The Parliament of the Commonwealth of Australia

Where to next?

– a discussion paper

Inquiry into substance abuse in Australian communities

House of Representatives
Standing Committee on Family and Community Affairs
17 September 2001

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Contents

APPENDICES

Foreword

In the last twelve months or so I have heard about and observed the closest thing in Australia that I have seen to hell on Earth.

Australia's substance abuse has taken me on a journey that I would have preferred not to have travelled and I have observed a lot of things I would prefer to know nothing about. However, as a Member of Parliament I share with my parliamentary colleagues a clear responsibility to address these issues.

The Australian community has in the main enjoyed mind-altering substances for reasons of recreation and social intercourse, and for relief of pain, both physical and mental. The community is seeing an increase in substance abuse and Australian society demands of its police, its courts, its gaols, and its health system - to name a few - up to 70% of the budget for these community services. Much of this is as a result of the luxury of having the freedom to consume legal and illegal substances.

Communities like California voted for example in a referendum to shift US$120 million from drug law enforcement to drug treatment less than twelve months ago.

Sweden has what is known as a zero tolerance approach after a more permissive approach previously and is reported to have a higher overdose rate than other European countries with a more permissive approach.

Australia is implementing variations on a theme to these overseas experiences.

Methadone treatment in Australia shows very large increases in participation over recent years and no movement away from substance abuse.

The issues for today's parents and dependents are described well by a most knowledgeable witness working in the field as follows:

> But if we are really talking about drugproofing, the things that we need to be enforcing are the valuing and the connectedness, spending time and effort to communicate with our children to indicate to them that we do care about what happened to them

> and that we do care when they are in trouble – and that we also care when they are doing well. It worries me that sometimes people get falsely focused on the drug-specific components rather than the big effort on those broader messages. I know many families who have a lot of knowledge about drugs. I have many colleagues who have been working in and know this area very well, and some of their children take drugs. If you can have all that knowledge and still have your own children taking drugs then I do not believe there is a way to drugproof your child by training…I think that sometimes programs can promise much and it is difficult for them to deliver.[1]

At the extreme end for parents the Committee heard the addict view as explained to a parent:

> Do not be ashamed, do not shun us. Give them refuge; offer a safe and sanitised atmosphere. Do not tell a family to disown their family, be there for them.[2]

Treatment services with professionally trained staff are at a premium and the lack of a coherent national understanding of availability of timely services was profound.

The degree of difficulty of dealing with abuse and addiction is at the heart of the service delivery issue. A low success rate for addiction solution, particularly in the early years of abuse and addiction, highlight the lack of maturity in the national capacity and are probably one of the main blockages to better progress.

Gaols are the holding paddock for much of Australia's substance abuse. The opportunity of managing better our most immediate substance abuse problems lies in our gaols where substance abuse appears to be a profoundly neglected issue.

The nation should not tolerate any of the crime, violence and all other negative impacts that substance abusers inflict on our society. The families, the addict and abusers should expect the strongest, professional support from the community where they all have a genuine interest in addressing the issue.

1 Evidence, p. 496.

2 Evidence, p. 615.

Every Australian should know that they have the right to say NO to alcohol, marijuana, heroin or any other substance if they so wish. Denying the profiteers, the dealers, the criminals and anyone else in the drug trade has to offer the stronger 'high' to all alternatives!

Mr Barry Wakelin MP
Chai

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Membership of the Committee

Thirty-ninth Parliament

Chair Mr Barry Wakelin MP

Deputy Chair Ms Annette Ellis MP

Members Mr Kevin Andrews MP

Ms Julie Bishop MP (*from 13 April 2000*)

Hon Graham Edwards MP

Mrs Kay Elson MP (*until 31 May 2000*)

Mrs Joanna Gash MP (*from 31 May 2000*)

Ms Jill Hall MP

Mrs Julia Irwin MP (*from 13 April 2000*)

Mrs Deanne Kelly MP (*until 7 September 2000*)

Mr Tony Lawler MP (*from 7 September 2000*)

Dr Brendan Nelson MP (*until 31 August 2000*)

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Terms of reference

In view of the level of community concern about the abuse of licit drugs such as alcohol, tobacco, over-the-counter and prescription medications, and illicit drugs like marijuana and heroin, the Committee has been asked by the Minister of Health and Aged Care, the Hon Dr Michael Wooldridge, MP, 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.

Executive summary

This discussion paper attempts to present an overview of what we believe is happening in relation to substance abuse in Australia.

Health economists Collins and Lapsley estimated that the social and economic costs of substance misuse were $18.8 billion in 1992 and we have no reason to suppose that, one decade later, these will have decreased substantially. The vast majority of costs are attributable to alcohol and tobacco, and misuse of these appears to have stabilised or declined over the past decade. However, costs associated with the misuse of illegal drugs will have risen over the past decade, consistent with a general increase in the use of illicit drugs and a dramatic trebling in overdose deaths between 1988-1999.

Families can play a pivotal role in the prevention and treatment of substance misuse problems, and in recent years governments have increased resources to programs which aim to support and better enable them to play a positive role. Nongovernment agencies are active in providing support to families adversely impacted by substance misuse, and are good at engaging families in a variety of ways to help others with similar issues. Governments, too, are beginning to appreciate the positive potential of involving families in the design and conduct of drug abuse prevention and treatment programs.

Depending on how drug-related crime is defined, as little as 10% or as much as 70% of crime can be said to be drug-related. Australia's strategic approach to drug problems involves balancing efforts to control the supply and reduce the demand for drugs. While for the past two decades a number of Commonwealth agencies have been working to reduce the supply of illicit drugs in Australia, under the National Illicit Drugs Strategy (NIDS) increased resources have been dedicated to supply reduction and also to diverting drug offenders from the criminal justice system. Recent heroin 'droughts' suggest that stepped-up drug supply control measures are working. The national drug diversion initiative looks promising and

could be extended, but it needs to be supported by more training for those involved in its implementation.

Random breath testing has been effective in reducing the number of people driving above the legal (blood alcohol concentration) limit and contributing to a significant decline in the number of alcohol-related road crashes, but there is some recent evidence suggesting a review of RBT strategies is warranted. There are technical obstacles to testing for drug driving and more research into this issue is required.

The effects of substance misuse on workplace safety and productivity are hard to quantify but are conservatively estimated to have cost Australia $9.2 billion in 1992. Despite evidence of the negative impacts of alcohol and other drugs on workplace safety and productivity, the issue is relatively under-researched and much more could be done to reduce the costs associated with substance misuse issues in the workplace. Workplace alcohol and drug policies need to be incorporated into broader occupational and health policies which may, in some circumstances, include drug testing.

Total health care costs associated with the use and abuse of legal and illegal drugs amounted to around $8 billion in 1992; legal drugs accounted for over 90% of these. Despite the fact that in recent years governments have increased resources to combat drug-related harms, especially ones associated with the abuse of illicit substances, service delivery systems are straining to meet demand and access to treatment is inadequate in many places. Management of the sector could be strengthened to improve accountability and ensure that interventions are as cost-effective as possible.

Communities have to be on-side to help governments devise and fund programs and services with the greatest potential to help, and the media could be enjoined to play a more constructive role in shaping public opinion on these matters. Politicians, too, have a special responsibility to assist and can do so by demonstrating bipartisan leadership in this area.

1

Introduction

1.1 This discussion paper attempts to present an overview of what we believe is happening in relation to substance abuse in Australia. As a Committee we have been bipartisan in describing the work of government and nongovernment agencies, and in reporting many of the issues raised by the evidence given in submissions, public hearings, and innumerable visits throughout Australia.

1.2 We have much more work to do before we are ready to make definitive recommendations. We anticipate the Committee's future work will be complemented by more detailed information about the spread of services, the expenditures of governments, as well as more current estimates of the social and economic costs associated with substance abuse. This latter information, for example, is expected to be available by mid-2002.

1.3 This paper should be considered as the outcome of the first phase of this Inquiry. We intend the next phase to entail a more focused investigation of national programming and to result in recommendations about how our strategic approach to this subject might be made not only more effective and efficient, but how it might better engage the community in the design and support of its recommendations.

1.4 The Committee believes the involvement of communities in the development of workable recommendations and programs is vitally important. As one witness said:

> … one of the important things is to actually take the community with us on the journey of understanding, exploration and dialogue.[1]

1.5 We believe that community involvement is essential. We understand these processes can be difficult and expose conflict, but there is a real diversity of opinion on these matters which we can ill afford to ignore, or deny.

1.6 Committee members reflect a diversity of opinion but also have a special responsibility to bring to this debate all the spirit of bipartisanship we can muster. Throughout this Inquiry there have been many calls for the demonstration of leadership in this area. Sometimes, this was a call for the demonstration of more leadership from the Commonwealth, but more often it was a call for the demonstration of more leadership from parliamentarians.

1.7 The community demands that, above all, Members of Parliament adopt a bipartisan approach to this issue. As one witness said to the Committee:

> That is why people are so disenchanted with politicians: they actually think that politicians should be better than us, not the same as us. They should not be following opinion polls; they should be leading the way forward, not sliding backwards.[2]

1.8 The Committee is unanimous in the view that the issues, views, and possible directions raised in this discussion paper should be contemplated and discussed by all who are interested and involved in this complex area.

1 Evidence, p. 494.

2 Evidence, p. 798.

2

Overview

A short history of Australia's National Drug Strategy

2.1 Nearly twenty-five years ago, the Senate Standing Committee on Social Welfare produced the first of a two-volume report into drug problems in Australia. The introduction to the first volume, *Drug Problems in Australia – an Intoxicated Society?* – is in the view of this Committee still apt today:

> The drug use debate has brought forth extremist views. Arguments are often biased, many cannot be justified, nearly all are emotional. In supporting calls for particular actions, some contributors to the debate have been quite ready to distort or misrepresent facts. Even research has not displayed desirable objectivity or aimed at an impartial search for knowledge.
>
> The extreme options being presented are heavy legal sanctions for breaking a strict prohibition on one hand, and total permission on the other. While we may reject these views, they have been taken into consideration when examining the evidence. A multiplicity of options can be found between these extremes. A re-orientation is needed, away from the protection of entrenched moral positions toward a constructive debate which has as its aim the diminution of the problems drugs present to our society. Attachment to this goal rather than emotional attachments to favoured solutions will aid the search for more reasonable and more efficacious strategies.

> The poor standard of the debate itself has contributed to the level and nature of drug use. One doctor has called it 'the drug problem problem'. It is important that the community understands not only all the issues but also the need for more responsibility and involvement in this debate. Unless the standard of debate improves appreciably, we shall not even begin properly to comprehend the problem, let alone move toward its alleviation.[1]

2.2 The 1977 Senate Standing Committee report (which subsequently became known as the 'Baume report') recommended the declaration of a national approach to drug abuse based on what was described as a 'seven point strategy'. The seven points counselled what might be described as a pragmatic approach to limiting the adverse effects of drug abuse. This emphasised the importance of balancing efforts to reduce the demand for and supply of drugs, as well as the desirability of viewing drug abuse primarily as a social / medical rather than a legal problem. [2]

2.3 In late 1984 the then Prime Minister signalled his intention to initiate a National Campaign Against Drug Abuse (NCADA) and, on 2 April 1985, a special Premiers' Conference on Drugs established NCADA. The overall aim of the national campaign was to minimise the harmful effects of drugs on Australian society and, towards this end, Premiers agreed to the formation of a Ministerial Council on Drug Strategy to coordinate and direct NCADA.

2.4 The Campaign launched by the then Commonwealth Minister for Health in 1985 was based on a number of key principles which continue to underpin what is now known as the National Drug Strategy. These are broadly consistent with those articulated in the Baume report in 1977. The approach was to be national and cooperative across jurisdictional boundaries, to be comprehensive in addressing problems related both to legal and illegal drugs, supply control and demand reduction strategies were to be integrated, and reliable data was to be collected to enable program monitoring and evaluation.[3]

2.5 A number of consultative and advisory structures have been developed to assist with the development and implementation of the National Drug Strategy. These include structures to facilitate:

- consultation and cooperation between government Ministers and government officials;

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1 Senate Standing Committee on Social Welfare 1977, *Drug Problems in Australia – an intoxicated society?*, AGPS, Canberra, p. 13.

2 Senate Standing Committee on Social Welfare. *Drug Problems in Australia – an Intoxicated Society?* The Commonwealth Government Printer, Canberra, 1977, pp 1-2.

3 Submissions Vol. 2, p. 322.

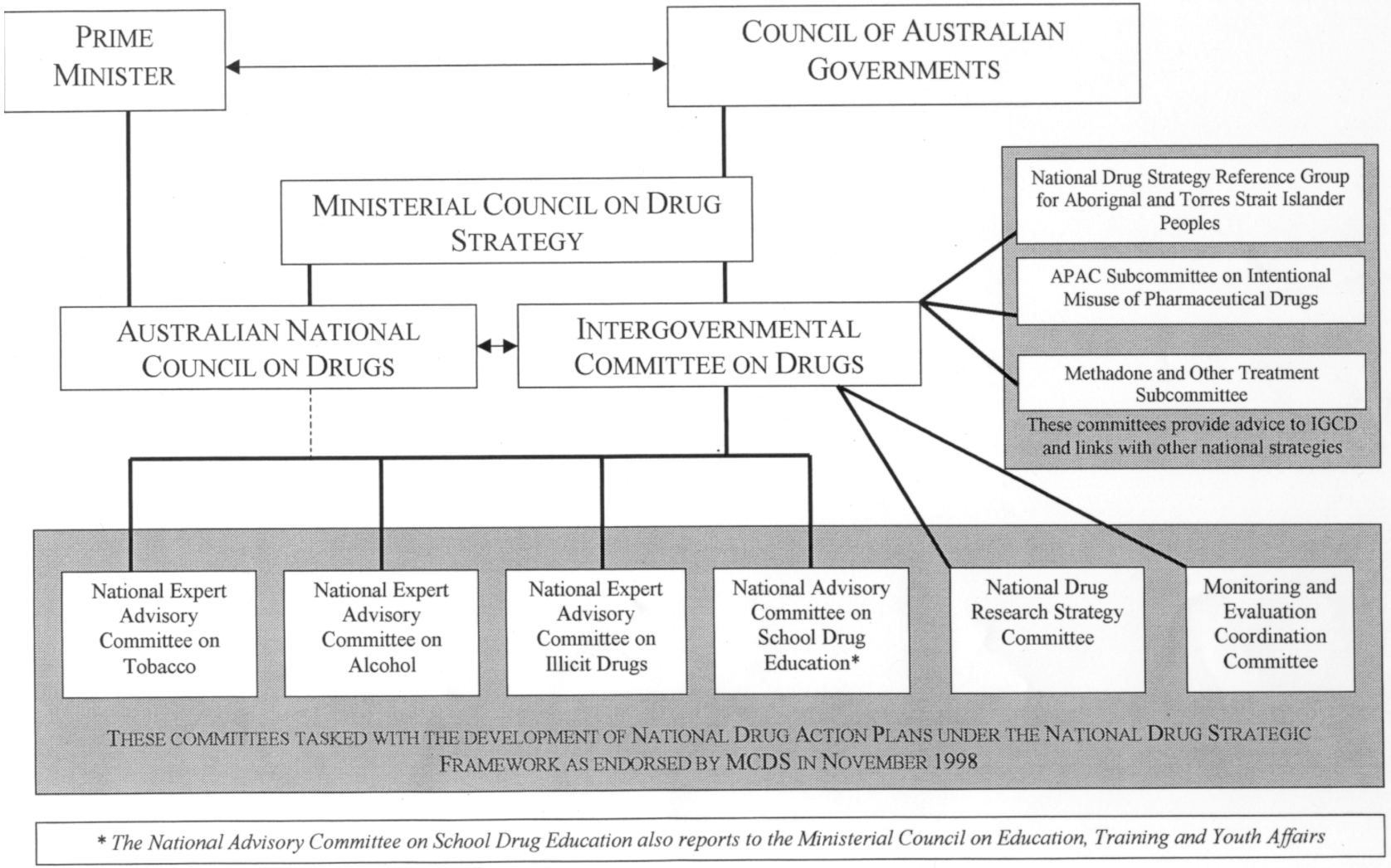
- consultation with community organisations working in the field and members of the public; and
- the provision of expert advice to government officials and Ministers.[4]

2.6 The inter-relationships between key structures, including the Ministerial Council on Drug Strategy, the Intergovernmental Committee on Drugs, the Australian National Council on Drugs, and the National Expert Advisory Committees, are represented schematically in the diagram on the following page.[5]

4 Submissions Vol. 2, p. 335.

5 Submissions Vol. 2, p. 339.

ADVISORY STRUCTURES FOR THE NATIONAL DRUG STRATEGIC FRAMEWORK 1998-99 TO 2002-03



** The National Advisory Committee on School Drug Education also reports to the Ministerial Council on Education, Training and Youth Affairs*

2.7 Under the National Drug Strategy (NDS), the Commonwealth Government has a dual role.[6] It is (1) responsible for providing national leadership in Australia's response to reducing drug-related harm, and (2) it has responsibility for implementing its own policies and programs to contribute to the reduction of drug-related harm. The Department of Health and Aged Care is the Commonwealth agency with overall responsibility for coordination of the National Drug Strategy and related programs. It is important to note however that a range of other Commonwealth Government agencies have responsibility for policies and programs that may impact on the demand for, or supply of, tobacco, alcohol, and other drugs. These include the Commonwealth Department of Education, Training and Youth Affairs (DETYA), the Commonwealth Attorney-General's Department, the Australian Customs Service, the Australian Federal Police, and the National Crime Authority.[7]

2.8 Under the NDS, State and Territory governments are responsible for providing leadership within their respective jurisdictions. They are responsible for policy development, implementation and evaluation and for the delivery of police, health (including drug treatment) and education services to reduce drug-related harm. Other activities for which State and Territory Governments are responsible under the NDS include:

- developing and implementing their own drug strategies from the perspective of law enforcement and population health, based on local priorities;
- controlling the supply of illicit drugs through both specialist drug law enforcement units and general duties police officers;
- enforcing the regulation of pharmaceutical drugs;
- enforcing laws regulating the consumption and availability of alcohol and developing and enforcing legislation relating to tobacco;
- implementing harm reduction strategies to prevent drink driving;
- providing public sector health services or funding community-based organisations to provide drug prevention and treatment programs;
- regulating and administering the delivery of methadone services and needle and syringe programs;
- developing effective and comprehensive professional education and training, research and evaluation strategies, in close cooperation with other jurisdictions so as to achieve consistency;

6 Submissions Vol. 9, p. 2000.

7 Submissions Vol. 9, pp. 2000-2001.

- assessing measures that allow police to exercise discretion in diverting drug users away from the criminal justice system into appropriate treatment options; and
- establishing an appropriate public policy framework to deal with drug use and drug-related harm in areas such as housing, school-based drug education, criminal justice and juvenile justice and liquor licensing.[8]

Overview of substance use in Australia

2.9 In 1998, around one in five Australians (22%) aged 14 years and over was a current regular smoker.[9] This figure has remained relatively stable between 1991 and 1998,[10] while the proportion of people who have never smoked increased (from 23% to 34%).[11] The highest smoking rates for both sexes were amongst those aged 20 –29 and, overall, men were more likely to be current smokers than women. [12] Based on per capita consumption of cigarettes for people aged 15 years or more, Australia was ranked 17th in the world in 1996.[13]

2.10 The most recent national alcohol use data show that the proportion of persons aged 14 years and over who are regular drinkers[14] of alcohol in Australia has remained fairly constant at 60% between 1991 and 1998.[15] 1998 data show that males are much more likely to be current regular drinkers than females (59% / 38%) [16]; these data also reveal that men are more likely than women (7% / 4%) [17] to be drinking at hazardous or harmful levels. In 1998, Australia ranked 19th in the world in terms of per capita consumption of pure alcohol. [18]

8 Submissions Vol. 9, p. 2005.

9 A current regular smoker is someone who has smoked at least once a day, or on most days, in the past twelve months.

10 Recent unpublished data suggests smoking prevalence is falling, with +18 year-old smoking rates down to an all-time-low of 20.3% in November 2000.

11 Miller, M., and Draper, G., 2001, *Statistics on Drug Use in Australia 2000,* Australian Institute of Health and Welfare, Canberra, p. 8.

12 Miller, M., and Draper, G., p. 2.

13 Miller, M., and Draper, G., p. 5.

14 A current regular drinker is somebody who has consumed alcohol at least once a week in the past twelve months.

15 Miller, M., and Draper, G., p. 13.

16 Miller, M., and Draper, G., p. 14.

17 Miller, M., and Draper, G., p. 15.

18 Miller, M., and Draper, G., p. 11.

2.11 Nearly half of all Australians aged 14 years and over have used illicit substances at least once in their life, while 23% report having used an illicit drug in the preceding 12 months. The most widely used illicit substance in Australia in 1998 was marijuana, with lifetime use[19] of 39% and recent use of 18%. Only 2% of the Australian population has ever used heroin, with 1% reporting recent usage. The prevalence of cocaine use is slightly higher, with 4% of respondents reporting lifetime use, and 1% recent use.

2.12 There has been a general increase in the use of marijuana, hallucinogens, ecstasy / designer drugs and amphetamines since 1991.[20] The only illicit drug use to decline over the past decade is the non-medical use of barbiturates, with numbers of those trying the drugs falling substantially after 1991.[21] As Professor Wayne Hall, Executive Director of the National Drug and Alcohol Research Centre, told the Committee:

> The evidence presented in our submission suggests that, notwithstanding the considerable efforts of governments, illicit drug use in Australia has edged up. Population surveys indicate that lifetime cannabis use in the 14 – 19-year age group may be as high as 45 per cent. The use of ecstasy and amphetamine-type stimulants appears to be becoming more widespread amongst teenagers and people in their 20s. Heroin-related deaths and overdoses have increased markedly. Polydrug use and injecting as a preferred method of administration are becoming more common practices. Finally, the age of initiation for those who experiment with drugs seems to be trending downwards.[22]

2.13 The Committee notes that, since Professor Hall made the foregoing statement at a public hearing one year ago, the number of heroin overdose deaths has begun to decline nationally after a nearly three-fold increase over the past decade. A number of reasons have been put forward for this decline, including the implementation of heroin overdose strategies in many States and Territories[23].

2.14 While reliable international comparisons are difficult to make given lack of comparability of data sets, Australia is not alone in experiencing an increase in illicit drug use.[24] The reasons for this are complex and inter-related, involving a number of factors such as the following, described by

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19 Lifetime use means use on at least one occasion in one's lifetime.

20 Miller, M., and Draper, G., p. 17.

21 Miller, M., and Draper, G., p. 20.

22 Evidence, p. 70.

23 The Director of WADASO in Western Australia said he thought the main reason for the decrease in overdose deaths related to increased access to treatment, especially methadone.

24 Evidence, p. 71.

a senior representative of the Commonwealth Department of Health and Aged Care at a public hearing before the Committee:

> …factors that seem to play a part include particular influences such as family stress and conflict, physical and sexual abuse, isolation from family support, low income, unemployment and homelessness…Beyond the interplay of these specific influences, but also related to them, research suggests that in some sections of society there is an increasing sense of social isolation, insecurity, powerlessness and loss of control in individuals, families and communities. It is hard not to draw the conclusion that there is something in all of this which makes some in our community more vulnerable. That translates into a greater propensity towards self-destructive and risk-taking behaviour which, for some, is manifested in a culture of illicit drug taking and binge drinking.[25]

Conduct of Inquiry to date

2.15 On 28 March, 2000, the Chair of the Committee, Mr Barry Wakelin, MP, wrote to the federal Minister for Health and Aged Care, the Hon Dr Michael Wooldridge, MP, proposing that, in view of the rising level of community concern about the continuing abuse of licit and illicit drugs, the Committee investigate and report on the social and economic costs of substance abuse with regard to:

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

2.16 On 30 March, 2000, the Minister wrote back to the Committee accepting the terms of reference for the proposed Inquiry and offering the support of the Commonwealth Department of Health and Aged Care. In mid-April, submissions to the Inquiry were solicited through:

- mid-week and Saturday advertisements in *The Weekend Australian*;
- dissemination of information to the 1000 subscribers of the free e-mail information service provided by the Alcohol and other Drugs Council of Australia (ADCA), the peak, national, nongovernment organisation

25 Evidence, p. 71.

representing the interests of workers and agencies in the alcohol and other drug arena; and by

- direct mail-out to approximately 250 government and non-government agencies and individuals on a Secretariat-generated database, compiled with the assistance of lists provided by the Commonwealth Department of Health and Aged Care.

2.17 On 9 June 2000 the Committee began its Inquiry with a private briefing at Parliament House attended by representatives from the Commonwealth Department of Health and Aged Care (DHAC), the Alcohol and other Drugs Council of Australia (ADCA), the Australian Institute of Criminology (AIC), and academics from the National Centre for Epidemiology and Population Health (NCEPH) at the Australian National University. By the end of June 2001, the Committee had visited all capital cities and a number of regional centres in all national jurisdictions, and consulted hundreds of individuals in the collection of formal and informal evidence for the Inquiry. In addition, the Committee received and authorised for publication over 220 submissions from governments, nongovernment organisations, and private citizens with a story to tell about the social and economic costs of drug abuse. Comprehensive lists detailing formal and informal consultation processes undertaken by the Committee are provided in appendices at the back of this report.[26]

2.18 In preparing for its national program of informal visits and public hearings and in the conduct of its Inquiry, the Committee sought the advice and assistance of many individuals, in particular people from the Alcohol and other Drugs Council, members of the Intergovernmental Committee on Drugs, and staff from the Commonwealth Department of Health and Aged Care, in particular those working in the Drug Strategy and Population Health Social Marketing Branch. The Committee would like to acknowledge their invaluable assistance in supporting the work of the Committee on this Inquiry.

2.19 This paper is organised according to the terms of reference of the Inquiry. It encapsulates the evidence presented to the Committee and is broadly descriptive of what is happening in the community. A range of views is canvassed. It is hoped this will encourage those who contributed to this Inquiry, and those who did not, to come back to the Committee with further thoughts.

2.20 Throughout this paper we use the terms ‘substance’ and ‘drug’ interchangeably. When we use either of these terms, we want readers to

26 Most submissions are available in electronic form through the Committee’s website on: http://www.aph.gov.au/house/committee/fca.

understand that we are not making distinctions based on the legal status of the drug or substance. Therefore, when we use the term drug or substance, we are referring to all kinds of mood-altering chemical products, including for example, alcohol, tobacco, marijuana and heroin.

