COMMUNITY DRUG SUMMIT

HELD AT PARLIAMENT HOUSE
PERTH

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The CHAIR (Hon Fred Chaney): Good morning, ladies and gentlemen. Welcome to the first formal session of the Drug Summit. I invite the Minister for Health, Hon Bob Kucera, to speak.

Mr KUCERA (Minister for Health): Good morning, Mr Chaney. Thanks, everyone. What a wonderful sight and what a wonderful pleasure to be here this morning, particularly in the people's House. It is wonderful to see again that it is turned into the people's House this morning. I thank you most sincerely for all being here and in particular for devoting your time and expertise to one of the most complex social problems facing our community today. I apologise for my back to those good people behind me. The House is a bit of a sardine tin this morning.

With this summit, each and every one of you has a unique opportunity to move the drug debate forward, to educate, to inform and ultimately to recommend how we as a community tackle drugs in the future. With this summit, we have a historic opportunity to bring all sides of the drug debate together. This summit meets a key election pledge made by the Gallop Labor Government as a result of simply listening to the entire community. I therefore think it is entirely appropriate, as I have already said, that this debate is held in this place, in the House of the people, in your House.

The summit really is a reflection of the deep concern that we all feel as family members and friends for the growing illicit drug problem in our community. It is also a response to an almost universal view that our current approach to drugs is simply not good enough. Drugs and their social and health costs are increasing in our community. Western Australia has the second highest use of illicit drugs in this great country of ours, Australia. An estimated 21 000 adults have used heroin in the past year, including some 8 000 in this State who are heroin dependent.

Illicit drugs cost our community a billion dollars every year. May I just say on a personal note that it is the personal cost. One of the most tragic times I ever spent in my 35 years in law enforcement was a Christmas morning, telling a mother and father that their son had overdosed in a toilet in a back lane in Northbridge. I suppose in many ways that if one looks at those people who have worked in the drug scene, like anyone who has worked in the drug field, as I did for so many years, we have all been to the mountain. Many of us have watched people climb and fall. It is now time that you can look at conquering that mountain, quite frankly.

Coordinating this summit has been an enormous task. A great deal of information has now been collected and is before us in the form of issues papers and a large number of public submissions. The issues papers alone pose more than 160 questions that need to be distilled into workable resolutions for consideration at the end of the summit.

I look around at some of the faces and I see many friends that I have met over the 35 years of my journey. I also see some people who at times have considered me an enemy. It is great to have you all here today working towards the one common cause. As delegates you have only three and a half days to frame the resolutions that you will then vote on later this week. Given this situation, the Chairs, Hon Fred Chaney, Professor Elizabeth Harman and Jade McSherry, approached me a few weeks ago and suggested that more guidance was needed on what were the issues that the Government is seeking advice about.

In response, the Government has provided two things. First, it has provided the Government's own policy statements. These are presented as matters for your consideration. I will just repeat that - matters for your consideration. Secondly, there are some principles for consideration. Those things that the Government sees as guiding its actions are also provided. Again I say - principles for your consideration. In each case we are seeking your views and advice on the issues that they raise.

In outlining the matters for consideration, the State Government acknowledges that the deliberations of the summit and the development of any strategies need to occur in the context of the agreed national strategy of demand, supply and harm reduction.

There is a national strategy and, indeed, an international strategy. The issues that will be raised during the summit, which are outlined in the delegates' papers, include: the value of different early intervention and education strategies, particularly those directed towards young people in different age groups, socioeconomic, cultural and regional settings. The criteria to be used to asses the desirability or otherwise of emerging treatment and rehabilitation initiatives will also be considered. From my point of view, that is one of the most important criteria we are asking delegates to consider. It is time to stop telling the community which initiative is best, and it is time to ask what criteria will provide an initiative that will work.

The Government would like the delegates to examine the value of a heroin prescription trial and the value of supervising injecting facilities in the Western Australian context. Delegates will be asked to consider the desirability of reviewing the existing illicit drug law enforcement framework in WA, specifically the Misuse of Drugs Act. We would like delegates to consider changes to the State's cannabis laws including the decriminalisation of the cultivation of up to two plants, possession of up to 50 grams of marijuana and the use of cannabis by adults on private property, while ensuring that the trade in cannabis remains illegal. Delegates must consider also the value of drug courts, whether diversionary options should be expanded, and whether there is a need for secure and separate drug-fee treatment centres or prisons for drug-dependent offenders.

Delegates must consider and recognise the range and complexity of the principle causes for illicit drug use and, therefore, the need to take education, prevention, treatment and law enforcement initiatives into consideration. The health and wellbeing of children is of fundamental importance; therefore, support must be given to families to prevent or minimise the impact of illicit drug use. Recognition must be given to the particular needs of young people when dealing with illicit drug use. Illicit drug use poses particular challenges for indigenous people; therefore, culturally appropriate services are required. The special needs of regional and remote communities that deal with illicit drug use must also be recognised.

In many ways, this State is unique. The sheer size of our State is one of the things that makes us great; however, it also makes it difficult to tackle the illicit drug problem. Delegates must commit to protect all sections of the community from the adverse impact of illicit drug use. We must acknowledge the particular difficulties that illicit drug use contributes to and creates for our prison population. Policies must be developed using evidence-based information and all programs and services must be properly evaluated. A commitment must be given to ensure that the best value is obtained from the resources utilised in addressing illicit drug use.

Essentially, the Government is offering delegates a framework for consideration. Although these matters are presented for the consideration of delegates, the Government is also completely open to listen to the views of the community. During the week, delegates will have an opportunity to address those principles as part of their deliberations. Over the past four months, a great deal of planning has gone into the summit to ensure that all views are canvassed and that all voices are heard. This summit represents a unique opportunity to have those views heard by the Government. The Community Drug Summit has carried out extensive community consultations, including visits across the State. Many delegates are here today as a result of that consultation process. Forums were organised by various industry bodies and community groups to provide feedback to the summit. In total, more than a thousand people have given their views. The interest to become a delegate has been immense. More than 1000 applications were received for the 100 delegate positions that you all now occupy. Such was the interest that as late as yesterday the Community Drug Summit was calling on reserve members to join the debate.

During the summit each working group will develop five priority recommendations that will be voted on by a simple majority. This, along with the range of views expressed, will help to inform the Government of the weight and balance of community views.

The advice from this summit, along with input from the community consultation process, will be presented to the State Government by mid-September, and the Government will respond formally by 19 October. The Government's expectation is that this Community Drug Summit will deliver recommendations that can provide the basis of a framework for effective and comprehensive strategies to combat illicit drug use. This Government believes that if we are to develop effective strategies to deal with the problem, a bold and open-minded approach needs to be adopted. However, we must also build on those strategies that have worked and do work. We also need to maximise the benefits we get from the State Government's expenditure of some $51 million and the Commonwealth's expenditure of over $7 million on programs and services targeted at illicit drug use in this State.

Finally, I must say that this is a unique moment. There is no doubt that your deliberations will require courage, a willingness to listen and a preparedness to embrace change. Franklin D. Roosevelt was talking about a different battle at the time, but his words seem very relevant to me today -

> We . . . are passing through a period of supreme test. It is a test of our courage - of our resolve - of our wisdom . . .
>
> If we meet that test - successfully and honorably - we shall perform a service of historic importance which men and women and children will honor . . .

Your task is a very important one, and I believe history may view each and every one of you as part of a unique group of citizens. I wish you well, and I look forward to the outcome of your deliberations. Thank you.

The CHAIRMAN (Hon Fred Chaney): Thank you very much, minister. On behalf of the Chairs of the summit, I thank you for responding to our request that you assist us and the summit by advising us of the issues on which the Government seeks the advice of the summit. That will be of great assistance to the delegates in examining the matters that are of practical importance in how matters move forward.

We have all been told that it is a unique use of this Chamber for this sort of public deliberation. I think we are about to see another historic first. I invite Ben Taylor and Dr Richard Walley to provide a Nyoongar welcome.

TAYLOR, MR BEN,
Nyoongar Elder.

WALLEY, DR RICHARD,
Visual and Performing Artist.

[Mr Ben Taylor and Dr Richard Walley provided the Nyoongar welcome.]

Mr TAYLOR: I welcome you on to the dreaming track of the sacred Wagyl. For thousands of years Aboriginal people have roamed this country, the dreaming track of the Derbarl Yerrigan - the Swan River. It has always been religious culturally and spiritually in the creation of my people. I would like to say to the Chair and everyone that, as a Nyoongar elder who has been around for over 60 years and seen suffering among my people, I look sadly today on my people as I work with the Aboriginal Catholic ministry. We have buried so many young Nyoongar people because of drugs, overdoses, murders and assaults. It is very sad. I look back on my days as a kid on the old reservation of Walebing. We never had this problem. We were not even allowed to have alcohol because it was against the law in the 1905 Act. In closing, I say a prayer of healing for the Aboriginal people.

[Aboriginal prayer of healing.]

Mr TAYLOR: Our father God, mother earth is happy that you have come here to talk; later on we will walk. I know through my people, the Nyoongar people, who are attending today, and through Mr Kucera, the minister, that drugs are a big problem with all walks of life today, and I know that something will come out of this and that I will be a part of it so that I can pass it on to my people. Thank you.

[Didgeridoo was played.]

Mr WALLEY: This gathering is taking place on Karta Koomba, the Bidenjarreb Nyoongar word for Kings Park, the traditional the place of gathering for Nyoongars for many years. A lot of meetings have taken place in Kings Park and around this area to do exactly what we are doing now: identify problems. In a lot of areas, things have changed, but in a lot of other areas, things have not changed. We are still coming together to identify the problems of the day and to look for solutions for the future. It is also very ironic that we are having this gathering in this place, because we are seeking to find a common solution in a place of disagreement. It is amazing how the western culture has an Opposition that makes sure that it opposes everything that comes up, and that is its duty in a democratic system, whereas in our culture we sit down and all come to a consensus in a traditional form, and we earn our place in many different ways. In saying that, what you have done as delegates is you have earned your place to have your say in this circle of decision. My brother Ben and I, and all the Nyoongar delegates, are proud to be here today, and we thank you for your recognition that this is a spiritual domain of Nyoongar people. May the good spirit watch you while you have your meeting.

[Traditional Nyoongar welcome.]

The CHAIR (Hon Fred Chaney): Perhaps there is dual symbolism in what we have just seen; the symbolism of a welcome from the traditional owners of this country is important. It is noteworthy that even a few years ago such a welcome would not have been considered; that it is now a commonplace part of Australian ceremonial occasions is a reminder that things do change and can change. That is in the spirit of this meeting. We hope that the unsatisfactory situation in Western Australia regarding illicit drugs can change.

We are running well ahead of the program and I hand over the Chair to Professor Liz Harman to conduct the next session.

The CHAIR (Professor Liz Harman): Before I call on the speakers there is one small housekeeping issue to address. Speakers and delegates should be aware that the proceedings are subject to live audio and video feed. The sessions are monitored within Parliament House and by radio station 6PR and the ABC. The sessions are also on the summit's web site. Speakers may be heard or seen at any time. There are four cameras in this Chamber and the microphones are picking up the audio live feed. We are about 10 minutes ahead of the schedule. I suggest that speakers keep to the time limit of 20 minutes that they have been allotted, in order to give additional time for questions later in the morning.

I invite Professor Fiona Stanley, who is well known to us all as eminent in her field in child health research, to speak. Professor Stanley will speak on the topic of "Early Causal Pathways and the Benefits and Limitations of Early Intervention".

STANLEY, PROFESSOR FIONA,
Director, TVW Telethon Institute for Child Health Research.

Professor STANLEY: I have only 20 minutes for my maiden speech and I ask that delegates not take up some of my time by clapping. It is an honour for me to be here. I am not a drug expert. I want to do five things: I want to set the scene with some statistics about the appalling state of our drug scene. I suggest that drugs are just part of a wider problem; what I call the great disruption in Australian society. I want to talk about the importance of causal pathways and how they may be

interrupted, and the importance of data and evidence and how we can get it right. I want to leave with a very upbeat message. I do not have to tell most people here, who are experts in the area, of the situation in Western Australia regarding drug use.

I will not read out all the statistics on the slides but I will give a few examples: 38 per cent of Western Australian students use cannabis and 21 per cent use tranquillisers. As we know, the drug scene is a problem. We have the second highest overall rate of recent use of illicit drugs, and 36 per cent of young people in Western Australia have recently used an illicit drug. We have high rates of usage compared with the rest of Australia.

As mentioned by the minister, the costs are enormous. Behind the costs is the anguish we have that our children and young people are so dependent, damaged and truncated by this activity. Drugs are part of what I consider to be a much broader problem in society. The data in Australia shows a crisis in developmental health and wellbeing. There are rises in mental health problems, in behavioural problems in children, and complex diseases such as asthma and type 1 diabetes, the rates of which are trebling. There are problems in the educational sector with literacy, retention rates and truancy, and there are increases in learning disabilities and the rate of attention deficit disorder. There are rises in juvenile crime, as well as a drug and substance use epidemic. We are seeing a total crisis in developmental health and wellbeing. I will touch on a few statistics to demonstrate that.

From our own data we see that one in four Australian children has a significant mental health problem. The rate is identical to that in Canada, where similar surveys have been done. Over the past 40 years the rate of suicide for young males has quadrupled and the suicide rate for young females has doubled. This is the tip of the iceberg of mental health problems.

People cannot get good data on child abuse. Western Australian data show that the most important increase in irreversible brain damage - cerebral palsy - is from the "shaken baby" syndrome, child abuse and neglect. That is a very hard statistic. The next factor is increasing literacy disparity - the gap, at year 3 and year 5, in literacy standard between the highest and lowest socioeconomic groups in the community. There is an enormous gap by year 5, and it will translate into an even bigger gap by year 12. I am not a crime expert, but when I got these data out, the rates of juvenile crime stunned me. In 1974, young males committed 24 times more assaults than young females. By 1994, the ratio had been reduced to 4 to 1. Young females are not just victims of crime; they are also perpetrators. The rate of assaults committed by young males in comparison to adult males has doubled in the period of this data. These are stunningly increased rates of crime. Of course, many of them are drug related.

