australia and Western Australia—about cannabis use?

Dr Weatherburn—I am not sure as to your question. What is your point?

Mr QUICK—To my mind, in South Australia there seem to be more liberal cannabis laws to do with prosecution and incarceration than there are in other states. We do not seem to have a level playing field. Consider the links between crime and law enforcement and what the states legislate. South Australia is more liberal. Would you have more or less crime there than if you were to have zero tolerance in, say, Western Australia or Tasmania?

Dr Weatherburn—I think you are talking specifically about cannabis because I do not think there are material differences in any other domain.

Mr QUICK—Yes, I am talking about cannabis.

Dr Weatherburn—There is not a lot of difference, if any, in the prevalence of cannabis use in states such as South Australia, where there is a fairly liberal approach to the drug, and its use in states such as New South Wales, where all use is prohibited. There is not a lot of difference in the prevalence of drug use. There may be a difference in levels of consumption, although that has not been well measured. But there is not a lot of crime committed to raise money to buy cannabis. The connection between cannabis and crime is more on the side of police corruption and people who are committing drug crime in a sense of importing the drug or cultivating it. There are not a lot of people out there committing property crime to raise money to get cannabis. I assume you are interested in the property crime connection, not the general question of how much corruption, for example, there is with cannabis.

Mrs DRAPER—Dr Weatherburn, I am interested in your comments relating to crime leading to drug use and vice versa. Some people may or may not argue that drug users using a lot of drugs would expand their activity into criminal behaviour. From memory, I think you said that crime and criminal behaviour leads to drug abuse.

Dr Weatherburn—I do not think one causes the other. There are characteristic patterns we have seen when we have interviewed heroin users, and similar studies have been conducted overseas. We asked people questions like: when did you first commit crime? When did you first use heroin? When did you regularly commit crime? When did you regularly use heroin? The typical answer to those questions is that they were involved in crime long before they started using heroin. When they became dependent upon heroin they committed more crime; it escalated. It is more a case of heroin or cocaine magnifying their criminal activity, as opposed to the media stereotype where lots of people who had become dependent upon heroin had been living law-abiding lives up to that point and had been suddenly drawn into criminal activity. I think those cases occur but they are the exception rather than the rule.

Mrs DRAPER—Was that specifically in relation to heroin and not other drugs?

Dr Weatherburn—Yes, specifically in relation to heroin. I would add injectable cocaine use as opposed to the snorting of cocaine, which is often done as a recreational activity by people, some of whom go on to become dependent but many of whom do not.

Mr CAMERON THOMPSON—In your presentation you spoke about strengthening non-custodial sanctions. It occurred to me that you did not make any comment about the impact of custodial sanctions—and I am thinking about some of the really over-the-top custodial sanctions in places like Singapore. What kind of impact do they have?

Dr Weatherburn—We do not have a lot of evidence here but in the United States it is fair to say that, over the period in which I think the level of imprisonment for drug use and trafficking tripled, cocaine prices actually fell by half. I have got full details of that. That is what gives me a sense of pessimism about the capacity to further suppress drug trafficking through longer prison terms. Had prison been an effective way of suppressing the drug market, you might have expected prices of illicit drugs in the United States to rise with the level of imprisonment for drug trafficking.

The conventional economic theory goes like this: traffickers factor in the risk of imprisonment when setting prices for the commodities they are involved in. If you are going to be at serious risk of imprisonment, you are not going to get involved in the drug trade unless you can make substantial sums of money. If that happens, the prices of the drugs you sell should rise. I hope I am not glossing too quickly over the economics of this. But precisely the opposite happened. When the risk of imprisonment for drug trafficking or drug use was rising in the United States, the price of cocaine was falling. Do not misunderstand me—I am not suggesting we abandon prison as one of our tools of crime control. I am just a little pessimistic about the scope for managing drug markets, illegal drug trafficking and drug related crime through the prison instrument. It seems to me that we are better off spending money trying to increase the risk of apprehension or reducing the motivation to offend through treatment and allied strategies.

Mr CAMERON THOMPSON—My question, though, was: what is the impact on the offender? I am not really interested whether the price goes up or down. Is there any evidence to say that a crackdown—with larger, stronger custodial sentences and a stronger apprehension of penalty—actually causes people to shy away from those types of drugs? Does it put any kind of restraint on their behaviour?

Dr Weatherburn—Are we talking about the property offender or the drug trafficker?

Mr CAMERON THOMPSON—I am talking about the people who are offending. I am talking about the penalties that are applied for possession and use of drugs.

Dr Weatherburn—When you increase the level of imprisonment, you get some effect on crime. The best study on this has been conducted by William Spelman at the University of Texas, but the relationship is not strong. Basically, he argues that, with a 10 per cent increase in the prison population, you get about a two per cent drop in serious crime. The debate has moved to the question—and I am not sure I am answering the question you want answered—of what the most cost effective way is of dealing with it. Given $1 million, is it better to spend $1 million raising prison sentences, $1 million expanding treatment or $1 million increasing the level of surveillance of people on non-custodial sanctions? Does that answer your question? I am not sure I have.