3

Family relationships

Introduction

3.1 Families and relationships are at the very heart of the vexed issue of substance abuse. The imagery of the recent National Illicit Drugs Campaign television advertisements featuring young people in bodybags or on the floor of grimy toilets, with voice overlays of their now lost childhood dreams represents the most extreme outcome. The Committee also recognises that these images may have little impact on people without these experiences, and may be traumatic for people whose family members have been injured or killed in other ways. Those close to this issue and traumatised by it can readily relate countless experiences that impact not only upon their immediate family and close friends, but in many cases the whole community.

3.2 Earlier this year, members of Family Drug Support (FDS), a nongovernment organisation dedicated to helping families with drug-dependent children, gave evidence to the Committee at a public hearing in Sydney. Individual FDS members told of their experiences in dealing with the difficult realisation that a loved family member was, or is, suffering from drug dependence. In the words of one of the members:

> I live on the North Shore, enjoying a middle-class socioeconomic life. I offer my children the privilege of a stimulating environment, education and nurturing and yet my youngest daughter, Sarah,

> has battled drug addiction for eight years. There is no drug she has not used, and she has singularly fragmented a strong family unit.
>
> We have struggled to keep faith in Sarah, to love and protect her, to support her, to keep having hope. It has not been easy and, in truth, it has torn the family to its heart. She is nearly 20 years old now; of high intellect. She is articulate and talented and yet she prostituted herself on every level to support a heroin habit almost to the point of death, which at the time, was acceptable to her in oblivion. But that has now become an intolerable memory and a burden almost too heavy to bear. We no longer grieve for 'what if?' or 'if only'. There are no easy solutions, but in this prolonged journey of supporting them in their illness it becomes even harder to help them bridge the gap between the world they have made their own and ours...For many people, the slow realisation that their child or loved one is using drugs opens the door to a darkness of which they never quite make sense.[1]

3.3 Over the past year hundreds of families have written to the Committee or appeared before it at public hearings to tell stories about how their families have been affected by drug abuse. The Committee applauds the courage of those witnesses whose testimony has helped to make the point, which the Committee would like to reinforce here: anybody can become addicted to a mood-altering substance. Any family can find itself embroiled in the drama which ensues when it is discovered that a loved family member is afflicted with a drug dependence. The Committee salutes those brave people who chose to play a part in challenging public perceptions and stereotypes prevailing in this area. It is hoped that this report does justice to their accounts, and properly honours their courage.

The need for support

3.4 Parents' suffering was described by one witness in Melbourne, who said:

> Parents of problematic drug users grieve over their hopes, desires and wishes for that toddler when they were thinking they were going to be an adult. They are grieving over their own son and daughter, who are operating under rules that are completely incongruous or foreign to a family concept of rules – that is, stealing, lying and those sorts of things of a repetitive nature that families do not often see, and the great hopes and falls. We need to

1 Evidence, pp. 614 – 615.

> think about parents of problematic drug users in regard to grieving and about how we can support them through that.[2]

3.5 The Committee learned that families need various kinds of support when they are confronted with the knowledge that a family member is suffering from a drug addiction of some kind. They need timely information and access to services that might be appropriate and available, as well as practical advice and counselling about what to do when faced with certain situations, for example discovery of stealing, or of illicit drugs and/or related equipment. They need the sympathy, understanding and expertise of friends as well as health and welfare professionals, and perhaps the support of an employer to provide some emergency leave.

3.6 Sadly, according to the testimony of many witnesses and agencies, support is not always immediately forthcoming, and delays in finding help can compound families' sense of isolation. Worry about the stigma surrounding drug addiction is a negative factor, too, as this can discourage families from accessing services that may be available. One witness in Western Australia told the Committee that she didn't tell anyone about her daughter's heroin addiction for three years:

> …I told no one about it, not even my parents or brother. Nobody knew. What do you do? Do you say, "Hey, my kid is an addict"? You do not do it.[3]

3.7 In Tasmania, a member of the Catholic Women's League of Australia cited removal of the stigma of addiction as a key priority for action because, as she said, '…a lot of families are really suffering'.[4]

3.8 It is clear to the Committee that one way in which Australian society can help relieve families' suffering, and encourage them to 'come out' for help when this is needed, is to challenge our own personal beliefs and attitudes to ensure that we are not contributing to families' problems at this juncture. Families are, as one witness put it, doing the hard yards out there,[5] and they do not need to carry with them the additional weight of community prejudice. We enjoin readers to learn more about this whole subject. We ourselves have found that many of our own beliefs and attitudes have changed as a result of our learning experiences over the past year with this Inquiry.

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2 Evidence, p. 521.

3 Evidence, p. 196.

4 Evidence, p. 1014.

5 Evidence, p. 520.

Support Provided by Governments

3.9 Through their submissions and public testimony, government agencies outlined for the Committee the sort of work they are doing to try to help families deal with the issue of substance abuse. In the following pages we summarise the main points emerging from governments' evidence describing initiatives specifically oriented towards family support. The health care chapter which follows provides more information and discussion about what governments are doing in terms of service provision.

The Commonwealth

3.10 Fifteen years ago saw the launch of the National Campaign Against Drug Abuse targeting Australian parents with The Drug Offensive booklet and a national telephone line to call for a comprehensive information kit. Subsequent Drug Offensive campaigns targeted parents with information about heroin in 1987, alcohol in 1988-89, and amphetamines in 1993.

3.11 On 25 March this year the first phase of a National Illicit Drugs Campaign began with the dissemination of a drug information booklet for parents. The booklet, *Our Strongest Defence Against the Drug Problem,* is one of a number of information resources to be provided to parents in this part of the Campaign. The Campaign is managed by the Commonwealth Department of Health and Aged Care (DHAC) and has been allocated $27.5 million in funds over four years; the second phase targeting youth is expected to begin in late 2001.

3.12 The main objective of the 'parent' part of the national campaign is to provide information and support to parents of 8 – 17 year olds about the role they can play in preventing drug use amongst their children and teenagers. Formative research conducted by DHAC in the development of the Campaign showed that, while most parents feel responsible for informing their children about drugs, they also believe their teenagers are better informed about drugs than they are.

3.13 Paradoxically, beliefs such as this are a potent argument of the need for campaigns such as the National Illicit Drugs Campaign, which aims to enable parents with information and encouragement to learn more about drugs and why young people are using them. The booklet provides information and advice for parents and, importantly, supplies contact details for readers wanting to learn more about the subject. Its contents reflect some of the key issues students raised with the Committee, for example the importance of parental role modelling, and it explores some of the reasons why young people choose to use drugs. The Campaign booklet does not purport to provide 'the answer' to the drug problem, and

nor should it be read as one. The Committee heard a range of views about it, and Members themselves had differing opinions about its merits.

3.14 In its submission to this Inquiry, the Commonwealth Department of Family and Community Services (FACS) said the only two initiatives currently within the range of its portfolio activities explicitly relating to substance abuse were: (1) the Strengthening and Supporting Families Coping with Illicit Drug Use program, and (2) the Child Care Family Crisis Pilots.[6] The former (now referred to as the Family Measures program) involves collaborating with State and Territory Governments in the provision of approximately $11 million in funding for services to support parents and families suffering from the effects of illicit drug use.[7] The sorts of services expected to be delivered (on the ground by the end of 2001) include:

- parent education and support programs;
- telephone advice and referral services;
- on-line information services;
- family education drug kits;
- training material for service providers;
- family support in rural and remote areas; and
- kinship support services targeted to indigenous families.

3.15 The second initiative referred to in the FACS submission, the Child Care Family Crisis Pilots, enables funding for pilot projects to assist families in extreme crisis, including crises relating to drug and alcohol dependence.[8] Funding for these projects was approved in November 1999, and projects approved at the time of the writing of the Department's submission included one specifically designed to support young families in extreme crisis due to drug dependency.[9]

3.16 While the above describes what FACS says are its key activities in the area of substance misuse, it is worth noting that the Department is dedicating $20 million per year to the funding of 'Reconnect' services, which target homeless young people (or those at risk of homelessness) and aim to achieve reconciliation, wherever practicable, between homeless or 'at risk' young people and their families as well as engagement of these young

6 Submissions Vol 10, p. 2617.
7 Evidence, p. 20.
8 Submissions Vol 10, p. 2646.
9 Submissions Vol 10, p. 2646.

people with employment, education, training, and community activities.[10] The Committee applauds the objectives of Reconnect and believes these have great potential not only for supporting families, but for preventing harms of all kinds, including drug abuse.

The Australian Capital Territory

3.17 The Australian Capital Territory (ACT) Government told the Committee it has secured funding from FACS (under the Strengthening and Supporting Families Coping with Illicit Drug Use Program) to provide skills training to parents and enhance the capacity of community service providers to deliver targeted skills training to affected families.[11] With this funding the ACT Government has developed a parent education and support program based on the premise that parents are the primary educators of their children, especially in the area of values education. The ACT's submission also referred to the Parentlink program, described as a progressive initiative which recognises the importance of families and the difficult challenges they face. The program comprises a range of initiatives to connect parents with information and support services in the ACT, including a telephone and internet information service.[12]

New South Wales

3.18 The New South Wales Government held a Drug Summit in the NSW Parliament from 17-21 May 1999. The Government's Plan of Action in response to Summit outcomes was outlined in the document *NSW Drug Summit 1999: Government Plan of Action, July 1999*. In this, the Government committed itself to a number of family-oriented drug abuse prevention measures including, for example, (1) plans to develop overdose prevention education sessions for families and carers, (2) the production and distribution of a family drug information kit, and (3) a partnership between NSW Health and key community agencies to develop five pilot programs to provide education and support for families.

3.19 Importantly, the NSW Government's *Plan of Action* announced that $54.2 million in funds would be dedicated to the Families First program, which is to be 'rolled out' across New South Wales over the next two to three years.[13] At a public hearing in Sydney earlier this year, NSW Government witnesses described Family First in the following terms:

10 Submissions Vol. 10, p. 2643.

11 Submissions Vol. 9, p. 2242.

12 Submissions Vol. 9, p. 2241.

13 Evidence, p. 575.

> The New South Wales government has considered the weight of evidence around the benefits of early intervention and put into practice these things by establishing the Families First program. And what we predict is that the Families First program will lead to communities and families that function in ways that make substance abuse less likely. Families First is a government sponsored strategy that aims to support families and work with communities to care and to assist their development in these critical early years of life. It links early intervention and prevention activities, and community development programs form a comprehensive network that provides wide ranging support to families raising children. Importantly, it is also breaking down the silo mentality that traditionally plagues government. It is equally important that the Commonwealth government, as a key player in the family support landscape, acknowledges this critical paradigm shift that has occurred in New South Wales and works cooperatively with Families First to achieve the best outcomes for children and their families.[14]

Northern Territory

3.20 A submission by Territory Health Services (THS) observed that many indigenous families in remote communities were coping with substance misuse, but that the complexity of indigenous family structures made it difficult to focus programs 'just at the parental level'. The submission noted that the extended family network system provides opportunities for exploring interventions based on the principles of social behaviour network therapy, which was described in the following way:

> The aim of social behaviour network therapy is to motivate problem substance users to make changes in their substance use through building a united network of family members and/or friends who provide the user with a positive social support network to make and sustain change.[15]

3.21 The THS submission went on to state however that, while support and care interventions are provided by some agencies to remote communities, these are neither widely available nor consistent in their provision.[16]

14 Evidence, p. 556.

15 Submissions Vol. 2, p. 286.

16 Submissions Vol 2, p. 286.

Queensland

3.22 Queensland's Drug Strategic Framework 1999-2000 to 2003-2004 *Beyond a Quick Fix* identifies family support as one of seven priorities for action. As a Government witness told the Committee:

> There have been a lot of very impressive longitudinal studies which have shown that high quality interventions very early in a child's upbringing can have substantial effects with respect to their behaviour later in life. Indeed, that is something that Queensland Health particularly is beginning to focus much more on, in recent months and years.[17]

3.23 While another Queensland Government witness conceded to the Committee that the State does not have in place a comprehensive structure and framework for the delivery of family support throughout Queensland, the Government has what it describes as a 'major best practice model' for helping families, which it would like to roll-out more extensively with the assistance of Commonwealth funds.[18]

South Australia

3.24 The South Australian Government's submission commented on the links between substance abuse and family violence, noting the complexities of these associations, but acknowledging that violence resulting from substance abuse is an issue of concern in the general community, and particularly in Aboriginal communities.[19] The Government cited ABS statistics highlighting the relative vulnerability of young women to violence from their partners.

3.25 In public testimony, Government witnesses made the point that in designing drug interventions, it is important to take into account different cultural values and family attitudes to drug use and treatment. [20]

Tasmania

3.26 The Tasmanian Government's submission referred to the high proportion of clients at the Government's Alcohol and Drug Service who report that alcohol and drugs are significantly impacting family life. Some of the ways in which substance misuse impacts on the social and economic well-being of families are described, though the submission does not elaborate about

17 Evidence, p. 718.

18 Evidence, p. 739.

19 Submissions Vol. 10, p. 2404.

20 Evidence, p. 237.

relevant Government interventions.[21] At the public hearing in Hobart in June, a Government witness referred to the *Making a Difference* program as a good example of:

> …where we are working and will be working continually with families to assess the amount of harm from substance abuse and also to inform communities about the issues surrounding substance abuse.[22]

3.27 The *Making a Difference* program is a three-hour, single session drug awareness program for parents; it is delivered free of charge to parents in their local communities by experienced alcohol and other drug workers. Basic information in three core areas (drug awareness, communication and general strategies) is provided, and parents are given a take-home information pack. The program was developed in North-West Tasmania in 1998, commenced operation in 1999, and was first evaluated in early 2000. Program evaluation findings have been incorporated into the second edition of the manual which is used by program facilitators.

Victoria

3.28 The Victorian Government's submission drew attention to research done in the 1990s linking a range of problem behaviours (including problematic substance abuse) developed in adolescence to what have been described as risk and protective factors. Factors operating at the level of the individual / peer, family, school and community were described in the submission.[23] This body of work suggests, not surprisingly, that increasing exposure to protective factors and reducing exposure to risk factors reduces subsequent development of problematic behaviour, including drug abuse.

3.29 At a previous public hearing the President of the Alcohol and other Drugs Council Australia referred to this body of work when he said:

> There are many studies…which show that, if children grow up nurtured and valued, they become resilient and protected from adverse factors during their development and adolescence and that these interventions, or this support of young developing families, can have very positive outcomes in adolescence – in mental health, in drug and alcohol use, in health problems generally, in improved outcomes in education and in improved employment.[24]

21 Submissions Vol. 9, p. 2108.

22 Evidence, p. 992.

23 Submissions Vol. 8, p. 2718.

24 Evidence, p. 5.

3.30 The Victorian Government's submission referred to parenting programs during early development as a type of intervention that can work at the family level to influence risk factors, but the Government was careful to point out that specific programs are more effective when they are delivered as part of a broader range of preventive interventions including, for example, enhancing the role of school communities and community strengthening.[25]

3.31 At a public hearing in Melbourne, the Victorian Government told the Committee it expects to receive $600,000 per year in Commonwealth funds to run parent education sessions out of schools, particularly in areas where participation in the school structure is relatively low. Government witnesses said that this money would sit alongside another $1 million per year in new money that would be dedicated to the following: (1) a new telephone support service for parents, operated by parents and backed up by professionals, (2) putting parent support workers on the ground in each of the State's regions to link parents to the treatment system, and (3) putting people with particular drug expertise into the community's generic family counselling infrastructure to help agencies deal with cases and support other family counsellors.[26]

Western Australia

3.32 Western Australia's submission to the Inquiry referred to *Working in Partnership with Parents,* described as a new initiative aiming to increase the range and level of supports available to families concerned about the use of drugs by a young family member.[27] Noteworthy recent developments in WA under this Strategy include the following: (1) statewide distribution of a *Drug Aware* Parent Booklet, (2) establishment of a confidential 24-hour Parent Drug Information Service staffed by professional counsellors, and (3) an innovative parent education project called *Helping Empower Local Parents (HELP),* which will establish a network of trained volunteer peer educators to provide drug education to parents in local communities across Western Australia.

3.33 A special feature of drug abuse prevention activities in Western Australia is the phenomenon of the 'local drug action groups' (LDAG); the Committee visited the Willetton LDAG at Willetton Senior High School in Perth last year to hear about their drug education activities. Local drug action groups are essentially community action groups, but these are supported in their work by the Western Australian Government through

25 Submissions Vol. 11, p. 2719.

26 Evidence, p. 448-9.

27 Submissions Vol. 8, p. 1766.

Community Drug Service Teams. LDAGs provide a family-friendly focus in local areas where people can access support and information; project funding is also available to fund family support activities. At the present time there are 80 LDAGs around the State, a number of which have established parent self-help support groups.

3.34 The WA Government hosted a Community Drug Summit at Parliament House in Perth from 13-17 August 2001. A key focus of the Summit was on how to improve levels of support for families coping with family members with substance misuse problems. The Summit made eight family-specific recommendations including, for example, that there be increased provision for whole-of-family residential treatment facilities; a Government response to Summit recommendations is expected in October 2001.

Support provided by nongovernment organisations

3.35 Nongovernment agencies play a vital role in the delivery of services to families. The Committee heard from many nongovernment organisations (NGOs) providing invaluable support to families in crisis over substance misuse. These agencies do more than bridge service gaps: they have the advantage of being run by people who have had similar experiences and who are, therefore, uniquely placed to offer a kind of 'wordless' understanding valued by many, including the witness cited at the beginning of this chapter. When distressed family members finally connect with a suitable support group, the relief experienced must be immense. There is gratitude, too, of the kind expressed by this witness in New South Wales:

> It was such a shock, when we found out that Ann was addicted to heroin. We were anxious, angry, ashamed, guilty, isolated, depressed and confused. A few weeks later, we found out that Ann's boyfriend was also addicted to heroin and physically abusing her, but we could do nothing about it, because he was 16. Any mother in this room will understand how it feels. The tension was so great that our family was nearly broken up. I have not been able to run my business properly, and it is still in financial difficulty. I have survived this ordeal and I am able to talk to you today because of the help that our family gets from the Ted Noffs Foundation.[28]

3.36 All around Australia, nongovernment agencies are running telephone counselling services, referring families to treatment services, developing

28 Evidence, p. 666.

education kits for parents and families, running drug education courses, offering respite care and crisis accommodation, and working in advocacy roles to influence drug-related policies and programs. Some NGOs receive funds from government agencies while others, church-affiliated organisations for example, are relatively self-sufficient. Most rely on the energy and commitment of volunteers to deliver their services, and insecure funding is an issue of ongoing concern.

3.37 Some NGOs deal mainly with what one witness described as the 'devastation of family violence' that is directly related to substance misuse.[29] Mofflyn in Western Australia, for example, helps children whose lives have been affected by the difficulties their parents face[30]. And Toora Women in the Australian Capital Territory provides crisis accommodation and other related support services for women who are homeless, drug-addicted, and escaping domestic violence.[31] Its Director told the Committee that:

> Many of the women we work with are escaping domestic violence. Lots of those women who are older or are from non-English-speaking backgrounds have gone to their local GP and have been prescribed drugs to deal with the fact that they live with violence. Often those women have been using benzos or antidepressants for up to 30 years, for long periods of time. They have been prescribed drugs as a way of dealing with their life situation.[32]

3.38 Family Drug Support (FDS), a nongovernment organisation established in 1997 as a support network for family members of illicit drug users, now has 1800 members around Australia and teams of volunteers operating a telephone counselling and referral service. The agency has developed and distributed, with the assistance of the NSW Government, education packs and courses to help guide family members through the process of dealing with drugs in the family.[33] These materials and other FDS activities, including the dissemination of regular bulletins and the conduct of regular open support meetings, can engender hope and increase the likelihood of positive developments. In the words of FDS founder Tony Trimingham at a public hearing in Sydney earlier this year:

> For years and years and years we've had a history in Australia of family support being neglected. Where family support is not present families do become disengaged from the drug user and

29 Evidence, p. 695.

30 Submissions Vol. 1, p. 140.

31 Evidence, p. 953.

32 Evidence, p. 953.

33 Evidence, p. 323-324.

> there is despair and of course there are a lot of negative consequences for the user as a result of that. On the other hand…where we do have family support in place and people do have access to other people who are affected and get awareness education and information, that leads to resilience, to coping, to management of the problem and to an altogether a better outcome.[34]

3.39 A number of NGOs have developed approaches to parent education. One such agency, Toughlove South Australia, works to empower parents by helping them to find new strategies for dealing with their own reactions to childrens' demands.[35] In evidence given at a public hearing in Adelaide, witnesses told the Committee that:

> Thanks to Toughlove a lot of parents throughout Australia and the world have been able to help change themselves and learn to cope by putting new strategies into place, thereby not tolerating the outlandish behaviours of their children as they come down from their highs. This is not easy and it is not a quick-fix situation but, with the support of other members of our group, we find they can learn new ways to deal with their problems, which ultimately teaches our children to become more responsible members of our society.[36]

3.40 Focus on the Family Australia, which describes itself as a non-denominational nongovernment organisation, developed their program *How to Drug Proof Your Kids* in response to a growing demand by parents for resources and assistance to help steer their children away from the harmful use of drugs.[37] Their popular six-week prevention and early intervention program seeks to reduce risk factors and strengthen protective factors. A witness for Focus on the Family described the agency's 'drugproofing' course in the following way:

> The program is designed to equip parents with [communication] skills within their families to be able to deal with the issue of not only drug education but, when a child is found to be on drugs, how to deal with it in a way that in no way puts the child down but has the effect of getting alongside and supporting them. The emphasis of the program is to do a lot of skill work in educating the parents.[38]

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34 Evidence, p. 607.

35 Submissions Vol 5, p. 1005.

36 Evidence, p. 383.

37 Submissions Vol 6, p. 1254.

38 Evidence, p. 480.

Involving families

3.41 While the nongovernment sector has been eager to harness the energies of concerned family members, governments in general, and the alcohol and other drug sector in particular, have not been good at engaging the family.[39]

3.42 This apparent reluctance may be starting to shift now and, certainly, there is good evidence of it in the attempts currently being made by governments to engage parents in school drug education programs.

School drug education

3.43 A submission from Melbourne's Turning Point Drug and Alcohol Centre suggested that school drug education is a good vehicle for the involvement of families:

> More recently school programs have worked to include families in their endeavours in the broadly-based drug education / prevention effort which is appropriate and probably the best systematic opportunity available.[40]

3.44 One of the objectives of the National School Drug Education Strategy, which was launched on 25 May, 1999, is:

> In partnership with other stakeholders such as health, inform, engage and involve parents about drug related issues.[41]

3.45 The Commonwealth has provided approximately $18 million over four years through the Department of Education, Training and Youth Affairs (DETYA) to develop and implement the Strategy. Additional funding of $9.3 million over four years is being provided by the Commonwealth for the Tough on Drugs in Schools measures agreed by the Council of Australian Governments (COAG). [42]

3.46 In Western Australia, part of the Government's comprehensive approach to supporting families involves ensuring that parents and communities are involved in the School Drug Education Project (SDEP), which is funded at $4.5 million over three years.[43] The School Drug Education Project has developed take-home educational materials specifically for parents to complement the new drug education curriculum designed for students.

39 Evidence, p. 520.

40 Submissions Vol. 8, p. 1793.

41 Submissions Vol. 9, p. 2092.

42 Submissions Vol. 9, pp. 2093 – 94.

43 Submissions Vol. 8, p. 1764.

Under this same Project the Government has recently devised, in partnership with parents and specialist agencies, an early intervention initiative to help school staff address students' alcohol and drug issues within pastoral care programs. In addition to this SDEP activity, the Government supports the work of local drug action groups around the State, and these provide a vehicle for facilitating family involvement in school drug education activities.

3.47 The Victorian Government has developed a new and integrated approach to school drug education[44] which is committed to the involvement of parents; running parent education sessions is integral to this. In evidence given to the Committee last year, the Victorian Government told the Committee that in the past two years, over 10,000 parents have attended parent education sessions.[45]

3.48 The NSW Government's Response to the Drug Summit referred to the fact that the Government would be conducting follow-up drug information sessions for parents to build on the parent information evenings held in every Government secondary school in 1998. In addition, Government witnesses told the Committee at a public hearing earlier this year that:

> Schools cannot be effective without parents. It is essential that we build the links. In the next three years we are going to see very, very strong program development and support around linking parents with the school developments. We want parents to know what is happening at schools. We want parents to be comfortable. We want to assist them in knowing how to deal with these issues. Again, there are significant Commonwealth and state funds going into that project.[46]

3.49 The Commonwealth Department of Education, Training, and Youth Affairs (DETYA) has advised the Committee that later this year a series of local school-community drug summits will begin in States and Territories, and the involvement of parents in these is expected to be significant. The summits aim to bring together school staff, parents and key community members to encourage the development of integrated community responses for addressing illicit and unsanctioned drug use by young people. States and Territories will adopt a range of approaches to the staging of these summits, and their focus will to a large extent be determined by the nature of the issues needing to be addressed at the local level.

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44 Evidence, p. 428.

45 Evidence, p. 448.

46 Evidence, p. 558.

Treatment

3.50 There is a tradition of viewing drug dependent people as isolated individuals, and of not involving families in treatment processes.[47] And yet, people with drug problems who are in treatment facilities are members of families: they have parents, brothers, sisters, and sometimes, children. Research indicates that most drug users under the age of 35 are in daily contact with at least one parent.[48] Families are sometimes seen as a source of trouble for clients, and communications between family members while one is in treatment can be strictly limited, or even forbidden. The pain and trauma this can cause is illustrated in the following story, which was provided by a member of the Families and Friends for Drug Law Reform:

> Gary, a father living on the Central Coast, after years of trying to help his daughter Sunny with her drug problem, finally got her into a rehabilitation centre in Sydney. She was insulin dependent as well as dependent on heroin. He phoned the centre almost every day to inquire of his daughter's progress and was told each time that she was doing well. About a month after his daughter's admission to the centre, Gary was visited by two police officers, who informed him of his daughter's death. Sunny had been evicted from the centre the day before for disobeying a rule. The father had not been notified of her discharge. Indeed, two years later, he has still not had satisfactory answers as to why she had been evicted. He would have gladly collected her, taken her home and kept her as safe as possible. Instead, Sunny was upset and very distressed at being discharged. She used heroin again, she overdosed and died. Sunny was 28.[49]

3.51 In several States and Territories work is being done to promote the adoption of family-inclusive practice in alcohol and drug services. In Victoria, the Turning Point Alcohol and Drug Centre has developed draft guidelines[50] for family-inclusive practice, and in Western Australia the Government has a *Family Inclusive Practice Development Project* which is involving families in the development and promotion of family-sensitive practices. In New South Wales, as part of the Government's Integrated

47 Submissions Vol. 8, p. 1794.

48 Stanton, M.D., and Shadish, W.R., 1997, ' Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies', *Psychological Bulletin*, 122, pp. 170-191.