So what do I mean by "the great disruption"? Some interesting data I have had to summarise in one slide show what has happened in Australia over the last 30 or 40 years. Good things have happened - we are a wealthy, well-educated and globalised country. All of these great things are supposed to be trickling down to help our community. In fact, for many families in the community, those with the least resilience are the ones most affected by the figures I have displayed. We know about divorce, family conflict, violence and stress, work stress, child care and families in poverty. Children needing fostering have more behaviour problems at a time when fewer families are putting their hands up for the job of fostering children. And so it goes on: extended adolescent dependency, unemployment, addictions, inequalities in wealth, health education, access to information, insecure neighbourhoods, social isolation, environmental degradation, racist sentiments, individual greed and corporate wealth, which has not trickled down for the new under-class in Australian society.

After the change in the legislation in 1975, 48 per cent of marriages this year will end in divorce, if the trends continue. Just to show that you do not have to be Aboriginal to be in severe poverty, 20 per cent of Aboriginal children in Australia are in severe poverty, compared with seven per cent of whites, but if you are a sole parent with three or more children, you have an equal amount of poverty, white or black. Delegates will see the very high rate. People talk about the lack of poverty in Australia, and that the situation is improving, but this burden is huge for some families.

I will now talk about causal pathways. We concentrate very much on children, families and schools, but we forget that these things are happening in a neighbourhood which is enormously influenced by the larger structural, socioeconomic, political and cultural environment, in which these families, schools and neighbourhoods are trying to counteract this great social disruption. When we talk about early pathways and causal pathways, we must put it into that kind of context, because your solutions this week may come from that large context, not from just targeting the poor, marginalised families who are trying to do their damned best in a very difficult situation. Genetic factors really should be taken into consideration. A typical causal pathway shows drug and alcohol use, depression, drug dependency, suicidal behaviour, crime and other poor outcomes for kids. Many of these pathways are common, and there are things here which impinge upon early neurological development - brain development. Things that happen antenatally can have an influence, and then parenting comes into the picture. People are targeting parents a lot, but intergenerational factors often provide barriers for parents. We must not always target parents as being the only factor in the equation. Diet and nutrition in pregnancy and afterwards also plays a part. These factors last into primary and secondary school age. What is so exciting about looking at these causal pathways is that they open up many more areas where we can start intervening. At every stage along these pathways there is evidence of effective interventions. Interventions that are early tend to be much more effective and cheaper than those that are late, where you are almost close to the outcome.

Delegates should remember that when thinking about the issues they will be involved in. However, they should not neglect that this early time may be much more powerful and effective than later in the equation. This slide shows the causal pathway of the impact of white colonisation on Aboriginal health today. The pathway starts with colonisation, which cannot be reversed - Aboriginals cannot go back to a hunter-gatherer lifestyle. However, look at the things that might be done if the focus is on the end of the pathway. We know that smoking and alcohol, for example, affect low birth weight and ear disease in Aboriginal children. The worst thing we could do would be to go into an Aboriginal community and target marginalised, poor, uneducated Aboriginal mothers and say, "Stop smoking, because it is bad for your kids". What we must do is look at the factors around those adverse consequences - the things that occur earlier in the pathway - and start addressing those, because then change has really happened. That has been shown with the intervention that has occurred in Kalgoorlie and urban Perth. This is important to show that it is not just social environments that are bad for children. Otitis media in early childhood is on a causal pathway to drug use, low self-esteem etc. These factors are important very early on if we want to reverse the kinds of things that might happen.

The solutions and opportunities that I see value in are early intervention, and similar pathways to diverse problems. We have the potential to address and overcome problems if we have well-designed early interventions. Data and evidence are absolutely vital. I will talk about that point in a moment. Some early interventions are known to be harmful. It is extremely important to have evidence of effectiveness. The good early interventions that are proven may simultaneously address a range of conditions. The things that delegates might implement or want to implement to decrease drug abuse in teenagers may also improve educational outcomes, make those people more employable and make them healthier as adults and as good parents themselves. I show this slide to politicians - please take note Mr Kucera - because it shows not only the increase in the welfare-dependent age in our community, which everybody knows about, although they are not planning particularly well for it, but also welfare-dependent young people. There is an increase in the number of young people who are committing crime, are on drugs and are unemployable. We must do something about reversing this trend if we want this group in the middle - the competent Australians who are in the work force - to support this trend. You can talk about innovation until the cows come home, but if an innovative work force is being dragged down by a welfare-dependent group of young people, we will not get very far.

I will finish by talking about the importance of data and evidence. The slide in front of delegates shows the very simplistic "world according to Stanley" about how research activities that will make a difference to young people should be run in our institute. We start off by looking at what is happening in terms of low birth weight, drug use and young people in schools. It is important to get the data and find out what is happening. The second step is to find out the important targets and markers of that; what are the important risk factors and in whom are they occurring? Then we ask whether there is evidence of an effective intervention that will prevent this problem. If there is, go for it - encourage implementation. If there is not, do not do it. Go and do research, so that you can get to a "yes" situation. Do the research - find out and trial it. People forget the meaning of "trial". "Trial" means an experiment to see whether something works. It does not mean that a heroin trial will be here forever. It is a trial; it will give an outcome and evidence. If it does not work, do not do it. If it does work, implement it. Then you go back to your database and ask, "Has it made a difference?" Get the data to show that it has made a difference and then you can say, "If it has made a difference, was it our intervention that did that." If it has not made a difference, perhaps we were wrong. Perhaps it was not effective or properly implemented. Get this cycle going; then you will be able to make a difference in this community.

I will give two examples of complex social problems that affect our community, but in which Australia leads the world. The first is HIV AIDS and the second is road traffic accident deaths. Australia is lauded as the world's best in these two incredibly important social problems that have affected us in the last several decades. I love this slide, because it shows that we are winning the fight against HIV. We have maintained a fall in HIV. It has been contained in the homosexual population and has not spread greatly into the heterosexual or drug populations. Australia is leading the world in that. The slide indicates the road accidents in Australia decreasing at a time when car usage doubled. It also decreased in young people as well as old people.

What were the attributes of success with these programs? The answer could be the basis of what delegates might want to think about. The first was political leadership. The next was a totally bipartisan commitment to the control and eradication of these problems. The other was fear. There is no doubt that HIV-AIDS - I should not say scares the pants off people, as that is perhaps inappropriate - scared people to death. It scared them to do something about it and scared them to put aside their political and other divisiveness to say, "We want to solve this problem for our people"; it was the same with road accidents. We need to get data into the community to demonstrate to people that this is a problem we need to work for. I loved the fact that the policy was driven by a research agenda and the research drove a policy agenda. In other words, all the virologists, the HIV people, the road traffic accident people and all the people doing research, such as those in our institute, were driven by the need to implement effective policy. It was incredible that research was being driven by a policy need; and that is what happened. There was evidence of the effectiveness of interventions. People made mistakes. However, people decided they would intervene and would monitor what they did. They experimented and found an effective path forward. We did things that were unable to be done anywhere else in the world. For example, we were one of the first places to introduce needle exchanges and to put explicit condom usage on television, which would never happen in America because, of course, they do not have sex in America under the age of 20! An incredibly important part of that path forward was the data gathered to monitor impact, progress and whether we were making a big difference.

I remember as a member of the HIV council fighting to conduct anonymous testing of antenatal specimens to see whether in fact HIV had got into the heterosexual population. People opposed that because anonymous testing might bring up some positives. In the end, it was done and it showed hardly any transfer into the heterosexual population, which was a fantastically important thing for us to know. There was a massive injection of commonwealth and state funds. Usually federation is a barrier to good things in Australia, but what was phenomenal was that state and commonwealth

cooperation was fantastic. That injection of funds resulted in the States being brought in to deal with the problem. I guess that is a lesson we can learn from, too.

In conclusion, I want to say that we have a problem in this State. We have data but we must continue to get the data on illicit drug use among young people. It is a growing problem with a high personal and social cost. Increasing drug use is one of the many indicators that point to an escalating crisis in developmental health and wellbeing in Australia, which we want to address in a larger, political, social and economic context; otherwise, in my opinion, we will not get there. We need to work to identify the causal pathways, which have demonstrated such powerful, negative influences on young people and our society. We are complex people. We live, work and interact in complex ways. However, we must identify the important causal pathways to the poor outcomes and to good outcomes so that we can start to work on them. This work should inform effective interventions and strategies which then need to be tested, because there is powerful evidence that these strategies work very early in pathways. However, we must do that in an Australian and Western Australian context to see how they can be used most powerfully to help our youth. Thank you very much.

The CHAIR (Professor Liz Harman): By the applause, delegates have acknowledged the extent to which Professor Stanley has set us up extremely well for the coming week with a rich, informative and data-driven approach to the summit.

I shall now call on Mr Torgny Peterson who will speak on the Swedish approach to illicit drugs, benefits and limitations. Mr Peterson is Director of the Hassela Educational Foundation in Sweden. I know, from speaking to him last night, that he is en route between different international locations to speak about the Swedish experience.

PETERSON, MR TORGNEY,
Director, Hassela Educational Foundation,
Sweden.

Mr PETERSON: Thank you very much for the invitation. I am very pleased to be in Western Australia. It is my second time in Perth. I would like to tell the summit a little bit about what we are doing in Sweden. I do not intend to introduce myself because I will lose a lot of time. I have only 20 minutes, which is not very much if I am to elaborate on what is happening in Sweden.
Speech Continues...

The Swedish drug policy is well known. Some people love it; others hate it. The basis for the Swedish drug policy, which is a bipartisan commitment, is that there are no hopeless people, only hopeless situations. It is easier to change a difficult situation early, which is why we work as much as possible with young people. Most of our effort goes towards helping young people and changing the situation for families with young people.

I hear much in this country about harm minimisation, harm reduction and risk management. Those words have a completely different meaning in our country. We would not regard heroin distribution, heroin injecting rooms or low-threshold management programs as harm minimisation or harm reduction, but as harm production. It would be political suicide in Sweden to propose a heroin distribution program or the mass distribution of syringes. Why? For the part 35 years, there has been bipartisan agreement on the desire to keep illicit drugs out of Swedish society. That has been the policy of the Swedish Government for years. Believe it or not, it does not matter if there is a change of government - whether to a left-wing, conservative or liberal government - the drug policy does not change.

The official policy document is available on the Internet. Unfortunately - or fortunately, depending on how one looks at it - I will not show any overheads. Everything I am talking about can be

accessed over the Internet. I will be here today and tomorrow, and I am happy to provide people with all the information. However, at this stage, I prefer to give an overview rather than details.

The Swedish Government's policy says that the overriding aim of creating a society free from drugs is to be seen as reflecting society's attitude on narcotic drugs. The aim conveys the message that drugs will never be permitted to become an integral part of society, and that drug abuse must remain unacceptable behaviour and marginal phenomena. That overriding aim indicates the direction of Sweden's drug policy. It was written by the Government and presented to the United Nations' 1998 summit on drugs. That is the direction we work towards. Consequently, there is no way that our country would legalise drugs. According to our law and system of government, anything involving drugs, including use of drugs, is a criminal offence. That does not mean drug users are put into prison. I do not believe that an active drug user should be put into prison. Instead, he should receive treatment. Some countries put too much emphasis on imprisonment. The United States, for example, stresses the need to put people in prison. I do not believe in that at all. I believe that treatment should be the number one goal for those already involved in drug use.

Of course, prevention of drug use is the most important thing, and that should start as early as possible. We must remember that heroin addicts in this town or in Stockholm were not born drug addicts. Something has happened along the road, be it a family or financial situation or involvement in a gang. It could be almost anything. No two people experience the same situation. In Sweden, we try to have a comprehensive view of the situation and make an impact as early as possible. That can be done in various ways.

I will tell the summit a little about the treatment possibilities in Sweden. The basis of all treatment for youngsters and adults is its voluntary nature. However, we also have a provision for compulsory treatment. If a young person of 16 or 17 years of age is using heroin and is posing a serious problem to himself, herself, his or her family or society at large as a result of criminal acts or lifestyle, the Swedish social welfare system can launch an investigation. This is not a criminal procedure; it is a social-administrative procedure. After the situation has been discussed with the youngster, parents, friends and perhaps the employer - everyone who has any connection with this youngster - the investigation will be brought before a civil court, at which a lawyer or a judge will decide whether it is a case for compulsory treatment. If it is, the young person will be transferred to an institution, which could be run by the State or a private organisation, for compulsory treatment. The treatment duration is always six months. That is not to say that it must go on for six months. If positive things happen after two or three months, it could turn into voluntary treatment. However, if continued compulsory treatment is required, the treatment can be extended for another six months. This measure is referred to as the "LVU law". Foreigners often think I am saying, "I love you." In a way, this LVU law is a way of showing love.

Many people think that it is a sign of freedom to use heroin. In my opinion, being a heroin addict has nothing to do with freedom - it is a compulsory way of living. When we refer to compulsory treatment and heroin addiction, we are referring to two different forms of compulsory behaviour. I do not have a problem with using this law if necessary. I would rather do that than see a young person die of an overdose. This is not a very controversial issue in Sweden, although it might be here. It is an option we have and it might be interesting to consider it here.

Why do we have the situation that exists in Sweden today? We had a huge alcohol problem in the nineteenth century. Many employees were paid on Saturdays with alcohol to keep them quiet and to ensure that they did not form trade unions to demand better salaries. It was a way to keep people in their place. Similarly, giving drugs to a drug addict is the best way to manipulate that person. If one wants a drug addict to do something, one can simply control the supply of drugs. The drug dealers are in charge, not the drug users or addicts. That is the case regardless of who distributes the drugs - the drug dealer or the State. The person or organisation in charge of the drug is in command.

The people being paid in alcohol in Sweden many years ago realised that they were being fooled, so they started to object. They said, "We don't want alcohol. We want proper education for our children and proper salaries. We want to become productive members of society." Many Swedish non-government organisations were formed at the end of the nineteenth century. They have been carrying on the work. First, they used to work primarily with alcohol, but today about 15 organisations are extremely active counteracting the use of illicit drugs and setting up institutions for young people who are using drugs - not only alcohol but also illicit drugs. These NGOs in Sweden are very powerful. We have a lot of communication with the Government and it would be very difficult for the Government to change direction without consulting all these various organisations. This has resulted in political consensus over party-political borders about the direction of this drug policy. In 1965 we had a trial with the distribution of drugs to drug users - which was a complete failure in Sweden - until 1967, when it was terminated after two girls died from drugs having been distributed from this trial, when everything was changed and we went back to a more restrictive drug policy. People called this drug policy repressive, but it was not repressive. Repressive is when people are put in prison for using drugs, which we do not do. I would call it a restrictive drug policy, which means we do not want drugs to become an integral part of society.