Mr CAMERON THOMPSON—You push non-custodial sanctions. I am saying there are also custodial sanctions and asking how effective they are.

Dr Weatherburn—I am not pushing non-custodial over custodial. I have been saying that I think non-custodial sanctions have not had the level of surveillance they deserve. They have

been too soft, if I can put it bluntly. There is no use putting someone on a non-custodial sanction, such as community service orders, if they do not turn up.

Mr CAMERON THOMPSON—I would agree with that.

Dr Weatherburn—That is the point I was trying to make. There is a tendency in popular debate to assume that there is either no penalty or that there is prison. An awful lot of people pass through the intermediate domain of community based penalties, and I am suggesting that there may be more scope for reducing crime by being tougher about those sorts of penalties. Is that clear?

Mr CAMERON THOMPSON—Yes.

CHAIR—Yes, I think that has clarified it very well.

Dr Weatherburn—It was not a vote in favour of non-custodial—

CHAIR—No. I think that has clarified it.

Ms GEORGE—In relation to the prison system, we have had evidence presented that there are still within the system high levels of heroin use and that there is a relatively small proportion of people on methadone—and there may be larger numbers wanting to be on methadone who cannot get on it. You say, which confirms earlier evidence, that there is a high recidivist rate of heroin users. Is there a case for any form of coercive treatment for people within the prison system? When I raised this issue earlier, I was told that going onto methadone was a matter between the patient and the doctor. Have you seen any evidence that coercion onto a methadone support program might be a better alternative while within the prison system?

Dr Weatherburn—I would not claim much expertise about the management issues that arise within the prison system, but I see a strong argument for expediting access to methadone for people released from prison. I think it is absolutely crucial. These are the people who have caused the community most of the grief and who have cost the community most of the money. It makes good economic sense to spend your dollars on this group and to make sure that every opportunity is provided to minimise the chances of their return and their reinvolvement in crime.

Ms GEORGE—What about within prisons, while they are there?

Dr Weatherburn—Within prison—I could not answer that. Clearly, what you do in prison would not be directed at dealing with or managing drug related property crime.

Ms GEORGE—But managing the addiction while they are there?

Dr Weatherburn—Managing the addiction may well be helpful. I am not an addiction expert. I am drawing on the knowledge I have of the effectiveness of methadone as a way of reducing property crime.

Mrs DRAPER—Jennie brought up the issue of methadone as a treatment. I notice that, in the discussion, naltrexone has not been mentioned as a treatment to get people off drugs—perhaps even in the prison system—before they are back outside.

Dr Weatherburn—I did not mean to push methadone to the exclusion of other pharmaco-therapies or other therapies—pharmacological or not. I think it is a matter for medical professionals to make the judgment, but I understand the view is that you need the broadest range of treatments possible and that there is not a one-size-fits-all approach to the problem. I would be supporting treatment. Methadone seems to be a very effective and well-tested treatment—not for all heroin users but for a proportion.

Mrs DRAPER—Although it is not a treatment; it is just a drug substitute.

Mr CADMAN—I wonder if you could help me by providing some statistics. You made a statement that a person in treatment is less likely to commit a crime. You said there is some evidence for that. Could you let us have details of the evidence that people on treatment are less likely to commit crimes and some background on the 50 per cent of assaults that are liquor or alcohol related. Underage drinking and abuse of alcohol are concerns for many parents. You have mentioned tougher liquor laws. Is there a group of strategies that you consider may be effective to reduce that high level of assault and abusive behaviour that seems to go with the use of alcohol?

Dr Weatherburn—I think I have two of those questions under the belt; you might have to help me again with one of them. The research on treatment and crime can be found, so far as methadone is concerned, in a bulletin which is on our web site called 'Methadone maintenance treatment as a crime control measure'.

Mr CADMAN—I was talking about alcohol.

Dr Weatherburn—The first point you made was: what is the evidence bearing on treatment and crime? Did you not?

Mr CADMAN—Yes, fine.

Dr Weatherburn—If you want quick access to a review of the literature on methadone maintenance as a means of limiting crime, which is by Professor Wayne Hall, you will find that on the bureau's web site.

Mr CADMAN—Okay.

Dr Weatherburn—With regard to your third question about ways of managing alcohol related crime, my principal concern is with the management of licensed premises themselves. I am sure there is scope for preventing young people from abusing alcohol, but the principal culprit, it seems to me, is the liquor industry. In a recent study—which is also on our web site—we found that a small percentage of licensed premises account for the vast majority of alcohol related crime on licensed premises. The majority manages their premises extremely well, but a minority does not and is repeatedly the site of crime and violence. We then surveyed a representative sample of people aged 18 to 29 and found a very big proportion of them had been

served alcohol while showing signs of intoxication. It is clear to me that sections of the liquor industry are in breach of the various state liquor acts—flagrantly in breach—and are generating crime, violence and public disorder as a result. So if you ask me how best to get this problem under control, the focus of my attention would be on those licensed premises that breach their obligations rather than mass campaigns for young people.

Mr WAKELIN—I sense that the reliance on methadone is rising. What efforts do you think are made at some point in the cycle to have people less reliant on methadone?