49 Evidence, p. 30.

50 Clapp, C., and Patterson, J. 2000, *Draft Guidelines for Developing Family Inclusive Practice in Alcohol and Drug Services*, Turning Point Drug and Alcohol Service, Fitzroy.

Care Trials for drug users, consideration is being given to the establishment of mechanisms to facilitate the ongoing involvement of families. The Committee believes this apparent move towards more family-inclusive practice is a good thing, and would like to encourage other jurisdictions to consider similar developments.

3.52 One aspect of the provision of sensitive, family-inclusive treatment services is ensuring that drug-addicted parents seeking treatment for drug dependence can access family-friendly residential treatment programs. Unfortunately, such facilities are rare, and their scarcity is a real obstacle for parents seeking treatment for drug dependency.

3.53 The Committee visited therapeutic communities, Karalika in Canberra, Banyan House in Darwin, Cyrenian House in Western Australia and Odyssey House in Victoria, where children are able to live with their parents while they receive treatment. The importance of this was explained in a submission from Odyssey House Victoria:

> Drug using parents have often had negative experiences of authorities becoming involved in the way they parent their children and are therefore reluctant to part with their children during the time it takes for them to complete a residential detoxification program. There are few detoxification places where parents can enter treatment and retain custody of their children.[51]

3.54 DRUG-ARM's submission to the Committee referred to the impacts of what they describe as 'chronic shortages' of family-friendly treatment options for women with children, noting that these greatly reduce the chances of mothers attending detoxification and rehabilitation programs.[52] A similar point was made by the National Council of Women who went a bit further, though, when they argued that treatment programs for women should be child-friendly as well as sex-specific, ie, it should be possible for men and women to access same-sex facilities.[53]

3.55 A related practical difficulty for people living in public housing wanting to enter residential treatment services is the fact that, in some jurisdictions, tenants must continue to pay full or partial rent to maintain their hold on their housing. Clearly, this financial burden could work as a disincentive to go into treatment. The Committee believes that governments should take steps to ensure that, as much as is practicable, these housing-related financial disincentives are removed.

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51 Submissions Vol. 10, p. 2386.

52 Submissions Vol. 12, p. 3286.

53 Submissions Vol. 1, p. 123.

Conclusion

3.56 In evidence given to the Committee last year, a witness for the Salvation Army said:

> I am reminded that in 1972 the Victorian government had a committee of inquiry into drug abuse, which was perhaps one of the earliest known major committees looking at illicit drugs. If you can find copies of that report, you will see that it found that there needed to be a greater emphasis on parenting skills, family support and so forth. I think that every committee of inquiry since has said almost the same thing, but very little has happened.[54]

3.57 There is a perception in the general community that little has changed in attempts to address the many issues relating to substance abuse. The Committee recognises, however, that there has been a concerted effort by governments recently to redress this deficiency. This needs to be underpinned by continued research, data collection and evaluation to contribute to our knowledge base about what is effective in this area.[55]

3.58 At the present time DETYA is running an *Innovation and Good Practice Research in School Drug Education* project which is providing support to schools to undertake research into the factors thought to be critical to the success of drug education activities. There is a need for more such work, and for information about it to be shared with front-line workers, who ought to be able to benefit from this helpful research. [56]

54 Evidence, p. 453.

55 Submissions Vol. 10, p. 2622.

56 Single, E., & Rohl, T. 1997, *The National Drug Strategy: mapping the future,* AGPS, Canberra, p. 87.

4

Health Care

Introduction

4.1 A person experimenting with the use of a drug might have the occasional misadventure and wind up in hospital as a result, but a person who has become dependent or addicted to a drug will have numerous encounters with the health system over the course of his or her life. As many witnesses said:

> Addiction is a chronic relapsing disorder and needs to be recognised as such.[1]

4.2 The Committee has found and accepts that the causes of addiction are various, and there are many different models by which people attempt to understand the phenomenon. We do not propose in this interim report to delve deeply into the causes of addiction; suffice it to say that currently many rearchers are pondering this complex problem.[2] It is enough for us to recognise that the implication of seeing addiction as a 'chronic relapsing disorder' is to appreciate that we need to ensure that our health system is working effectively, in every sense, to maximise the probability that, as one witness put it, someone in a position to help will be in the right place at the right time in a person's life.[3]

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1 Evidence, p. 30.

2 Evidence, p. 842.

3 Evidence, p. 116.

Costs and burdens

4.3 As the Alcohol and other Drugs Council of Australia pointed out in their submission to this Inquiry, approximately one in five deaths in Australia is drug-related.[4] In 1997, 22,724 people died from drug-related causes, and 256,991 hospitalisations were drug-related.[5]

4.4 Tobacco and alcohol are responsible for the vast majority of these drug-related deaths and hospitalisations. The Australian Institute of Health and Welfare estimates that the use of tobacco accounts for over 80% of drug-related deaths and around 60% of all drug-related hospitalisations, while the use of alcohol is responsible for around 16% of drug-related deaths and 37% of drug-related hospitalisations. Illicit drugs are responsible for 4% of these deaths and hospitalisations.[6]

4.5 In 1996, health economists Collins and Lapsley estimated the overall tangible and intangible costs of drug abuse in Australia in 1992 to be $18.8 billion; those associated with tobacco ($12.7 billion) comprised 67.3% of overall costs, while those associated with the abuse of alcohol ($4.4 billion) made up 23.8%; costs associated with illicit drugs ($1.7 billion) formed 8.9% of total costs.[7] Collins and Lapsley also estimated the health care costs (tangible and intangible) associated with the abuse of these three categories of drugs. Total 1992 health care costs associated with the abuse of alcohol were estimated to be around $1 billion dollars, those associated with the abuse of tobacco around $6.4 billion, and those related to the abuse of illicit drugs around $ 433 million.[8]

4.6 In 1999, the Australian Institute of Health and Welfare (AIHW) published the results of the Australian Burden of Disease and Injury Study, which enables the quantification of the 'disease burden' created by drugs for certain population groups. This study reveals that alcohol dependence and harmful use and road traffic accidents are the leading causes of disease burden for young Australians aged 15-24 years, while heroin dependence and harmful use is the fifth leading cause of disease burden for this age group, accounting for 6% of the total disease burden for this age group.[9]

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4 Submissions Vol. 3, p. 551.

5 Submissions Vol. 8, p. 1699.

6 Submissions Vol. 8, p. 1699.

7 Collins, D.J., & Lapsley, H.M.,1996, *The social costs of drug abuse in Australia in 1988 and 1992*, AGPS, Canberra, p. vii.

8 Ibid., pp. 41, 43.

9 Mathers, C., Vos, T., Stevenson, C., 1999, *The burden of disease and injury in Australia – summary report.* AIHW, Canberra, pp. 19-20.

Responses

4.7 The following section describes in general terms what the Commonwealth government and nongovernment agencies are doing in the areas of prevention and treatment to try to minimise drug-related harms in Australian communities. Family-oriented initiatives, diversion, and school drug education programs will not be revisited here, as these were discussed in previous chapters. Issues relating to health care delivery will be discussed in a later section, which will be illustrated with evidence received from State and Territory governments.

Commonwealth

4.8 The Department of Health and Aged Care is the Commonwealth agency with responsibility for coordinating the National Drug Strategy and related programs. It plays a key role in the development of drug policies, supports the development of research and best practice agendas which inform these, funds the Australian National Council on Drugs as well as the Alcohol and other Drugs Council of Australia[10], and provides financial assistance to the States and Territories to support the implementation of the National Drug Strategy.[11] The Department also provides funds to support the operation of many generalist health services which are used by people with drug problems. In short, the Department undertakes and administers a wide range of activities with the potential to prevent and / or reduce drug-related harm.

Prevention and early intervention

Illicit drugs

Community Partnerships Initiative

4.9 Under the National Illicit Drugs Strategy, $8.8 million (over four years) has been allocated to the Community Partnerships Initiative, which is modelled on the World Health Organisation's *Global Initiative on Primary Prevention of Substance Abuse*. The aim of the Initiative is to encourage quality practice in community action to prevent illicit drug use and build on existing activity occurring across Australia.[12]

4.10 At the time of the writing of the Department's submission, 87 community-based projects had been funded under the Initiative to a total value of

10 Submission Vol. 9, p. 2011.

11 Submissions Vol. 9, p. 2009.

12 Submissions Vol. 9, p. 2012.

approximately $5.9 million[13]. Some of these were described in the submission from the Department of Health and Aged Care (DHAC) to give a feel for the sorts of projects funded under the Initiative. One example cited was the Manly Drug Education and Counselling Centre, which has received funding of $32,000 for one year for the 'Drugs Stop' project to use peer education as a strategy to educate young people (12 – 18 year olds) about the harms of both licit and illicit drug use.[14]

Needle and Syringe Programs

4.11 In April 1999, the Council of Australian Governments (COAG) approved a $221 million package of measures which included $30.6 million in funds (over four years) for the support of Needle and Syringe Programs (NSPs). Of the $30.6 million allocated for the support of NSPs, $27 million is being provided to States and Territories and the balance is for a range of related national activities which the Department is administering.[15]

4.12 The rationale for the expenditure is to increase the number of clients accessing education and treatment services, and increase the availability of sterile needles and syringes to reduce the transmission of HIV, hepatitis B and hepatitis C.[16] The Committee received evidence which argued that NSPs have been shown not only to be an effective way of preventing the spread of HIV, but also a good way to provide illicit drug users with an opportunity for health promotion and referral to other health and treatment services.[17]

4.13 While the Committee does not question the potential public health benefits of NSPs, some members do have concerns about the management of these programs and the adequacy of the oversight of needle distribution and retrieval. While in some jurisdictions needle exchange services are working well, with return rates in the order of 95%[18], in other areas control mechanisms are inadequate and a significant percentage of distributed needles and syringes are ending up on the streets, parks, properties and laneways of cities - and becoming a big headache for local councils.[19]

13 Submissions Vol. 9, p. 2013.
14 Submissions Vol. 9, p. 2049.
15 Submissions Vol. 9, p. 2024.
16 Submissions Vol. 9, p. 2025.
17 Submissions Vol. 9, p. 2025.
18 Evidence, p. 129.
19 Evidence, p. 596.

Legal drugs

National Tobacco Strategy

4.14 The National Tobacco Strategy was endorsed by the Ministerial Council on Drug Strategy (MCDS) in June 1999 and the 1998-99 budget provided $6.1 million over three years for tobacco harm minimisation measures[20]. The Strategy includes the following prevention measures:[21]

- changing tobacco excise arrangements to effect price rises on low weight cigarettes;
- reviewing current health warnings on tobacco products to see if these can be made more effective;
- phasing out all tobacco sponsorship at international sporting events by 2006;
- developing (together with the Australian tobacco industry) an agreed voluntary disclosure protocol about disclosing the ingredients found in cigarettes;
- developing, implementing and evaluating a national best practice model for the design of programs discouraging sales to minors;
- working with States and Territories in the development of a national response to passive smoking.

4.15 In addition, the Department is collaborating with the Australian Cancer Society (ACS) in scoping a research agenda to inform future policy development for nicotine regulation.[22]

4.16 The Department's submission estimates that its social marketing activities under the National Tobacco Campaign, which was launched in June, 1997, have reduced adult smoking prevalence and saved an estimated $24 million in health expenditure.[23]

Alcohol Action

4.17 A National Alcohol Campaign was launched on 20 February 2000. The Campaign, to which the Commonwealth has committed $5.4 million, targets teenagers, young adults, and the parents of 12-17 year olds in an effort to minimise alcohol-related harms.[24]

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20 Submissions Vol. 9, p. 2015.
21 Submissions Vol. 9, pp. 2015 – 2017.
22 Submissions Vol. 9, p. 2036.
23 Submissions Vol. 9, p. 2019.
24 Submissions Vol. 9, p. 2018.

4.18 In the 2000-2001 Budget, the Government announced an additional $4 million in funding over four years to implement the National Alcohol Action Plan 2000 – 2003 and support the development and implementation of the Commonwealth's own Alcohol Action Plan.[25]

4.19 At the time of the writing of this report, national endorsement of the draft National Alcohol Action Plan was imminent. One of the principal themes of the Plan is prevention and early intervention.

4.20 The Commonwealth's own Alcohol Action Plan will:

- complement State and Territory initiatives under the National Alcohol Action Plan;
- support collaborative projects with industry, community and other government agencies;
- augment the National Alcohol Campaign, launched in February 2000;
- provide for further development of the evidence base for alcohol policy;
- increase public awareness of responsible drinking behaviour; and
- promote evidence-based prevention and treatment of alcohol dependence.[26]

4.21 The Commonwealth's Department of Health and Aged Care is currently planning a major public education campaign to accompany the imminent release of revised National Health & Medical Research Council (NH&MRC) Drinking Guidelines.

Pharmaceutical misuse

4.22 The Health Insurance Commission administers the Commonwealth's Medicare and Pharmaceutical Benefits Schemes and, as such, receives a large amount of data about medical services rendered and medication prescribed.[27] For the past four years, the Commission has been running a 'doctor shopping' project which has aimed to achieve better health outcomes for people identified as being at risk of taking large quantities of pharmaceutical drugs.[28] So far the project has achieved cost savings of approximately $16 million, and reduced the number of 'doctor shoppers' by around 35%.[29]

25 Submissions Vol. 9, p. 2017.
26 Submissions Vol. 9, p. 2017.
27 Submissions Vol. 6, p. 1233.
28 Evidence, p. 960.
29 Evidence, p. 961.

4.23 The Pharmaceutical Health and Rational Use of Medicines Committee (PHARM), an expert committee which advises the Government on the quality use of medicines, formed a working party in 1999 to systematically examine the inappropriate prescribing and use of benzodiazepines. The Benzodiazepine Working Party is reviewing current practices and seeking to establish a national program for health services and health professionals to reduce benzodiazepine prescribing and promote positive alternatives, and encourage health services and health professionals to be involved in support and education programs.[30]

4.24 In public testimony before the Committee, the Commonwealth Department of Health and Aged Care acknowledged that intentional misuse of pharmaceuticals has not received as much attention as it should have under the National Drug Strategy[31]. The Commonwealth intends to do more work in this area under the current phase of the NDS, and the Committee will be more energetic in its collection of evidence on this subject when it continues this Inquiry in the next Parliament.

National Prevention Agenda

4.25 In February 2000 the Intergovernmental Committee on Drugs agreed to develop a national prevention agenda to sharpen the focus of the National Drug Strategy on preventing harmful drug use.[32] At this stage the Department of Health and Aged Care (DHAC) has commissioned the production of a monograph which will provide a comprehensive international review of the literature and examine the application of this to drug policy and strategy. The monograph is expected to be completed in May 2002.

Treatment

4.26 While the Department of Health and Aged Care does not directly provide treatment services, it facilitates access to such services in a number of ways. The Illicit Drug Diversion Initiative discussed in Chapter 3 is an example of such a mechanism; under this Initiative, the Commonwealth is providing States and Territories with $105 million over four years to ensure that diverted offenders have access to suitable treatment services. Other mechanisms through which the Commonwealth dedicates funds for treatment include the Pharmaceutical Benefits Scheme and Medicare.

30 Submissions Vol. 9, pp. 2062-63.

31 Evidence, p. 78.

32 Submissions Vol. 9, p. 2012.

Pharmaceutical Benefits Scheme

4.27 The Commonwealth Government funds the cost of methadone syrup under Section 100 of the Pharmaceutical Benefits Scheme and payments are made directly to suppliers on a monthly basis. In 1999-00 the Commonwealth spent $3.9 million on the provision of methadone syrup. As of 30 June 2000, there were 30,237 people on methadone programs in Australia.

4.28 Methadone treatment is recognised nationally and internationally as an effective way of treating opioid dependence and reducing the individual and social harms associated with the use of illicit opiates. A recent review of the national and international medical and scientific literature conducted by the National Drug and Alcohol Research Centre (NDARC) found that methadone maintenance treatment is more effective than a range of alternative approaches to treatment for opioid dependence.[33] It is, as one witness said to the Committee, the 'gold standard' for best practice for heroin dependence.[34] Many other witnesses sang its praises, including the Health Minister of the Australian Capital Territory, who described it as 'our major and most successful form of treatment for many years'. [35]

4.29 The Committee does not question the fact that methadone enables people to stabilise their lifestyle. Methadone is, however, a highly addictive substance[36] from which it is difficult to withdraw; [37] its prophylactic value is better at higher doses, [38] but this makes it harder to come off the drug. It is possible that we have not focused enough on the transition from dependence on methadone to a non-dependent state and that, as one witness suggested, alternative pharmacotherapies might help to manage this transition better.[39]

4.30 A range of other pharmaceutical products used in the management of dependence are available at subsidised rates under the PBS - acamprosate and naltrexone, for example, when these are used within a comprehensive treatment program for alcohol dependence.[40] Naltrexone for use as a detoxification agent in the treatment of heroin dependence does not currently attract a subsidy under the PBS. As of 1 August, 2001, buprenorphine will be subsidised through the PBS, as research has

33 Submissions Vol. 9, p. 2030.
34 Evidence, p. 857.
35 Evidence, p. 91.
36 Evidence, p. 140.
37 Evidence, p. 827.
38 Evidence, p. 564.
39 Evidence, p. 858.
40 Submissions Vol. 9, p. 2030.

demonstrated it is an effective opioid substitution treatment. The Committee considers that naltrexone should be subjected to comparable research and trialing to determine whether it, too, should be subsidised through the PBS as a treatment agent for opioid addiction.

Medicare

4.31 Treatment for many drug problems occurs through generalist health services, incuding general practitioners and public hospitals. Commonwealth funding for these interventions is provided under Medicare, mainly in the form of:

- subsidies for prescribed medicines and private medical expenses;
- substantial grants to State and Territory governments to contribute to the costs of providing access to public hospitals, at no cost to patients, and other health services; and
- specific purpose grants to State / Territory governments and other bodies.[41]

NGO Treatment Grant Program

4.32 Under the National Illicit Drugs Strategy (NIDS), approximately $57 million in funds (over four years) have been allocated to 133 drug treatment programs across Australia.[42] The Program has a particular emphasis on filling geographic and target group gaps in the coverage of existing treatment services. Funding has also been allocated for expanding and upgrading existing non-government treatment services to strengthen the capacity of NGOs to deliver improved services and increase the number of treatment places available. Of the 133 projects funded under the NIDS NGO Treatment Grants Program, 45 specifically target young people.[43]

Specific Populations

4.33 The Commonwealth Department of Health and Aged Care's Office for Aboriginal and Torres Strait Islander Health (OATSIH) administers the Aboriginal and Torres Strait Islander Substance Misuse Program which provided, in 1999-2000, $18.4 million towards the operation of 69 community-controlled health and substance misuse services nationally. Twenty-six of these services provide residential rehabilitation and treatment for acute and chronic alcohol problems.

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41 Submissions Vol. 9, p. 2032.

42 Submissions Vol. 9, p. 2030.

43 Submissions Vol. 9, p. 2048.

4.34 Substance misuse services are located across urban, rural and remote locations and deliver education and prevention programs, early intervention strategies, as well as treatment and rehabilitation within non-custodial settings. Some community-controlled health services funded by OATSIH also provide substance misuse services as part of their overall service, even those these are not specifically funded by the Substance Misuse Program. [44]

Research

4.35 Under the National Drug Strategy, Australia has been committed to the role of research in policy development. The Commonwealth has established three national 'centres of excellence' to support policy development in this area and, in addition to the ongoing research products of these Centres, the Government occasionally dedicates additional funds to other research agencies to undertake particular pieces of commissioned research.

Centres of Excellence

4.36 In 1986, the Commonwealth established the National Drug and Alcohol Research Centre (NDARC) and the National Drug Research Institute (NDRI). These were funded as Centres of Excellence to undertake research on, respectively, the prevention of drug abuse (the NDRI), and the treatment and rehabilitation of alcohol and drug dependent persons (NDARC).[45] In 1999 another centre, the National Centre for Education and Training on Addiction (NCETA), received funding under the National Drug Strategy to research issues relating to the education of professionals and non-professionals working in the field of drug and alcohol addiction.[46] The total amount of Commonwealth funding received by these Centres in 2000-2001 was $4,052,177.

4.37 Under the NIDS, $1.3 million in funds have been dedicated to the National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD) project, which NDARC is coordinating. The three-year project, which began in July, 1998, recently released its report recommending, among other things, that diversity of treatment options for heroin dependence should be promoted on the basis that patients will require different forms of treatment at different stages of their drug-use career. [47]

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44 Submissions Vol. 9, p. 2040.

45 Submissions Vol. 4, p. 847.

46 Submission Vol. 9, p. 1997.

47 National Drug and Alcohol Research Centre 2001, *National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD): Report of Results and Recommendations*, UNSW, p. 10.

4.38 NIDS has also dedicated $1.1 million in funds for the development of cannbis cessation strategies for adults and adolescents, and research into factors which act as barriers or incentives for treatment. It is anticipated that, after an intervention strategy is developed and clinically trialled in several jurisdictions, a resource package and training module for health care workers will be developed and distributed through a national training program.[48]

The National Health and Medical Research Council

4.39 The NH&MRC has received approximately $4 million under the National Illicit Drug Strategy to undertake an expanded program of interdisciplinary research to achieve innovation in the prevention and treatment of illicit drug use.[49] In June 1998 an Expert Committee was established to manage the development of a research agenda, and in January 2000 funding for sixteen projects was approved.[50]

4.40 In the future, the Committee would like to explore the possibility of expanding the NH&MRC's research role in substance abuse. Furthermore, it notes there is as yet no national clearinghouse for drug-related information, [51] and it would like to investigate the possibility of having the NH&MRC assume responsibility for the establishment of this.

Promoting Best Practice

4.41 Many individuals will consult their own doctor, community nurse, pharmacists or other community workers about the harms arising from the use tobacco, alcohol, pharmaceuticals and illicit drugs. Others will come into contact with police, ambulance officers, and youth and correctional staff. In short, there are few working in the health, welfare, law enforcement or justice sectors who will not meet people with alcohol and other drug-related problems. The Commonwealth Department of Health and Aged Care's submission argues therefore that providing appropriate education and training for these workers, and producing and disseminating best practice guidelines, is essential to the effectiveness of any harm-reduction strategy.[52]

4.42 Accordingly, under the National Illicit Drug Strategy, $3.0 million dollars has been allocated for the 'Training of Frontline Workers Initiative' to

48 Submissions Vol. 9, p. 2038.

49 Submissions Vol. 9, p. 2037.

50 Submissions Vol. 9, p. 2038.

51 The establishment of one of these was recommended in the 1997 evaluation of the NDS by Professors Single and Rohl.

52 Submissions Vol. 9, p. 2033.

fund projects aiming to better equip front-line workers (including general practitioners, hospital staff and police officers) coming into contact with drug users or at risk groups.[53]

Nongovernment Organisations

4.43 The Committee received evidence from many NGOs operating in this arena. These can be distinguished according to whether they are principally: (1) service providers, or (2) agencies which can be said to be operating, mainly, as lobby groups or advocates for change to government policies.

4.44 The following section describes in general terms the nature of the work of nongovernment agencies in this area, and refers to some of the issues raised by peak NGOs - for example relating to access to treatment. Issues will be elaborated in a later 'Issues' section.

Service provision

4.45 Most nongovernment service providers receive some funding either from State / Territory governments or the Commonwealth, or both, and it is clear that governments rely very much on the dedication of this sector. In many ways NGOs have become, as one witness put it, the 'little fingers of government'[54]. In Victoria, for example, all treatment services are provided by nongovernment agencies.[55]

4.46 Nongovernment organisations provide a range of residential and non-residential treatment services, including 'outreach' services designed to support users on the streets, counselling programs, and community education and referral services. Outreach services, such as those provided by Victoria's Youth Substance Abuse Service (YSAS), enable health workers to go to where help is needed rather than wait for would-be clients to knock on the doors of treatment services. YSAS reported to the Committee that in one year it responded to over 8000 young people '…with brief intervention, harm minimisation strategies and immediate support to their problematic drug issues'.[56]

4.47 Some NGOs, such as Odyssey House in Victoria[57] and the Ted Noffs Foundation in New South Wales,[58] offer both non-residential and

53 Submissions Vol. 9, p. 2002.
54 Evidence, p. 768.
55 Evidence, p. 430.
56 Submissions Vol. 6, p. 1276.
57 Submissions Vol. 10, p. 2384.
58 Evidence, p. 668.

residential treatment services. One advantage of offering both is that this can facilitate the assessment and transition of an at risk substance abuser from a community setting into a more protected residential treatment environment.

Residential treatment

4.48 In the main, residential treatment services provided by NGOs are non-medical, though DrugBeat in South Australia is an example of a place where detoxification can take place in the same setting as rehabilitation[59]. In most cases, though, a person needing treatment for drug dependence would need to have been 'detoxified' of drugs prior to being admitted into such a program. Detoxification facilities are usually provided by hospitals, but people can opt for a medically supervised 'home detox', if they are fortunate enough to have a home, supportive friend or family member to help them through the process.

4.49 The sorts of programs and treatment modalities on offer in residential facilities vary – and this is a good thing because, as many witnesses told the Committee, there is no one treatment type which will suit all individuals.[60] Programs vary in terms of length and formality of structure, but also in terms of the relative emphases given to factors thought to have contributed to the development of the drug dependence problem. Interventions may differ, therefore, in terms of the relative amount of attention given to supposed underlying physical, psychological, spiritual, and social issues. As one witness in Canberra told the Committee:

> Your perception of the nature of addiction will determine for you the nature of the intervention that you want to provide.[61]

4.50 The Committee visited a number of residential facilities and therapeutic communities including, for example, the one run by Odyssey House in Victoria, where 80 residents live in a drug-free therapeutic community.[62] The Committee visited similar places in South Australia, the Australian Capital Territory, Western Australia, the Northern Territory, New South Wales, and Queensland, and received submissions from many more than could be visited.