Has this present drug policy been effective - yes or no? If we look at Swedish drug use today and compare it with that in other countries, Swedish drug policy has been quite effective. The most clear evidence that one can look for if one is interested in finding out more about European drug policy is this report called the Espad report, which contains comparisons between drug use in 30 European countries. The good thing about this report is that it is based on exactly the same questions being asked in the same way of the same age groups and school kids in these countries. I will be around and I will tell delegates more about this afterwards, if they are interested; I do not have time to go through this book in 20 minutes. I will read a few lines about the Swedish situation -

> The proportion of Swedish students who had been drinking any alcohol during the last 12 months is equal to the average of all ESPAD countries. However, the proportion reporting drunkenness during the same period is higher than average. The lifetime prevalence of smoking cigarettes is about average in Sweden, while the proportion of students who have smoked during the last 30 days is somewhat below. Use of marijuana or hashish is reported by 8 per cent, which is half the average of all countries in the ESPAD report, as is the proportion reporting use of illicit drugs other than cannabis. The proportion of students who have used inhalants is close to average and so is the proportion reporting use of tranquillisers or sedatives without a doctor's prescription. Use of alcohol in combination with pills is more common in Sweden than the average of all countries.
>
> [Quote not verified.]

So what can we learn from this? If we compare the use of alcohol and illicit drugs in Sweden, alcohol is a much bigger problem than illicit drugs. We have roughly 5 500 alcohol-related deaths in Sweden, and the number of drug-related deaths would be roughly 250. Many people say that 250 people dying from drug overdoses is very high. Look at the Netherlands, some people say, where only 35 people died from drug-related deaths, which means that Swedish drug policy is not as good as the Dutch drug policy. I want to make it perfectly clear when we are talking about drug-related deaths and looking at statistics that we compare what is happening in Sweden with what is happening in the Netherlands, in Switzerland, in France, or any of these countries, because the criteria to measure drug-related deaths are different. This is a major problem. When we are talking about almost anything that has to do with statistics, to be able to compare things we need to know what we are talking about - are we talking about the same thing? I will give delegates another example. When we talk about drug addicts in Europe, what is a drug addict?

In the Netherlands a drug addict is somebody who uses heroin; in Switzerland it is somebody who uses cocaine or heroin and in Sweden it is somebody who injects any illicit drugs, or uses cannabis on a regular basis. It is very important to know these differences when comparing statistics between various countries. A very interesting report that I received before I came here, and that I recommend everyone read - especially as Dutch people have been involved in writing it - is titled "The Drug Policies of the Netherlands and Sweden: How do they compare?" This makes interesting reading. It confirms what I have been saying, that it is extremely difficult to compare countries due to the fact that the criteria for comparisons are so different. I agree with Professor Stanley who said that we need scientifically based material when we make decisions for future interventions. I urge everyone not to use information from Europe that they cannot confirm. People should not listen to hearsay or wishful thinking; they should carefully check their sources, otherwise they might end up in blind alley and their information may be completely wrong. I do not think that it is possible to copy a drug policy from one country to another. However, during this week, if people find anything that they think would be useful to steal from Sweden, please feel free; we will not object to that.

Drug use in Sweden today is primarily about cannabis and amphetamine use. Our use of heroin is much smaller than it is in this country. Heroin is not such a big problem. Cannabis use is on the increase. Amphetamines have been around for many years; they are the typical Swedish drug. We notice today that the influence from other European countries, the worldwide discussion about decriminalisation and the possibility of a more tolerant attitude in our drug policy has had some impact on young people in our country. However, the official policy of the Swedish Government is to keep its restrictive drug policy. The present ministers for justice, and health and social affairs, do not intend to change their policy. On the contrary, we expect more funding and more staff to be able to develop the restrictive drug policy.

I believe in learning by doing. I would like to invite people from Western Australia to apply for two scholarships: one is for an active heroin addict; the second is for anyone in this room, or anybody who is not a drug user, who would like to come to Sweden for one year. This is a scholarship, so everything is paid for. You will have an opportunity to participate in programs for young people, because that is our primary work. You would have to cover the airfare, but apart from that everything is covered and you will receive a monthly allowance of $A1 200. We hope that this may increase the interests of international cooperation. As we all know, drugs know no borders. We need local, regional, national and international cooperation.

This was a very brief overview of what we are trying to do in Sweden. I will be around today and tomorrow - I am leaving on Wednesday morning - so please feel free to contact me and I will be happy to answer any questions that I can.

The CHAIR (Professor Liz Harman): I compliment all our speakers so far for the discipline they are showing with the program. Minister, did you wish to respond to the offer of the scholarships? It seems an absolutely wonderful one.

Mr KUCERA: I think we would take that up - not the politicians, I might say. I thank you, Mr Hosek, most kindly.

The CHAIR: I wish to draw all the delegates attention to page 9 of our program. In the interests of maintaining 20 minutes available to our speakers, I am not rehearsing all of their experience and all of the background that has led the summit organisers to bring here to the table today such eminent speakers. Delegates can find the details of the background that Mr Peterson has brought to bear in talking about the Swedish experience. I now invite Mr Martin Hosek, who is from the Swiss Federal Office of Public Health, to speak on the Swiss experience in drug strategies and evaluation of practice.

HOSEK, MR MARTIN,
Swiss Federal Office, Public Health.

Mr HOSEK: Ladies and gentlemen, first, I say thank you to the organisers of the summit for the invitation to a Swiss representative, thus giving me the opportunity of explaining to you the drug policy of our country. Ours is the other country in Europe that starts with S after Sweden. We have a drug policy that is slightly different to the one in Sweden. I will try to give an overview of that in the next 20 minutes.

At the end of the 1980s, Switzerland was confronted with a growing drug problem, manifesting itself especially by people consuming heroin. The fast spread of HIV-AIDS among drug users led to growing death rates. In some cities the misery of the drug addicts became visible to everybody by the phenomenon of the so-called open drug scenes. The Swiss Government, convinced then that concerted action was needed, adopted in 1991 a policy based on a broad national consensus and good cooperation at all levels of administration, the so-called fourfold approach.

In my contribution to this summit I would like to show you the factors that made our pragmatic drug policy necessary and possible, tell you something about the four strategic elements and roughly inform you of the services and programs that reflect that policy. Towards the end I will show you some figures that illustrate the impact and the results of the fourfold approach policy.

In comparison to Australia, Switzerland is that small thing all of you can see on the slide. On the same scale as Australia it seems really very small but that does not mean that drug addiction is a smaller problem than in Australia. Switzerland is situated in the middle of the European Union without being a member. It has boundaries with five neighbouring countries. The borders are quite difficult to control, which makes Switzerland an excellent destination for drug trafficking. It has about seven million inhabitants and a political system that is based to a large extent on consensus and compromise. The result is political stability but also slowness of all changes. Our seven ministers who form the Government are not elected by the people but by the Parliament which grants the four leading political parties at least one seat each. The Swiss political reality therefore is not based on two major political forces, one being in power and the other in opposition, but rather on a multiparty system where power and influence are shared.

The drug policy in Switzerland was not developed all at once in some Cabinet or commission; it has taken shape over several years. In this process the bottom-up influence was probably more determining than the top-down input. The process itself was often enough a struggle causing considerable controversy at some time.

The first factor that influenced the establishment of the drug policy as it exists today was the human immunodeficiency virus epidemic. In middle of the 1980s, it was a shock to realise how the population of drug users was being affected by that epidemic. Drug-related prostitution meant a growing danger of HIV infection for the non-drug addict population through the clients of prostitutes.

Another determining factor was the existence of the so-called “open” drug scenes. News about them even reached the English speaking part of the world through some popular US television news programs that referred to “needle park” in Switzerland. Zurich and other smaller cities were confronted with the drug problem and that had a great influence on the public debate. It forced people to recognise something with which they hoped they would not have to deal.

The cities, not the national Government, were confronted with the drug problem in the first instance. Therefore, the cities put pressure on the cantons and the Government. They said that they were not able to deal with the problems and that they could not solve the drug problem of the nation, as thousands of drug addicts flocked to the cities. The instruments and tools available to the cities to deal with the problem were not sufficient. They had to be allowed to try new approaches

and, if necessary, to amend the law. Local politicians and professionals applied significant pressure to the national Government and administration.

At the beginning of the 1990s the national authorities developed some leadership. Today this leadership is recognised and plays an important role in the implementation of the federal drug policy. The main task of the federal administration is to coordinate activities, to make information available, to moderate between different opinions, to promote research and evaluation and to supervise closely the practice of heroin assisted treatment - the so-called heroin prescription. Above all, it was essential to have a clear commitment from the national Government to carry out the tasks I mentioned earlier. Last but not least, public debate and public support were also important factors that influenced the current drug policy.

Switzerland is unique because it votes four times a year on specific national, regional and community issues. These democratic rights were determining factors for the consolidation of the drug policy in Switzerland. Between 1997 and 1999, Swiss voters were called to the polls for three popular votes on drug policy. The first of these initiatives asked for a restrictive drug policy aimed at restricting the type of treatment that could be offered to drug-dependent people that was exclusively and directly aimed at abstinence. That would have meant the end of the needle exchange programs, many methadone programs and heroin-assisted treatment. In September 1997, about 70 per cent of the voters turned down that proposal.

One year later, another proposal, which came from a totally different political background, suggested that the opposite policy be adopted. It suggested that drugs should be available, more or less, to anyone who wanted them. Seventy-three per cent of Swiss people voted against that proposal. A third referendum was held, in 1999, on heroin-assisted treatment. Parliament passed a Bill to make heroin prescription available on a regular basis. Since this new type of treatment was no longer in the trial or scientific experimental phase, the law had to be amended in order to continue the offer. A group of conservative politicians disapproved of that decision and called for a referendum. However, 54.5 per cent of the voters were in favour of the continuation of heroin prescription.

I will tell delegates about some guiding principles of the four-fold approach. Pragmatism is probably one of the most important guiding principles of drug policies in Switzerland. Once one accepts that it is a question not of ideologies and religious beliefs but, rather, of what works in the field, one can begin to reflect upon possibilities of change.

Consensus at a political level, within the population and between the various professionals involved is of great importance. How do we reach consensus? It is not easy and it can never be taken for granted. It must be worked upon all the time, and we need to seek cooperation, even if the differences of opinion seem unable to be breached at the beginning.

Evidence is another guiding principle. We are systematically carrying out research projects that review the outcome of abstinence-oriented therapies. There was a big research project on heroin-assisted treatment, a national evaluation of the implementation of drug policy in Switzerland over the past 10 years, and many smaller projects on specific aspects. We also tried to bring attention to the results in the political arena, since it is very important to provide facts and figures to decision makers.

The last point in the slide that is now being shown is innovation. Several programs and projects that were of an innovative character at their time have already been mentioned. The first safe injection room was created in the city of Bern in the last 1980s. Low-threshold facilities for drug addicts were established a few years later. The first needle exchange program in the city of Zurich faced strong opposition in the beginning. Heroin-assisted treatment was definitely an approach that was considered quite innovative and daring, since a lot of controversy surrounded it at the time. The fourfold approach in Swiss drug policy is built on prevention, therapy and rehabilitation, harm

reduction and repression. Switzerland is reputed to have a quite liberal drug policy, but half the money spent on drug issues at all levels is still spent on repression - police forces - and control.

The prevention programs have been developed enormously in the past 10 to 15 years. Today, health promotion approaches play an important role in prevention. The promotion of life skills, the empowerment of children and the solving of conflicts are essential. Schools strive to become settings that promote health and provide a nurturing environment for children. We work together with schools and try to involve families. We consider the overall activities in the school as a health promotion approach, which tries to be as extensive as possible and which addresses specific risk behaviour, rather than focuses on the various substances and drugs.

Our office has also implemented a big project with sports associations. We have just started a national research project on early intervention. It supports children and youth who have problems at school and who show signs of risk behaviour. The project helps the youngsters to overcome the underlying problems. Of course, drugs are often an issue, but are rarely the only problem. The research protocol of this project should evaluate what kind of intervention is able to stop negative development and how young people can be enabled to deal with their problems in a more constructive way.

The field of therapy and rehabilitation has seen considerable changes since the late 1980s. In those days, the focus was exclusively on abstinence-oriented residential therapy and rehabilitation. Today we have about 1 800 treatment slots for residential therapy. By now, the largest portion of the treatment offered is methadone substitution. About 16 000 people, or 56 per cent of the estimated 30 000 problematic users of hard drugs in our country, benefit from substitution with methadone dispensed in outpatient clinics by general practitioners or in pharmacies. Methadone programs were widely extended as an answer to the AIDS epidemic and to the open drug scenes.

The most recent development is the heroin-assisted treatment that started in 1994. Even though it has drawn a lot of attention in past years, heroin-assisted treatment is available for about only 1 200 drug addicts in Switzerland in highly regimented outpatient clinics. This represents four per cent of the estimated number of drug addicts. I point out that we do not see heroin prescription as a first step toward legalisation, as has been mentioned by opponents of the trial and the treatment. We use heroin as a form of bait for addicts who, for 10 or 15 years, could not sustain treatment and now, through the provision of heroin, can get into a treatment plan and obtain psycho-social counselling; that is, medical and psychiatric treatment. I can produce more figures on the treatment later.

Outpatient treatment without substitution is often provided by social workers or psychologists and psychiatrists. About two-thirds of our drug addicts, about 21 000, are currently receiving some form of treatment. Our harm reduction approaches have been developed since the late 1980s as an answer to the rising death rates among drug addicts because of the spread of HIV and AIDS. The first large-scale harm reduction program was the needle exchange project that started in 1986 in the open drug scene in Zurich. The safe injecting rooms were established some years later. There are currently eleven rooms located in five cities. For people who are not capable of holding a regular job, special opportunities to find work on a day-to-day basis were created. Though it may be difficult to believe, as Switzerland has a reputation of being a wealthy country, there are shelters for homeless people. They are in response to a clear need. In low threshold facilities, so-called contact centres, drug addicts can establish contact with the health system in a very informal way. Addicts can receive advice, assistance and information or they can just have a coffee and be left alone.