Dr Weatherburn—That is a good question. I think the received wisdom to date has been that it is best to keep someone on methadone more or less in perpetuity—that is to say, not put too much pressure on them to leave methadone, whether for abstinence or any other form of therapy. I am a bit troubled by this, not because I hold the view that abstinence is the appropriate goal for every dependent drug user but because a person who is on methadone for 10 or 15 years is occupying a place that could be given to someone who might profit more from getting two years of stability and life. I wonder—and it is only speculation—whether there does not come a point where the advantages of keeping someone on are way offset by the opportunity cost of denying someone else a place. There will always be limited resources. As long as there are limited resources, it seems to me there may be a case for attempting—once a person has stabilised their lives—to ease them off the drug so that those funds and those places can be given over to others who just discovered that their drug dependence is out of control and want to bring it to a halt.

Mr DUTTON—Following on from some evidence you gave before in relation to coercion into treatment, we have taken some anecdotal evidence around the country from different rehabilitation facilities about how people have put themselves in for rehab and that it is really only a way out of the cycle—they have run out of money for heroin and want a couple of days off to dry out. They take the places, in my opinion, of people who legitimately might want to start the process of rehabilitation. Have you done any research on drug-free prisons, say, in the United States, where the courts are ultimately left with an option of directing these people into incarceration for the purpose of rehabilitation for extended periods? Is that something that you have looked at? And, secondly, is it feasible?

Dr Weatherburn—No, I have not, but I share your concern. I share your concern about people parking themselves in drug treatment as a means to escape pressure they are temporarily under. I think that is one of the attractive features of programs such as the drug court program: you cannot just momentarily park yourself there. Basically, you have stay there for as long as it takes to expiate your sentence or sort your life out. Having said that, it is difficult drawing up any program which has rules that do not cast the net too wide or too narrow. If you do not allow anybody on unless they stay on for a year, some people who might have profited from it might not come on at all. If on the other hand you institute an open slather, there are clearly going to be people who come on just briefly because they cannot find heroin or because they are worried the court is going to imprison them. I think it is a difficult call, but I think certainly something that deserves a lot of attention is the circumstances in which people come on and the circumstances in which they go off.

Mr QUICK—To what extent has the increased availability of stimulants increased crimes of violence, including domestic violence? Is there a linkage between the increasing crime trends over the last 30 years and the side effects of increasing drug use?

Dr Weatherburn—Although I know there is a lot of anecdotal evidence concerning stimulant use and violent crime, I have not seen any hard evidence—none that would persuade me—that the shift to cocaine or amphetamines is responsible for an upsurge in violent crime. I would want more than the case studies that are handed to the media from time to time. I might also mention in passing that the so-called shift to stimulants appears to have evaporated, at least in Sydney, because the last round of DUMA tests—you might remember I mentioned these earlier—has shown that the increase in cocaine use has ceased, and cocaine and amphetamine use levels has fallen back to what they were immediately after the drought, even though heroin use is still suppressed. So I am not sure about this mass migration from heroin to stimulants that people have spoken about. There is no doubt, though, that people who do abuse stimulants are prone to become psychotic and violent; I am arguing about the scale of that effect. What has pushed crime up over the last 10 years? It is probably heroin as much as anything else, but there are other factors. Long-term unemployment has been one of the driving forces in the rise of breaking and entering, but the growth in heroin dependence has played a big part.

Mr CAMERON THOMPSON—My question fits nicely with your answer to Peter Dutton. I wanted to know about drug courts and, if they were a successful strategy, what was successful about them and what your thoughts were on drug courts as a method of dealing with this problem.

Dr Weatherburn—We did a cost effectiveness comparison of drug courts with conventional sanctions—for the most part imprisonment—and found the drug court was more cost effective than imprisonment as a way of reducing drug related crime. Essentially, when the court deemed a group of people eligible for the drug court, we allocated them to groups. There were insufficient places, so those who could not get a place were allocated to a control group and the two groups were followed to see which group turned up in court the most and so on. The short answer to the story is that the drug court won, compared with prison. Having said that, it was an expensive program; it was not a lot cheaper than prison. It was cheaper, but not by much. The drug court would be much more cost effective if they could more effectively target the clientele—that is, more effectively identify those who will do well on the program. I think that is what they are working on now.

I think the drug court is an encouraging new development, an encouraging new option. But I must say that, in general, I think courts are waking up to the idea of intensive supervision of people under these non-custodial sanctions. In the old days, they would say, ‘You go off and get treatment and come back and I’ll have a look at how you are then.’ The approach that is growing in strength now is that you do not just ‘go off’—people actively supervise you on these programs, and there are sanctions for noncompliance with them. Under that kind of regime, I think they work well and are probably cheaper than custodial sentences. But there will come a point where someone has to go to jail, where they mucked up on a drug court program and there are no options left.

CHAIR—Thank you very much, Dr Weatherburn. We really appreciate your coming and taking the time to attend this morning.

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

That this committee accepts submission No. 275 as evidence and authorises it for publication as part of the inquiry.

[11.26 a.m.]