4.51 Typically, establishments like these offer individual counselling and group therapy in a drug-free environment, which gives residents a chance to confront personal issues and begin a journey of self-discovery. At Logan House on the Gold Coast, for example, residents undertake a 12-week self-

59 Evidence, p. 405.

60 Submissions Vol. 8, p. 1776.

61 Evidence, p. 854.

62 Submissions Vol. 10, p. 2384.

improvement and change program based on a particular psychological model of behaviour. Other residential programs, such as those employed at Karralika in Canberra, Odyssey House in Victoria and Banyan House in Darwin, are structured around the 'level' principle. The way these places work was explained in a general way by one witness, who said:

> It is based on the levels principle, which mimics the way larger society operates. Under this system residents come into the program on a low level, with few responsibilities and likewise few privileges. As the residents show that they are motivated to changing their lifestyles and are participating fully and sincerely in the program, they advance to higher levels where they take on greater responsibilities and gain greater privileges.[63]

4.52 Depending on the understandings informing them, programs are more or less insistent on the importance of abstinence as a basis for long-term recovery; these differ too in the extent to which they appeal to spiritual values or encourage participation in self-help groups, such as Alcoholics Anonymous or Narcotics Anonymous, to assist with the maintenance of recovery after rehabilitation. The Salvation Army's Bridge Program is based on the 'disease' model of addiction and has adapted for its purposes the 12-step program of Alcoholics Anonymous, which is founded on a recognition of the basic importance of total (and permanent) abstinence as well as surrender to a personal conception of a 'higher power'. Many rehabilitation programs are based on variants of this model.

4.53 It would be wrong to suppose that abstinence-based programs are inimical to the principles of harm minimisation or opposed to the recognition of addiction as a chronic relapsing disorder. The Salvation Army's submission notes that, while it does promote an abstinence lifestyle in its treatment services, it recognises that some people are not yet ready for that choice and so it is always ready to offer options across what it describes as a continuum of care.[64]

Advocacy

4.54 For ease of discussion, advocacy agencies are distinguished according to whether they work specifically in the area of alcohol and other drugs (AOD), or whether they do more general public health advocacy work.

AOD specialist agencies

4.55 There are many such agencies but only two will be discussed in this section: the Alcohol and other Drugs Council of Australia (ADCA), and

63 Evidence, p. 686.

64 Submissions Vol. 2, p. 266.

the Australian National Council on Drugs (ANCD). Their importance and effectiveness is reflected in the fact that key representatives of each will be at the helm of a new Alcohol Education and Rehabilitation Foundation, which will soon be responsible for managing $115 million in Commonwealth funds for the prevention and treatment of harms related to the abuse of alcohol and other licit substances.

The Alcohol and other Drugs Council (ADCA)

4.56 ADCA is the peak body for the alcohol and other drugs sector in Australia. It develops, in consultation with its broad membership base and through a number of expert reference groups, comprehensive policy positions which it then advocates to governments, businesses and communities.[65]

4.57 ADCA has developed a strategic drugs policy document, *Drugs Policy 2000,* which identifies ten key areas for action in reducing drug-related harm. The policy document presents detailed recommendations for action under each of these and raises a number of important questions about the conduct of the current National Drug Strategy (NDS) , including:

- the balance of funding between prevention, treatment and supply reduction initiatives;[66]
- whether in its operation the NDS reflects a true partnership with the nongovernment sector;[67] and
- whether, in the absence of targets for harm reduction and annual reporting by governments on expenditure and outcomes of drug-related policies and service delivery, the NDS can be effectively evaluated.[68]

The Australian National Council on Drugs (ANCD)

4.58 The ANCD was established in 1998 in part as a response to the 1997 evaluation of the National Drug Strategy, which argued that nongovernment organisations were not sufficiently involved in the development and management of the National Drug Strategy, and that the NDS was weakened by its failure to more fully engage the sector.[69] The Council is tasked with facilitating an 'enhanced partnership' between

65 Submissions Vol. 3, p. 548.

66 Submissions Vol. 3, p. 581.

67 Submissions Vol. 3, p. 580.

68 Submissions Vol. 3, p. 581.

69 Single, E., & Rohl, T. 1997, *The National Drug Strategy: mapping the future,* AGPS, Canberra, pp. 68-69.

governments and the nongovernment sector[70] and providing independent expert advice to government on drug policy and programs.[71]

4.59 The Council's submission to the Inquiry:

- expressed its support for the availability of not only a wide range of treatment options, but also sufficient places within these treatment facilities, in appropriate geographical locations;[72]
- expressed its concern about the number of reports it is hearing about people being unable to gain access to treatment services[73];
- argued there is a shortage in skilled, trained, professional workers in the alcohol and other drug sector;[74] and
- said there is a need to raise levels of public awareness about drug and related public health issues, and an associated need to encourage balance in media portrayals of drug-related issues.[75]

Public health NGOs

4.60 The Committee received submissions from a number of public health associations in the business of advocating for changes in public health policy-making. These were notable for their concentration on minimising the costs associated with the use and abuse of legal substances, ie, alcohol and tobacco, and their emphasis on evidence-based approaches to dealing with the challenges posed by the abuse of illicit drugs.

4.61 The Australian Medical Association (AMA) observed that the Government commits less money per death to tobacco-related public health measures than it does to other major public health programs, despite the fact that tobacco consumption is the major cause of drug-related death in Australia.[76] The Public Health Association noted that expenditure on public education about tobacco has been declining for many years.[77] Both agencies provided detailed recommendations for strategies to intensify tobacco control efforts.[78]

4.62 The AMA expressed concern about the phenomenon of 'binge drinking', which it said is associated with suppression of the central nervous system,

70 Submissions Vol. 9, p. 1991.
71 Submissions Vol. 2, p. 297.
72 Submissions Vol. 2, p. 302.
73 Submissions Vol. 2, p. 302.
74 Submissions Vol. 2, p. 303.
75 Submissions Vol. 2, p. 305.
76 Submissions Vol. 7, p. 1469.
77 Submissions Vol. 10, p. 2440.
78 Submissions Vol. 10, p. 2436, and Submissions Vol. 7, p. 1469.

stomach inflammation, toxic damage to the bowel, suicide and falls, motor vehicle and pedestrian accidents.[79] The PHAA submission referred to binge drinking too, and argued that:

> Vastly greater costs to society are incurred from the lower ends of the continuum of alcohol use (eg binge drinkers) than from the few people (problem drinkers) at the severe end of the continuum, and this is supported by epidemiological evidence.[80]

4.63 The AMA and PHAA submissions provided detailed recommendations for ways of alleviating the burden of disease and social disruption associated with excessive alcohol consumption, including the introduction of a 'volumetric' approach to the taxation of alcoholic beverages which would mean that tax on alcoholic beverages would directly reflect the total volume of alcohol in the product.[81]

4.64 Both the AMA and the PHAA expressed their support for the conduct of properly evaluated trials and research to facilitate the expansion of viable treatment options for opiate dependence.[82] The PHAA further argued that it believed current national policy was too focused on supply reduction and appeared, to an increasing number of people, to be arbitrary and punitive.[83] The PHAA's submission also argued that treatment programs for users of illicit drugs should not be rationed – that people seeking treatment should have immediate access to expert help.[84]

Issues

4.65 A number of key issues emerged from the evidence. These are discussed under the following headings: service delivery, management, and community attitudes.

Service delivery

4.66 As has been previously mentioned, under the National Drug Strategy, State and Territory governments are responsible for provision of law enforcement, education, and health (including treatment) services. In the following sections, four service delivery issues are discussed.

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79 Submissions Vol. 7, p. 1469.

80 Submissions Vol. 10, p. 2443.

81 Submissions Vol. 10, p. 2444, and Submissions Vol. 7, p. 1471.

82 Submissions Vol. 10, p. 2448 and Submissions Vol. 7, p. 1464.

83 Submissions Vol. 10, p. 2448.

84 Submissions Vol. 10, p. 2448.

Access to treatment

National stocktake

4.67 The Government of the Australian Capital Territory (ACT) operates a 12-bed detoxification facility at Canberra Hospital and funds a local nongovernment agency to manage another 10-bed detoxification service. The Government also funds the Alcohol and Drug Foundation of the ACT, which manages a suite of residential programs for people with drug and alcohol problems. The primary service is Karralika, a 50-bed therapeutic community, but the agency also manages four half-way houses; one of these is for women and children, one for families, and two for men.[85] The Government also provides financial support to the Salvation Army, which runs a residential rehabilitation program for men, and the Ted Noffs Foundation, which has recently opened a residential rehabilitation service for youth. In total, the Government funds the provision of 100 residential rehabilitation beds. The ACT runs a needle and syringe program (boasting excellent return rates)[86] and a methadone program (with three streams)[87].

4.68 The New South Wales Government told the Committee it is committed to the view that, when it comes to treatment and rehabilitation, governments need to try to provide a range of options for people. [88] In June 2000, the NSW Government released its promised Drug Treatment Services Plan 2000 – 2005, which is dedicating $120 million over four years towards the enhancement of the range, quality, and availability of drug treatment services in NSW. [89] The Plan, which proposes to augment the number of residential detoxification beds by 42,[90] identifies there is a significant need for more detoxification services for women, Aboriginal and Torres Strait Islanders, adolescents and young people in the State.[91]

4.69 The Northern Territory Government operates a 10-bed detoxification facility in Darwin and supports the operation of a four-bed detoxification facility in Alice Springs. In addition to this, the Territory Government funds a large number of nongovernment organisations to deliver rehabilitation services for people suffering from substance misuse. Altogether, nongovernment organisations manage 167 rehabilitation

85 Submissions Vol. 9, p. 2243.

86 Submissions Vol. 9, p. 2268.

87 Submissions Vol. 9, p. 2271.

88 Evidence, p. 553.

89 NSW Health Department 2000, *The NSW Drug Treatment Services Plan 2000 – 2005,* NSW Health Department, Sydney, p. v.

90 Ibid., p. 19.

91 Ibid., p. 21.

beds.[92] The Territory Government does not currently operate a methadone maintenance program[93], but it runs a needle and syringe program which distributed 440,686 syringes in the 1999-2000 financial year.[94]

4.70 The Queensland Government told the Committee that, while it does not offer long-term residential treatment services, over the past two years it has funded a considerable number of detoxification beds in non-government facilities; at the present time it is funding a withdrawal service for young people at the Mater Hospital. [95] Nongovernment agencies estimated that there are around 50 detoxification beds available throughout the State[96], and between 350-450 rehabilitation beds.[97] The Government's strategic plan advises that the Government has received $4million in NIDS funding for the enhancement and diversification of needle availability and support services, and provided an additional $1.3 million in 1998-99 to expand the State's methadone program.[98]

4.71 The South Australian Government's Drug and Alcohol Services Council fully funds a therapeutic community, the Woolshed, and provides financial assistance to approximately twenty other treatment and rehabilitation services including, for example, the Archway Sobering Up Service. [99] Overall, the State funds the provision of a total of 24 detoxification beds and 171 places in residential rehabilitation establishments. The State has a heroin overdose strategy which Government witnesses claim has been very successful[100], and operates needle and syringe programs with 'as little intervention as possible' to encourage people to use them. [101] The Government told the Committee it has received funds to expand its community-based Clean Needle and Syringe Program, [102] and that it has a 'wait and see' position with regard to supervised injecting facilities.[103]

4.72 The Tasmanian Government operates a ten-bed detoxification facility at 56 Collins Street in Hobart[104] and provides community outpatient support

92 This number is expected to be reduced by 22 sometime in the near future.

93 Evidence, p. 703.

94 Evidence, p. 681.

95 Evidence, p. 736.

96 Submissions Vol. 12, p. 3292.

97 Submissions Vol. 12, p. 3293, and Evidence, p. 772.

98 Queensland Government, 1999, *Beyond a Quick Fix: Queensland Drug Strategic Framework 1999/2000 to 2003/2004,* pp. 96-97.

99 Submissions Vol. 10, p. 2411.

100 Evidence, p. 229.

101 Evidence, p. 236.

102 Submissions Vol. 10, p. 2396.

103 Evidence, p. 237.

104 Evidence, p. 1045.

through alcohol and drug services in the north and south of the State[105]. The State does not run any long-term rehabilitation services because it considers these not to be cost-effective.[106] Two nongovernment organisations operate medium and long-term rehabilitation programs in the State, and one of these receives NIDS funds through the Tasmanian Government. A Needle and Syringe Availability Program (NSAP) has been operating in Tasmania since the introduction of the HIV / AIDS Preventive Measures Act (1993). Needles and syringes are distributed through some 90 outlets in the State.

4.73 The Victorian Government is working to expand treatment services and options; expenditure in this area has more than trebled over the past five or six years.[107] With financial assistance from the Commonwealth, the Victorian Government funds 120 beds for residential drug withdrawal, 176 residential rehabilitation places, and 380 beds for alcohol and drug supported accommodation;[108] all services are community-based. By 2003, the Government expects there will be 800 beds available for rehabilitation, withdrawal, and supported accommodation; this would represent a four-fold increase in bed numbers since the mid-1990s. The State has a Needle and Syringe Program and is planning to further increase the resources dedicated to these services – and to put particular emphasis on retrieval strategies. [109] It has also developed a heroin overdose prevention package which will employ peer education strategies designed to reinforce health education messages to users.[110]

4.74 The Western Australian Government told the Committee its treatment services have been subsantially expanded by a number of measures, including the establishment of 12 Community Drug Service Teams which provide treatment, support to mainstream agencies, and support to the community to prevent drug abuse. [111] The Government funds provision of 29 detoxification beds, 17 through its Specialist Drug and Alcohol Services at Next Step, and 12 through the Salvation Army's Bridge Program. It also funds five major nongovernment agencies which provide, altogether, a total of 117 residential rehabilitation beds. Methadone treatment services

105 Evidence, p. 998.

106 Evidence, p. 997.

107 Evidence, p. 443.

108 Alcohol and drug supported accommodation treatment services provide short-term, safe, secure and affordable supported accommodation to alcohol and drug clients who have undergone a drug withdrawal program or who require assistance in controlling their alcohol and drug use.

109 Evidence, p. 441.

110 Evidence, p. 440.

111 Submissions Vol. 8, p. 1763.

have been expanded through community-based programs, [112] and the State provides naltrexone free of charge to about 450 people through its primary service, Next Step.[113] The Government provides a needle and syringe service which is innovatively linked to the State's heroin overdose strategy: the cost of ambulance call-outs to overdoses is nil, because these are funded by a levy on needles and syringes.[114]

Adequacy of access

4.75 Governments appear to be working hard to ensure that suitable treatment services are available to assist drug dependent people wanting to address their drug dependence problems. Despite this, the Committee heard from many sources that treatment services simply are not as available as they need to be to facilitate rehabilitation from drug abuse. The Australian Association of Social Workers, for example, told the Committee that:

> We find all the time that there simply are not the services, the range of services and the diversity of services that there ought to be to cater for them. We have got massive waiting lists all the time to get into residential rehabilitation…[115] .

4.76 In Tasmania, a doctor working at the Hobart Clinic told the Committee that:

> If you are looking at a return for an intervention in the whole alcohol and drug field, methadone stands out. For each dollar you spend on methadone, you save the community between $4 and $20, depending on which study you look at…Yet in Tasmania, there is a huge waiting list for methadone.[116]

4.77 Timely access to treatment is as critical for drug addiction as it is for any other potentially fatal health condition. Access to drug treatment services is a widespread problem, but it appears to be worse for people suffering from mental health as well as drug problems, Indigenous Australians, young people, and people living in rural and remote parts of Australia.[117] The Committee heard, for example, that there are no indigenous illicit drug rehabilitation centres in South Australia, Western Australia, or the Northern Territory.[118]

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112 Submissions Vol. 8, p. 1764.
113 Evidence, p. 114.
114 Evidence, 121.
115 Evidence, p. 910.
116 Evidence, p. 1066.
117 Submissions Vol. 13, p. 3709.
118 Evidence, p. 311.

4.78 Detoxification from alcohol and other drugs is a pre-requisite for gaining entry into most treatment facilities, but there are few detoxification beds available, and hospitals appear to be pulling back[119] from providing this relatively costly service. [120] A lengthy waiting period may be involved before access is obtained, and then after a medically-supported withdrawal there might be another wait before access to a suitable, nearby rehabilitation facility is secured. These waiting periods are risky, and many opportunities for recovery are wasted as drug users drift back into their old, familiar, drug-using environments.

4.79 Cost is another aspect of 'access'. While methadone is supplied free-of-charge by the Commonwealth, and most jurisdictions have public programs which supply this for free, most methadone users obtain this from pharmacies and pay from between $25 - $50 / week, a not inconsiderable amount for someone on a low, fixed income.[121] A witness from the Salvation Army told the Committee:

> …our family support services would see people who are getting emergency relief of food parcels and fares because they need their money to pay for methadone.[122]

4.80 Other forms of treatment such as naltrexone programs and rehabilitation clinics can cost thousands of dollars, an insurmountable obstacle for prospective clients without well-heeled connections.[123]

Funding

4.81 The Government of the Australian Capital Territory (ACT) spent nearly $8.5 million providing alcohol and other drug services in 2000-01, and expects to spend around $9.5 million in 2001-2002. The New South Wales Government's Plan of Action, developed in response to the Drug Summit in July of 1999, will involve over $500 million in expenditure over the four-year period from 1999-2000 / 2002-2003.[124] The Northern Territory Government spent a total of $13.6 million in 1999-2000 on the provision of alcohol and drug services. In Queensland, the Health Department spent $37 million on dedicated alcohol and drug services in the 2000- 2001 financial year. In South Australia, fourteen new initiatives are receiving a total of $31 million over four years; the Commonwealth is contributing

119 Evidence, p. 500.
120 Evidence, p. 999.
121 Evidence, pp. 181, 508, 657.
122 Evidence, p. 459.
123 Evidence, pp. 836, 405, 772, 1017.
124 Evidence, p. 551.

$13 million for four of these, while the SA Government is contributing $18 million for ten.[125]

4.82 The Tasmanian Government estimates that in 1999-2000 it spent approximately $6 million on its Alcohol and Drug Service budget and grants to nongovernment organisations. In addition to this, the Government spent $2.6 million on drug-related costs at the Royal Hobart Hospital.[126] The Victorian Government has a comprehensive and integrated drug policy framework based on harm minimisation principles, and a dedicated drug budget of some $67 million.[127] In Western Australia, direct expenditure by the Government for drug-related programs across all government services is estimated to have increased by 78.6% from $28.1 million in the 1996-1997 year to $50.2 million in 2000-2001.[128]

4.83 Despite evidence that in recent years some governments have increased expenditure in this area, adequacy of funding remains an issue. One submission cites survey results revealing that demand for services has risen three times faster than funding increases[129]. The Alcohol and other Drugs Council of Australia (ADCA) points out that, while the Federal Government collects about $7 billion each year in alcohol and tobacco taxes, it returns only about 1.6 %[130] (of this amount) each year to prevention and rehabilitation programs. [131]

4.84 Funding inadequacies are reflected in lengthy waiting lists for treatment, described above, but pressure on resources can also affect the quality of service delivery when agencies feel they cannot afford, for example, to hire extra staff, diversify program offerings, evaluate services[132], or send staff off for training to upgrade their skills.[133] As one witness said:

> …drug treatment really works but it's inadequately funded. We cannot get capacity, quality or the range of treatments up with the funding that we have got at the moment.[134]

4.85 Methadone programs should, for example, be comprehensive and involve ongoing counselling and health education as well as dose monitoring.

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125 Submissions Vol. 10, p. 2396.

126 Submissions Vol. 9, pp. 2115-2116.

127 Evidence, p. 429.

128 Submissions Vol. 8, p. 1766.

129 Submissions Vol. 13, p. 3708.

130 This percentage includes an amount of $115 million obtained from invalidated beer excise revenue collected by the Commonwealth Government on draught beer sales.

131 Submissions Vol. 13, p. 3707.

132 Evidence, p. 134.

133 Evidence, p. 11.

134 Evidence, p. 628.

However, resource shortfalls mean that many of these services are operating principally as methadone distribution centres.[135] People on methadone may not be getting the sort of help they need, as this witness pointed out:

> We are not against methadone, but we certainly think it does not have the counselling, support and guidance at a level that it should have. It is often a matter of stabilising people and putting people on to the program and letting them sit there. [136]

4.86 Insecurity of funding and time-consuming submission-driven funding processes are other important funding-related issues for nongovernment service providers. Many NGOs complained of onerous grant application processes[137] and the frustration of getting up good programs only to have these de-funded several years later.[138] The National Aboriginal Community Controlled Health Organisation, NACCHO, argued that these processes appear to reward the quality of grant applications, rather than the relative merit of proposals.[139] Some witnesses acknowledged that the competitive nature of submission-driven funding processes was divisive and meant that the NGO sector was not working as cohesively as it might.[140]

Workforce development

4.87 According to many witnesses, training for workers in the alcohol and other drug arena is under-funded[141] and there is a shortage of skilled staff in the alcohol and other drug sector. The Australian National Council on Drugs (ANCD) wrote in their submission:

> …the Council is aware of an existing shortage in skilled, trained, professional workers in the alcohol and other drug sector. The current shortage is set to worsen if more efforts are not made to entice professionals such as psychologists, doctors, counsellors, and others to the field.[142]

4.88 In Victoria, for example, the Committee took evidence from the Clinical Director of the Victorian Institute of Forensic Mental Health, who was

135 Evidence, p. 613.
136 Evidence, p .772.
137 Evidence, p. 1031.
138 Evidence, p. 303.
139 Submissions Vol. 7, p. 1491.
140 Evidence, p. 1060.
141 Evidence, p. 11.
142 Submissions Vol. 2, p. 303.

described by one of his colleagues as the only expert in the field of forensic mental health in Australia. The Director told the Committee that:

> We actually allowed knowledge and training in this field to deteriorate in Australia to the point where we do not have any experts of international standing who can combine the knowledge of the treatment of the mentally ill and the treatment of severe and serious substance abuse.[143]

4.89 In an effort to address the issue of workforce development, State and Territory governments around the country are:

- supporting the delivery of tertiary-level training and education of drug service providers, as well as other health and welfare workers;[144]
- investing in the training of youth workers to give them competence to deal with drug issues;[145]
- running training workshops for community-based drug and alcohol workers and developing culturally-sensitive training programs;[146] and
- supporting collaborations between tertiary training providers and government service providers to develop volunteer training programs.[147]

4.90 But the solution to this problem will require more than simply throwing more money into training, as the Director of Victoria's Turning Point Alcohol and Drug Center pointed out to the Committee:

> We have engaged in this country in endless one-off, itsy-bitsy programs, saying 'Throw a bit of training at it; that will be a good thing to do'. We just cannot keep doing that. If there are not proper career structures for workers, we will never have a good drug and alcohol work force. So it is absolutely essential that we work hard across some of the key professions to see what is necessary to have a critical mass of well qualified, trained and committed people, and to keep them in the sector.[148]

4.91 A submission from the National Center for Education and Training in the Addictions (NCETA) pointed out that, while there has been a substantial increase in the provision of alcohol and other drug (AOD) training over

143 Evidence, p. 473.

144 Queensland Government 1999, *Beyond a Qiuick Fix: Queensland Drug Strategic Framework 1999/2000 to 2003/2004*, p. 97.

145 Evidence, p. 428.

146 Submissions Vol. 2, pp. 286-287.

147 Evidence, p. 113.

148 Evidence, p. 502.

the past ten years at the tertiary provider level, there has been little definitive documentation of this development. NCETA further noted that at the present time in Australia, there is no overarching mechanism to monitor and guide advances in AOD education and training. NCETA is currently working to establish such a mechanism.[149]

Integration and coordination

4.92 The Committee heard much about the 'siloed' structure of government services, and how lack of coordination is resulting in the duplication of services[150] and / or the neglect of the needs of certain people[151]. One witness explained the problem in the following way:

> The alcohol and drug field is especially affected by the siloed structures of our systems and services, as this field is characterised by its multidisciplinary nature. Alcohol and drug problems are complex, and require comprehensive, multi-sectoral responses. Hence, a shared knowledge and skill base is more pertinent here than perhaps in many other areas. A comprehensive understanding of these phenomena requires high level integration and synthesis.[152]

4.93 People suffering with both a mental disorder and a drug dependence ('comorbid', or with a 'dual diagnosis') were often cited as an example of where lack of coordination in the health system is resulting in a real failure to assist.[153] The Mental Health Council of Australia pointed to research suggesting that 46 percent of females and 25 percent of males with substance use disorders also experience a mental illness.[154] Conversely, between 30 and 80 percent of those people who are in our mental health services now in Australia have an underlying or associated drug and alcohol problem.[155] However there are very few services equipped for dealing with individuals with 'dual diagnosis', and so they tend to fall between the 'silos' of service structures. As one witness explained:

> When people turn up to the hospital they will not accept them in the mental health ward because they have a drug problem, and

149 Submissions Vol. 12, p. 3403.
150 Evidence, p. 319.
151 Evidence, p. 916.
152 Submissions Vol. 12, p. 3403.
153 Evidence, pp. 471, 822, 875, 953.
154 Evidence, p. 952.
155 Evidence, p. 3.

> they will not accept them into detox because they have a mental health problem.[156]

4.94 The Committee notes that the Commonwealth Department of Health and Aged Care is currently running a National Comorbidity Project[157] which is working on the development of integrated services (at all levels of the health system) for dealing with the challenge of comorbidity. The Committee looks forward to the results of this Project, and to continuing its investigation of this subject as part of this Inquiry in the next Parliament.