Repression and control were probably the first attempts to avoid and reduce the drug problem and they still have their place in a comprehensive strategy if targeted meaningfully. Control of precursors used for the production of drugs and combating drug trafficking, organised crime and money laundering contribute to the reduction of the availability of illicit drugs. Switzerland cooperates closely with the international community, as drug-related crime has a global dimension.

What is the outcome of this comprehensive approach that targets the drug problem? It is difficult to get a clear picture of the number of people who use drugs but, from health surveys, it is known that in the beginning of the 1990s the number of people using hard drugs like heroin and cocaine increased, whereas since 1994-95 the figures have been stable. The rate of heroin use dropped between 1992 and 1997. On the other hand, there is a clear increase in the use of marijuana, ecstasy, alcohol and tobacco, especially among young people. Over 10 years, the number of drug addicts in treatment has doubled. As I said, about two-thirds of the drug-consuming population benefit from some kind of treatment.

From the beginning of the 1990s, when needle exchange programs started operating on a large scale, the number of injecting drug users diagnosed with HIV-AIDS decreased. It is no longer the injecting drug users who represent the biggest proportion of new HIV infections; it is heterosexuals. Not only the needle exchange programs, but the information and awareness campaigns targeting injecting drug users, contributed to the positive developments.

The graph shows the number of drug-related deaths caused by overdose. In 1992, 419 drug-related deaths were recorded. It is the highest figure so far. In 2000, there were 196 deaths. That represents a reduction of more than 50 per cent. The level is now that of the late 1980s. We consider this development a result of the implementation of our drug policy.

Approaching the problem in a pragmatic way took away a lot of the mystical attraction of heroin that made it especially interesting for young people in search of a new alternative, or rebel lifestyle. Our evaluators confirmed that the image of heroin among young people has undergone a substantial change. Whereas, only 10 years ago, it was a "rebel" drug, it is now considered the "loser" drug for sick people, distributed to some people in sterile outpatient clinics three times a day. This is an unintended, but important, effect of the social aid and the medical measures, and has a great influence on the consumption habits of teenagers, who now rather tend to avoid heroin.

Finally, one of the most important outcomes of drug policy in Switzerland might well be the change in the perception of the problem. A couple of statements illustrate this conclusion. Drug dependence is now perceived as more of a health issue than one of law enforcement. The drug problem cannot be solved, it can only be handled. Ideology does not help; it is important to look at reality and to search for pragmatic answers to problems, ensuring cooperation and a balanced approach is a continuous struggle. We have never really achieved it, since the many aspects of the problem are constantly changing. Balance between the interests of the population and the needs of drug-dependent people must be found; this is vital. There is no single measure, activity or project that makes the difference; it is the package of them all.

What are the prospects for Swiss drug policy? There is still a lot of work to be done. I was happy to see that both legal and illicit drugs are included in the issue papers for this summit. In Switzerland, this integration process is now on its way. The mechanisms of becoming dependent are identical and the social conditions similar. In Switzerland, as well, alcohol and tobacco still represent the biggest public health problems of all addictions. That is why, over the coming years, more emphasis will be placed on the coordination and integration of measures taken in the field of illegal and legal drugs.

Ladies and gentlemen, thank you very much for your attention.

The CHAIR (Professor Liz Harman): Thank you very much indeed, Mr Hosek. I am sure delegates will be as tolerant as I was of the small overrun in time, given the difficulties we had with the microphone arrangement earlier.

I ask those in the back row, if at any time they cannot hear, to simply raise their hands. That will signal to us up here that alternative arrangements need to be made.

We can now turn to question time. We have a generous amount of time in which to address questions before morning tea. In order to maximise opportunities for delegates to ask questions, I

ask three things. First, those of you who wish to ask a question, please ask only one question. We may be able to give you a second opportunity, but there are many people in the Chamber, and it would be extremely useful if delegates could limit themselves to a single question. Secondly, if you have a statement you would like to share with us, you are asked to keep that for your working group sessions at 11.00 am. Delegates will remember that, after morning tea, the summit will move into working groups. Alternatively, delegates can share statements at the plenary session tomorrow morning. Delegates will remember the yellow sheets I showed people yesterday. You will need to complete one of those. Please do not make a statement this morning. Limit your statements to the working group sessions and tomorrow's plenary. Finally, I remind delegates to state their names when asking questions and indicate to which of the main speakers they are directing questions.

Can I have an indication as to those who wish to ask questions? I will take three questions at the moment, and then I will ask again. I ask Greg Duck to stand, please.

Mr DUCK: I hope this is not a statement in disguise. My name is Greg Duck and I direct my question mainly to Professor Stanley. I admire how far she has come with the scientific model, but I ask her to allay some of my fears.

Professor Stanley, I thought you suggested that we do not go down any new paths without scientific proof to back them. However, subsequent speakers gave evidence that that is not the way things work. My worry is that if we wait for scientific proof, it will be a reason for not doing anything. The Swiss make their decisions based on emotional responses to public heroin use. I believe that they have made the right choices.

Professor STANLEY: Thank you for the question. What I suggested was that we must experiment and go forward. However, we must gather good data to monitor the impact of that, as we did with HIV. What I am suggesting is that this will enable us to leap forward with greater bounds, because there will be a capacity to monitor progress. Yes, you can make all the decisions you want, even if they are the wrong ones. If you have the capacity to monitor the impact of those decisions, either in deaths of drug users or other good indicators of process or outcome, at least when you make mistakes with interventions, you have a measure of those mistakes. You can then pull back and go down another blind alley or a good alley. My point was not to wait until there was randomised control and trial evidence of every factor before intervening. The package that Martin Hosek spoke about is not a real world. I love those four points - pragmatism, evidence, consensus and innovation. That is what it is about. I am not saying to wait until it is all absolutely perfect, because the real world is not like that. However, data should be in place, so that surveys can be made year after year and can determine whether it was a good decision or a bad decision.

Ms BOLDY: My question is primarily to Mr Peterson. Could you elaborate on the effectiveness of compulsory treatment for people upon release?

Mr PETERSON: That is an interesting question. Compulsory treatment for young people has been successful. Personally, I doubt whether it is a good option for adults. I am against compulsory treatment for adults unless it contains something that is an alternative to drug use. Studies have compared the outcome for people who have been treated through voluntary treatment and compulsory treatment in Sweden and have indicated that there is really no difference. Compulsory treatment is primarily something that the client, student or patient - whichever you prefer to call him - is affected by in the beginning. Whoever is subjected to compulsory treatment would object to it at the beginning of that treatment. If you were to come to any of the centres that I have been connected with and asked the kids who have been there three or four months, I am sure that most of them would say that it does not make a difference to them any longer. Whether they are there on a voluntary or compulsory basis is not a problem at that stage. The problem arises when the police grab a person when he is in the middle of injecting a drug or smoking cannabis.

Compulsory activities should be used as an opportunity to motivate people. Compulsory treatment within a social welfare system has nothing to do with punishment. It is a way to compete with a

compulsory heroin addiction. Being addicted is a compulsory situation. We are talking about two different sides of compulsory activities. My answer to your question is that when young people are released from treatment, be it voluntary or compulsory, there is no major difference in outcome. A study carried out on one facility for young people looked at the point that you raised. That study should have been released before I came here, but now will not be released until the end of October.

Mr MEOTTI: My question is directed to Mr Peterson and Mr Kucera. I am interested to know the percentage of funds per capita spent on drug treatment between Sweden and Western Australia to give me a comparison.

Mr PETERSON: I can give a straight answer to that question, as I have the figures with me. The latest figures available from 1997 in the municipalities - I am talking only of municipal input for the treatment of drug addicts - was $US325 million. Sweden has a population today of roughly 10 million.

Mr KUCERA: I did not intend to take any active part in this conference. However, I believe the State's total expenditure was $51 million. I am unsure whether that is all spent on treatment or a proportion goes on drug enforcement. Western Australia has a population of 1.8 million. I shall get figures during the day and give them to the conference organisers.

The CHAIR: I indicate that we are extremely grateful that the minister is able to come in and out of the conference at different times during the week. I understand he will not be able to be present all the time. Delegates should not address questions to the minister during the conference. He has indicated that he is here to listen rather than to speak.

Mr MACKAAY: Is compulsory treatment a possibility for adults in Sweden? If so, what would be the family outcome if a 48-year-old father of three were put into compulsory treatment?

Mr PETERSON: Compulsory treatment for adults is available but I do not believe in it. The outcome is very poor. The provision in Swedish law is for compulsory care to take place for a maximum of six months and it is clearly stated in the law that it is for motivational purposes. A 48-year-old man with a family of three kids would most certainly not be eligible for compulsory treatment. Compulsory treatment is primarily used for single males who have been into drug use for a very long time. In my opinion, when they use this law in Sweden - I am talking about benefits and limitations - there is a serious limitation to it because it is more about locking up people to make them sober. It might be a good thing for a short period, but not in the long run. It is a completely different situation with young people who have a long treatment procedure with follow-up, which might take anywhere between 12 and 24 months.

Mr LOVETT: My question is to Martin Hosek, who spoke of job programs for rehabilitated drug users. Although my question is not part of the summit and I may get a bit of flak for it, do you have any programs for drugs and alcohol in the workplace or can you lead us in some direction on that problem? It is an issue for me.

Mr HOSEK: Thank you for that question. Are you talking about the prevention of alcoholism and drug use in the workplace?

Mr LOVETT: Yes, a way to deal with drugs and alcohol in the workplace.

Mr HOSEK: There are programs in the workplace that are part of what could be called working security. However, those programs are not managed by the Swiss Federal Office of Public Health for which I work, but by a state insurance institution that insures against working accidents. There are programs in that direction too but they are not part of the package I was talking about.

Mr LOVETT: Could I catch up with you later and get some information on that?

Mr HOSEK: Yes.

Mr TOON: A surprisingly high percentage of people accepted into the heroin supply program trial moved back to other forms of drug substitution or into drug-free treatment. Has that continued now that the program has moved beyond the trial stage?

Mr HOSEK: In 2000, 75 per cent of people who quit the heroin prescription program went into either the methadone prescription program or abstinence-oriented withdrawal treatment. Of the people who quit heroin treatment in 1999, 66 per cent were what we call good entries; that is, they either went to methadone substitution or made a withdrawal. The figure increased from 66 per cent in 1999 to 75 per cent in 2000. Not many people leave the treatment. It is a long-term treatment, and people stay three to five years or longer. In the context of quality assurance, we are trying to figure out the most effective duration of treatment. That is the issue we are working on for the coming year.

Dr HATTON: Is there a needle exchange program in Sweden and if not, does Mr Peterson have any figures on the prevalence of hepatitis B and C?

Mr PETERSON: A small needle exchange program operates in two cities in the south of Sweden. It is a project - at least that is what they have called it for the past 15 years. It is a very long project. There is no scientific evidence that this has resulted in a decrease in the incidence of drug use or HIV infection. The Government has announced that it will decide whether this project will continue or be permanently closed down. That decision will be made in October. It is a very small project, and operates only in two small cities in the south of Sweden. There is no intention to introduce any more programs. The methadone program in Sweden is also very small; only 800 slots are available.

Dr HATTON: Do you have any figures on the prevalence of hepatitis B and C as a result of these initiatives?

Mr PETERSON: The prevalence of hepatitis B and C is low. I have the figures and will look them up during the break. We are considering offering testing for hepatitis. It is not a major problem, although we have noticed an increase. The rate of HIV infection among intravenous drug users is still low, and only three newly infected cases have been reported in Stockholm this year.

Ms MORAN: Does Dr Stanley consider the early identification or mediation of attention disorders and associated learning disabilities in children as an effective strategy in the prevention of substance abuse in later life?

Professor STANLEY: I made it clear in my simplified causal diagram that there are many pathways to outcomes such as drug abuse. Early identification of behavioural and learning problems presents an important opportunity for intervention. The randomised control trial result of our positive parenting program showed that 30 per cent of children in the high-risk area exhibited behavioural problems. By the end of the first year, that incidence among the intervention group had dropped to 10 per cent. If that is sustained through school, it will be fantastic. The figure in the non-intervention group was stable at 28 per cent.

Yes, it is almost immoral not to offer help to those children we can identify as being at risk with regard to these problems, particularly when there is evidence of effectiveness.

Mr HINDS: I refer to matters for consideration. Some drugs begin as legal drugs and then are diverted to less than legal uses - for example, dexamphetamines and benzodiazepines. Is discussion of this matter within the ambit of the summit?

The CHAIR (Professor Liz Harman): I will take that question on notice and discuss the issue with my co-chairs and staff.

Mr MOYSES: Dr Peterson, to what extent do you think the Swedish social security safety net plays a role in preventing people being drawn into problematic drug use?

Mr PETERSON: That touches upon what Professor Stanley mentioned about looking at the wider social situation. The first paragraph of the Swedish Social Welfare Act states that anyone who is in need should be able to receive help. The provisions of that Act, the activities of a large number of non-government organisations and the Swedish attitude towards illicit drugs all play an important role.

We must remember that in Sweden, 8 per cent of kids are regular drug users; but we must also remember that 92 per cent are not. Therefore, drug use is a deviant behaviour. Using the various components of the laws, the non-government organisations and the Swedish society's attitudes, we try to catch those who fall out through the net. Of course, that is not always successful. However, the awareness of the problem and the dedication of authorities and NGOs provide good opportunities for people to get help.

At the same time, many drug users do not want help or are not capable of asking for it because they are so heavily involved in drug use. How do we develop good measures to reach those who are not interested in getting help or who are not interested until we have the opportunity to explain that help is available? It is very difficult to explain to an active heroin addict that we can offer something other than heroin. That is the point at which compulsory care comes in. That gives us an opportunity to help some kids out of the drug scene and away from the influence of drugs, and to explain and discuss their options. I am convinced that no kid born in this country or anywhere else says when he is five years old that his dream is to become the worst drug addict in the country. That is not the case. Things are happening and it is up to the welfare sector and all members of society to try to discover these kids and see what we can do to help them. Our system is good, even if we do not reach everyone.