DRUMMER, Professor Olaf Heino, Head, Scientific Services, Victorian Institute of Forensic Medicine; Adjunct Professor, Department of Forensic Medicine, Monash University

CHAIR—I welcome you, Professor Drummer. I remind you that the evidence that you give at this public hearing is considered to be part of the proceedings of parliament. I therefore remind you that any attempt to mislead the committee is a very serious matter and could amount to a contempt of the parliament. I invite you to make your presentation, before I invite our members to proceed with their questions.

Prof. Drummer—I have prepared a number of slides. I will try not to be too technical on the slides, but I believe the committee has heard some evidence on road trauma and the involvement of drugs from Dr Swann. I have focused my presentation on that and some associated matters that deal with road trauma and the involvement of drugs. You also have some notes that I presented earlier, which summarise the presentation I will make today. I can leave those notes with the committee. Most of what I will be talking about today is a study that I have been involved in for about 10 years. It has involved a number of jurisdictions: Victoria, New South Wales and Western Australia. It is funded by a number of bodies: the road safety organisations in New South Wales and Victoria, Austroads and a number of other organisations.

The study was aimed to establish what risks drug use has on road trauma. It has been very difficult to come to grips with that issue. It is very difficult to make a connection between the drug use of a person who is using an illicit drug or other recreational drug and the cause of a particular crash. What we have done is develop a methodology. I will not spend a lot of time on this, but please ask questions in terms of how we did this. Essentially, it was an epidemiological analysis we developed back in the early nineties. We evaluated for the effect of alcohol in road crashes, and we have used that to look at the effect of a whole range of drugs—largely recreational drugs—in road trauma over the last 10 years.

So that you can understand the way that we did this, we looked at the rate of responsibility of a driver in a particular drug group and used the drug-free drivers as the control group. So the hypothesis we set ourselves was that, if drugs were increasing accident risk, the proportion of responsibility in that group would increase. We looked at a number of what we saw as mitigating factors. There are eight factors. They are fairly standard factors: road condition, vehicle condition, driving condition, fatigue et cetera. We made sure that any legal interpretation of causation or responsibility was not taken into account. We were looking at factorial analysis of accident causation.

Just so that we do not get confused too much: psychotropic drugs are drugs that are capable of causing impairment of one or more functions such as hand-eye coordination, vigilance or cognitive functions—thought and response to traffic situations. All the drugs we are talking about today are psychotropic drugs. They have one or more abilities to impair those functions. Trucks in my discussion today are mainly large or articulated trucks, rather than smaller vans and those sorts of vehicles. The odds ratio is simply a statistical measure that I am using today

to show the risk, if any, of drug use in a particular population. I thought I might mention this: one of the problems we had—and it is no criticism of the jurisdiction involved, it is just a function of the way Australia has developed over the last couple of hundred years—is that it was more difficult to get information from regional parts of Australia than from Melbourne, Sydney or Perth. That is because of the way the coronial system has developed—the detail of crash investigations and so forth. It would be useful to find some way of developing that in the future.

In the 10-year database, there are almost 3,400 drivers who have been killed in road traumas. That is quite a large number of drivers. You can see the breakdown between the three states. Males, as has been typical, represent over three-quarters of the crashes. Single vehicle accidents represent about half; the other half, obviously, being multivehicle accidents. This shows the summation of all those 3,400 cases in terms of the prevalence of drugs. You can see alcohol at 0.05 or higher was involved in almost 30 per cent of those accidents. There is some regional variation—Victoria has the lowest incidence; Western Australia has the highest—but it averages out at about 30 per cent. A large number of drivers had over 0.15 per cent of alcohol in their bloodstream. It has always been an interesting facet that very few are around the legal limit of 0.05 or less; a lot of them are over 0.15 per cent. Importantly, drugs—meaning any drug measured in the coronial sphere in any one of the states—were present in about 26 per cent of these accidents. There is some regional variation as well, but the average is 26 per cent.

By far the most dominant drug in that group is cannabis. I am sure you have heard about cannabis in evidence before. It has been, in a sense, one of the more problematic drugs in terms of causation. It is fairly commonly used in the community, and there is a lot of debate about whether or not it has a strong involvement in road crashes. Opiates—largely morphine, methadone and a bit of codeine—were present in about 4.4 per cent of these cases. Stimulants, which I will talk a bit more about later on, were present in a bit under four per cent of these cases—that includes amphetamines and cocaine. Benzodiazepines are actually legal, but they are often used recreationally. They are minor sedatives in 3.6 per cent of drivers, and in about three per cent of cases miscellaneous drugs were present. To a large extent, these were prescription drugs, and so these were people who were taking medications and were involved in crashes. That is a representation of our data. Where I refer to 'THC positive' in bold on the chart, the figure represents drivers where the active form of cannabis was found in the blood, as distinct from a metabolite. That presence of metabolite suggests past use that is perhaps not relevant to the circumstances of the crash. THC occurred in about eight per cent of those cases, so eight per cent of drivers were using cannabis fairly soon before or during driving and crashed with THC present in their bloodstream.