4.95 Some governments have attempted to facilitate coordination of the delivery of alcohol and drug services by establishing offices with responsibilities for coordination. In New South Wales, for example, the Government has established an Office of Drug Policy which, among other things, is charged with coordinating drug policy across government and facilitating the integration of programs.[158] Similarly, Western Australia has a Drug Abuse Strategy Office (WADASO) and a designated Minister who is responsible for drug abuse strategy.[159] While the establishment of coordination mechanisms like these has undoubted advantages, WADASO's Director told the Committee that coordination remains a challenge :

> So, trying to coordinate that effort across government and across the community requires a lot of hard work. Structures take you half the way – and I think our structures are good – but I repeat: there is no magic in them.[160]

Management

Planning and evaluation

4.96 Current national drug strategic planning processes are broadly consultative and provide for national leadership while allowing flexibility for States and Territories to ensure that plans developed to address drug problems are responsive to the needs and priorities of particular jurisdictions.[161] National strategies and action plans do not provide, therefore, the specificity about outputs and performance indicators which is necessary to evaluate the effectiveness of national harm minimisation

156 Evidence, p. 875.
157 Submissions Vol. 9, p. 2050.
158 Evidence, p. 552.
159 Submissions Vol. 8, p. 1765.
160 Evidence, p. 107.
161 Submissions Vol. 9, p. 1992, and Evidence, p. 230.

efforts. With regard to the recently-developed National Tobacco Strategy (NTS), for example, the federal Department of Health and Aged Care said:

> In terms of performance information, the NTS currently identifies long and short-term indicators, including reference to existing baselines and sources of data. It recognises the need to strengthen existing, or develop new, baselines against the prevalence indicators and process indicators against which the strategies will be assessed.[162]

4.97 During the Inquiry, a number of key nongovernment agencies called for governments to be more specific in their goal-setting – in short, to set some hard targets. The Alcohol and Drug Foundation of Queensland, for example, strongly recommended that all government strategies and programs state benchmarks and quantitative goals. It said that very few programs and services forecast what is hoped to be achieved.[163] The CEO of the Alcohol and other Drugs Council of Australia (ADCA) suggested a reason for this could be:

> The setting of targets is too often avoided by organisations as they are afraid they will be held accountable if they are not achieved.[164]

4.98 Related to this call for greater specificity about desired outcomes is the recommendation that strategic approaches be more focused on the needs of particular population groups.[165] Where resources are not infinite, it is obviously critical to ensure these are dedicated in the most cost-effective ways and directed to areas of greatest need.

4.99 Greater specificity about program outcomes is a pre-requisite for the generation of useful program evaluation information. The most recent evaluation of the National Drug Strategy recommended there be a significant increase in the proportion of treatment and prevention programs which are subjected to systematic outcome evaluation.[166] A number of witnesses passed on this message to the Committee.[167] One said:

> I would like to push that we really need good research and evaluation frameworks because we cannot be dynamic and progressive in this issue unless we constantly self-assess it and

162 Submissions Vol. 9, p. 1993.

163 Submissions Vol. 12, p. 3313.

164 Evidence, p. 4.

165 Submissions Vol. 8, p. 1817, and Evidence, p. 951.

166 Single, E., & Rohl, T. 1997, *The National Drug Strategy: mapping the future,* AGPS, Canberra, p. 86.

167 See for example Evidence, p. 434.

> self-evaluate what is going on. I would say that that is a real priority, both locally, nationally and globally…[168].

Accountability

4.100 The Committee was disappointed to find a lack of easily-accessible, coherent, basic information which could have supported deliberations on this Inquiry. It sought, for example, a comprehensive list of treatment service providers from the Commonwealth, only to discover that such a thing did not exist. In the end, the Committee obtained information directly from jurisdictions, and the ANCD told the Committee it has commissioned some work to:[169]

> …try to get a map of what drug and alcohol services exist, where they are located, whom they service and how many beds are available. It is difficult to make decisions when you do not have a complete map of what exists here and now.

4.101 Similarly, a submission from the National Centre for Education and Training in the Addictions (NCETA) pointed to the lack of a consolidated national database to support workforce development planning.[170]

4.102 The Committee is equally concerned about the fact that, at the present time, it is not possible to get a firm handle on national expenditure in the AOD arena. While such an undertaking would always have been a substantial challenge, it has been made even more difficult since the Commonwealth has been providing NDS financial assistance to States and Territories through a broadbanded funding mechanism (the Public Health Outcome Funding Agreements, or PHOFAs) which does not require the reporting of expenditure for particular programs.[171] The National Public Health Expenditure Project was established to facilitate the development of agreed national reporting procedures to enable cost-benefit analyses of different kinds of public health activities[172]; the Committee understands that work is currently underway and results are expected to be published later this year and early next year.

4.103 The Committee supports the call made by the Alcohol and other Drugs Council of Australia (ADCA) for all governments, including the Federal Government, to report annually to their Parliaments on the amount of

168 Evidence, p. 700.
169 Evidence, p. 850.
170 Submissions Vol. 12, p. 3408.
171 Submissions Vol. 9, p. 2009.
172 Submissions Vol. 9, p. 2010.

money spent on all alcohol and other drug programs, and on the outcomes generated by this expenditure.[173]

Balance of effort

4.104 Health experts have long argued that there is an imbalance in the amount of effort and resources going into prevention and treatment areas. While there is obvious merit and economies to be gained by investing in prevention, treatment services have usually received the lion's share of resources. This has been true in the AOD area as well, but, as previous sections of this report have indicated, there is a recent burgeoning of interest and expenditure in the prevention of drug problems, and the Committee applauds this development. While the Committee sees the merit of placing a greater emphasis on prevention, it would not like to see this achieved at the expense of a diminution of resource allocation for treatment.

4.105 Of greater interest to the Committee in this Inquiry has been the balance of effort with regard to licit and illicit drug abuse; it seemed to Members that the preponderance of interest and activity was directed at illicit drugs. Numerous agencies [174] expressed their dismay at how a preoccupation with illicit drugs has resulted in relative inattention to the social and economic costs associated with the abuse of alcohol and tobacco, which accounts for the vast majority of social harms. This disproportionate focus on illicit drugs is reflected in relatively modest Commonwealth outlays for alcohol and tobacco programs, though the Committee is pleased to see that this imbalance has been somewhat redressed by the recent announcement that $115 million of Commonwealth monies are to be dedicated (through the newly-established Alcohol Education and Rehabilitation Foundation) for licit drug harm minimisation activities.

4.106 The Committee acknowledges there has been a disproportionate emphasis in the Inquiry thus far to the social effects of illegal drug abuse. This reflects, we think, greater levels of community concern about the abuse of illegal drugs.

Community attitudes

4.107 The NSW Government acknowledged to the Committee that it was having trouble locating treatment services in some areas of need because of the 'NIMBY' (Not in My Back Yard) factor. A Government witness explained to the Committee that:

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173 Submissions Vol. 13, p. 3707.

174 See, for example, Evidence, pp. 453, 983, 132, 589.

> There is a problem in expansion of treatment services and as a member for this area you will be well aware of that in that there is a very strong NIMBY factor that goes with treatment services, that people are concerned about having such facilities located in their areas. We have to try and find ways to deal with that particular characteristic but it has caused some delay for us in terms of expansion of services. I have additional funds for additional services for this area and we are having great trouble in expanding services in relation to that.[175]

4.108 Other State and Territory governments experience similar problems in their jurisdictions.[176] The Committee thinks it is a sad irony that, while many in the community are demanding more resources to help deal with this important social problem, others are denying the scope of the drug problem or else insisting on its being dealt with somewhere else. A member of Family Drug Support (FDS) in Sydney said:

> We need to have an acceptance. It angers me so much to hear the mayor Fairfield sitting here this morning spending $2 million on surveillance cameras and paying lip service to treatment, yet they will not have a treatment centre in Fairfield or Cabramatta. The state government is willing to provide them with one. Now it is just bullshit when he sits here and he says, 'It's their fault'. I commend the community of Kings Cross, who have lived with this problem for 30 years and have said, 'We have got the problem. We are not in denial; we are willing to accept it.'[177]

4.109 Lack of acceptance and understanding about drug abuse is widespread in the community and sometimes it is encountered where it is least expected. The Committee heard stories from people on methadone complaining about the attitude of some chemists, for example. A mother in Western Australia said:

> Amanda would go into the chemist and there would be three people there, and so she would wait. Then more people would come in, and he would make her wait until there was no one in there, and then he would make a big thing of giving it to her. Or if she said, 'Look, I am really in a hurry', or whatever, he would say, 'You are only getting methadone; you can wait'. It was that sort of attitude.[178]

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175 Evidence, p. 578.

176 Evidence, p. 118.

177 Evidence, p. 616.

178 Evidence, p. 199.

4.110 The CEO of the Youth Substance Abuse Service in Victoria said that some chemists probably did need to improve the way in which they regard individuals coming in to fill methadone prescriptions. He pointed out that one of the possible consequences of a negative experience at the chemist is dropping out of treatment[179] - a move which can have fatal results.

4.111 The Australian National Council on Drugs argued in their submission to the Inquiry that more needs to be done to educate the community about drugs. The media, they suggested, could play a more positive role:

> Council is urging the sector to engage with the community in an attempt to raise the level of understanding and awareness of both the broad drug issue and the specific nature of the services provided in their area. Media portrayals of drug-related issues is not always balanced, and often focuses on negatives, and it is important to attempt to achieve a balance in the information getting out into the public arena.[180]

4.112 Certainly, there were many witnesses who referred to the negative role played by the media in creating unnecessary levels of fear and division in the community.[181] The Committee had experiences of its own which illustrated the negative potential of the media in this area.[182]

4.113 The Committee is persuaded that governments and people employed in the alcohol and other drug (AOD) sector need to work harder at engaging the media to do what it can to promote reasoned debate in the community. Some governments [183] already appear to be engaging successfully with the media in this way.

4.114 The Committee convened a private meeting at Parliament House on 8 August 2001 to discuss the role of the media in the area of substance abuse – in particular, whether the development of voluntary media guidelines for the reporting of drug issues might help to improve the quality of general reportage. The Committee was encouraged by the response of the media and NGO representatives who attended the meeting, and would like to continue to explore this particular issue as part of this Inquiry in the next Parliament.

179 Evidence, p. 527.

180 Submissions Vol. 2, p. 305.

181 See for example Evidence, pp. 582, 864, 847, 887, 240, 241, 437, 495.

182 Evidence, p. 437.

183 Evidence, p. 111.

Summary

4.115 The Committee is aware of the magnitude and complexity of the challenges facing governments tasked with the job of figuring out how to devise and fund service delivery systems that are innovative but responsible, humane but effective and efficient, flexible but accountable. The sorts of system challenges posed by substance abuse are not unknown in the health arena, where one often hears of the need for better coordination and cooperation, not to say better funding and accountability.

4.116 Try as we might to argue it is more appropriate and helpful to regard substance abuse as a chronic, relapsing disorder, in many sectors of the community there persists the view that people with drug dependence problems are bad, rather than sick. One of the reasons why it is difficult to combat this widely-held impression is that the phenomenon of addiction to illegal drugs is linked – in reality and in peoples' minds - with crime. Life is tough for alcoholics, but at least they don't have the additional misfortune of being addicted to a substance which is illegal. They, too, can find themselves on the wrong side of the law, but the negativity directed at them is nothing compared to that which is reserved for those who are dependent on other (illegal) substances.

4.117 We have to work harder to combat the corrosive effects of prejudice and ignorance. We believe these are limiting the ability of governments and communities to devise health systems with the capacity to provide, as we said at the beginning of this chapter, the services and staff which we need to have in a position to help, at the right time and place in the life of a person with a drug dependence problem.

5

Crime, Violence, and Law Enforcement

Introduction

5.1 Not a day goes by, it seems, when we don't hear about some horrible crime, or else see some scary television footage featuring scenes of mayhem and destruction. It is no wonder we are afraid: no one wants to be a victim of a violent home invasion, syringe-stabbing, or ATM-mugging.

5.2 These are the images presented to us when we hear about drug-related crime, and it is no wonder many of us have little sympathy for people we regard as criminal perpetrators. The thought of being alongside all this is so threatening it is tempting to demonise it all – to imagine that a person in gaol for a drug-related offence is evil and somehow less than human.

5.3 During the course of this Inquiry, we have visited a number of gaols and met with people whose lives have led them into drugs, crime, and gaol. We have talked with them and decided: they are not angels, but they aren't monsters, either. They are people who have been born into families and raised in communities, with us, and we believe we bear at least some responsibility, collectively, for their fate.

5.4 We agree with the witness who argued before us that the justice system shouldn't be used as a dumping ground for social problems [1]. As parliamentarians and members of communities, we need to ask ourselves

1 Evidence, p. 706.

what we think we are achieving when we incarcerate people with problems, offer them little by way of assistance, and then return them to society where, in fear, we ostracise them and help to make their return to prison almost inevitable.

Links between substance abuse and crime

5.5 Determining the strength of the links between drug use and crime is more complicated than might be imagined, for it depends on how these are defined. If only those offences that are associated with illegal drugs are considered, then according to the Australian Institute of Criminology (AIC), approximately 10 – 12% of crimes can be categorised as drug-related. If the illegal status of drugs is ignored, and the property, violence and other offences committed while under the influence of drugs is considered, then the AIC estimates that approximately 35% of all crimes are drug-related. But if an even broader definition of drug-related crime is adopted (one which includes crimes committed by drug users as well as drug-related crimes which are committed by non-drug-users), then approximately 70% of all crime can be said to be drug-related.[2]

5.6 Since 1999 the AIC's Drug Use Monitoring in Australia (DUMA) pilot project has been collecting data on the prevalence of drug use in the 'arrestee population'[3], and this suggests there is a strong link between opiate use and property offending[4]. Key findings were described to the Committee in the following terms:

> So in all the data and all the stuff that we are starting to assemble we find that people who get caught for property offences…are more likely to be drug users. Ninety-three percent of property offenders said that they tried illicit drugs, 85% had used them in the previous six months, 53% had said that they were addicted, 41% said that their offending was due to their illicit drug use, and about 26 % said they were sick for illicit drugs at the time of the offence and that they were really hanging out for them.[5]

5.7 While findings such as these are illuminating – they suggest, for example, that by reducing levels of drug dependency amongst the criminally active population there could be significant benefits for society[6] - it is important

2 Submissions Vol. 9, p. 2311.
3 Submissions Vol. 9, p. 2205.
4 Submissions Vol. 9, p. 2206.
5 Evidence, p. 924.
6 Submissions Vol. 9, p. 2207.

to remember that offender and illicit drug user populations are different. The National Drug Research Institute (NDRI) pointed out in their submission that, while much acquisitive crime appears to be related to the use of heroin, it is not the case that most drug injectors engage in acquisitive crime.[7] The Institute pointed to a Western Australian study conducted on a diverse group of drug injectors (that is, users who were not in gaols or in a treatment facility) which found that only a small minority (7%) of injectors was involved in drug dealing or other crime as a form of income. [8] The head of the Western Australian Drug Strategy Office said to the Committee:

> …the first point I would make very strongly is that the amount of crime that is due to drugs is often exaggerated. Certainly, the people who use drugs do a lot of crime, but they are not responsible for all the crime. The best estimates we have are of the order of 30 to 40 per cent, which is often much less than is cited.[9]

5.8 A submission from the Alcohol and other Drugs Council of Australia (ADCA) estimated that about a third of Australians aged 14 – 19, and over half of those aged 20-24, suffered some form of alcohol-related personal abuse in 1998.[10] Other submissions specifically highlighted the links between alcohol abuse and violence, and referred to the large proportion of police resources which is dedicated to addressing problems related to alcohol. One from the Northern Territory reported that in 1997-98, 71% of sentenced prisoners committed their offence under the influence of alcohol, and that in remote communities 98% of police resources are used to address excessive drinking.[11] When alcohol restrictions were tried in Tennant Creek in the Northern Territory and per capita consumption of alcohol went down by 25%, there was a corresponding three-fold reduction in violence against men and women.[12]

5.9 The WA Government estimates that approximately 70% of police duties involve or revolve around the use and abuse of alcohol by members of the community [13], and this proportion is the same for Tasmania.[14] The SA Government's submission noted that of particular concern there is the incidence of violent crime in the vicinity of licensed premises.[15] A witness

7 Submissions Vol. 6, p. 1370.
8 Submissions Vol. 6, p. 1371.
9 Evidence, p. 115.
10 Submissions Vol. 3, p. 560.
11 Submissions Vol. 2, p. 288.
12 Evidence, p. 696.
13 Submissions Vol. 8., p. 1768.
14 Evidence, p. 991.
15 Submissions Vol. 10, p. 2404.

from the SA Police told the Committee at a public hearing in Adelaide that:

> For one reason or another, we have seen an escalation in violence over the last decade, a condition which is in large part attributable to alcohol.[16]

5.10 Alcohol and other drugs are linked with domestic violence, but the nature of these links is contentious. The political nature of this issue was outlined by the Tasmanian Government, which wrote in its submission:

> When alcohol is present with domestic violence, it is not causal. This is in contrast to a commonly held belief that alcohol causes violence. In most cases where the perpetrator drinks, domestic violence occurs with or without alcohol. Only in a minority of cases does abuse occur only when the perpetrator is drinking. Alcohol can provide a socially acceptable excuse for male violence in the home. It can provide a powerful reason for men to avoid taking responsibility for their actions.[17]

5.11 The Western Australian Network of Alcohol and other Drug Agencies (WANADA) agreed that alcohol should not be regarded as the cause of domestic violence, but rather a 'significant contributor' in 50% of cases.[18] The Queensland Government noted that alcohol and drugs do not cause domestic violence, but can intensify the level of abuse.[19] The Western Australian Government estimated that alcohol and other drugs were involved in approximately one-third of cases reported to their Family and Domestic Violence Unit; it further reported anecdotal evidence that the proportion of domestic violence cases involving alcohol in country areas could be as high as 80%.[20]

5.12 The Committee took evidence from the Victorian Institute of Forensic Mental Health which pointed to what it described as:

> …increasing evidence that the co-existence of substance abuse and serious mental disorder not only prolongs the illness and makes treatment more difficult, but also dramatically increass the likelihood of violence.[21]

5.13 Forensic are referred to Victorian research demonstrating that those who had a history of substance abuse in public mental health were over seven

16 Evidence, p. 231.
17 Submissions Vol. 9, p. 2126.
18 Evidence, p. 137.
19 Evidence, p. 722.
20 Submissions Vol. 6, p. 1432.
21 Submissions Vol. 2, p. 406.

times as likely to have acquired a conviction than those in the general population; in convictions for violent offences it was nearly ten times as high.[22] The Committee considers the links between mental illness, drug abuse, and crime are worthy of further investigation and it looks forward to taking more evidence on this complicated nexus when it continues its deliberations on this subject in the next Parliament.

5.14 While there are, undoubtedly, strong links between the use and abuse of drugs (including alcohol) and crime, it would appear that at the present time these cannot be described with enough confidence to enable us to understand all of what is happening. In Victoria, a government witness told the Committee that, while certain figures on the proportion of crime attributable to drug abuse were 'bandied about nationally', he was not in a position to substantiate these. [23] And in Queensland, one police inspector said:

> The straight answer is that we do not know exactly what percentage of police work is related to either alcohol or illicits. We know anecdotally that it is a very high percentage.[24]

5.15 The Commonwealth Attorney-General's Department argued in their submission to the Inquiry that much of the discussion on the link between drugs and crime in Australia is based on anecdotal evidence, or localised studies, and that more rigorous national data collections are required for evidence-based policy making purposes. [25] This view was echoed by Dr Adam Graycar, Director of the Australian Institute of Criminology, when he told the Committee at a public hearing in Canberra that:

> Our crime statistics do not tell us about cause and they collect fairly limited information. By and large, when we start to deal with some of the big questions about what comes first, drugs or crime, or whether drugs cause crime, or the options, or how well law enforcement is doing, we do not really have the data to answer many of our big questions unequivocally and clearly.[26]

5.16 The Committee agrees it is of vital importance that national data sets are adequate for the purposes of planning and effective policy formulation. It notes, there is a risk that if analysts in this area are unable to explain what is happening with clarity and certainty, we will not be able to tell what is working, and we will all become more vulnerable to sensationalist and

22 Submissions Vol. 2, p. 407.
23 Evidence, p. 436.
24 Evidence, p. 732.
25 Submissions Vol. 9, p. 2205.
26 Evidence, p. 924.

unhelpful media reportage conjuring images of Australia rushing, pell-mell, into a violent, American-style 'war on drugs'.

Not a war on drugs…

5.17 Unlike the United States,where it is said there is a war on drugs, Australia is not running a 'war on drugs'; nor does the Committee think Australia ought to go down that road. The combative policy of the United States is widely regarded as being not only ineffective but extremely costly, in every sense of the word. The US federal government will spend over $US19.2 billion dollars this year on the War On Drugs and incarcerate approximately 236,800 people for drug law violations, at a rate of around 648 people per day.[27] The United States has one of the highest incarceration rates in the world; it jails around 700 per 100,000 of population, compared with Australia's rate of about 100 per 100,000 of population.[28]

5.18 Australia's approach to drug problems was contrasted with that of the United States in this way by a witness from the New South Wales Police:

> I think that if the governments, state and federal, were to say, 'We want to declare a war on drugs', I think we could solve the drug problem in Australia relatively quickly. I think, however, society would suffer much as a result of that. The fact of the matter is that in war you kill people, they don't face trial, they are arbitrarily interned, there a whole range of human rights that are given up in the face of war. We have never declared that situation to be the case here with drugs. What we are doing is trying to have a law enforcement role in a civil and democratic society.[29]

5.19 Australia's response to drug problems has been based, in large part, on the recommendations of the 1977 report of the Senate Standing Committee on Social Welfare, which was quoted in Chapter 2 of this report. This argued, among other things, that: (1) the total elimination of drug abuse is unlikely, and (2) efforts to reduce the supply of and the demand for drugs are complementary and interdependent, and Commonwealth programs should be based on a balance between these. [30]

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27 Information is taken from the drugsense website at www.drugsense.org.

28 Evidence, p. 627.

29 Evidence, p. 565.

30 Senate Standing Committee on Social Welfare, *Drug Problems in Australia – an Intoxicated Society?*, The Commonwealth Government Printer, Canberra, 1977, pp. 1-2.

5.20 Sectoral collaboration, in particular between the health and law enforcement sectors, has been a defining – and much lauded - feature of Australia's strategic approach to drug-related issues (the National Drug Strategy) for the past two decades. It has been, and still is, based on a number of principles, most notably perhaps that of harm minimisation, which is the term now widely used to distinguish Australia's approach to substance misuse from, for example, that adopted in the United States of America.

5.21 Harm minimisation has been described by the Commonwealth Department of Health and Aged Care as:

> … encompassing supply reduction strategies to disrupt production and supply of illicit drugs, demand reduction strategies to prevent the uptake of harmful drug use, and harm reduction strategies to reduce drug-related harm for individuals and communities.[31]

5.22 The nature, strength, and viability of the partnership between health and law enforcement in the delivery of Australia's national drug strategies has been the subject of some disputation over the years. One witness in Canberra denied, however, that relative expenditure by governments on health and law enforcement measures was a big stumbling block:

> Relative expenditure by governments on health and law enforcement measures should not be the central issue. What is important is that health and law enforcement agencies work in partnership to combat illicit drugs.[32]

5.23 Relative expenditure has been a sensitive issue, though. An analysis of total (Commonwealth, State and Territory) licit and illicit drug budget expenditure in 1991-2 revealed that 33.1% of the total budget was spent on law enforcement, and 58.4% on health. However, when budgetary expenditure on licit drugs was removed from these calculations, the vast majority of expenditure (ranging from 76.3% - 97.3%) at the Federal and State / Territory levels was shown to be oriented towards law enforcement rather than to health measures.[33]

5.24 An evaluation of the National Drug Strategy (NDS) from 1993 to 1997 reported that, despite the acknowledged success of the partnership between health and law enforcement in the NDS, it was widely recognised that there were a number of tensions in the relationship, and more could be done to ensure that the health and law enforcement sectors were true

31 Submissions Vol. 9, p. 1988.

32 Evidence, p. 58.

33 Submissions Vol. 9, pp. 2190-91.

'equal partners' in their working relationship. The evaluation report recommended, among other things, that consideration be given to increasing the proportion of cost-shared NDS funds allocated to law enforcement.[34]

Tough on Drugs

5.25 *Tough on Drugs* or the National Illicit Drugs Strategy (NIDS), the most recent phase of the NDS, was launched in November 1997. Under the Strategy, the Commonwealth has allocated $516 million over four years for a range of measures designed to provide a balanced and integrated approach to reducing the supply and demand for illicit drugs and minimising the harm these cause.[35]

5.26 Relative expenditure for health and law enforcement under this phase of the Strategy appears to be fairly evenly split, with approximately $213 million being dedicated to supply control measures, and $303 million for demand reduction measures including health, education, and family activities.[36] Of the $303 million earmarked for demand reduction measures, approximately $275.5 million is for health measures, and $27.5 million for education initiatives. Included in the $275.5 million dedicated for health demand reduction measures is $111.5 million for the diversion of drug users from the criminal justice system into education and treatment.

Supply control measures

5.27 Controlling the supply of illegal drugs is important to try to do because, as a number of witnesses argued, demand reduction interventions, which aim to educate about the risks associated with taking drugs, are less likely to be effective in an environment of unfettered supply.[37] As one witness explained:

> It seems to us that it is unlikely that the problems of demand can be dealt with adequately as long as the flow of illicit drugs continues unimpeded. Reducing the demand for drugs through education, treatment, rehabilitation is absolutely crucial. Unless more effective curbs can be placed on drug supply, and those who

34 Single, E, and Rohl, T. *The National Drug Strategy: mapping the future*. Ministerial Council on Drug Strategy, Canberra, 1997, p.89.

35 Submissions Vol. 9, p. 2199.

36 Evidence, p. 79.

37 Evidence, p. 57.

traffic in drugs, demand reduction is unlikely to achieve its full potential.[38]

What is being done

5.28 Since the beginning of the *Tough on Drugs* Strategy in 1997, considerable funding and law enforcement effort has been directed at reducing the supply of illicit drugs entering Australia. While Commonwealth law enforcement agencies such as the Australian Federal Police (AFP) and the Australian Customs Service (ACS) have shared responsibility for reducing the supply of illicit drugs for around twenty years, it is only since the beginning of the Tough on Drugs Strategy that law enforcement agencies have received resources specifically targeted to carry out this function.

5.29 *Tough on Drugs* money has been allocated in the following ways:

Australian Federal Police (AFP)	$74.2m
Increase protection of our borders	$69.9m
Enhance capacity of National Crime Authority (NCA)	$22.6m
Research into drug and crime links	$3.3m
Australian Transaction Reports and Analysis Centre (AUSTRAC)	$1.8m
Further investigation and training activities of AUSTRAC	$9.5m
Expansion of international law enforcement liaison	$18.9m
Enhance AFP and NCA investigatory procedures	$11.7m
Total	$211.9m

5.30 Under *Tough on Drugs* the Commonwealth Government has, among other things:[39]

- developed a Law Enforcement Cooperation Program (LECP) in the Asia-Pacific region and in other parts of the world. The LECP is designed to assist overseas law enforcement agencies to improve their capacity to investigate drug trafficking and contribute to the collection of law enforcement intelligence;
- created new AFP liaison posts in key transit countries to assist in closing gaps in Australia's capacity to combat international drug trafficking and transnational crime directed at Australia. The network facilitates the exchange of drug and other crime related intelligence between the AFP and other Australian and international law enforcement agencies;

38 Evidence, p. 558.

39 Submissions Vol. 9, pp. 2163-4.

- enhanced the NCA's capacity to intensify targeting of south-east Asian organised crime, in particular heroin importation and distribution, through the Blade National Task Force, comprising all Federal and State law enforcement agencies;
- established a Heroin Signature Program which aims to determine the unique signature of any heroin samples seized and help establish common features between seizures and so help trace distribution networks in Australia; and
- set up a technical assistance fund of $A1 million to be used to support United Nations International Drug Control Program (UNDCP) initiatives in the Mekong subregion; two projects have so far been approved under this initiative.