The CHAIR (Professor Liz Harman): That is an appropriate message on which to conclude this session - no child is born wanting to become a drug addict.

We will break for morning tea, after which delegates will move to working group sessions. We wish all delegates well in those activities.

Please join with me in thanking the speakers who have attended this morning to start the summit process.

Summit suspended at 10.30 am

Summit resumed at 1.30 pm

The CHAIR (Ms Jade McSherry): Firstly, I would like to answer the question that was raised by Adrian Hinds earlier today. The chairs and I have consulted with the Director of the Community Drug Summit and say that the use of a prescription drug in a manner other than for its purpose is defined as an illicit drug.

Regarding the acoustics, the parliamentary staff is attempting to improve the sound quality. However, the uncorrected *Hansard* reports will be presented to each working group as soon as they become available, so anything that delegates were not able to clearly hear they will be able to read. Copies of speeches made by individual speakers will also be placed on the Community Drug Summit web site in time. Today's overheads and PowerPoint presentations will be available for each working group tomorrow morning, and after that delegates will receive them after each session.

Due to the difficulties that were experienced during Martin Hosek's presentation, we will give each delegate a copy of his speech. I will now introduce our speakers for this session. Our first speaker is Graham Mabury, whose presentation is titled, "The Role of the Media in Influencing the Drug Debate: The Good, the Bad and the Ugly". Graham is a 6PR radio presenter. He is the inaugural

chair of the Living Stone Foundation, which is now Lifeline, and he is senior pastor at the Mount Pleasant Church. Welcome, Graham.

MABURY, MR GRAHAM
6PR Radio Presenter, Inaugural Chair Living Stone Foundation,
Senior Pastor, Mt Pleasant Church.

Mr MABURY: My thanks to those responsible for this invitation for the privilege of being able to address those present today. I am not sure I thank them for allocating me the position immediately after lunch, which my physiology lecturer said is the time when the blood rushes away from the brain towards the gut to begin the necessary work of digestion. The advice of this man was, "Don't fight the urge." so I stand between you and his advice.

We are discussing a deeply personal set of issues. From 1974 to 1981, following experience in secondary education, I was involved in working with homeless young people at a time when their existence was questioned by policymakers. I have maintained a close interest during 24 years of involvement with the media. As a wise person once said to his audience, "When addressing you I feel like a mosquito at a nudist colony; it is wonderful to see you all here, but I am not sure where to begin." I understand the impossibility of endeavouring to speak on behalf of the hugely diverse group of media colleagues who I represent. They are incredibly diverse and heterogeneous and it would be presumptuous of me to attempt to speak for all of them, so this will be a personal view. There are excellent publications on the subject of, and very good local academics who can talk about, the sociological impact of media and its function. However, my aim is to give one person's view forged over a quarter of a century of participating in and observing both the media and the industry sector.

The obvious point I must make is that the media are often portrayed as demons of destruction. We used to have Ned Kelly; sadly, he was hanged because when he was alive he was very useful. If the minister's daughter was threatened or the bank was robbed, "the Kellys did it". Now, apart from God, we have the media and "the media did it" whenever it is not what we want. I find it fascinating that the people who rail against the media for scapegoating, marginalising, sensationalising and stereotyping in the drug debate do precisely that to the media. This unilateral condemnation of media fails to acknowledge key realities. The media are incredibly diverse. Yes, the media can and does reinforce stereotypes - I am not here to defend that - but they can and do win awards from people in this sector. An editorial on 10 August in *The Australian* reads -

> There is a compelling case right now for much greater funding for treatment and rehabilitation services, so that those who want to beat their addiction - as opposed to those who would continue it - can have a better chance of winning their battle. The federal Government recently spent $27 million on anti-drug advertising. Putting the money into treatment and rehabilitation would have been an infinitely better investment.

This criticises the National Crime Authority's report that advocates a heroin prescription trial. *The Australian* takes a clear stand on a controversial issue. It quotes its view of international evidence, but sensationalist, stereotypical, and marginalisation? I think not.

However, it does highlight one reality that we all face in this Drug Summit. The media have the ability to seize on one issue and the media merits can decide that issue, so that the entire summit could become the story of that issue regardless of the value of everything else that happened in here. This is partly because of the realities of creating in the hotter medium of television, the hourly or the nightly news. It is a ravenous, hungry beast that must be fed. There are the realities of time pressure, experience and deadlines, but it is reality. The point I want to make is that media reflect

reality. Media live in the same world that we all do. Media live in the world of stress, the land of the 65-minute hour where every red light is a challenge. Media live in the world where you do, where you duck down the aisle of a supermarket to buy food to which you are allergic rather than face someone whom you have not seen forever but always meant to get together with, because you cannot put that sick smile on your face once more and say, "We must get together soon. How is John? Oh, he has died. Well, we will only book for three then." It is a world that everybody shares - media and you alike.

In a world where stress is endemic, time is rare and endangered. When time is rare and endangered, communication will be a casualty. This will lead to two outcomes. It can cause lowest common denominator communication, and it does. In lowest common denominator communication, stereotypes and prejudices are reinforced and the myth is believed that everyone is entitled to an opinion. Everyone is, but every opinion is not entitled to equal respect, particularly where fact must be part of the opinion. I guess the clearest example to me of this is the way in which groups of young people are treated by media and society alike when they gather in public to do nothing more than socialise. To quote one infamous eastern states policymaker, one young person is a problem, two are a drug deal and three are a gang. That is appalling, but it was not said first by a journalist - reinforced absolutely.

Lowest common denominator reinforcing of stereotypes exists. I have for example a personal challenge to address that because I happen to believe there is also highest common factor reflections of reality in the media. By that I mean that there is this quantum leap perhaps for some to make that journalists do have social consciences. They have them in roughly the same proportion as the general community. They engage with issues in ways that go beyond the deadline and the editorial policy of their group. For example, I remember being privileged to be part of a photograph of a group of community leaders who were gathered together specifically for the purpose of illustrating their support for a diverse and multicultural Australia. The Governor, the Chief Justice and a bunch of others attended. It was entirely an initiative of *The West Australian* and was featured in its coloured magazine on its highest circulation daily. It was clearly a statement of position. It was clearly driven by social conscience and not circulation gain.

In that same light of highest common factor, I need to keep a debt of honour to one of my listeners. Many of you will know the story. Her daughter had recently tragically lost her life. She buried 20 of her friends before losing her own life. Her mother rang me on the night she had identified the body of her daughter in the morgue, and her question was, "Why is it that when repeated requests for help for mental health services were made, my daughter was turned away?" The mother was convinced her daughter died not as a drug addict but as someone with mental health challenges that went unmet. I pass that on in a sense of highest common factor and because I promised that mother I would.

We need to move beyond this because media not only reflect reality but also have a role in defining reality. Media define reality. We can see that by acknowledging another reality which until now I have not mentioned, although I have said the word "reality" fairly often. This other reality that we need to acknowledge is that, however balanced and comprehensive coverage of an event is, whatever we say about this gathering, it will probably not be the most powerful formative influence on the target audience this week. Do you know what will be the most powerful formative influence this week? "Not happy, Jan." You laugh because all except the brain dead now know that phrase. This is because of commercials.

If we do not take commercials into our consideration, we are ignoring a major slab of the communications debate. Neil Postman said that in the first 20 years of an American child's life, he or she will see something approaching one million television commercials at the rate of about 1 000 a week. This makes the television commercial the most voluminous information source in the education of your child. A commercial teaches a child three interesting things: all problems are

resolvable, all problems are resolvable quickly and all problems are resolvable quickly through the agency of some technology. Fascinatingly, Postman adds that this technology may be a drug. If this summit is to be honest, I am delighted to hear that it is keeping in perspective the damage done by legal prescription drugs. Delegates should consider the number of people who die by legal prescription drugs. Although the summit cannot give its time to the effects of alcohol and nicotine, to ignore them in the overall scene would show incredible tunnel vision.

I will refer to my version of how the communication process works in advertising. It is a simple version, and is not as elegant as Postman's, but it is how I see it. A desirable but totally unreal image is created. Advertising asks, "Is it like this for you?" Sexuality is the clearest example. If the image of sexuality were accurate, all of us would get no sleep because of the people screaming in delight in the suburbs, and those who manipulate backs would be the richest members of the community. When asked, "Is it like this for you?" the required response is "No." Advertisers can then say, "But if you buy this, it will be." Powerful but unobtainable images create mega-profits.

I do not want to vilify my colleagues in advertising, the way it sometimes happens in a unilateral way to people in the media. However, Jerry Della Femina said -

> Advertising deals in open sores . . . F. Greed. Anger. Hostility. You name the dwarfs and we play on every one. Everyone has a button. If enough people have the same button, you have a successful ad and a successful product.
>
> [Quote not verified.]

Good or bad, advertisers will find the button and press it.

It worries me that I read consistently in literature stories about the damage wrought in young lives by the failure to meet unreal expectations, and we must come to terms with the vested interest that has as its aim the creation of those unrealistic expectations.

I will refer to the media as companion, confessor and confidant. When Marconi first had his inspiration, Bertolt Brecht, the playwright, said, "Look at radio, it is immediate, it is intimate; if it could only be made interactive, it would be the perfect vehicle for creating a sense of community." That has formed the way I have been broadcasting for 20 years. By making talkback radio interactive, I have been able to do what I can to attack the stigma, which was still attached when I began broadcasting, to mental health. Radio is a platform for me to express my views while expressing the views of others. I tackle the issue of not only why someone takes drugs, but also why they become involved in drugs. I deal with not only their psychological wellbeing, but also their spiritual wellbeing. Any policy that does not at least consider all of those matters is one leg short. Radio gives me a vehicle to discuss these issues and it gives those with whom I interact a vehicle to respond.

A joke that many people in their senior years love to tell me is that they go to bed with me every night. My standard response is, "You might as well, my wife never gets to." or, "If you go to bed with me, you will wake up with Baz and Barra!" Nevertheless, that does not disguise the fact that that is absolutely true for them. Radio provides an intimate sense of belonging. These days we chat over an electronic fence.

The challenge for delegates is to effectively use that electronic fence. While the media is vilified and railed against and while people fail to understand it, they sacrifice one key way in which they can influence the debate. People fall for the myth that millions of dollars of advertising achieves nothing other than spending millions of dollars on advertising and that perhaps the community is built person by person and not slab by slab. That is something for the working groups to think about.

Mayhem can be created if someone speaks in an elevator or if someone stands and faces the back wall of an elevator. If you smile and chat to someone, they will get out at the next floor, despite where they were travelling. In a communication-starved society, we seek to continually look to

programs, objects and other things to do what only people can do. We in the media move like Bedouins. I am atypical because I have been in the one place for 20 years. We are optimists if we take our lunch, and nobody buys a weekly bus ticket. If I pick up a memo to see who has resigned I might find out that it is my resignation. However, we usually bob up somewhere else - it is a small pond.

Two matters should be considered. First, a group in the media, with far broader experience than I, should work with the summit to establish paradigms of acceptable reporting and understanding so that together, we can begin to address those occasions in which that is breached.

There is no time to go into the detail of that. However, when there is empirical evidence to show damage from that breach, I do not see that that should be any different from defamation. Secondly and perhaps far more importantly, we can together work to present positive images and to create a means of communication that can achieve great goals. Instead of sporadic awards being given, progress in systematic communication can be achieved.

I guess I will leave delegates with these words in wishing you well with your deliberations for the rest of this conference: I know that it is easy to be cynical and to dismiss this as a talkfest. The way the media picks up what has happened here and misreports it, in your view, or chooses only one issue, or stays with the symptoms and does not develop the cause, may be frustrating to you. However, I still believe that for all the effort you put into this it is worthwhile, because it is better to light one candle than to curse the darkness. Thanks for the chance to speak to you.

The CHAIR (Ms Jade McSherry): Thank you, Graham. Our next speaker is Jack Johnston. He will present his talk on the national drug strategic framework. Jack is the Chair of the Intergovernmental Committee on Drugs and Deputy Police Commissioner of Tasmania. Welcome, Jack.

JOHNSTON, DEPUTY POLICE COMMISSIONER JACK,
Chair of Intergovernmental Committee on Drugs and Deputy Police Commissioner, Tasmania.

Mr JOHNSTON: I will start by asking whether delegates at the back can hear me well enough. Secondly, I apologise to each of the delegates behind me because I will be standing with my back to you for the next 15 minutes. Can I maybe apologise to everyone else in the room because it is very hard to try to sell you the steak knives after a presentation such as Graham's.

The simple reality is that I intend to bring to your deliberations, I hope, more information on which you will be able to contextualise the remainder of your discussions for the rest of this week. During my presentation, I ask you to reflect on what you heard this morning, because you will see great similarities between what you heard from our international speakers and what I will present to you this afternoon as being the environment in which Australia also operates.

The national drug strategic framework is a framework with a shared vision. It is a framework for cooperation among jurisdictions, for building partnerships and for coordinated action. Why? What is that framework all about? The reality is that its aim is simple; that is, to prevent the uptake and to reduce the harmful effects of illicit and licit drugs in Australian society. I also congratulate the chairs. It may have been unwittingly, but they made a decision to embrace the issues raised by Adrian about whether licit drugs used illicitly is illicit drug use. The reality is that the national drug strategic framework gives guidance in that regard - it says that of course it is. I encourage delegates to engage in that issue over the next four days.

I also point out that, as part of this policy framework that has been set nationally, some of the outcomes that have been delivered in recent times include such things as the Council of Australian Governments' prevention agenda, some of the national illicit drug action plans, the action plans in relation to tobacco and alcohol, a heroin overdose strategy, dealing with buprenorphine as a treatment option and the clinical guidelines for its use. They are the sorts of materials that come from the national framework in which we engage.

I make a couple of background points. The national drug strategy started in 1985 as an initiative of the then Prime Minister, Bob Hawke. The Hawke Government decided that something needed to be done, and the simple fact was that he called together, under the umbrella of the Council of Australian Governments, the Ministerial Council on Drug Strategy, which engaged the law enforcement and health ministers from every jurisdiction in the country to come together as the pre-eminent organisation for the determination of national policies on illicit drug use and abuse. That national campaign against drug abuse, or NCADA, as it was called, led to the development of the national drug strategic plan, which embraced those years and took on board, as its prime concept, harm minimisation. I will discuss harm minimisation in a few moments. However, it is a term which has received some vilification but which has high credibility.