The data we see on this next overhead is for alcohol, as against some of the risk figures on this data. You may have seen this data before. It has been reproduced over many years since Dr Borkenstein originally produced that work back in the mid-1960s in the US. But it shows that up to about 0.05 per cent there is no increase of risk—odd's ratio of one being, in a sense, the control group. As you go from 0.05 per cent to 0.1 per cent, it is threefold higher on this model. You can see how it goes up quite a lot as it gets to a point beyond 0.1 per cent. That is what we expect to see: as there is a greater amount of alcohol present, the risk increases quite substantially. The average alcohol level is around 0.16 per cent to 0.18 per cent in drivers who are tested positive for alcohol. So it is quite a large increase of risk.

When we first started this study, all of the jurisdictions that we are looking at were measuring the inactive form of cannabis. I know Dr Swann mentioned this in his discussion with you some time ago. As a result of national discussions, the laboratories around Australia agreed to measure THC back in about 1998 or 1997. What I will be showing today is the active THC component of the investigation, rather than all of the information we have available.

I should say here than, when THC is consumed by drivers, it would be fair to say that there is really no dispute that cannabis, if used in other than very trivial amounts, has a great capacity to impair a range of functions that are required for safe driving. For example, hand-eye coordination, lane control—staying in the right lane, not going over the white lines or off the edge of the road—perception of time and space, perception of traffic around oneself, vigilance and awareness of what is happening on the roads and particularly cognition; in other words, the way you respond to visual signals and translate them into some sort of function and thought process. That lasts for a relatively short period of time, depending of course on the amount consumed. I am saying that it could be perhaps up to two hours. It could be longer. Certainly up to two hours it probably has a very significant effect on those driving skills.

Some researchers overseas have looked at the relationship between blood concentrations and the impairment of these driving skills. While there is some doubt about when they set in—obviously it will be different from one person to another—around 5 nanograms per mil is when one expects significant decrements in one or more of these skills in most people who use cannabis. This next overhead shows graphically the time curve to make it clear to you that beyond one to two hours there is very little cannabis left in the body as a THC measurement, although one can measure the metabolite for some days to weeks after past use.

Do not be too concerned about the numbers here. The second line, THC only, shows the drivers who have had a crash where there is no other drug or alcohol present in their bloodstream, so there are no other competing factors here. For those drivers with only THC, suggesting recent use of cannabis, the risk is almost three times higher on this most recent data. If one looks at those drivers who also use alcohol—and there is a substantial proportion of drivers using cannabis who also use alcohol, somewhere around 40 per cent to 50 per cent—that increases the risk a further threefold from the risk that alcohol has already caused.

Mr CADMAN—Threefold? Do you think that shows threefold?

Prof. Drummer—Yes, 2.9. That is almost threefold higher in addition to the effects of cannabis.

Mr CADMAN—I am with you.

Prof. Drummer—The concentrations of these drivers have ranged there from one to 100 nanograms per millilitres. There are fairly high levels there. But the median is about 10, which is above what we would normally expect for a decrement of one or more of these key driving skills. They have present relevant concentrations of THC, and we see in this model an elevation in risk compared to a drug-free driver. That shows the concentrations in four bands and that red line shows the point at which we might expect significant decrement of these driving skills. We see most of these drivers with substantial amounts of cannabis. That is THC. One would expect

to have some diminution of driving skills, irrespective of whether we can show this in an epidemiological model of risk that we are doing here.

If we look at those drivers who have even higher amounts of THC—and I am using five nanograms per millilitre as a cut-off—the risk goes up to almost sevenfold. We are seeing some form of dose dependency, which we see for alcohol and which we are also seeing with cannabis. It is what you would expect: the more cannabis present, the more THC present, the greater the effect on the driver. That is what you would expect. That is showing up in this model here.

This next overhead just shows another way of presenting the data and perhaps relates to Mr Cadman's question about alcohol, only the risk is twelvefold on the second row and fifteenfold with cannabis present—the difference being three. That is what I was saying before. The risk is going up. Perhaps when we look at that it is not a great deal—12 to 15. They are still both very high figures but it is still an increase in risk. So for people using cannabis plus alcohol the risk increases as a result of both drugs.

As a matter of interest for the committee, I have just shown the risk numbers to other groups. On the extreme left, you have the control group, which is 1.0. Any drug is a bit under 2.0. Alcohol is 0.5 at 0.1 and 0.1 at 0.15. The next two bars are THC and then THC above 5.0. It goes up substantially, and if you include alcohol it goes up even further. It just gives you a relative indication of that risk on a bar graph representation.

Mr CADMAN—Five would be how many cigarettes?

Prof. Drummer—One cigarette could produce that figure. Also, as a matter of interest, the use of cannabis and its presence in drivers involved in motor vehicle related deaths in Australia is not unique to them. It does appear in a lot of other cases. That just shows you the proportion of cannabis usage in those various cohorts. We had a discussion before about heroin usage and its effect on property crime. There is quite a high incidence in the heroin users on the extreme right of the graph. Over 30 per cent of heroin users are using cannabis. Other drug deaths are about 20 per cent, and homicide about 15 per cent. On the extreme left, natural deaths, as you would expect, are quite a low proportion. It gives you an idea that cannabis use is not just restricted to one particular part of the community.