Issues

5.31 While it is impossible to know with certainty what proportion of illicit drug supplies is interrupted[40], the United Nations Office for Drug Control and Crime Prevention estimates that the global interception rate for heroin was 17% in 1998, and argues that this represents a substantial increase on the average of 10% prior to 1998. In Australia law enforcement agencies have reported record seizures of illicit drugs over the past few years [41], and one witness from the AFP argued the case that authorities were making inroads into the supply of heroin in the following way:

> If you look at the figures, and again I am simplifying here, the amount of to-take heroin that is interdicted has risen by roughly 500 per cent in the last decade. I think it would defy the imagination to suppose that the amount of use of heroin has risen that much in the last decade.[42]

5.32 The Committee is aware that recently there have been heroin shortages in several jurisdictions, and these could be interpreted as evidence of the positive impact of supply reduction strategies. Certainly, an Assistant Commissioner in the New South Wales Police believed this to be the case:

> …present shortfalls in supply suggest that increasing disruptions in the supply chain at the highest levels are having a positive impact on the trade.[43]

5.33 However, other possibilities were proffered as possible explanations for what appear to be periodic supply shortages, including that suppliers are

40 Evidence, p. 60.

41 Submissions Vol. 9, p. 2159.

42 Evidence, p. 64.

43 Evidence, p. 559.

manipulating these in order to force up prices.[44] One Queensland witness said:

> The big hauls of recent times would be blips on the market and usually do not really interrupt supply for very long, as we have seen with the local heroin drought that has hit across the country and up here as well. We suspect that is more about market forces and market manipulation than about intercepts.[45]

5.34 While the reasons for supply shortages can be debated, it is undoubtedly the case that illicit drug shortages result in troubles of various kinds. These were outlined to the Committee, which happened to be conducting part of its program of public hearings and visits at the same time that a heroin shortage was emerging in various parts of Australia.

5.35 Witnesses in Canberra, Queensland and New South Wales pointed to how heroin shortages had resulted in price rises and, associated with this, ironically, increased levels of crime and violence. Addicts forced into withdrawal encountered inadequate drug treatment systems, and inability to find suitable assistance compounded their desperation.[46] The situation in Sydney was described this way:

> When there is a reduction in supply there are some very negative consequences. Our support line is receiving lots of phone calls about more violence, more polydrug use, an increase in use of benzodiazepines, amphetamines, particularly and cocaine, crime is increasing because of the increase in price and we of course are having people demanding treatment now. There are no detox places available, yet people are hammering at the doors because they are forced into withdrawal because of a reduction in supplies.[47]

5.36 It is distressing and confusing for anyone concerned about substance abuse to realise that what might be a good news story for law enforcement has the potential to be experienced as a disaster for those working with drug dependent people in the health sector. Realisations like this highlight the complexities of implementing a comprehensive strategy such as the National Illicit Drugs Strategy, and serve to emphasise the importance of cross-portfolio cooperation and collaboration across all levels of government to ensure 'harm minimisation' applies to individual users on the streets, anywhere.

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44 Evidence, p. 812.

45 Evidence, p. 765.

46 Evidence, p. 881.

47 Evidence, p. 608.

Demand reduction measures: the National Drug Diversion Initiative

What it's about

5.37 On 9 April 1999, the Council of Australian Governments (COAG) agreed to work together to put in place a new nationally consistent approach to drugs in the community involving diversion of drug offenders by police to compulsory assessment. The diversionary scheme subsequently agreed by COAG emphasises diversion of offenders by police at apprehension to maximise the opportunities for early intervention with illicit drug users.

5.38 At a meeting of 10 June 1999, the Ministerial Council on Drug Strategy (MCDS) endorsed 19 principles to underpin the national diversion scheme. These include respect for jurisdictional flexibility within the operation of a broad national framework which emphasises the need for inter-sectoral and intergovernmental collaboration to achieve the following outcomes:

- people being given early incentives to address their drug use problems – hopefully before they incur a criminal record;
- an increase in the number of illicit drug users diverted into drug education, assessment and treatment; and
- a reduction in the number of people appearing before the courts for use or possession of small quantities of illicit drugs.

5.39 The Department of Health and Aged Care is currently administering the following funds for a range of diversion initiatives, including:

- $111.5 million over four years to support the diversion of drug users by police into education, counselling, or treatment by:
  - ⇒ creating an increased assessment and referral capacity for illicit drug users diverted by the police;
  - ⇒ providing additional funding for a range of community-based education, assessment and treatment services to provide police with an additional option in managing illicit drug users;
  - ⇒ producing and distributing training resources for law enforcement and health personnel involved in the programme and material for use in counselling and training programmes for users; and
  - ⇒ increasing capacity for the education and training of health workers in the assessment and management of people with drug problems.
- $58 million over four years for a range of supporting measures, including funds for the following:
  - ⇒ $1.2 million for the development and dissemination of cannabis cessation strategies for adults and adolescents;

- ⇒ $17.6 million for increased education, counselling and referral services provided through community-based programmes;
- ⇒ $10.6 million for the augmentation of the existing community-wide education and information campaign on illicit drugs;
- ⇒ $4 million for additional funding for the Community Partnerships Initiative, which provides grants to communities to undertake projects aimed at preventing illicit drug use and the harm associated with such use;
- ⇒ $12.9 million for increasing the number of pharmacies and other outlets distributing needles and syringes; and
- ⇒ $0.252 million for research to investigate barriers and incentives to illicit drug users accessing and remaining in treatment.[48]

5.40 The following amounts have been offered to the States and Territories as part of the COAG Illicit Drug Diversion Initiative for the four-year period 1999 / 2000 to 2002 / 2003:

New South Wales	$31.9 m
Victoria	$23.0m
Queensland	$19.5m
Western Australia	$11.1m
South Australia	$9.2m
Tasmania	$3.8m
Australian Capital Territory	$2.9m
Northern Territory	$2.7m
Total	$104.1m

5.41 To date, seven jurisdictions have signed agreements with the Commonwealth to implement the Diversion Initiative, and it is anticipated that shortly an agreement will be signed with the Northern Territory. For those jurisdictions that have signed agreements, the following amounts have been paid up until 31August 2001:

- NSW $8.8 million;
- Vic $6.4 million;
- Qld $5.3 million;
- WA $3.2 million;
- SA $1.5 million;

48 Submissions Vol. 9, p. 2003.

- Tas $1.3 million; and
- ACT $0.7 million.

Implementation of the scheme so far: issues arising

5.42 The principles underlying the Illicit Drug Diversion Initiative speak of a national approach embodying the ideals of cooperation and collaboration and, certainly, many witnesses before the Committee pointed to the scheme as a good example of intergovernmental cooperation. A government witness in New South Wales said:

> In terms of partnership between the state and the Commonwealth, the Commonwealth-state drug diversion agreement is an excellent example of a partnership agreement between two spheres of government. It is extensively funded by the Commonwealth and all diversion programs…are embodied in that agreement. The funding provided under that agreement is providing an enormous number of services to support young people and young adults and divert them from the criminal justice system.[49]

5.43 The Illicit Drug Diversion Initiative certainly does provide significant opportunities for intergovernmental cooperation in efforts to minimise harms to individuals and communities relating to the use and abuse of illicit drugs. It is ambitious and worthy and, while it is premature yet to comment on its effectiveness, a number of issues arose from the evidence provided to the Committee. Two of these are discussed below: (1) the need for more training for law enforcement personnel involved in the diversion process, and (2) the need to ensure that prisoners also have access to opportunities for treatment and rehabilitation.

Need for training in diversion for law enforcement officers

5.44 Under the diversion scheme, police are asked to exercise discretion with regard to whether a particular offender is or is not eligible for referral to health authorities for assessment and treatment. In some jurisdictions, police will divert certain offenders directly to drug education. While each jurisdiction is expected to develop their own diversion eligibility criteria, the nationally-agreed diversion framework provides that certain minimal criteria should apply to the determination of eligibility for diversion.

5.45 Police need to consider whether offenders meet the eligibility criteria of their particular jurisdiction, and then make reasonable attempts to ensure that offenders understand their rights and responsibilities under the diversion program. Furthermore, the 'notices of diversion' they provide need to comply with certain nationally prescribed minimal elements,

49 Evidence, p. 572.

principally designed to ensure that sufficient information about compliance is collected to enable evaluation of the Initiative.

5.46 Some members of the police service are uncomfortable with the sort of work they are doing with diversion. It isn't really what they expected to be doing when they joined up to become police officers. One witness in Western Australia, for example, said to the Committee:

> One of the notions about harm minimising policing is that police could use discretion in whether or not to arrest a person or to issue a caution, or whatever, at the point of apprehension. In WA, particularly, we found that the police have some difficulty with the notion of discretion. They believe it puts police officers in a very untenable position, and that is based on previous experiences within the WA police service. I believe that is something police have to address if they are going to look seriously at the national harm minimising policing.[50]

5.47 And in Tasmania, the Deputy Commissioner of Police said:

> It is fair to say that in a lot of cases operational police officers do not initially subscribe to the benefits of a drug diversion program. A lot of police officers who encounter these problems on a day-to-day basis feel that the best approach to managing drug offenders is to charge them and allow the courts to deal with their unlawful behaviour – which is what it is.[51]

5.48 An Assistant Commissioner with the South Australia Police said that more needed to be done in terms of training police about harm minimisation[52], and in Queensland the Officer in Charge of the Drug and Alcohol Coordination Unit in the Queensland Police Service described the potential benefits of such training in the following way:

> All Queensland police officers received training in the Queensland Police Service Drug Diversion Program during the latter half of 2000...We have also developed training with police on harm minimisation principles. With regard to harm minimisation, it is fair to say that there has been some form of reluctance on behalf of some police to adopt that philosophy. But it is interesting to note that, when you talk to groups of police around the state and actually explain what harm minimisation is, probably 99 per cent of all police would certainly support that philosophy.[53]

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50 Evidence, p. 173.

51 Evidence, p. 997.

52 Evidence, p. 231.

53 Evidence, p. 724.

5.49 The Committee notes that one of the principles underpinning the national Illicit Drug Diversion Initiative refers to the importance of acknowledging the need for training and educating all stakeholders involved in the diversionary process, including police; another refers to the requirement for a clear understanding of the procedures and protocols to be followed in the management of the diversion process. The Committee considers that suitable training ought to be provided to police, as much of the success of this Initiative rests on their shoulders.

Prisoners need treatment, too

5.50 There were 21,714 prisoners in Australia on 30 June 2000, and for 10% of these a drug-specific offence was the most serious offence for which they were imprisoned.[54] However, as the Director of the Institute of Criminology pointed out to the Committee:

> as many as 70 to 75% of people who commit offences that we know about commit offences where there is some drug link there[55].

5.51 Some witnesses estimated that the proportion of the prison population with a drug or alcohol problem was as high at 75%[56], and certainly this is consistent with the informal evidence given to the Committee by staff and prisoners in its Inquiry-related visits to gaols in four jurisdictions around Australia. Furthermore, many people imprisoned for drug-related offences have been there before: ABS statistics reveal, for example, that 51% of those gaoled for possession or drug use charges in 2000 had been inside gaol before.[57]

5.52 As part of its consideration of the Illicit Drug Diversion Initiative, the Council of Australian Governments noted, as its meeting of 9 April 1999, that drug use in prisons is common, and a large proportion of prisoners are incarcerated for drug-related crime. To prevent re-offending and to promote public health, states and territories agreed to develop and fund programs to:

- intercept the supply of drugs to prisons and be tough on dealers within prisons; and
- develop and trial diversionary treatment programs within the gaol system so that dependent users can break their addiction.[58]

54 Australian Bureau of Statistics 2000, *Prisoners in Australia (4517.0),* Canberra, pp. 3, 29.

55 Evidence, p. 923.

56 Evidence, p. 232-233.

57 Australian Bureau of Statistics 2000, *Prisoners in Australia (4517.0),* Canberra, p. 14.

58 Submissions Vol. 9, p. 2005.

~~5.53~~ It makes sense to ensure that suitable treatment programs are made available to dependent drug users in prison, and to take advantage of what one witness described as the 'very special opportunities for intervention' provided by a captive population.[59] Where a substance abuse issue underlies or contributes to criminal behaviour, the Committee strongly believes addressing it on the 'inside' will serve to help prisoners break free from addiction and crime.

5.54 Drug dependent prisoners need medical support to assist with withdrawal when they arrive in prison, and while they are on the inside they need to have access to treatments such as methadone maintenance or naltrexone to help to stay 'clean' and off heroin. Prisoners need to have access to drug education and counselling services, and pre-release programs should support them with planning to help ensure a successful transition into a new life on the outside. Education and training opportunities ought to be generally available to prisoners, too, to improve their employment prospects on the outside.

5.55 The Committee was dismayed to discover that corrective service departments around the country are not dedicating sufficient resources to support the health and welfare needs of drug dependent prisoners. The Committee notes that no Federal monies have been specifically earmarked for the treatment trials recommended for the 'Tough on Drugs in Prisons' initiative. The Committee heard that in Western Australia, for example, the Ministry of Justice claims to deal with these issues, but:

> The major problem is that they do not resource it. As I said earlier, there is a substance abuse unit there, I think, which has about four staff in it. They are expected to service 14 or 15 prisons around the state with pre-release substance abuse programs. It is a total physical impossibility. They have been going around doing prison inspections in the state. One of the things that keeps popping up in those reports is the fact that this unit does not do its job. It is not that it is not doing its job. It is because it is not resourced to do its job.[60]

5.56 The Committee has seen and heard much evidence of short-staffing and the difficulty inmates have in gaining access to suitable drug-related health and counselling services on the inside. In some gaols pre-release programmes consist of opening up the gate for the offender at the end of his or her term. In most, educational opportunities are strictly limited and employed as mechanisms of control rather than rehabilitation. The Australian National Council on Drugs expressed its concern to the

59 Evidence, p. 567.

60 Evidence, p. 179.

Committee about high (Hepatitis C and HIV/AIDS) infection rates in prison populations and argued that more needs to be done in the prison setting to address inmates' drug dependence issues.[61] One witness said:

> People get very little help in our prisons here, even less than in the United States. They come out of prison, and the correctional health system and the health system in the community don't connect up, so that person is stranded and has difficulty getting on to methadone programs or other forms of drug treatment. It is a system that is really designed to set people up to fail and, of course, they do fail and when they fail they are blamed for it.[62]

5.57 It may be, as some witnesses suggested, that the balance between supply and demand reduction measures at the State/Territory government level needs to shift to enable more resources to be dedicated to health-promoting measures in prisons.[63] Governments should invest more on the provision of health, education and welfare staff to help prisoners. Some positive developments are apparent: the New South Wales Government told the Committee it plans to expand treatment options (especially detoxification facilities) in prisons across the State[64], and the Committee understands that a major re-development of the Risdon Prison Complex currently being contemplated in Tasmania will enable the delivery of more comprehensive health care to all prisoners, including those with drug dependency problems.

Summary

5.58 A simple way of describing Australia's current policy on illegal drugs is to say it is two-pronged, comprising efforts to be both tough on the suppliers and traffickers of illegal drugs, but tolerant and helpful towards those who are drug dependent, who are best understood as suffering from a health problem. While public opinion supports increasing penalties for the sale or supply of 'hard drugs'[65], the Committee doubts that the public is entirely comfortable with the idea that drug problems are health problems.

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61 Submissions Vol. 2, p. 301.

62 Evidence, p. 627.

63 Evidence, p. 1608.

64 Evidence, p. 567. The Government's Response to the Drug Summit (July 1999) says that additional funding of $16.6 million is to be provided over four years.

65 Makkai, T. & McAllister, I..1998, *Public opinion towards drug policies in Australia, 1985-95,* AGPS, p. 36.

5.59 In Australia the vast majority of arrests are cannabis-related and most are consumer rather than provider-related.[66] The Committee believes it is appropriate, to divert young illicit drug users away from the criminal justice system, while aggressively pursuing and incarcerating others who are regarded as being more serious offenders – heroin traffickers, for example.

5.60 However, as a number of witnesses explained to the Committee[67], many heroin users elect to support their addiction by supplying illegal drugs; this is considered preferable to prostitution or committing burglaries. A recent study reveals that over one quarter (26%) of intravenous drug users engage in dealing to help support their habit[68], and these people are not easily accommodated by diversion schemes which are clearly designed to assist those apprehended for use or possession of small quantities of illegal drugs – cannabis, mainly.

5.61 A key element related to the implementation of the Illicit Drug Diversion Scheme is the adequacy of treatment places to cope with those offenders. The Committee looks forward to the findings from on-going monitoring and evaluation processes and assumes that these will be fed back, as appropriate, into the design and operation of these schemes.

5.62 The Committee recognises that evaluation of these schemes is one of the principles underpinning the national Illicit Drug Diversion Scheme. The Scheme's ability to fulfill its potential as a good vehicle of harm minimisation policy will depend very much on the realisation of this commitment. It concurs with the words of the witness who said:

> Clearly, diversion has the potential to be very effective in bringing people out of the criminal system and into a helping system while, at the same time, not taking away the fact that the community does not tolerate that particular behaviour and sees it as criminal…But, like …most researchers, I would have to say that all of those kinds of mechanisms need very careful evaluation. We need to be absolutely certain that there are not unintended consequences of the range of diversion programs that have been put in place. I am not suggesting that there might be; I am suggesting that we should, as a matter of course, do that evaluation to reassure ourselves that things are working the way they are intended to work.[69]

66 Submissions Vol. 9, p. 2311.

67 Evidence, p. 85.

68 Miller, M.& Draper, G. 2001,*Statistics on drug use in Australia 2000,* AIHW cat.no.PHE 30, Canberra: AIHW (Drug Statistics Series no. 8, p. 58.

69 Evidence, p. 173.

6

Road Trauma

Introduction

6.1 The white crosses that can be seen on the side of Australian roads are poignant reminders of the fact that many people die and are injured every year on highways and city streets. Just how many is shocking. From July 2000 to June 2001 there were 1775 road fatalities. On a calender year basis, the lowest number of road fatalities from 1986 to 2000 was 1755 in 1998.[1] In 1996 the estimated total financial cost of road crashes was $15 billion.[2] Of this cost, it is estimated that alcohol use was responsible for approximately $1.3 billion and other drugs represented between $0.21 and $0.46 billion.[3]

6.2 Hospitals and laboratories gather information on the presence of alcohol and other drugs following road fatalities and serious accidents, but this is not collected in standard form throughout Australia. Only Victoria, Western Australia and New South Wales routinely test all fatalities for the presence of mood-altering substances[4]. At the roadside, drivers have been effectively tested for alcohol for many years. In contrast to alcohol:

> there seems little prospect of developing methods for fast, cheap, non-intrusive and accurate measurement of all relevant drugs, that

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1 Australian Transport Safety Bureau June 2001, *Road Fatalities Australia*, pp. 3, 10.

2 Submissions, Vol 10, p. 2683.

3 Submissions, Vol 10, pp. 2683-84.

4 Austroads, *Drugs and Driving in Australia: First Report of the Austroads Working Group*, Sydney, 2000, pp. 4, 13, 15, 33-34.

> could stand alone as evidence in a court of driver impairment caused by drugs.[5]

6.3 In Australia alcohol remains one of the biggest single causes of road deaths and injuries; in 1997 28% of driver and motorcycle rider fatalities involved a blood alcohol concentration above 0.05.[6] Alcohol is so evident in these statistics not only because alcohol is widely used, but also because it appears to increase users' crash risk more than any other drug that commonly turns up in fatality or injury statistics.[7]

6.4 The Commonwealth Department of Transport and Regional Services reported that a recent study by Austroads[8] estimated that if no drivers used alcohol, the number of fatal crashes would be reduced by about 25% and the number of serious injury crashes by 9%.[9] This equates to about 250 fewer driver and rider fatalities in 2000-2001.[10] Alcohol use by pedestrians is also a significant problem, with around 40% of adult pedestrians killed on roads having an elevated blood alcohol concentration. For young adults and older teenagers the figure is even higher.[11]

6.5 While alcohol has the greatest impact on road safety, all psychoactive drugs are of concern because these act on the brain or central nervous system and affect perception, behaviour, judgment and reaction time. Psychoactive drugs, including depressants such as alcohol, antidepressants, stimulants, hallucinogens and some pain-killers, are found in about 24% of driver fatalities.[12] This may seem a high proportion, however one witness told the Committee three caveats need to be borne in mind:

> The first is that a lot of the crash-involved drivers in whom drugs are detected have also been using alcohol – roughly two in five of them, in fact. The second is that the drug positive cases can include people with quite low concentrations of drugs in their system, including therapeutic drugs. The third, particularly in relation to cannabis, is that many studies have classified people as cannabis positive when what have been found in them are

5 *Drugs and Driving in Australia,* p. 25.

6 Submissions, Vol 10, p. 2678.

7 Evidence, p. 97.

8 Austroads is an association of Australian and New Zealand road transport and traffic authorities: submissions, Vol 10, p. 2678.

9 Submissions, Vol 10, p. 2683.

10 Australian Transport Safety Bureau June 2001, *Road Fatalities Australia,* p. 3.

11 Evidence, p. 97; 40% of the pedestrians killed in 2000-2001 equals 110 people: Australian Transport Safety Bureau June 2001, *Road Fatalities Australia,* p. 3.

12 Evidence, p. 97.

> breakdown products of cannabis that can remain in the body for several days after use. So you are identifying they are cannabis users but not necessarily people who were behaviourally affected by cannabis at the time of the crash.[13]

Drink driving

Random breath testing

6.6 Random breath testing (RBT) involves the police stopping drivers and analysing their breath to determine if the driver has a blood alcohol concentration higher than the legal limit. If so, a graded system of penalties applies related to the severity of the offence.

6.7 RBT had been introduced into every state and territory by 1989.[14] It was a radical step at the time, and as one witness said:

> The police were given powers to stop people who were committing no offence, doing nothing to attract attention to themselves, but they could be stopped, checked, and suffer very severe penalties if they were over the limit. That is so radical that a lot of other countries still do not think they can do it.[15]

Deterrent factor

6.8 The Committee was advised that the application of random breath testing and its associated components has had considerable success in reducing the incidence of drink driving in Australia.[16] Evidence that supports this view can be found in the numbers of driver and rider fatalities testing above 0.05 over a number of years. On a national scale, in 1981 the percentage of driver and rider fatalities testing over 0.05 was between 40% and 44%. That figure now is about 28%.[17]

6.9 Different jurisdictions provided information to the Committee that supported this national trend. For example, the ACT Government noted that for the year ending June 1996, 11.7 drivers per 1000 tests were charged

13 Evidence, pp. 97-98.

14 Submissions, Vol 9, p. 2112.

15 Evidence, pp. 100-101. The Commonwealth Department of Transport and Regional Services advises that in both the United States and Canada, law enforcement officers must have a reason to check a driver for alcohol. In the United Kingdom, neither random breath tests nor sobriety checkpoints are conducted.

16 Submissions, Vol 10, p. 2678.

17 Evidence, p. 101.

with exceeding the limit, while for the year ending June 1998 this figure had dropped to 7.1 drivers per 1000 tests.[18] In Queensland, 26.3 drivers per 1000 tests were charged with a drink-driving offence in 1996-97, while the number currently stands at 8.7 drivers per 1000 tests.[19]

6.10 The effectiveness of RBT as a deterrent depends on two factors. These are the penalty that is attached to the offence and the probability of being tested.[20] In regard to penalties, all States have 0.05 as a basic limit, with special limits for professional drivers, and in most States for young people in the first three years of driving. All jurisdictions have adopted a graded system of penalties relating to the severity of the offence, with some variations between the jurisdictions. While some States apply point demerits to low range alcohol offences, the general perception in the community is that penalties are tough.[21]

6.11 A high probability of being tested obviously plays a large part in deterring people from driving over the legal limit. To enhance the perception that drivers will be tested, most jurisdictions now seek to conduct one random breath test per two licensed drivers per year.[22] The Queensland Police Service informed the Committee that in 1998 the Service targeted 70% of licensed drivers; in the year 2000 the target was increased to 100%.[23] The Commonwealth Department of Transport and Regional Services commented, however, that there is still scope for further enhancement of RBT efficiency and effectiveness, including increased intensity in some jurisdictions.[24]

Success rates

6.12 While it would appear that RBT has been successful in reducing the numbers of people driving above the legal blood alcohol limit, a number of issues were raised in evidence. One is that the success of the RBT strategy should be seen as part of a road safety package incorporating legislation, enforcement, public education and media advertising activity.[25] Another is that RBT does not test for drugs other than alcohol, an issue which will be explored further below.

18 Submissions, Vol 9, p. 2250.
19 Evidence, p. 722.
20 Submissions, Vol 9, p. 2112.
21 Evidence, p. 100.
22 Evidence, p. 101; Submissions, Vol 9, p. 2251.
23 Evidence, p. 722.
24 Submissions, Vol 10, p. 2678.
25 Submissions, Vol 10, p. 2678; Vol 9, p. 2111.