Towards the conclusion of the national drug strategic plan, a review was conducted by Professors Eric Single and Timothy Rohl. Eric Single is an eminent Canadian. At the end of that review, they commented that the national drug strategy has led the world through its innovative approach. These are not simply the words of some Australian academic who lives in an insular environment but are the words of pre-eminent international academics. Therefore, we should take great credit from the fact that we are not living just in our own insular domain. We are, in fact, often at the leading edge, but we do not see it.

From the national drug strategic plan came the current national drug strategic framework. That framework includes probably the one item that was missing from the national drug strategy; that is, the strategic framework now has a series of performance indicators and a method of evaluation. In Australia, our key features, as I think we all know, are harm minimisation, a coordinated and integrated approach, and a partnership approach; and you can see the others on the presentation. I will comment on each of them as we go through. What we have as harm minimisation is simple: it is a series of interlocking circles, similar to how we would describe the Olympic rings. It is about each of the supply reduction strategies, demand reduction strategies and harm reduction strategies. I suggest that the biggest argument we have in the environment in Australia is more about the balance: how much should we emphasise supply reduction, how much should we emphasise demand reduction, and what sorts of strategies should we have in harm reduction? It not about whether something is right or wrong. It is more about how much of each makes up the pie.

This morning, I found it particularly interesting to hear that one of the international examples is still asserting that 50 per cent of its effort is going into law enforcement, whereas the current debate in this country is suggesting that there should be a dramatic reduction in the law enforcement effort in order to contribute more towards the treatment effort. Harm reduction or harm minimisation is not necessarily about saying no to drugs, but it does not exclude that option; that is one of the options that is still available. Harm minimisation is about reducing the harms that are associated with drug use. The practical examples of some of these fall off everybody's lips. A significant example is needle and syringe availability programs. Another example is the fact that the police attend heroin overdoses only if there is a death that requires coronial intervention. Another example is the fact that everyone is working towards reducing the significance of some of these harms.

The framework demands a coordinated, integrated approach. There is a need in this process for community ownership, for participation by Governments, and for policy makers to listen. There is no better example of this part of the framework in action than this summit in Western Australia, but the reality is that it is about the politicians hearing the voices of the people and being able to give

some effect to what those voices are saying. This is, in fact, one of the things that underpins the whole framework approach that we have. It is about us all working together.

No bureaucrat can ever complete a presentation without going through some sort of organisational chart. My example, as I tried to say before, is that the Council of Australian Governments came together and provided the oversight to the Ministerial Council on Drug Strategy, which comprises law enforcement and health ministers from every jurisdiction around the country. It also includes, in the case of jurisdictions like Western Australia and New South Wales, a third minister who has some direct responsibility for drug matters. That group of people is informed by the intergovernmental committee on drugs, which comprises bureaucrats from around the country who represent both law enforcement and health. It also engages the education sector and commonwealth law enforcement through the Attorney General's Department and others. They are the bureaucrats through whom a range of national expert advisory committees do their work and report to the Ministerial Council on Drug Strategy. The committees come together as a range of experts in the field and inform ministers and provide them with the best possible policy advice from a non-partisan environment. They are a group of people who can do the best work available; they can do the research and identify all the options available and present the information to ministers. In turn, the ministers become the policymakers for the whole of the nation.

There is another group of committees that informs the intergovernmental committee. When issues affect an indigenous community, the issues are run through a particular group to ensure that the product that comes from them has the best chance of success. It involves getting the views of those involved and engaged to ensure that the best outcomes are achievable.

In recent times, the Prime Minister established a national council on drugs to provide independent advice to him, which is independent of the advice he receives from bureaucrats. As I mentioned before, the partnership approach talks about law enforcement, public health and governments working together and community partnerships. It concerns engaging everybody - as far as possible - in the determination of the policy approach.

It is important that we have a balanced approach to all this. It is all right for each of us to have views at either end of the spectrum. I am sure that Mr Kucera will tell us that it is harder to achieve the radical than it is to achieve the middle ground. The middle ground is where we all want to be and it is where we can get things done. It is safe territory. If I had one criticism of the framework approach I talk about, it is that, at times, it does not challenge the boundaries. I will return to that point later. The reality is that we have to move forward. We heard this morning of the need for an evidence-based approach. I agree totally with the professor when she said this morning that having a need for an evidence-based approach does not mean that we do not introduce innovation. It means that when innovation is introduced it is done in a planned and strategic way and the outcomes that are hoped for are outlined at the start so they can be measured. At the end of the process, it can be determined whether they have been successful. That is what is important in this process. It means that those involved in evidence-based practice around the world - the researchers and others - have their views well and truly taken account of. It is interesting that the evidence-based approach allows us to embrace the argument put by people like Gary Cook from the National Crime Authority who argues for heroin prescription trials but, in the same day, Mick Kelty, the Commissioner of the Australian Federal Police, argues strongly against them. They are two people who one would normally call right of centre who argue totally different positions. I find it a very challenging condition of the Australian environment that people such as these are happy to come out publicly under a national framework and argue diametrically opposed positions.

None of this can happen unless it happens within an environment of social justice. It needs to happen with the views of all our respective communities in mind. There is no point in developing something that will not gain credibility or credence. The way forward is the way that you have chosen to go. The community drug summit is all about gaining the views of the community and the

opportunity to engage widely. It is an opportunity to push the envelope. Without people being prepared to challenge the norm, we will never go forward. It is about developing strategic directions but having sufficient ownership within the group - the broader community - to say, "Yes, we engaged in this although we may not totally agree with it, but we are prepared to give it a try." We must be prepared to look at it to ensure that every opportunity to do greater good for the whole Australian community is not ignored. The reality is that we know the current envelope and the boundaries but we do not know how far we are prepared to stretch them as a community. We do not know whether the environment is right to stretch them. What I have described today is an opportunity for us all to go forward because the next iteration of the national policy is due shortly.

The consideration about what will be contained within that, and how far the boundaries have been stretched, will be challenged over the next 18 months. This is an opportunity for Western Australia to have a very strong voice in helping to guide that future national direction. I encourage delegates to think about the current national strategic priority areas. From what you have already seen this morning, there is nothing new in this. It is nothing different for Australia. These are the words that were used by our Swiss and Swedish representatives. They are the areas we should be focusing on, so that the national drug strategic framework, the whole national environment in Australia, can deliver better outcomes for our communities. Thank you, chair.

The CHAIR (Ms Jade McSherry): I remind delegates of the rules. Make sure that all mobile telephones are turned off in the Chamber, to show some respect to the speakers.

Our next speaker is Detective Superintendent Fred Gere, who comes to us as the head of the Organised Crime Division of the Western Australian Police Service. His presentation is about what is on the streets.

GERE, DETECTIVE SUPERINTENDENT FRED,
Head of Organised Crime Division, WA Police Service.

Mr GERE: I will set the parameters before I begin. This is very much a snapshot of what is available on the streets. It is focused purely on the drugs covered by the Misuse of Drugs Act 1981. As delegates can appreciate, there is quite a black market for some licit drugs, so it would probably take me a good hour to go through all the drugs that are available on the streets.

The Organised Crime Division has changed since 1997. It has moved towards intelligence-driven policing and the upper echelon of criminal activity. Many of the statistics I will show today come not only from the Western Australia Police Service, but also from the Australian Bureau of Criminal Intelligence's illicit drug report of 1999-2000. It is a mixture of material from a number of sources. I have tried to get as much information as I can to arrive at this snapshot approach.

The first drug I am going to talk about is heroin, which was very freely available in Western Australia in 2000. Over eight kilograms were seized in that year by the Western Australia Police Service. Comparing that to the two or three kilos of the year before indicates that it has impacted on the way the police have done business. From February this year the availability of heroin has gradually reduced, with just over 800 grams having been seized in the past seven months. Bulk heroin is usually sold in block form, usually as a Chinese half-weight, which is about 350 grams. Purity on the street averages 59 per cent. This high purity results from the block form, which is very difficult to break down. Previously, the drug was sold in powder form, and people could very easily cut it down. Some very ingenious people can cut down block heroin, putting it though a blender, and re-packing it in block form to put on the street. During 2000 the price ranged between $400 and $600 a street gram, which is an actual-weight gram. This year the price is reported as being up to $1 200 a gram, because of the short supply. It is also sold in smaller quantities, such as

a "taste", a "point" and even a "packet", ranging in size from less than a gram to about 0.1 gram, which is a "point". The bulk price ranges from $10 000 an ounce to $60 000 for a Chinese half-weight, of 350 grams.

Intelligence suggests that little heroin is imported directly into Western Australia. It is usually sourced from overseas, and comes in through the eastern States. Normally the Western Australian dealers go to the eastern States and bring it back here. In the eastern States, the prices are a lot lower than they are here.

Statistics of heroin overdoses have been kept for the past four years. A quick snapshot of heroin-related deaths is that 83 occurred in 1997, 78 in 1998, and 89 in 1999. By this time last year, 52 young people had lost their lives from heroin-related causes. Bear in mind that a lot of those deaths were a result of poly-drug use; it was not heroin alone. So far this year, 27 people have died. There has been a dramatic reduction in the number of deaths, which is in line with the available supply.

If I had been standing here three weeks ago, I would have said that cocaine was difficult to obtain in Western Australia. However, that was before over one tonne was brought in through Dulverton Bay. Mr Jackson from the Australian Federal Police will talk about that later in the week. Cocaine is still a niche market in Australia. We picked up about half a kilogram late last year from a syndicate that was bringing the drug in from the eastern States. The median purity of cocaine on the street is about 25 per cent. The government chemical laboratories have determined purity as ranging from four per cent to 80 per cent. The price ranges between $250 and $600 a gram and up to $90 000 for a pound. A lot of the black market commodities start at grams and go to ounces, pounds, kilograms and half-weights - there is no such thing as a purely metric system in the black market. The majority of cocaine is sourced from South America, with the supply to Western Australia arriving from the eastern States. It is interesting to note that I put this information together three weeks ago. There is a niche market for the drug in Western Australia.

Amphetamines are the biggest demon available at the moment and remain the most widely available drug after cannabis, with a wider user base. In the past, it has been referred to as poor man's coke, crank, etcetera. Purity of the drug on the street ranges from 12 per cent to 98 per cent. During 2000-01, the street median purity was around 15 per cent. The price of a street gram is roughly $200. It can go up to $300, depending on the availability of the commodity. The price of a kilogram of amphetamines ranges between $50 000 and $80 000. It is a different commodity and uses a different weight system, so it goes up in kilograms. Speed is available in what is known as an eight ball, which is one eighth of an ounce, and is also sold in ounces and grams. Intelligence suggests that organised crime is heavily involved in this commodity. It is also the preferred commodity manufactured and distributed by members of outlaw motorcycle gangs. Amphetamine continues to be made locally in clandestine laboratories and is also imported from the eastern States. Twenty-six speed laboratories were located in Western Australia last year. Up to date, seven major laboratories have been located. The reason I use the word "major" is because these labs are getting bigger. We have also seen the rise of suitcase laboratories. If you open up one of these suitcases, it looks normal and filled with clothes. However, it has a full lab built inside. The people who use those labs go out and cook wherever they have to before packing it up in the suitcase.

As far as I am concerned, ecstasy is probably the biggest problem we face at the moment. The world has seen an explosion in the use of ecstasy because it is a cash commodity and because of the ease of packaging; it comes in a tablet form. What have people been taught all these years? Take a tablet and your headache will go away. The same marketing strategy has been used with ecstasy. Availability of the drug is very good, specifically in the dance and club scenes. There has been a swing by organised crime syndicates and outlaw motorcycle gangs to this commodity.

So far this year a total of three kilograms has been seized, with 2.7 kilogram having been seized since 1 July. Its purity ranges from about 40 per cent down to about 31 per cent, with a street median purity of around 23 per cent. The problem is that methylenedioxymethamphetamine is also

sold as an ecstasy tablet. The reason for that is that when it is mixed with ketamine it gives a similar effect to MDMA and it is easier to make. We have also seen heroin, benzodiazepines, caffeine, agricultural chemicals, lycergic acid diethylamide - LSD - and paramethoxyamphetamine - PMA - being sold as ecstasy. The reason for that is that one does not know what the hell people are taking out of those drugs. That is the danger for young people taking ecstasy tablets. For instance, Mitsubishis came on the market with the Mitsubishi symbol on it. It became the love drug of the 1990s and was absolutely fantastic. There are more than 50 types of Mitsubishis currently on the market. The reason for that is that people have noticed that Mitsubishis are selling, therefore they are making them. People now are not buying Mitsubishis that came from the original source but from a market of 50 different sources and containing different chemicals. The price ranges between $25 and $70, with a street median price of $50 a tab and, as people buy in bulk, the price drops.

As to the source, real ecstasy continues to be brought in from overseas. Significant numbers of a lesser quality are coming in from Indonesia - mainly MDMA, with the danger of PMA being involved. A couple of deaths have occurred as a result of PMA being sold as ecstasy. The best, high-quality ecstasy continues to come from the United Kingdom and the Netherlands. The Australian Customs Service report indicated that seizures in excess of three kilograms are now a common occurrence. An MDMA laboratory was located in Western Australia about a week ago. It is therefore happening in this State.

Methylamphetamine hydrochloride, known as ice, is the big demon currently on the street. It is normally called shabu. That name has not been used for some time and everybody on the street calls it ice. It is a crystal form of methylamphetamine and is a new trend in methylamphetamine-type substances. It is crystalline and can vary in colour. We have seen it pink and blue, and the one shown on the slide is white. The problem Australia has is with South East Asia. I read a snippet on the Internet that stated a 12-member syndicate was charged with smuggling 2 310 kilogram of ice between 1998 and 2000 from China to the Philippines. Delegates may have read about what happened in the Philippines involving the Australian Federal Police, which indicated that a huge amount of these types of drugs are being manufactured in South East Asia. Ice is currently available right across the market. Most of it comes from the eastern States. Some of it is being imported and apprehended at the airport.