Mr CAMERON THOMPSON—That is drugs found in the people who have died, is it?

Prof. Drummer—Yes, these are all deaths—all cases reported to the coroners. These are Victorian cases for 2000-01. These are just reflections of drug use. Except for natural deaths, in those columns they have died by unnatural means. We do drug testing—it could be a legal case classified as a homicide or it may be just for the purpose of a coronial investigation. We see that drug use is quite prevalent, including the use of cannabis.

Stimulants is perhaps the other drug group that has sparked a lot of interest in Australia—not only Australia, but around the world. We have looked at that in this study and, just in terms of what we call stimulants, they are clearly amphetamines and ecstasy, which I have included in that category there. They include cocaine, although there are very few cases in that 3,400 where cocaine has been used. It is a relatively small problem in terms of road trauma. There are ephedrines—largely Sudafed type pills. They are really only a problem if they are abused. You

need a lot. A truck driver is probably an example where they may be abused. There are weight pills—amphetamine being an example where they have been abused in the past for the purpose of stimulation. All of these stimulants in the right setting can either cause aggressive and dangerous driving or, more likely, cause poor road control and a variety of visual hand-eye coordination defects that have been often called hallucinations, although that is probably a strong word to use, right down to the extreme end where the effects wear off and they develop rebound fatigue, fall asleep at the wheel and run into an object, such as another car, or run off the road.

In our analysis, looking at the third row, stimulants or drivers, the risk is a bit over two and that is 3.8 per cent of the drivers. If you particularly look at truck drivers, the incidence of stimulant use is 23 per cent. That is 10-times higher effectively than any driver and the risk is 8.8 times, so it is really quite substantial. I should warn the committee that in regard to truck drivers using stimulants, it has been really difficult to include the effects of fatigue in that figure. Although we tried to correct for fatigue, it is very hard to quantify it. There is certainly an association between using stimulants and risk. I am sure fatigue, which may be the reason for using stimulants in the first place, is a factor so the risk is probably not 8.8 from the use of drugs alone, but it is a combination of driving behaviour and risk-taking behaviour in using stimulants. It is quite a significant finding that there is this high-incidence group and the risk seems to be quite high.

I will give you a bit more of a breakdown of the figures for those drivers. It is interesting that alcohol use of truck drivers is a lot lower than for car drivers and motorcyclists, which you heard before was about 30 per cent. The prevalence of alcohol used by truck drivers is much lower. Their cannabis use is also a lot lower than for the average driver and there is very little in the way of other drugs present. Stimulants are the top drug followed by alcohol and cannabis. That is really quite a different profile from what we see for drivers of cars and motorcycles, which does suggest that stimulants play a role in their overall employment and driving long distances.

We looked at some other drugs as well. The second row shows drivers who use multiple psychotropic drugs. The rate is fivefold higher. People might use amphetamines plus cannabis or opiates plus cannabis. Whatever the combination, the risk increases quite substantially. The risk is very high for any drug used with alcohol. There is only a small increase in risk using the minor tranquillisers—the benzodiazepines. A lot of the studies overseas have shown that the risk increases in some of the driving groups, particularly for elderly people using these minor tranquillisers. Use of opiates, which are largely heroin, morphine and methadone, shows up as a relatively low risk. In fact, we are not seeing any significant increase in this population using one or more of these opiate-type drugs.

This next overhead shows you the trends over the last several years around Australia. The top row shows alcohol use, and it is heartening that all the work people around Australia have been doing has reduced the incidence of alcohol in fatal road trauma from 33 per cent to 28 per cent in the last couple of years of the study. The drugs have increased from 20 per cent to 27 per cent. I think that is in line with household surveys conducted by the Department of Health and Ageing, which show increased drug use.

Mr CADMAN—Could you explain what drugs is as compared with 'others' because the ones that come below it seem to be drugs also?

Prof. Drummer—Drugs means all drugs, including those drugs listed below.

Mr DUTTON—All illicit drugs, not alcohol.

Prof. Drummer—All psychotropic drugs. The benzodiazepines may be used illicitly on some occasions but are also prescribed. It is very difficult to know whether a person is getting hold of those drugs illicitly or licitly. These are all psychotropic drugs which probably shows a reasonable proportion of the illicit drug use in the community. Those next three show largely illicit drugs: cannabis, opioids, and stimulants. Methadone, as I mentioned before, is a legal drug and it is used for treatment of heroin dependency. It is very hard to know where it comes from; sometimes it is diverted to other people by users. The data shows an increasing prevalence of those drugs in drivers in that time period and shows a gradual reduction in the prevalence of alcohol.

CHAIR—Professor Drummer, is there anything specific that you would like the committee to know and perhaps we could move to those areas? In that way I can give the members of the committee the opportunity to ask you questions.