6.13 A third is that there is evidence at the national level to suggest there has been an increase in the numbers of people driving while over the legal limit. The Tasmanian Government's submission referred to National Drug Strategy Household Survey findings as well as drink driving figures from the Bureau of Crime Statistics indicating a rise in recent years which has been described as 'disturbing' and warranting a review of RBT strategies.[26]

6.14 Finally, there is some evidence that RBT has been less effective in rural than in urban areas.[27] Research into this issue was described by a witness as follows:

> First of all, it is essentially as issue with the country drivers rather than city visitors. The issues include the fact that country people can have fewer alternatives than city people, that is, there is not necessarily a tram or a bus or a taxi to get you to or from the pub if you want to take some option rather than using your car. A second thing that comes out is that country people have very good networks, and news about exactly when and where the random breath testing is going to be can perhaps travel better than it does in the city. There was some concern expressed by research done in Victoria that was suggesting that in some cases very visible enforcement could actually have a perverse effect because everybody knew when and where the booze bus would be and so they got home by taking the back roads. However, back roads are more dangerous roads than main highways.[28]

Consequences

6.15 Jurisdictions have adopted a graded system of penalties related to factors such as the extent to which a person's blood alcohol level is above the legal limit, and whether the person has previously committed a similar offence.[29] In addition to the penalty, there can be other penalties for the driver, relating to obtaining motor vehicle insurance or needing to pay increased premiums.[30]

6.16 Some jurisdictions, such as the Northern Territory, also make attendance at an alcohol education or counselling session a prerequisite for the driver being reissued a licence.[31] The alcohol education or counselling session

26 Submissions, Vol 9, p. 2112.
27 Submissions, Vol 10, p. 2678.
28 Evidence, pp. 101-102.
29 Submissions, Vol 10, p. 2678.
30 Submissions, Vol 9, p. 2112.
31 Evidence, p. 689.

may lead into further treatment or rehabilitation, or raise general health issues associated with alcohol. The Salvation Army recommended to the Committee that referral to treatment and rehabilitation programs should be adopted as an essential part of the penalties for drivers.[32]

Drug driving

6.17 As noted above, traces of drugs other than alcohol are found in about 24% of driver fatalities. Austroads estimate that if the use of all drugs other than alcohol could be eliminated, the number of fatal crashes could be reduced by between 4% and 11%, and the number of serious injury crashes by about 1%.[33] Using the figures for 2000-2001, the reduction in driver and rider fatalities would range between 42 and 115 people.[34]

6.18 Driving under the influence of drugs other than alcohol is illegal in every State and Territory in Australia and the penalties are quite severe, although the exact form of legislation and the mechanisms for enforcement vary between jurisdictions.[35] Complicating factors associated with enforcing anti-drug-driving legislation are determining precisely what quantity of drug is dangerous and devising an easy method of testing for drugs other than alcohol.

Drugs and culpability

6.19 There is some difficulty in establishing whether the presence of the drug caused an accident and what quantity of drug is dangerous. For example, the Victorian and West Australian Governments provided to the Committee figures on drugs found in driver fatalities, but both stressed that this did not mean these drugs caused the accident.[36]

6.20 One method of determining what drugs contributed to a crash is called culpability analysis. Information on what drugs are present in which drivers is combined with data on responsibility for the crash. The basic logic there is that anything that has a causal link for crash involvement ought to be found more in the at-fault drivers than in the not-at-fault drivers.[37]

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32 Evidence, p. 452.

33 Submissions, Vol 10, p. 2683.

34 Australian Transport Safety Bureau June 2001, *Road Fatalities Australia*, pp. 3, 10.

35 Evidence, p. 99.

36 Submissions, Vol 11, p. 2709; Vol 6, p. 1433.

37 Evidence, p. 98.

6.21 This sort of analysis reveals that alcohol, and alcohol in combination with other drugs, stands out as being linked to culpable driving. The use of both licit and illicit drugs without alcohol appears to be a less important causal factor in serious road crashes than alcohol, speeding or fatigue.[38] Drivers who are cannabis users, and test negative for alcohol, have not been found to have a significantly elevated crash risk.[39] Benzodiazepines emerge as significant for serious injury cases, with a study by South Australia finding these drugs contributed to road crashes.[40]

6.22 Following an inquiry into managing fatigue in transport last year, a House of Representatives Committee made two recommendations to the Government relating to drugs in transport.[41] The first recommended the development and implementation of a drug-free policy for the road transport industry, including mandatory drug testing in the workplace. The second recommended the development of a program aimed at discouraging employees from taking drugs and encouraging employers to establish work practices which respect basic fatigue management principles. These recommendations seek to address research findings suggesting around 30 per cent of truck drivers use drugs and one study that found 40 per cent of fatally-injured drivers of heavy trucks had drugs in their system.[42]

6.23 The Austroads report *Drugs and Driving in Australia* cited research conducted in 1994 and 1995 which found that 16 per cent of truck drivers tested positive for licit stimulants and 5 per cent for illicit stimulants. This compared to 2 per cent of car drivers testing positive for licit stimulants and 1 per cent for illicit stimulants.[43] Austroads observes that research on the impact of stimulant use on driving is inconclusive, but notes that 'rebound fatigue' experienced when stimulants wear off causing drivers to fall asleep while driving is a matter of concern.[44]

Testing for drugs other than alcohol

6.24 The Committee received a submission from the Centre for Accident Research and Road Safety (Queensland) which reported on one study

38 Submissions, Vol 10, p. 2682.

39 Submissions, Vol 10, p. 2682.

40 Evidence, p. 98; Submissions, Vol 10, p. 2406.

41 House of Representatives Standing Committee on Communications, Transport and the Arts, 2000. *Beyond the Midnight Oil: Managing Fatigue in Transport*, The Parliament of the Commonwealth of Australia, p. 122.

42 *Beyond the Midnight Oil*, pp. 118-119. Stimulants made up 21 per cent and alcohol 19 per cent.

43 Austroads, *Drugs and Driving in Australia: First Report of the Austroads Working Group*, Sydney, 2000, pp. 6-7. Examples of a licit stimulant is Sudafed and an illicit stimulant is amphetamine.

44 *Drugs and Driving in Australia*, p. 11.

where participants showed little concern for driving under the influence of an illicit substance.[45] While participants in the study gave a number of explanations for this lack of concern, participants also thought that it was unlikely or highly unlikely that they would be caught driving under the influence of an illegal drug.[46] In contrast to the community's general view about RBT, study participants had a perception that the police could not or would not test for illicit substances.

6.25 The inability to test quickly and easily for drugs other than alcohol means that more elaborate processes are required. A Deputy Commissioner of Tasmania Police informed the Committee:

> In relation to the issue of drug use, and its effect on the management of road safety issues, where a police officer, for argument's sake, becomes concerned that the driver of a vehicle is affected by a drug other than alcohol, then the officer has the opportunity to undertake certain tests and then to require urine samples or blood samples.[47]

6.26 In Queensland, a representative of the Queensland Police Service told the Committee:

> A further problem…is the issue of drugs – other than alcohol – and driving. The Queensland Police Service is exploring strategies to address this issue. Technological advances and practical policing techniques, which rely upon a person's indicia[48], are currently being evaluated…all members of the Queensland Police Service receive training in the use of roadside breathtesting and field impairment testing to detect drug drivers.[49]

6.27 The *Drugs and Driving in Australia* report notes the distinction between roadside screening for drug-related impairment and roadside screening for drug presence[50]. Simple devices can test for the presence of a range of drugs, but only well-equipped hospitals and specialist laboratories can confirm the amount of a drug from a blood sample.[51] Austroads recommends a two-fold national approach to addressing roadside screening for drug driving.[52] First, the offence should be driving while

45 Submissions, Vol 12, p. 3365.

46 Submissions, Vol 12, pp. 3365, 3371.

47 Evidence, p. 986.

48 Examples of indicia that NSW police use are set out on page 41 of *Drugs and Driving in Australia*. These include the state of a drivers eyes, breathing, speech, balance and movement.

49 Evidence, p. 722.

50 Austroads, *Drugs and Driving in Australia: First Report of the Austroads Working Group*, Sydney, 2000.

51 *Drugs and Driving in Australia*, pp. 25-26.

52 *Drugs and Driving in Australia*, pp. 25.

impaired, thus focussing on the state of the driver and not on a specific substance or concentration. Second, the approach of New South Wales should be adopted. This approach combines evidence from police assessment with expert testimony regarding the impairment likely to have been caused by drugs detected by blood analysis.

6.28 While the Committee commends the efforts of police to address some of the practical issues associated with testing for drug driving, it notes that some witnesses expressed the view that 'drug driving' did not warrant the attention it seemed to be attracting. Certainly, some witnesses were concerned that it might deflect valuable resources away from RBT.[53] Austroads believes:

> While the apparent extent of the problem as shown by mass statistical data does not warrant diversion of major resources, there remains a need to actively discourage the likely impairment that can occur due to road users using drugs, both legally and illegally. There is sufficient evidence from individual cases of severe and dangerous impairment to justify action, with a resource commitment commensurate with the size of the problem in Australia.[54]

Conclusion

6.29 Information provided to the Committee indicates that the incidence of road trauma associated with substance use has declined over the last decade. The introduction of RBT is a key factor in bringing about this trend, although it is possible that more needs to be done in regional areas to augment the effectiveness of RBT. The success of the RBT strategy depends upon the perception of being caught and the penalty applied once caught. Information referred to in the submission prepared by the Tasmanian Government suggests that RBT could be losing some of its value as a deterrent, though, and if this becomes established as a trend it certainly would warrant having another look at current RBT strategies.

6.30 The Committee treats as serious the issues surrounding drug driving but does not consider it has taken enough evidence on the matter to present an informed view about its relative importance in this interim report. The Committee looks forward to making a more complete investigation of the subject when it continues its Inquiry in the next Parliament.

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53 For example, Evidence, p. 143.

54 Austroads, *Drugs and Driving in Australia: First Report of the Austroads Working Group*, Sydney, 2000, pp. 28, 36.

7

Workplace Safety and Productivity

Introduction

7.1 Collins and Lapsley note that the workplace costs of drug abuse can be categorised as resulting either from absenteeism or reduced productivity in the workplace.[1] They go on to say that absences not associated with any health care services (the 'sickie') and reduced on-the-job productivity resulting from drug abuse proved impossible to quantify. With these caveats in mind, for 1992 Collins and Lapsley estimated that the production loss in Australia caused by all drugs was $9.2 billion.[2] The International Labour Organisation (ILO) has estimated that 20% – 25% of all occupational injuries are a result of drug and alcohol use, while 3% - 15% of fatal injuries are related to drug and alcohol use.[3]

7.2 The ILO statistics provide an indication of the impact that can be associated with substance use in the workplace. But there is another aspect of this – the impact that a person who abuses substances has upon others. As one witness told the Committee:

> I know there were days when my work came second – when I would spend the time talking to Amanda on her bad days and when I had to leave to put money in the bank for her, go and see

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1 Collins, D. J and Lapsley, H. M., 1996, *The social costs of drug abuse in Australia in 1998 and 1992*, AGPS, Canberra, p. 15.

2 Collins, D. J and Lapsley, H. M., p. 41.

3 Submissions, Vol 10, p2405.

her after distraught phone calls, go to hospitals, attend doctors or visit her in rehab.[4]

Health and Safety in the Workplace

7.3 The problematic substance user can affect workplace health and safety in a number of ways. These include creating a harmful environment, such as through tobacco smoking or carelessly disposing of needles and syringes, and creating an immediate danger to themselves or others through intoxication, such as when operating machinery.

7.4 General initiatives by governments to control tobacco smoking are outlined in Chapter 6. The Committee notes that specifically in relation to the workplace, the National Drug Research Institute advised that

> …smoking bans are prevalent across the Australian workplace and policy positions across government, business organisations, and employee bodies are congruent on this issue.[5]

7.5 The ACT Government claimed in its submission that 'non-smoking was the norm' in the ACT. An insight into their successful approach is revealed in the following passage:

> In the ACT, the widespread adoption of non-smoking as normal practice in workplaces, both voluntarily and as a result of an occupational health and safety code of practice, has been achieved by focusing on *where* people smoke rather than *whether* they smoke.[6]

7.6 The Public Health Association of Australia (PHAA) advised the Committee that there are benefits in having smoke-free workplaces. The PHAA argues that there is evidence to show that the adoption and enforcement of smoke-free policies reduces both the prevalence of smoking and daily consumption of tobacco by continuing smokers.[7]

7.7 The inappropriate disposal of needle and syringes can be a real issue for all employees. This is especially the case for those employees whose job it is to collect inappropriately discarded injecting equipment. As the Mayor of Fairfield City pointed out:

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4 Evidence, p 195.

5 Submissions, Vol 6, p 1373.

6 Submissions, Vol 9, p. 2252.

7 Submissions, Vol 10, p. 2437.

> We have had to put risk management strategies in place to protect our employees, including specialised training, providing specialised protective clothing and equipment, modifying work practices…and vaccinating staff against infectious diseases such as hepatitis A and B.[8]

7.8 The impact of alcohol and other intoxicating substances on the health and safety of the workplace, and by extension the loss of productivity, is clearly demonstrated in the ILO statistics noted above. Based on this impact, the Committee expected there would be a considerable body of local research about the impact on workplace safety and productivity. However, as the National Drug Research Institute pointed out, the issue of alcohol and other drugs (excluding tobacco) in the work place is under-researched.[9]

7.9 Perhaps this is why there were few illustrations of programs that seek to promote awareness about the hazards of alcohol and drug use in the workplace. Examples that were provided to the Committee tended to focus on programs in the building trades.[10] These programs extend to treatment facilities set up by the Construction, Forestry, Mining and Energy Union for its own members.[11]

Loss of Productivity

7.10 Dr Christine Murphy, General Manager, Employee Assistant Service, Northern Territory, informed the Committee that 1991 research indicated that the cost of alcohol to the Northern Territory community was $150 million per annum in relation to lost productivity.[12] A latter Northern Territory study estimated that lost productivity from excess alcohol use cost the Territory $400.15 million over a four-year period from July 1992. This was using a methodology that placed great weight on future lost productivity resulting from premature death.[13]

7.11 An individual may be less productive in the workplace through effects caused by the abuse of alcohol and other drugs before commencing or during work. As well as the loss of productivity by the substance user, the

8 Evidence, p. 593.
9 Submissions, Vol 6, p. 1373.
10 Submissions, Vol 8, p. 1634; Vol 9, p2253; Vol 10, p. 2447.
11 Evidence, p. 9.
12 Evidence, p. 682.
13 Submissions, Vol 6, p. 1373.

behaviour of a user might have a significant impact on the productivity of those around them who are concerned with that person's use. The creation of a challenging environment might also take place. For example, the Brotherhood of St Laurence operates The Cottage Centre opposite a high rise housing estate in Melbourne. Staff have had to respond to calls for help and are constantly picking up used syringes. As the submission expressed it:

> It is distressing for staff to have to work in this environment. To hear people yelling and arguing over drug deals, to watch paramedics attempting to resuscitate someone, aware that someone is close to death.[14]

Improving workplace safety and productivity

7.12 The Committee took evidence from many witnesses about the most appropriate way to address substance abuse in relation to workplace safety and productivity. Workplace drug testing, impairment panels and comprehensive drug and alcohol policies were all raised in the course of the Inquiry and will be briefly discussed below.

7.13 Workplace drug testing generated some debate with witnesses. The Festival of Light (FoL), for example, recommended to the Committee that:

> The Commonwealth Government should make Commonwealth funding of research, counselling, treatment and policy development relating to illicit drugs conditional on those responsible being subject to random urine or blood testing for illicit drug use.[15]

FoL representatives also raised the idea of legislators volunteering for drug testing to set an example.[16]

7.14 The New South Wales Users and AIDS Association outlined an approach based on the concept of impairment, where impairment panels are set up to monitor the workplace impacts of a range of impairment factors. The impairment approach caters for those whose impairment is a consequence

14 Submissions, Vol 5, p. 995.

15 Submissions, Vol 6, p. 1246.

16 Evidence, p. 397.

of factors other than drugs, as well as those whose drug use does not impact upon the performance of their work.[17] As one witness said:

> A lot of things can impair people, such as psychological issues, stress, tiredness, et cetera….It is very difficult to see how impaired someone is just by testing for the drug.[18]

7.15 Other witnesses stressed to the Committee that workplace alcohol and drugs policies should be incorporated into broader occupational and health policies, which might or might not include drug testing. The rationale for AOD policies is based on two arguments. First, the safety of individuals and their fellow workers is paramount. Second, such policies give people an opportunity to address their problematic substance use. As Major Brunt of the Salvation Army noted:

> …we would believe that early identification of drug and alcohol problems, and referral straight from employment to rehabilitation or counselling, would be a great cost saving exercise for the community, rather than waiting for people to be dismissed from their employment before they can actually seek some help.[19]

7.16 The Alcohol and Other Drugs Council of Australia (ADCA) believe that drug testing is essential in some situations where it affects occupational health and safety, but that such testing needs to be part of a very broad occupational health and safety program.[20] This view was echoed by Dr Christine Murphy, who told the Committee:

> We need to look at the bottom line to ensure that employers and organisations in the Northern Territory implement policy, not just testing, because we need to show them that on the bottom line, as we have in many years of occupational health and safety, good policy works.[21]

7.17 The importance of incorporating drug testing into a broader occupational health and safety policy was also emphasised by the Western Australian Network of Alcohol and other Drug Agencies (WANADA). WANADA also stressed to the Committee that there needs to be ownership by stakeholders; management should not impose these policies:

> There is again a sense of ownership within the workforce and that management adopt the comprehensive policies they are planning

17 Evidence, p. 655.
18 Evidence, p. 655.
19 Evidence, p. 453.
20 Evidence, p. 15.
21 Evidence, p. 683.

> and that their implementation involve all the stakeholders within that group.[22]

Conclusion

7.18 The Committee did not receive as much information in regard to substance abuse and workplace safety and productivity as it did for other areas. However, work such as that done by Collins and Lapsley reveals the enormous impact that substance use can have in the workplace. The relative lack of research and programming on workplaces may be one reason why the issue was not raised much before the Committee.

7.19 Another reason could be that there is inertia in the workplace, where the culture condones, or at least does not discourage, substance use. Major Brunt told the Committee that workplace programs have never been really supported in any great way,[23] and Dr Christine Murphy elaborated that:

> One of the things we see in workplaces is fridges full of alcohol. We go to workplaces and there is a culture in workplaces to indicate that you have your Friday afternoon drinks or you have your afternoon drinks. There is a real culture. We need to be looking at that in workplaces[24].

7.20 The Committee believes that more could be done to address the impact of substance use on the workplace. A drug and alcohol policy situated within a broad occupational health and safety policy would be a step forward. But it is not just up to management. As one witness said:

> It's about workers taking responsibility for fellow workers.[25]

22 Evidence, p. 135.
23 Evidence, p. 453.
24 Evidence, p. 683.
25 Evidence, p. 135.

Appendix A - List of submissions

1	Mr John Edge
2	Mr Geoffrey Grantham
3	Mr Ross Ollquist
4	Mr M Heuston
5	Mr Frank Robinson
6	Humanist Society of South Australia
7	Mr Phillip Dawson
8	Ms Carole Hubbard
9	Mr Martin Wurzinger
10	Mr Steve Liebke
11	Ms Ruth Strout
12	Mr Brian Clarke
13	Confidential
14	Mr Jim Sheedy
15	E D Webber
16	Mr Evan Thomas
17	Department of Obstetrics, Gynaecology & Reproductive Medicine
18	Mrs Beverley Hellyer
19	National Council of Women of Australia
20	Ms Sherron Dunbar
21	Tablelands Alcohol & Drugs Service
22	Confidential
23	Ms Denise Mullan
24	MOFFLYN
25	Country Women's Association of NSW
26	Dr Wendell Rosevear
27	Mr Duane Stanfield
28	Ms Betty Arrowsmith
29	Dr Andrew Byrne
30	Sisters Inside
31	Ms Bronwyn Barnard
32	Mr Mike Riley
33	Holyoake Tasmania Inc.
34	Mrs Pauline Whieldon
35	Australian Drug Law Reform Foundation Inc.
36	Confidential
37	Ted Noffs Foundation
38	Australian Drug Foundation
39	The Law Society of NSW
40	Confidential
41	Confidential

42 Mr Peter Beswick
43 The Salvation Army
44 Territory Health Services
45 Mr Steve Kendal
46 Mrs Kathleen Waters
47 Australian National Council on Drugs
48 Department of Chemistry, Materials & Forensic Science
49 Australian Bureau of Criminal Intelligence
50 Department of Health & Aged Care
51 National Organisation for Foetal Alcohol Syndrome & Related Disorders
52 Victorian Institute of Forensic Mental Health
53 Australian Federation of AIDS Organisations
54 Mental Health Council of Australia
55 Australian Olympic Committee Inc.
56 Aboriginal and Torres Strait Islander Commission
57 The Victorian Healthcare Association
58 Ms Lyn Roberts
59 Winemakers Federation of Australia
60 Caroline Chisholm Centre for Health Ethics
61 Alcohol and Other Drugs Council of Australia
62 Teen Challenge and InTouch Medical Centre
63 Ms Helen Daley
64 Toughlove NSW Inc.
65 Families and Friends for Drug Law Reform (ACT) Inc
66 Mr Bruce Taggart
67 Mr Trevor Barker
68 Ms Peta Blackford
69 Ms Rebecca Muldoon
70 Mr Strider
72 National Drug & Alcohol Research Centre
73 Australian Family Association
74 City of Monash
75 Catholic Women's League of Australia
76 Brotherhood of St Laurence
77 Toughlove South Australia
78 People Against Drink Driving Inc.
79 Mr Ben Heinecke
80 APESMA
81 Mr Owen Phillips
82 Mr Rick Langtree
83 Fairfield City Council
84 Ms Nola Harrison
85 Mr Paul Carew
86 Family Council of W.A.
87 Family Drug Support
88 National Woman's Christian Temperance Union
89 St. Mary's Convent
90 Mr Geoff Page
91 The Western Australian Network of Alcohol and other Drug Agencies
92 Caroline Chisholm Centre for Health Ethics inc.
93 AL-ALON FAMILY GROUPS (AUSTRALIA) PTY.LTD
94 Office of the Lord Mayor, Brisbane
96 SANE Australia
97 Society without Alcoholic Trauma Inc.
98 Health Insurance Commission
99 Mr Michael Blackwell
100 Festival of Light (South Australia)
101 Focus on the Family Australia
102 Youth Substance Abuse Service
103 University of New South Wales

104 Australian Association of Social Workers
105 Australian Healthcare Association
106 'Anxiety & Panic Hub'
107 Inner Eastern Melbourne Division of General Practice Ltd.
108 Young Women's Christian Association of Perth (Inc.)
110 Curtin University of Technology
111 Australian National Council on Aids, Hepatitis C & Related Diseases
112 Cancer Foundation of Western Australia Inc.
113 Australian Intravenous League (AIVL)
115 WA Drug Abuse Strategy Office
116 Dr Mal Washer MP
117 South West Healthcare
118 Adelaide University
119 The Anti-Violence Project
120 Australian Association of Christian Schools
122 National Aboriginal Community Controlled Health Organisation
123 Curtin University of Technology
124 Philip Morris
125 Health Consumers' Council WA (Inc)
126 Assisting Drug Dependents Incorporated
127 The Society of Hospital Pharmacists of Australia
128 NSW Users and AIDS Association
130 National Consortium for the Quality Use of Medicines in General Practice
131 The Hon John Della Bosca MLC, Special Minister of State
132 Tranquilliser Recovery and New Existence Inc.
133 Australian Medical Association Limited
134 Ms Judy Aulich
135 HEMP SA inc
136 Western Australian Government
137 Turning Point Drug & Alcohol Centre
138 Catholic Health Australia
139 OUTCARE Inc.
140 Logan Youth Health Service
141 Ms Jennifer Nosovich
142 The Australian Associated Brewers Inc.
143 Brisbane Youth Service
144 Australian Hotels Association
145 Commonwealth Department of Health and Aged Care
146 Australian Nursing Council Inc
147 Department of Education, Training and Youth Affairs
148 Tasmanian State Government
149 Commonwealth Attorney-General's Department
150 ACT Legislative Assembly
151 Pharmacy Guild of Australia
152 Australian Institute of Criminology
153 Australian Drug Law Reform Foundation Inc.
154 Granville Central
155 Odyssey House Victoria
156 South Australian Government
157 St Vincent's Hospital
158 Independent Winemakers Association
159 Public Health Association of Australia
160 Mr Michael Robinson
161 City of Newcastle
162 Commonwealth Department of Family and Community Services
163 W Toomer
164 Commonwealth Department of Transport & Regional Services
165 Drug Advisory Council of Australia Inc.
166 Victorian Government
167 National Council of Independent Schools' Associations

168 Dr John Gladstones
169 National Aboriginal Community Controlled Health Organisation (supplementary)
170 City of Perth
171 Ms Peta Blackford (supplementary)
172 The National Council of Women of WA
173 Independent Winemakers Association (supplementary)
174 Mr Michael Stojanovic
175 Advance
176 Advance (supplementary)
177 National Heart Foundation
178 Mr Ron Natoli
179 Accelerated Inner-Mind Healing Centre
180 South City 7-Day Family Medical Centre Pty Ltd
181 Aboriginal Drug & Alcohol Council
182 The Australasian Therapeutic Communities Association
183 Drug Advisory Council of Australia Inc.
184 Mr Alwyn Samuel
185 Canterbury Community Health
186 Mr Grant Cassar
187 Dr Les Drew
188 Ms Songsri Shinn
189 Ms Jan Robertson-McMahon, Wu Chopperen Medical Service, Cairns
190 Ms Isobel Gawler, Drug Advisory Council of Australia Inc. (supplementary)
191 Ms Jill Rundle, The Western Australian Network of Alcohol and other Drug Agencies (supplementary)
192 Ms Geraldine Spencer, Canberra Ash Incorporated
193 Dr Alex Wodak, Australian Drug Law Reform Foundation (supplementary)
194 Ms Maureen Steele, NSW Users and AIDS Association (supplementary)
195 Mr Terry Mott, The Australian Associated Brewers Inc. (supplementary)
196 Dr Aidan Foy
197 Ms Margaret McKay, Keep Our Kids Alive
198 Mr Nick Gill, Drug and Alcohol Services Association Alice Springs Inc.
199 Mr Dennis Young, DRUG-ARM
200 Mr Bob Aldred, Alcohol and Drug Foundation Queensland
201 Dr David Kavanagh, Royal Brisbane Hospital
202 Ms Rose Isherwood, Tablelands Alcohol & Drugs Service (supplementary)
203 Fr. Paul Sullivan, Alcohol Awareness & Family Recovery
204 Mr John Brodie J.P.
205 Ms Irene Fisher, Jawoyn Association
206 Mr Jeremy Davey, School of Psychology, QUT
207 Ms Debbie Kilroy, Sisters Inside (supplementary)
208 Ms Ann Roche, National Centre for Education and Training on Addiction (NCETA)
209 Mr Gordon Broderick, The Distilled Spirits Industry Council of Australia Inc
210 Mr David Huggonson
211 Ms Janice Jessen, Northern Territory University
212 Mayor Robert Watkins, Fairfield City Council (supplementary)
213 Ms Patricia Johnson
214 Mr Terry Murphy, Health Department of WA (supplementary)
215 Mr Graham Strathearn, Drug and Alcohol Services Council (supplementary)
216 Ms Kylie Jackson, Department of Health and Human Services (supplementary)
217 Ms Glenys Beauchamp, ACT Department of Health, Housing and Community Care
218 Mr David Wright, Department of Humans Services Victoria
219 Mr Paul Bartholomew, Territory Health Services
220 Mr Stephen Greenwood, Pharmacy Guild of Australia
221 Professor Ian Webster, Alcohol and Other Drugs Council of Australia
222 Mr John Della Bosca, NSW Health

B

Appendix B - List of Public Hearings and Witnesses

Monday 14 August 2000 – Canberra

ACT Government

Ms Frances Barry

Ms Glenys Beauchamp

ACT Legislative Assembly

Mr Michael Moore MLA - Minister for Health and Community Care

Alcohol and Other Drugs Council of Australia

Ms Caroline Fitzwarryne - Chief Executive Officer

Professor Ian Webster - President

Mr Wayne Smith - Policy Manager

Commonwealth Attorney-General's Department

Mr Ian Carnell – General Manager, Criminal Justice and Security Group

Ms Sheridan Evans – Senior Adviser, Law Enforcement Group

Mr Matthew Stephenson – Project Officer, Law Enforcement Group

Mr Andrew Hughes – Acting General Manager, National Operations, Australian Federal Police

Dr Alexander Gordon – Intelligence Adviser, Australian Federal Police

Department of Education, Training and Youth Affairs

Ms Mary Johnston – Assistant Secretary, Quality Schooling Branch, Schools Division

Department of Family and Community Services

Mr Peter Humphries – Business Manager, Centrelink National Social Work Team

Mr Ian Sharples – Director, Employment Strategies Section

Mr Ian Boyson – Director, Indigenous Policy Unit

Ms Jenny Bourne – Assistant Secretary, Youth and Students Branch

Ms Rosemary Delahunt – Executive Officer, Family Capabilities

Ms Robyn McKay – Executive Director, Family Capabilities

Mr Andrew Herscovitch – Assistant Secretary, Office of Disability Policy

Department of Health and Aged Care

Mr David Borthwick - Deputy Secretary,

Ms Cheryl Wilson – Director, Illicit Drugs Section

Department of Health and Aged Care

Ms Sue Kerr - Assistant Secretary, Drug Strategy & Population Health Social Marketing Branch

Mr Brian Corcoran - First Assistant Secretary, Population Health Division

Families and Friends for Drug Law Reform (ACT) Inc

Mr Brian McConnell - President

Mrs Marion McConnell - Member

Mr William Bush – Vice President

Federal Office of Road Safety

Mr Chris Brooks – Team Leader, Research Management and Strategy

Mr Vivan Mawhinney – Acting Assistant Secretary, Non Self Governing Territories Branch

National Drug & Alcohol Research Centre

Professor Wayne Hall – Director

Wednesday 13 September 2001 - Perth

Alcohol Advisory Council of WA

Mr Terry Slevin, Management committee Member

Cancer Foundation of Western Australia

Ms Denise Sullivan, Manager, Policy and Tobacco Program & Target 15

Cancer Foundation of Western Australia Inc.