Purity is a real stunner - this sort of stuff is 80 per cent pure. It is difficult to break down as it is sold in a crystalline form. It is very much like rock heroin, that cannot be broken down, sold and then recrystallised. Therefore, the stuff hitting the streets currently is 80 per cent pure. The current street price is up to $300-plus per gram and an average of $8 000 per ounce. Compare that with $3 500 for amphetamine.

We must ensure that the community understands the purity of these drugs is having an impact on young people. We believed that crystal amphetamine was still solely imported until the other day when we seized one of the first clan laboratories in Western Australia that was making ice. Intelligence would indicate that there are labs in other States. No doubt when the method of making this particular form of ice is taken from the Internet, or from other sources, it will commence to be manufactured. Because of its being new on the street, everyone wants to have a go at it.

I spoke about price. I talked about tablets and that sort of thing. The tablet press for hydroponics showing on the slide now was seized at a house belonging to an outlaw motor cycle gang. One can see the tablet presses that are available. They are not one, single-tablet presses, but machines that make many tablets per minute.

Cannabis resin and cannabis oil are still not widely available throughout Western Australia. Cannabis oil has about 15 per cent of tetrahydrocannabinol - THC - and cannabis resin about 5 per cent. Hash sells for about $50 to $100 a gram, and hash oil sells for $30 to $50 a cap. A cap is the normal “double 0”-sized caps of general-use tablets. The main source is the Middle East, although

some local manufacturing has been seen in the south west. However, it comes mainly from overseas.

Cannabis is widely available throughout the metropolitan area, with a massive swing towards hydroponically grown cannabis. The potency of cannabis continues to increase through the use of hybrids and clones. While in the past mainly bush crops were grown, it is now grown mostly indoors, and more potent plants are produced. The price in 2000 remained stable at about $50 a deal. Bush cannabis costs about $200 an ounce, compared with $500 an ounce for hydroponic cannabis. Some varieties, such as Buddha sticks, are imported from overseas. Some importations come from the eastern States, mainly South Australia. Much hydroponic cannabis is distributed Australia-wide.

The CHAIR (Ms Jade McSherry): Our next speaker is Dr Bill Saunders, a consultant. He will present his speech on "Concepts, Models and Frameworks: An Overview in Relation to Western Australia".

SAUNDERS, DR BILL,
Consultant.

Dr SAUNDERS: Good afternoon. It is a pleasure and a privilege to be here. I start with an opening framework that psychoactive drug use should be seen as a moral problem. Everyone in this room has a sense of morality about drugs. The pharmacological cowards believe that the use of any mood-altering substance for any reason whatsoever is morally reprehensible and should not happen. The morbidity managers' view of mood-altering substances is that they can be used, but only for the relief of pain and addiction. Drugs must not be used for fun. Utilitarians believe in the greatest good for the greatest number. This is a reduction-of-harm approach. These people go for the pragmatic rather than the attractive. Finally, the psychotropic hedonists believe that a day not wasted is a day wasted.

As a community and as a group, we all feel passionately about how the world should be, and our sense about drugs is driven more often by our sense of morality than by anything else. For example, the PCs and MMs believe that drug use is an aberrant behaviour and that if there were no drugs there would be no problems, no cars, no road traffic accidents, no sex and no sexually transmitted diseases. They believe in "just say no" education, abstinence treatments, zero-tolerance policing and drug-free worlds. They believe that in their souls, and they will go to their deaths proclaiming, "Over my dead body we will move from this position". They are always very concerned about sending the wrong message about drugs. It must not be done. The "utes" and the "heds" - the utilitarians and hedonists - believe that psychoactive drug use is normal and here to stay. They also believe in harm reduction at all costs, "how to do it safely" education, maintenance-based treatments, needle and syringe exchanges, heroin trials, injecting rooms and drug law reform.

Everyone sits somewhere on this continuum, and much of the debate turns to the evidence, of which there is plenty. Drugs have been with us since the beginning of time and huge volumes of research are available. This research is often conflicting because the world is not a simple place, human beings are very complex and the evidence is often contradictory. As Gustave Flaubert reminds us, there is no truth, only ways of seeing. People's morality interrupts how they see things. A reverend from Teen Challenge - I admire his work - uses the example of cannabis use and schizophrenia in Swedish soldiers to show that cannabis causes schizophrenia. I can use the same evidence to prove it does not. That depends on our moral position. Evidence is used as a commodity to support one's position rather than to inform the debate. We have a box of evidence, and we pull out the bits we want to use to defend our morality. That will happen among the delegates this week.

I was at a pub last night alongside a group of Fremantle Dockers supporters and a group of Eagles supporters. I will refer to them as the "PCs" and the "MMs", or the "Utes" and the "Heds". They were arguing about the game for hours. At the end of the night not one of them said, "Blow me, silly me - I have been arguing for hours and talking complete nonsense. You are absolutely right." Arguing does not work; it does not change people's perceptions.

The challenge is there and delegates have plenty to argue about. However, rather than focusing on and arguing about issues on which they cannot agree - for example, John Howard's statement that there will be no heroin trials while he is Prime Minister - delegates should focus on what they can agree about. When in a room arguing furiously, delegates should stop, take a breath and try to talk about points of agreement. If we are to move forward, we need a genuine search for common ground.

We should consider the Western Australian history of this issue. There does not appear to be much evidence about what happened in this State prior to the 1960s. Alcoholism was very much a disease - Alcoholics Anonymous groups were operating - and psychiatric hospitals dealt with most of the people suffering alcohol dependence or withdrawal problems. We also had the Convicted Inebriates' Rehabilitation Act 1963. It was a lovely piece of legislation that allowed the authorities to send people to a prison farm if they drank excessively. It was compulsory treatment; so the Swedes have not really pre-empted us. In the 1970s, the terms changed and we started to talk about "alcohol dependence". Political involvement in the drug issue commenced with the Hon R.J.L. Williams inquiry in 1972.

I recently asked a British politician what he intends to do about the drug problem. He replied, "I hope never to mention it. I want to escape from discussions about drugs as quickly as possible - before my reputation is hopelessly tarnished." He referred to Ann Winterton, a Tory member who said she wanted a policy of zero tolerance to cannabis use and who, as a result, became a figure of national ridicule overnight. Hon Michael Portillo, who ran for the leadership of the Conservative Party, acknowledged that he might consider decriminalisation - he did not win the leadership. Whatever politicians do in this area, they are damned. Mr Kucera is a brave man.

We then had the establishment of the Western Australian Alcohol and Drug Authority. The Williams report noted the need for a specialist agency with staff who had experience with dependence to reduce the stigma of people going into psychiatric hospitals. It referred to mainstreaming expertise into general hospitals and treatment largely based on in-patient services. In 1978, only 70 per cent of all in-patient days related to illegal drugs. In the 1980s, we had the social learning model and wonderful debates about whether people suffering from alcohol dependence could engage in controlled drinking. Much fire and anger was generated in discussions about such things.

We had another select committee report and there was a shift away from residential treatment to briefer interventions. It was suggested that non-government organisations should work in conjunction with ADA and mainstreaming was recommended. Alcohol was still the focus, but the rise of illegal drug use was beginning to be acknowledged.

In the 1990s, the focus was on illegal drugs. We had another select committee report and the together against drugs strategy was implemented in 1997-98. That was an across-government, comprehensive, centrally coordinated approach. It was very interesting. The magnitude of the problem meant that, rather than having a specific agency - the Alcohol and Drug Authority - out of government dealing with all the alcohol and other drug problems, it was recognised - quite properly - that the issue had to be dealt with across government. In fact, the response to the alcohol and drug problems in the community went into mainstream government. That clearly was a good idea. However, the tone was politically very conservative and, as somebody who was critical of some of the actions at the time, there was almost a sense of, "We know what we are doing and it is right".

Let me have a note of caution in all of this. It is easier to see what is absent rather than that which is present. In a drug debate like this, you may well be - and the newspapers have done it over the past week - tempted to focus on what is not there. That quote comes from Homer Simpson on Friday night, and it is absolutely appropriate. We need to be mindful, if we look at the web site, of the current services and strategies in Western Australia. What is available is comprehensive. There is a lot more out there. I will flick through this very fast. There is an extensive, coordinated, comprehensive and relatively expensive current response. It is very easy to see what is not there, and sometimes we miss what is. There is in-school education, parent education, public education.

This will cause problems for the Hansard people, but there is a lot of this about. There is even that stuff buprenorphine, narcan, ADAPT. That is the attempt to coordinate people with drug problems and mental health conditions. There is cautioning, the drug court, in-prison programs, general hospital projects, heroin overdose strategies, reintegration strategies - all this and a drug summit, too. Let me give you a word of caution. There is a lot out there. I would be mindful, before you wail at what is not there, to have a good look at this document. It is comprehensive indeed.

Expenditure on alcohol and drugs: in 1976 the figure was $3.2 million, in 1998, $8.3 million - this is direct government expenditure. Obviously there is expenditure by the police and the courts, which is drug related but it is not earmarked specifically as a drug issue. In 1998, $35.7 million. There was a considerable upturn in expenditure. By 2000, it was $46.9 million, and it is estimated to be $57.9 million in 2002.

There was an interesting question this morning about how that looks against the Swedish experience. One way is to do this in dollars adjusted for the consumer price index. Back in 1975, 84c was spent directly on alcohol and drugs, $1.19 by 1980, $1.88 in 1985, $2.70 in 1990, $2.58 in 1995, $3.20 in 1998 and in 2001 it will be about $4.12. That is an estimate that I did. If you translate that across into current dollars, it is about $25 per head of population. Of course, the Swedes this morning mentioned a figure in the region of $US32 per head. The challenge really is how much money does any community wish to spend on responding to drug problems. I have just come from working in a jurisdiction which spends 10 times that amount in responding to drug problems, but it was a very wealthy community. I suspect you can only pay for what you can afford.

Distribution of the money that is spent: 49.9 per cent goes on treatment, 33 per cent goes on prevention, corrections 2.4 per cent, and law enforcement 14.3 per cent. One of the questions you have to ask yourself is: Is this the right balance? Personally, one would have to look at the evidence from Sweden, but if we are only spending 2.4 per cent of our money in the correction system, that is very light on, when the Swedish experience is something like $200 000 over a two-year period for every person who comes into clinical contact. I am not absolutely sure I heard that this morning, but I think I did.

A concluding comment: I do not think there is an easy fix. My experience over the years is that solutions which are quick and simple are also wrong. I think we have the basis of a comprehensive, complex, systemic and coordinated response which is needed, and I think there is a framework in Western Australia. I would invite you to think of finetuning, not revolution, and as a last comment - remember your morality.

The CHAIR (Ms Jade McSherry): On behalf of the chairs, I thank speakers for their well-informed speeches and wonderful presentations. It is a pleasure having you take part in this Community Drug Summit. I now call on my fellow chair, Hon Fred Chaney.

The CHAIR (Hon Fred Chaney): The program provides us with just under one hour primarily for questions for the panel speakers whom we have heard. I will mention a couple of technical points. One is that the audio will not pick up the question if delegates do not announce themselves. In order to pick up the question for Hansard, if you would not mind - even if I call you by name, which is probably not the common way that I will call you - please repeat your name and cause before you

ask your question. That will enable it to be a full *Hansard*-type record. The second point was raised by one of the delegates; namely, there are time limits on the speakers except on those answering questions. I draw the attention of the speakers to that fact, and because there are a large number of delegates and a limited time, I would be grateful if they would answer questions fully but in the minimum time that permits them to do that.

Mr COE: My question is to Dr Saunders and is based on his last comments that the systemic approach already exists; that it needs finetuning, so do not revolutionise it. The papers within our kits talk about the holistic approach, better coordination and better facilitation. Dr Saunders, could you share with us how the systemic approach already exists?

Dr SAUNDERS: The framework for a systemic approach is here. If you look at the current services and structures that are in place you can see activity across the board. To be honest, I wanted to be relatively critical and find the essential flaw in the services that was not here. The only thing I could spot was the lack of a rest referral scheme. Having come back from working overseas, I am, on balance, impressed by what is available. Of course, things can be better. The area in which I am particularly interested - the management of mental health conditions and alcohol and drug problems - could be better. However, even then, there are initiatives there. At the end of the day it comes down to how much money and resources we put into this. Clearly we can always have more. Then we have the question: more what? I am a clinician, so I will argue for more treatment. On balance, the framework is there and we need to question people in the Western Australian Drug Abuse Strategy Office and Kevin Larkins from the Health Department - the people who have better detail and knowledge than I do, about how this can be made to work better. I do not have a sense - as a bit of an outsider - that a revolution is needed. Much good work has already been done. I think that a drug summit can almost encourage a sense that we are not doing well. I agree with Jack Johnston's comment that things are not that bad. We are doing this much better than are some other places. That would be my personal view.

Ms JEFFREYS: I want to pick up on that theme and challenge what has been said. As someone who has been a drug user in Perth for about 10 years, I can say that services are not easy to access. You can be in and out of places within about an hour with the doctor saying to you, "Go on methadone" or "I don't have anything else to offer you". Up until this year, morphine was $50 for a script. All the 24-hour, face-to-face needle service providers were closed down under the Liberals.

The CHAIR (Hon Fred Chaney): Could you direct a question to the panel.

Ms JEFFREYS: Is there a time for comment in the next hour?

The CHAIR (Hon Fred Chaney): If we run out of questions.

Ms JEFFREYS: Dr Saunders, I do not understand how you can say it takes finetuning. I can list 16 or more innovations that should occur. I think they will all come out in the workshop groups. What drug users have said to you that all services are fine and they do not need addressing but need only finetuning? Even the people who work at Next Step would have to say, and I am sure have said to you, that they cannot address the needs of drug users.

Dr SAUNDERS: Of course you are right: we can always do things better and we can improve access. I chaired the group on the treatment discussion paper. I clearly heard from everybody that access is an issue. It is probably about spending more money and making more services available. It is not about revolutionising the way we do things. I think there has been an expectation that a drug summit will change things radically. I would be cautious about that. Of course we could change things. I have some ideas, as do you, about things we can do.