Prof. Drummer—This is probably of relevance. With an instance of 26 per cent or so of drugs in this 10-year study, not all of those drivers using drugs have caused the accidents. Some are innocent or their drug use has not caused the accident. Our estimate is that about eight per cent of the road traumas caused by drugs versus the 28 per cent caused by alcohol gives us a relativity of drug trauma versus alcohol trauma in the community. Perhaps I could also say very briefly that, with drivers who are picked up by the police in Victoria and assessed to be impaired, the drugs that we see are similar to those we see in fatal accidents. You can see that data in my submission. Cannabis is one of the dominant drugs there. A lot use multiple drugs.

Perhaps I should just say that one of the things that perhaps the committee may consider is that the institute, in association with all the states around Australia, have developed a national coroners information system. This has received funding from the federal government through the Department of Health and Ageing. As we develop the system and as we get a better idea of data around Australia we will get a better handle on this aspect of road trauma and other aspects of drug use in the coronial sphere. We will get a better idea of drug use in people apprehended for crimes, which is something that we would like to see happen as the result of systems developed around Australia. Finally, as I heard some discussion before, I might just give you an idea of the change in heroin use with the heroine drought that occurred about a year and a half ago. In Victoria that showed a substantial reduction in the heroin toll, but it only represents a proportion of drug-caused trauma in the community.

CHAIR—Thank you, Professor Drummer. Before we move on to questions, can we have a copy of your presentation?

Prof. Drummer—Yes, certainly.

CHAIR—Thank you. Mr Dutton.

Mr DUTTON—In relation to cannabis use in particular, there seems to have been for a number of years what you might call a fallacy or certainly a perception within the community that cannabis is a soft drug or a harmless or less evil drug. In the light of your evidence today and some we have taken previously, particularly in relation to it being a mind-altering substance, do you still maintain that view or do you think there is a change in perception in the community that cannabis should be treated more seriously than it is now?

Prof. Drummer—It is hard to know, but I think cannabis is a relatively harmless drug. It is perhaps not much more harmful than tobacco in terms of its mind-altering activities. You can see from the data here that people using cannabis in a social environment at a party, for example, and not driving afterwards are probably not causing a great deal of harm. But using cannabis and driving has the potential to cause harm. I think the community does not appreciate that link. Certainly when drug users have been asked if they have any concerns about using alcohol and driving or taking cannabis and driving, they are more inclined to think that cannabis is not harmful to driving, whereas alcohol is. That perception needs to change. While not as harmful for other reasons as heroin, cocaine and amphetamines in terms of links to violence and crime, it is certainly not a safe drug in the context of road trauma.

Mr DUTTON—Following on from that, I come from Queensland where there seems to be some reluctance by the state government to introduce some method of testing in the same way as we do for alcohol at the moment with random breath testing or for the police to be empowered to test people for driving while under the influence of cannabis, even though we have taken some evidence that the technology exists to be able to do that now. Why would the Queensland state government be so reluctant?

Prof. Drummer—It is possible, but it is not easy. Alcohol is quite easy to breath-test. There is certainly no question that it is very easy to do and gives you a result almost immediately. There are devices being developed that allow saliva testing, of which you may have heard. At the moment they have not proven to be useful to the point of being reliable. You do not want to have a person being falsely accused of using cannabis or have a person who has cannabis present, but is not being detected because of a sensitivity issue with the device. It will take some time for the various manufacturers to validate those devices and prove to all of us that they are reliable and able to do that job. They will probably be a lot more expensive than a breathalyser. There is a cost factor here in terms of any random, or even targeted, testing of drivers. The other relevant issue is that these devices, at this point in time and probably for some time to come, are not evidentiary, in that at a roadside one can only get a reasonable suspicion of cannabis, opiate or amphetamine use. One will still rely on some sort of confirmatory test in a forensic or other laboratory to prove that that substance was present, whatever the offence is, when we are taking it through the courts.

Mr DUTTON—Would you still have to take blood as a subsequent step?

Prof. Drummer—It would have to be relied on, but that fluid needs to be taken to a laboratory, you need to await a result and then feed it back to the police system. That means that you do not have what you have now with breathalysers—an instant test where you do not dispute the alcohol reading. In the preliminary breath test or the evidentiary breath test, there is some element of doubt. We do not know what doubt exists, given that we do not have enough validation of these devices and they are still at the early stage of development. I am hopeful that we

will validate some ourselves and see how useful they will be in the future, but at the moment this committee could not say, 'They now exist. You can now take these into a particular situation and have a confirmatory test on the spot.'

Mr QUICK—Does any country have a roadside testing regime in operation for drugs?

Prof. Drummer—Various countries have adopted various assessments of sobriety where they do a visual examination of people's ability to pass or fail certain tests and they use that as evidence of impairment. Some European countries have passed laws which make it illegal to drive whilst using a prohibited substance—largely cannabis, opiates, amphetamines and cocaine. Labs must come back with a result. You do not get on-the-spot proof of the presence of that illicit substance, although there may be suspicions as a result of some initial tests. Drugs will always be more difficult to deal with in this environment than alcohol. It is a question of cost and logistics. Every jurisdiction has developed a different way of doing this at the moment, but at this point in time it is largely based on evidence of impairment rather than on a chemical test.

Mr CADMAN—Part of the evidence we took came from an adviser to the Victorian government, who said that they felt that cannabis-affected drivers were safer because they tended to drive more slowly and therefore exposed themselves less to the risk of a road accident. Is that a reasonable view, based on the evidence that you have taken?