Mr Michael M Daube, Chief Executive Officer

Curtin University of Technology

Professor Tim Stockwell, Director, National Drug Research Institute

Education Department of WA

Mr Richard Crane, Manager, School Drug Education Program

Health Department of WA

Mr Kevin Larkins, Director, Drug & Alcohol Policy Unit

Ministry of Justice

Mr Andrew Marshall

MOFFLYN

Ms Nova Fariss, Director, The Uniting Church in Australia (WA)

Ms Vivien MacLean, Administrative Officer

Mrs Sandra-Sue Nemaric, Family Care Worker

Ms Carole St George, Co-ordinator, Intensive Family Unit

National Drug Research Institute

Associate Professor Dennis Gray, Team Leader - Indigenous Research Program

Associate Professor Wendy Loxley, Deputy Director

Mr Richard Midford, Senior Research Fellow

OUTCARE Inc.

Mr Peter Sirr, Executive Director

The Western Australian Network of Alcohol and other Drug Agencies

Ms Jill Rundle, Director, WANADA

WA Drug Abuse Strategy Office

Mr Terry Murphy, Executive Director

WA Network of Alcohol and other Drug Agencies

Captain Michael Coleman, Executive Committee Member

Mr Chris McDonald, Agency Member

WA Police Service

Superintendent Murray Lampard, Executive Superintendent, Crime Investigations Support

West Australian Network of Alcohol and other Drug Agencies

Ms Jan Battley, Executive Committee Member

Tuesday, 21 November 2000 – Adelaide

Aboriginal Drug & Alcohol Council

Mr Geoffrey Roberts, Project Officer

Mr Scott Wilson, State Director

Australian Regional Winemaker's Forum

Mr Dominic Nolan, Executive Officer

Department for Correctional Services

Mr John Paget, Chief Executive

Department of Human Services

Dr Arthur van Deth, Executive Director, Metropolitan Division

Department of Education, Training and Employment

Ms Stephanie Page, Director Student & Professional Services

Drug and Alcohol Services Council

Mr Graham Strathearn, Chief Executive Officer

DrugBeat South Australia

Mrs Ann Bressington, Administrator

Mrs Kate Gosling, Representative

Festival of Light (South Australia)

Mr David d'Lima, Field Officer

Mrs Roslyn Phillips, Research Officer

National Organisation for Foetal Alcohol Syndrome & Related Disorders

Mr Dallas Dunn, Secretary

Mrs Lyn Flynk, Committee Member

Mr Graham Harradine

Ms Sue Miers, Spokesperson

Mr Tony Miers, Chairperson

Ms Kerry Zagni, Member

Public Health Association of Australia Inc

Professor Fran Baum, National President

SA Police

Mr Paul White, Assistant Commissioner of Crime

Toughlove South Australia

Mrs Mary Stephens, Secretary

Mrs Robyn Kemp, Representative

Mrs Janine Vanalopulos, Deputy Chairperson

Winemakers Federation of Australia

Mr Stephen Strachan, Policy Director

Mr Ian Sutton, Chief Executive Officer

Thursday, 23 November 2000 – Melbourne

APESMA

Mr Paul Gysslink, Professional Issues & Research Officer, Pharmacists Branch

Australian Family Association

Mr Bill Muehlenberg, National Secretary

Brotherhood of St Laurence

Ms Ainslie Hannan, Coordinator, Ecumenical Migration Centre

Mr George Housakos, Manager

Ms Angela Kyriakopoulos, Tenancy Worker, Rental Housing Support Program

Ms Margie Powell, Manager, Rental Housing Support Program

Mr Don Siemon, Acting Director, Social Action and Research

Caroline Chisholm Centre for Health Ethics

Ms Diedre Fethersonhaugh

Department of Human Services

Mr Ray Judd, Assistant Director, Drugs, Food and Health Development

Drug Advisory Council of Australia Inc.

Ms Isobel Gawler, Hon.Sec.

Focus on the Family Australia

Mr Bruce Challoner, National Manager, Education and Counselling

Mr Peter Tyrell, National Product Manager

People Against Drink Driving Inc.

Mr Donald Cameron, State Director

SANE Australia

Ms Barbara Hocking, Executive Director

South West Healthcare

Dr Rodger Brough, Drug and Alcohol Physician

Teen Challenge and InTouch Medical Centre

Mr Michael Hosking, D&A Counsellor

The Salvation Army

Major David Brunt, Territorial Programme Director, Drug & Alcohol Services

Mr John Daziel, Territorial Director for Information and Media

Turning Point Drug & Alcohol Centre

Professor Margaret Hamilton, Director

Victoria Police

Mr Bill Severino, Assistant Commissioner

Victorian Institute of Forensic Mental Health

Mr Michael Burt, Chief Executive Officer

Prof Paul Mullen, Clinical Director

Dr Michele Pathe, Assistant Clinical Director, Community Operations

Youth Substance Abuse Service

Mr Paul Hogan, Manager, Residential Services

Mr Paul McDonald, Executive Officer

Individuals

Mr Brian Collingburn

Ms Nola Harrison

W Toomer

Wednesday, 21 February 2001 - Sydney

Attorney-General's Department

Mr Bill Grant, Deputy Director - General

Australian Drug Law Reform Foundation

Dr Alexander Wodak, President

Commission for Children and Young People

Ms Gillian Calvert, Commissioner for Children and Young People

Department of Education and Training

Ms Eleanor Davidson, Executive Director, Student Services & Equity Programs

Drug and Alcohol Services

Miss Jennifer Rosewood

Eastern and Central Sexual Assault Service

Mr Mark Griffiths, Deputy Coordinator

Fairfield City Council

Mayor Robert Watkins, Mayor of Fairfield City

Family Drug Support

Mr Bruce Gordon, Member

Mr Thomas Havas, Volunteer

Mrs Karmen Hill, Volunteer / Member

Ms Elli Inta, Board Member

Mrs Lorrimer Jenkins, Volunteer

Dr Donald Matthews, Volunteer

Ms Faye Morritt, Board Member

Ms Penelope Stratton, Volunteer

Mr Tony Trimingham, Chief Executive Officer

National Drug & Alcohol Research Centre

Professor Wayne Hall, Executive Director

NSW Expert Advisory Group on Health

Professor Ian Webster, Chair

NSW Health

Dr Andrew Wilson, Chief Health Officer

NSW Police Service

Mr Clive Small, Assistant Director

NSW Users and AIDS Association

Ms Susan McGuckin, Information Officer

Ms Maureen Steele, Acting Co-ordinator

Mr Gideon Warhaft, Hepatitis C / HIV Support Officer

Office of Drug Policy

Mr Geoff Barnden, Director

Premiers Department

Mr Michael Hogan, Director, Strategic Projects

Regenesis

Mr Kevin O'Neill, Director

St Vincent's Hospital

Dr Steven Faux, Director, Rehabilitation Medicine

Ted Noffs Foundation

Mr Matthew Stubbs, Training and Research Officer

The Australian Associated Brewers Inc.

Mr Terry Mott, Consultant

University of Technology

Dr Michael Dawson, Senior Lecturer

Wooloware Branch of Liberal Party

Mr David Williamson, Delegate-NSW Council

Individuals

Dr Richard Crane

Ms Helen Daley

Dr Katherine Lennane

Mrs Lynette Roberts

Reverend Michael Robinson

Mrs Songsri Shinn

Mr Michael Stojanovic

Mr Evan Thomas

Mr Robert Walsh

Mr Ian Wilson

Friday, 20 April 2001 – Darwin

Aboriginal and Torres Strait Islander Commission

Ms Barbara Cummings, Chairperson

Alcohol Awareness & Family Recovery

Mr Paul Sullivan, Director

Amity Community Services

Ms Fiona Leibrick, Counsellor

AMSANT

Ms Pat Anderson, Executive Secretary

Dr John Boffa, Medical Adviser

Anglicare Top End

Mr Peter Fisher, Director

Mr Murabuda Wurramarrba, Manager

Australian Medical Association of NT

Dr Paul Bauert, President

Banyan House Therapeutic Community

Ms Denise Gilchrist, Director

Mr James Walker, Clinical Coordinator

Commonwealth Department of Health and Aged Care

Ms Leonie Young, Manager

Council for Aboriginal Alcohol Program Services Inc.

Ms Tarnikinga Kantilla, Community Based Field Worker

Mr Roger Sigston, Acting Director

Drink Driver Education (Katherine)

Mr Craig Spencer, Facilitator

Drug & Alcohol Services Association

Mr Nicholas Gill, Manager

Employee Assistance Service NT Inc.

Dr Christine Murphy, General Manager

F.O.R.W.A.A.R.D

Ms Barbara Mills, Alcohol Counsellor

Law Society - Northern Territory

Mr Jon Tippett, President

Northern Territory Aids Council

Ms Kitty Gee, Project Officer

Northern Territory Government

Hon Stephen Dunham, Minister for Health, Family & Childrens Services

Northern Territory University

Ms Janice Jessen, Lecturer, Alcohol & Drug Studies

Dr Bridie O'Reilly, Senior Lecturer

Top End Users' Forum Inc.

Ms Helen Vandenberg, Public Officer

Individuals

Ms Donna Kittel

Wednesday, 2 May 2001 - Brisbane

Alcohol and Drug Foundation Queensland

Mr Bob Aldred, Chief Executive Officer

Brisbane Youth Service

Mr David Clements, Drug Treatment Outreach Worker

Ms Leanne McLauchlan, Health Team Leader

Mr Michael Tansky, Director

Department of Premier and Cabinet

Mr Douglas Watson, A/g Director, Social Policy Unit, Policy Division

Drug Awareness & Relief Movement

Dr Michael Bolton, External Adviser

Mr Mitchell Dobbie, Queensland Manager

Dr John Roulston, Chair, Queensland Committee

Mrs Rowena Solomon, Intervention & Support Coordinator

Mr Dennis Young, Executive Director

Drug Free Alliance

Dr Albert Reece, Consultant

Queensland Health

Dr Kevin Lambkin, A / g Manager, Alcohol, Tobacco & Other Drug Services, Public Health Services Board

Queensland Police Service

Inspector Felix Grayson, Alcohol & Drug Coordination

Queensland University of Technology

Mr Jeremy Davey

Sisters Inside

Ms Debbie Kilroy, Director

Ms Anne Warner, President, Management Committee

Stonewall Medical Centre

Dr Wendell Rosevear, Director

The Woman's Christian Temperance Union of QLD Inc.

Mrs Marjorie Entermann

University of Queensland

Professor John Saunders, Alcohol and Drug Studies, Department of Psychiatry

Individuals

Mrs Peta Blackford

Mr Geoffrey Grantham

Professor David Kavanagh

Ms Jennifer Nosovich

Mrs Debra Sands

Mr Gary Sands

Mrs Pauline Whieldon

Monday, 21 May 2001 – Canberra

Alcohol & Other Drugs Council of Australia

Ms Caroline Fitzwarryne

Assisting Drug Dependants Inc.

Ms Elizabeth Skinner, Acting Director

Australian Association of Christian Schools

Mr Peter Crimmins, Executive Officer

Australian Association of Social Workers

Ms Jo Gaha, National President

Ms Sarah Hordern, National Policy Officer

Mr Tony Magers, General Manager

Mr Maurie O'Connor, General Manager

Australian Council of State School Organisations Inc.

Ms Penny Cook, Executive Officer

Ms Julie Roberts, External Representative

Australian Hotels Association

Mr Simon Birmingham, National Manager

Australian Institute of Criminology

Dr Adam Graycar, Director

Dr Tony Makkai, Director of Research

Mr Paul Williams, Head, Public Policy & Drugs Program

Australian Intravenous League (AIVL)

Ms Nicky Bath, Policy Officer

Ms Jude Byrne, Education Program Manager

Ms Annie Madden, Executive Officer

Australian Medical Association

Dr Carmel Martin, Director, Health Services Department

Ms Joanne Murray, Youth Health Advocate

Dr Bill Pring, Chair, Public Health and Aged Care Committee

Dr Kate Stockhausen, Senior Research Officer

Australian National Council on Drugs

Mr Gino Vumbaca, Executive Officer

Professor Ian Webster, Executive Member

Australian Nursing Council Inc

Ms Jan Fletcher, Overseas Assessment Manager

Mrs Marilyn Gendek, Chief Executive Officer

Catholic Women's League of Australia

Mrs Anne Rosewarne

Mrs Mary Uhlmann, National Bioethics Convenor

Families and Friends for Drug Law Reform (ACT) Inc

Mr Brian McConnell, President

Health Insurance Commission

Mr Peter Brandt, Manager - Compliance Branch

Mental Health Council of Australia

Mr Desmond Graham, Chief Executive Officer

Dr Carmen Hinkley, Policy Officer

National Aboriginal Community Controlled Health Organisation

Ms Lee-Anne Daley, Deputy Chief Executive Officer

Ms Helen Kehoe, Policy Officer

Mr Craig Ritchie, Chief Executive Officer

Ms Julie Tongs, Director

National Centre for Aboriginal and Torres Strait Islander Statistics

Dr Janis Shaw, Director

National Centre for Education and Training on Addiction (NCETA)

Ms Ann Roche, Director

Pharmacy Guild of Australia

Mr Denis Leahy, Program Manager

Ms Khin May, Policy Officer

Ms Wendy Phillips, Director

Toora Women Inc

Ms Jacqueline Pearce, Executive Director

Women's Information Resources & Education on Drugs & Dependancy (WIREDD)

Ms Bridie Doyle – Co-ordinator

Individuals

Ms Judy Aulich

Mrs Bronwen Barnard

Dr Leslie Drew

Mr Michael Gardiner

Ms Ann Gardiner

Mr Stephen Kendal

Mr Steve Liebke

Mr Geoff Page

Thursday, 14 June 2001 – Hobart

Alcohol and Drug Service

Dr Michael Crowley, Senior Clinical Psychologist

Catholic Women's League of Australia

Mrs Nicola Galea, Member

Mrs Betty Ann Roberts, Member

Mrs Marea Triffett, Member

Colony 47 Inc.

Ms Sue Ham, Chief Executive Officer

Commonwealth Department of Health and Aged Care

Mr Anthony Speed, A/g Assistant State Manager

Department of Education - Tasmania

Ms Esme Murphy, State Project Officer

Ms Kate Shipway, Director, Equity Standards Branch

Department of Health and Human Services

Ms Cecile McKeown, State Manager, Alcohol & Drug Services

Department of Justice & Industrial Relations

Mr Richard Bingham, Secretary

Drug Education Network

Mr Ron Mason, State Manager

Holyoake Tasmania Inc.

Ms Kim Churchill, Chief Executive Officer

Mr Michael Dixon, Board President

Ms Cheryl Shadbolt, Board Member

Launceston City Mission

Mr Tony Butters, Deputy Manager

Royal Hobart Hospital

Mrs Jennifer Boyer, Deputy Manager - Pharmacy

Ms Elizabeth Walker, Registered Midwife

Tasmania Police

Mr Jack Johnston, Deputy Commissioner of Police

University of Tasmania

Mr Raimondo Bruno, Researcher

Your Place Inc.

Ms Nell Ames, President

Ms Melinda Tonks, Manager

Individuals

Ms Katherine Howard

Ms Lucia Ikin

Mr David Jackson

Mrs Carolyn Jeanneret

Ms Denise Mullan

C

Appendix C - Informal consultations and inspections by the Committee

Friday, 9 June 2000

Alcohol and Other Drugs Council of Australia, Canberra, ACT

Australian Institute of Criminology, Canberra, ACT

Department of Health and Aged Care, Canberra, ACT

National Centre for Epidemiology and Population Health, Canberra, ACT

National Drug and Alcohol Research Centre, University of New South Wales, Canberra, ACT

Monday, 26 June 2000

Alcohol and Other Drugs Council of Australia, Canberra, ACT, Arcadia House Withdrawal Centre, Canberra, ACT

Karralika Therapeutic Community, Canberra, ACT

The Salvation Army Bridge Program, Canberra, ACT

The Ted Noffs Foundation, Canberra, ACT

Winnunga Nimmityjah Aboriginal Health Service, Canberra, ACT

Wednesday, 9 August 2000

Turning Point Alcohol and Drug Centre, Melbourne, VIC, Youth Substance Abuse Service, Melbourne, VIC

Thursday, 10 August 2000

Australian National Council on Drugs, Melbourne, VIC

Odyssey House Victoria, Melbourne, VIC

Monday, 14 August 2000

Al-Anon Family Groups, Canberra, ACT

Alcoholics Anonymous, Canberra, ACT

Narcotics Anonymous, Canberra, ACT

Monday, 11 September 2000

Cyrenian House (Rick Hammersley Centre), Perth, WA

Next Step, Perth, WA

Nyandi Prison, Perth, WA

Willetton and District Local Drug Action Group, Perth, WA

Tuesday, 12 September 2000

Aboriginal Advancement Council of Western Australia, Perth, WA

Alcohol Advisory Council of Western Australia, Perth, WA

Anglicare—Step One Street Work Program, Perth, WA

Cyrenian House (Rick Hammersley Centre), Perth, WA

Hearth (Wesley Mission Perth), Perth, WA

Hepatitis C Council of Western Australia, Perth, WA

Hills Community Support Group, Perth, WA

Holyoake—The Australian Institute on Alcohol and Addictions, Perth, WA

Independent Winemakers Association, Perth, WA

Life Long Learning Centre, Perth, WA

Local Drug Action Groups, Perth, WA

Mission Australia, Perth, WA

North Metro Community Drug Service Team, Perth, WA

Palmerston Association, Perth, WA

Palmerston Farm, Perth, WA

Perth City Mission, Perth, WA

Perth Community Drug Service Team, Perth, WA

Perth Naltrexone Clinic, Perth, WA

St Bartholomews House, Perth, WA

St Patrick's Care Centre, Perth, WA

Serenity Lodge, Perth, WA

Stirling Coastal Local Drug Action Group, Perth, WA

Swan Emergency Accommodation, Perth, WA

The Salvation Army Bridge Program, Perth, WA

Western Australian Network of Alcohol and other Drug Agencies, Perth, WA

Western Australian Substance Users Association, Perth, WA

Wednesday, 11 October 2000

Australian Institute of Aboriginal and Torres Strait Islander Studies, Canberra, ACT

Monday, 20 November 2000

Drug and Alcohol Services Council, Adelaide, SA

Kalparrin Community—Murray Bridge, Adelaide, SA

Lower Murray Nungas Club—Murray Bridge, Adelaide, SA

South Australian Police, Adelaide, SA

The Woolshed Drug Rehabilitation Community, Adelaide, SA

Wednesday, 22 November 2000

Australian Retailers Association (VIC), Melbourne, VIC

Department of Criminology, The University of Melbourne, Melbourne, VIC

Drug Policy Expert Committee, Department of Human Services, Melbourne, VIC

Lend Lease Retail, Melbourne, VIC

Melbourne City Council, Melbourne, VIC

Port Phillip City Council, Melbourne, VIC

Youth Substance Abuse Service, Melbourne, VIC

Wednesday, 6 December 2000

Department of Health and Aged Care, Canberra, ACT

Standing Committee on Communications, Transport and the Arts, Department of the House of Representatives, Canberra, ACT

Monday, 19 February 2001

Goulburn Correctional Centre, Goulburn, NSW

Liberty Christian Fellowship, Goulburn, NSW

Southern Health Area Service, Goulburn, NSW

Tuesday, 20 February 2001

ADRAcare, Fairfield, NSW

Cabramatta Youth Team, Cabramatta Community Centre, Fairfield, NSW

Fairfield City Council, Fairfield, NSW

Open Family Australia, Fairfield, NSW

The Salvation Army, Fairfield, NSW

Alcohol and Drug Service, St Vincent's Hospital Sydney, Sydney, NSW

Medically Supervised Injecting Centre, Uniting Church of Australia, Sydney, NSW

National Drug and Alcohol Research Centre, University of New South Wales, Sydney, NSW

Thursday, 22 February 2001

Alcohol and Drug Services Unit, Department of General Medicine, Newcastle Mater Misercordiae Hospital, Newcastle, NSW

Hunter Mental Health Services & Health Services Planning and Performance, Hunter Area Health Service, Newcastle, NSW

Newcastle City Council, City of Newcastle, Newcastle, NSW

The Salvation Army Bridge Program, Newcastle, NSW

Wednesday, 7 March 2001

Department of Health and Aged Care, Canberra, ACT

Wednesday, 4 April 2001

Townsafe, Fairfield City Council, Canberra, ACT

Wednesday, 18 April 2001

Banyan House, Darwin, NT

Darwin Correctional Centre, Darwin, NT

Don Dale Juvenile Detention Centre, Darwin, NT

Menzies School of Health Research, Royal Darwin Hospital, Darwin, NT

Thursday, 19 April 2001

Anglicare, Katherine, NT,

Centrelink, Katherine, NT

Jawoyn Association Aboriginal Corporation, Katherine, NT

Kalano Rehabilitation Facility—Rockhole, Kalano Community Association, Katherine, NT

Katherine Town Council, Katherine, NT

Katherine Women's Crisis Centre, Katherine, NT

Katherine Youth Net and Correctional Services, Katherine, NT

Kintore Clinic, Katherine, NT

Mental Health Services, Territory Health Services, Katherine, NT

RAAF Base Tindal, Katherine, NT

St Joseph's College, Katherine, NT

St Vincent de Paul Society, Katherine, NT

Somerville Community Services, Katherine, NT

Wurli Wurlinjang Aboriginal Health Service, Katherine, NT

Ms Sandy Bennett, Katherine, NT

Mr Kerry Bradshaw, Katherine, NT

Ms Jan Cole, Katherine, NT

Pastor James Cox, Katherine, NT

Ms Yiama Paterakis, Katherine, NT

Ms Marion Scrymjocw, Katherine, NT

Tuesday, 1 May 2001

Abaleen Detoxification Services, Brisbane, QLD

Alcohol and Drug Foundation—Queensland, Brisbane, QLD

Association of Independent Schools of Queensland, Brisbane, QLD

Drug Awareness and Relief Movement, Brisbane, QLD

Gold Coast Drug Council, Brisbane, QLD

GOLDBRIDGE, Brisbane, QLD

Goodna Youth Accommodation Service, Brisbane, QLD

Goodna/Ipswich Youth and Community Combined Action Association (operating `The Base' Youth Agency), Brisbane, QLD

Life Education—Queensland, Brisbane, QLD

Logan House Drug Rehabilitation Centre, Brisbane, QLD

Meeanjin Treatment Association, Brisbane, QLD

Queensland Intravenous Aids Association, Brisbane, QLD

St Vincent's Community Services, Brisbane, QLD

Schizophrenia Fellowship of South Queensland, Brisbane, QLD

Self-Health for Queensland Workers in the Sex Industry, Brisbane, QLD

The Salvation Army Bridge Program, Brisbane, QLD

The Salvation Army Care Line, Brisbane, QLD

The Salvation Army Youth Outreach Service, Brisbane, QLD

Wednesday, 6 June 2001

Department of Health and Aged Care, Canberra, ACT

Wednesday, 13 June 2001

Drug Education Network, Hobart, TAS

Risdon Prison Complex, Hobart, TAS

Tasmanian Poppy Advisory and Control Board, Hobart, TAS

The Link Youth Health Service, Hobart, TAS

Your Place, Hobart, TAS

Wednesday, 8 August 2001

Alcohol and Other Drugs Council of Australia, Canberra, ACT

Australian Associated Press, Canberra, ACT

Daily Telegraph, Canberra, ACT

Federation of Australian Commercial Television Stations, Canberra, ACT

Pophouse, Canberra, ACT

The Australian, Canberra, ACT

The Canberra Times, Canberra, ACT