Prof. Drummer—There is certainly a view held by many that cannabis does tend to make one drive slower. I have personally been involved in a number of investigations where speed was certainly a factor in the crash and they were using cannabis. Where a person has been to some sort of function or party and has not consumed alcohol but had some cannabis, that person is basically happy and relaxed, hops in their car and is not really into making a fuss and is happy for other traffic to pass them. If that were to occur, it would perhaps reduce the risk that we see in our cases, but our studies are showing increased risk. Certainly, anecdotally, speed was a factor in some of the crashes that I have investigated. I think that it is perhaps a bit of a myth going around the community. While it may occur for some individuals, I do not think that we should assume that there is an element of safety associated with it.

It is a bit like stimulant use. There was the view held some years ago that if you were tired and you had to drive from Canberra to Sydney, you could take a stimulant rather than not. But there is no safe dose of amphetamine that one could take to guarantee that safe passage. It also reflects the difficulty that drugs affect us differently and variations in dry effects are very hard to put into pigeonholes. I would regard this as more of a myth and perhaps a danger for the community to hear rather than really getting the message that taking cannabis and driving is actually quite dangerous.

Mr CAMERON THOMPSON—You mentioned that the profile of use among truck drivers was different. That is probably driven by the fact that they want to stay awake rather than abuse a drug. What evidence is there of the rate of use of stimulants among truck drivers? I am particularly interested in whether other things are helping them to stay awake now—for example, mobile phones—and whether that may reduce the extent to which they take stimulants. I know a lot of them talk all night on their phones.

Ms GEORGE—Or on their two-way radios.

Prof. Drummer—I do not know whether I have enough expertise in the area to answer all of those questions.

Mr CAMERON THOMPSON—The core question is this: is the use of stimulants among truck drivers remaining constant?

Prof. Drummer—Surveys that have been conducted do show that it is a significant issue. As you would expect, voluntary surveys probaby give an underrepresentation of the true use of stimulants. There has been a lot done in recent times by the Transport Workers Union and associated unions and trucking organisations to make drivers aware of the dangers and I think that has helped. I am not enough of an expert in that industry to make valid comments but if a driver were to use a mobile phone or engage in conversations with a passenger or over a CB radio—anything like that—it would increase vigilance. Any activity that gets away from the humdrum driving along a long road will increase vigilance—but vigilance must be maintained. I imagine it is hard to speak continuously for hours on end. When the conversation stops there is the danger that they will fall back and get to the stage where they are starting to nod off. Beyond that I do not think I can add much more expertise.

Mr QUICK—Victoria led the way in trying to reduce the road toll through a variety of strategies and it set targets. Is there a safe limit if you are a cannabis user? For example, the alcohol limit is .05. I blew .025 the other night and I was safe. Is there a safe limit for cannabis? We have heard evidence that we still have the rail gauge mentality—some states want to get involved and others do not. I think we should have a national database. Are there any countries that have set one up and received some benefits?

Prof. Drummer—As to your first question about cannabis, my view is that there is no safe usage of, or limit to, cannabis and driving. My recommendation would be that with any illicit drug you really could not define an amount to allow safe driving. With illicit substances such as the ones we are talking about today, as in Europe, it should be an offence to drive while using a drug. It is always difficult to detect those offences in a roadside setting, as I mentioned before to Mr Dutton, but there are means to do that and increasingly it will become easier for us to do that. As soon as we say that having half a joint or a weak joint of cannabis is safe then we come up against questions such as how much you inhale of a joint. It is like tobacco; if you inhale more you absorb more. You set a precedent where people can say, 'I have had a small amount; I am safe because the government told me I was safe.' But having two might be dangerous. The variability of absorption is such that we really cannot define a safe level and therefore any usage must be seen as unsafe. Any use of amphetamines, cocaine or heroin and driving should be seen as unsafe. It should be avoided at all costs.

On the database question, we are the only country in the world that has been able to at least initiate a national database of coronial information. Given that we are a pretty good country in the way our resources and jurisdictions work, because of our size and the way the system has developed, for us to get a database going to the point where various arms of government, the Road Safety Organisations of Australia and other groups can look at this data and have all the data in a valid searchable form will be quite a job. So any assistance in doing that would be appreciated, and would be used by all road safety groups, WorkCover groups, illicit drug trend

groups and organisations around Australia. At the moment, we have a start and we are working very hard towards achieving that goal, but it will take a while for us to achieve the end of having all data—

Mr QUICK—How much would it cost?

Prof. Drummer—It is a question of costs to a degree, but it is also a question of reforming the way data is collected in our coronial jurisdictions around Australia and the way it is centralised into one location in the state and passed on. I am not the manager of that particular database, but I can refer you to a person who has more information on that. Money and resources are important, but they are not the only answer to the problem.

CHAIR—Thank you very much, Professor Drummer. We had not covered this part of the evidence in the in-depth manner that we had hoped to, and you have provided us with some excellent information. I thank Dr Weatherburn and Professor Drummer for appearing before us today.

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 12.07 p.m.