If we take the idea of a heroin trial, for example; how many people will a heroin trial really help? We would be talking about probably four or five per cent of the community of heroin-dependent people. Methadone is good. One of the examples we can learn from Dr George O'Neil's naltrexone clinic is its accessibility. I have concerns about other aspects of the clinic, but the

strength of the clinic is its accessibility because people can walk in and be seen. Clearly that is not the case with some other agencies. Perhaps an issue for delegates to discuss is accessibility. If people have a mental health problem and a drug problem, it is hard for them to gain access quickly to services. Clearly that aspect needs to be addressed. However, I do not believe that the decision makers are not mindful of it. That is what I am trying to argue: not that everything is okay but, as an outsider and as a bit of an independent, I believe the structure is there and we probably need to work together better to make it better. I could be wrong, but I do not see a major failure of resources, innovation or willingness to make things better.

Ms McKENNA: My question is to Graham Mabury. You talked about developing acceptable reporting paradigms for media. Have you given some thought to how that might happen?

Mr MABURY: Yes, I have. Let me make a mitigating statement first. I have had a fair bit of time in the sector in various ways but a very narrow experience in the media, in that I have been a radio broadcaster predominantly. I am in danger of not knowing enough about either, so I am in a very invidious position. However, I hope that one of the initiatives to come out of this summit will be an approach to bodies like the Australian Press Council, the Advertising Standards Council and the Australian Broadcasting Corporation to ask, with the regulatory regime that already exists, whether there is some way in which together we can devise at the very least a self-regulatory paradigm of acceptable reporting? Bill will know more about this than I do, but - in the same way that if someone defames another, that person can cause the other monetary loss - if people can show there is a causal link and that journalists make the job of clinicians worse, I do not see why that should not be covered in the same regulatory framework. Can the working groups of this summit consider ways of interacting with journalist groups and advertising groups to establish those policies and guidelines?

Mr MEOTTI: My question is to do with terminology that is used in the media. I have been involved with this issue for quite a few years. I have explained ad nauseam to the media aspects of medically supervised injection rooms or medically supervised heroin prescriptions, and I have canvassed law reform. When I have done so, the headline might be "Cannabis decriminalisation and legalisation, free heroin trials and shooting galleries". Quite a few politicians in their press releases will use those terms as well, which does not help. How can we change the culture of sensationalism which tends to polarise people and hinder the debate?

Mr MABURY: Maybe it does. I will echo what Dr Bill Saunders said; that is, if there were an easy answer, we would have found it long ago. It is impossible to give one answer for the whole of the media. Members of the public have their say on talkback radio. They get direct access to the media, and those issues can be addressed.

I will put on my media hat for a moment. We live in a world of horror of political correctness, in which gender-neutral persons are accessed in a user-friendly hands-on manner at the coalface in an ongoing syndrome of sociopolitical quasi-religious variables. That is something about which delegates must decide. I empathise with Mr Meotti because I share that frustration from the media's side. Predominantly, it is something that can be solved mostly by education rather than by regulatory control. I do not think that the fourth estate would warmly embrace regulatory control, and I am not sure how it would be enforced.

I cite an example that perhaps seems unrelated, and I hope that delegates will either understand the connection or consider me as a case study for this summit. I have often spoken to politicians off-the-record and asked them whether a journalist had ever broken their trust and reported a not-for-publication comment - perhaps the chair could comment on this matter. In my experience, it has not happened. I do not suggest that members of the media are Florence Nightingales, but if it is done once, no politician will trust the journalist again.

Relationships are the key. Although members of the media shuffle around a lot, we tend to bob up in other areas in the media. The most effective control is education by relationship. I stress the

point I made in my address that, in my experience, journalists have social consciences and passions about these matters in roughly the same proportion as members of the general community. I hope that answers the question.

Mr BOYLE: Will Detective Superintendent Fred Gere tell us roughly what percentage of the supply that was seized by police, was accounted for in the past year? In response to that, how important is the supply reduction in the triangle of the three strategies of harm minimisation, demand reduction and demand minimisation?

Mr GERE: I will try to answer that question. Since 1997, the operations of the Police Service have changed, specifically the way it deals with organised crime. Most of my investigators now target the organised crime groups rather than the commodity. We work in partnership with the Australian Federal Police and customs, and that is a new development. We are the leaders as far as working together across Australia is concerned.

Harm minimisation is an important part of the drug strategy. I mix closely with the executive superintendent who looks after the aspect of harm minimisation. Much of this harm minimisation is addressed at the Police Academy prior to police officers getting into the work force, and it requires a balance. Organised crime will not focus on a commodity and say that one group deals with only heroin, another group deals with only cannabis and yet another group deals with only ice. Criminals seek any commodity to make money. They do not care what commodity it is. They will examine marketing and the ease of the supply. If they cannot get their supply easily from overseas, they will manufacture it here.

We do not focus on the end user. We believe strongly at the organised crime division, as do the majority in the Police Service, that the end user is regarded as a health issue. Our focus is primarily at the upper echelon and the organised criminals who make money out of other people's misery. That is whom we are trying to take out of business. Does that answer your question?

Mr BOYLE: The police can take so many kilos off the streets. How many kilos are still on the streets? In one example, the market price doubled. The seizure of that commodity obviously had some impact. Despite that success, how many more drugs are out there?

Mr GERE: It is very much a black market. It is no different from asking how much stolen property is out there. Normally the price gives us an indication of the supply, and we compare that with the demand. When heroin costs around $1 200 a gram, there is no doubt that it is very much in short supply. One would virtually need a crystal ball to know how much we take off the street and how much is left on the street. Perhaps one of my learned friends here could comment on that.

Dr SAUNDERS: There has recently been some research by the Imperial College of Science, Technology and Medicine in London. It looked at the island of Jersey where I was working, and it was able to work out by a sophisticated triple dipping system - I will not worry too much about that - how much heroin was being used by the heroin users in Jersey. It took that as the annual amount which was needed and which was coming into the island to satisfy the habits of those heroin users. It then compared that with police seizures. Police seizures were less than two per cent of all the heroin needed for the island. My view is that that figure is probably slightly low, but I think police officers generally would not argue that much above 10 per cent is the interception rate.

Mr GERE: Yes, 10 per cent is probably the interception rate. However, as I said, when the price of heroin goes up to $1 200 a gram, there is no doubt that it has reached its peak. At other times the interception rate will fall below 10 per cent. On average, that is a fairly good figure.

Ms RUSSELL-BROWN: My question is for Dr Saunders, although Mr Johnston may also be able to help us. As treatment providers, we hear often about the need for greater coordination and integration of service provision. I think Elena's comment underlies the fact that many people still find access to treatment very difficult, even though, as the evidence that Dr Saunders presented today shows, there are quite a few treatment services available. Do you have any wisdom for us

from your overseas work, or perhaps from the rest of Australia, on how we could handle this coordination a bit better?

Dr SAUNDERS: I might invite one or two people in the audience, who are the clinicians who do the work, to comment. One of the answers is to spend more money. That is always an issue. A number of clinicians here, such as Pam McKenna, Ali Marsh, Dr Hatton or Greg Duck, may want to comment. Rather than my talking about this as an outsider, perhaps we should receive the benefit of some internal, hands-on experience.

Ms McKENNA: Anne is also a service provider.

Dr SAUNDERS: Indeed.

The CHAIR (Hon Fred Chaney): We cannot hear from over 100 delegates on this point. However, can we follow up that invitation: would a clinician like to comment on the question?

Dr HATTON: One of the needs is coordination. At present there is a lot of overlap. I work at the Perth Naltrexone Clinic. Much of the work we do is duplicated by Next Step Specialist Drug and Alcohol Services. I often find that clients who get the whole range of our services also get the same range of services at Next Step. Duplication is a very common problem, and it needs to be addressed.

Mr TOON: My question is to Jack Johnston. One of the figures that Bill presented concerned the low amount of money spent on people who are incarcerated. I wonder whether you would share your thoughts about treatment for incarcerated people and also about the increased risk of particularly hepatitis C and other blood-borne disease infections for people who are confined and using dirty equipment.

Mr JOHNSTON: I say at the outset that, being a police officer, I am used to dealing with what are sometimes seen as interesting cultures. However, there is probably no more interesting culture than that shared by prison officers. To encourage corrective services officers to take up harm minimisation strategies has been a challenge that I know prison administrators around the country have grappled with for a long time. It is fair to say that the numbers bandied about at the moment concerning the low level of activity within our corrective services environment are correct. One of the simplest statements one can make is that when one considers the people who are in that environment, the reason they are there and the fact that their incarceration usually heightens the problems with which they are dealing, as opposed to ameliorating them, there is a pretty significant demand for an increase in services in that area. If I were to seek anything from this summit, it is that I would encourage delegates to consider the balance that Bill has talked about and that I spoke about earlier, because perhaps that is one of the areas that does need some significant change.

Ms MORAN: I have a question for Dr Saunders. Could you name the alcohol and drug services within the general and Aboriginal community that deal with chronic substance abusers who have significant comorbid problems such as depression, suicidal tendencies, attention disorders or learning disabilities? Could you name the services that deal with those comorbid issues?

Dr SAUNDERS: I suspect you know the answer to that question. I suspect you are saying there is none. Is that correct?

Ms MORAN: I am asking whether there are any such services, so that people who have a problem in accessing those services may be able to access them.

Dr SAUNDERS: Am I correct in believing that you know the answer and you believe there is none?

Ms MORAN: No. I am asking the question, because I would like the answer.

Dr SAUNDERS: I do not know the answer to the question. What is your answer to the question?

Ms MORAN: I do not know, but I will find out.

Ms ADAMS: I have a question for Detective Superintendent Fred Gere. I am a rural delegate. You have given us a good breakdown of the substances that are available. Could you further that by telling us how prevalent those substances are in the rural sector?

Mr GERE: Our main focus in rural areas is, of course, the clandestine laboratories, going as far north as Port Hedland and as far south as Albany, and into the Kalgoorlie area. We have changed the focus with the devolution, and a lot of the responsibility for drug enforcement has gone out to the districts as being the stepping stone for their specific areas. However, we go out and give support. A lot of rural areas have severe problems. Geraldton, for example, has a fairly large heroin problem. It could be due to the fact that Geraldton has a port. Apart from the metropolitan area, Geraldton would probably be the other place in which we work quite significantly. Over the years, Kalgoorlie has had some problems with heroin addiction. I do not think we can say that illicit drug use will not happen in Merredin, but it will happen in Kalbarri. It happens in all walks of life, and it is spread throughout the rural areas in some very small towns and some of the larger cities. We support the local police in many of these areas, and in the past I have even gone out and met some of the local drug action groups. We always think that rural areas are safe areas in which to bring up our children, and it is quite devastating that drugs are having the same impact in rural areas as they are having in the city. It is very dissatisfying to me to see the addictions to illicit drugs that the people in some of these places have.

Mr HICKS: My constituents, if you like, have asked me to address a question about the importation of illicit drugs into the goldfields, so my question is obviously to Detective Superintendent Gere. Motorcycle gangs are quite prevalent and well established in the goldfields, and there is a perception that Kalgoorlie-Boulder is the gateway for the importation of drugs from the east, particularly by trucks and other means of transport. Is that true; and, if it is true, how are you targeting the importation of drugs through that mechanism?

Mr GERE: As you would probably appreciate, a lot of operations are going on all the time, and it would be very unwise of me to openly discuss some of the operations that we are currently conducting. One thing I can tell you is that a lot of narcotics are brought in through all sorts of transportation, including motor vehicles, aircraft and trains. One operation that I can talk about to a certain extent involved targeting a group of people from an eastern European country. We managed to get about eight kilograms of heroin from that group last year. Every time we found them using one form of transport, they would change and use another.

We play a cat and mouse game. There are two outlaw motorcycle gangs in Kalgoorlie and a number of others along the coast. We continue to monitor them and work with local police. There are a number of continuing operations across the spectrum. That is as much as I can say. We are addressing a lot of the issues but it would not be wise to say how, when and why.

Hon DAVID MALCOLM: Does Dr Saunders agree that there is a need for a secure drug treatment facility that caters for juvenile offenders and young adult offenders in the age group of 18 to 24 years, for whom a sentence of imprisonment is necessary by reason of the seriousness of an offence but whom it would be undesirable to incarcerate in a conventional prison or conventional juvenile detention facility?

Dr SAUNDERS: The British experience is that the selection of who goes into drug-free units in prisons is the key to the issue. I am aware that part of the Tony Blair involvement of the criminal justice system as a treatment "stick" has only been partially successful because some people who do not really want to stop have been lobbed in with people who do. There are lessons from Sweden about making sure that assessments are done very well. Each prison needs to have a drug-free area, with special privileges and activities and greater access to things such as phones, television and time out of the prison, but they must also retain compulsory urine testing. A therapeutic regime can be created within the facilities. My experience of working in one like that is that the lads will police it themselves because they know they have a lot of privileges and they do not want some idiot

bringing illegal drugs into the prison. We all know that no matter how secure a prison is, drugs can always get in. More security is not the answer. There needs to be more collaboration and cooperation with people who want to make the break. The extension of drug-free wings and careful selection are the key issues, and that means spending more money.

Mr LOVETT: My question is to Fred Gere. There is a lot of hydroponically-grown marijuana from the eastern States available. It is much stronger and more expensive than traditional bush marijuana. The Government asked us to look at having a cultivation limit of two plants per person. I know that I and a lot of other elderly people around the place do not mind the occasional smoke. I do not smoke hydroponic marijuana because of the strength of the chemicals in it. If the proposal of two cultivated plants per person were accepted, would it have an impact?

Mr GERE: I can only comment on what I have learnt from my fellow officers in South Australia. There is no doubt that organised crime has got involved in South Australia. I think the limit in South Australia is more than two plants. People do not have to wait until hydroponic plants get 15 or 20 feet tall, they can be as short as two or three feet. They can be full of heads and can be cloned to produce very potent cannabis. If an organised crime syndicate has 50 people working throughout the metropolitan area, and each of them is growing two hydroponic plants that can be harvested every six to eight weeks, there will be a surplus that can be sold in other States.

I am only going on what I have been told from South Australia. That is the impact it has had there. All of a sudden, all this cannabis is being grown under syndication. Rather than working in reverse to get organised crime out of that field, the situation has been reversed. Organised crime has become involved in the area, because the criminals know that a person can only receive an infringement notice for growing two, or four, cannabis plants, whatever the case may be. In hindsight, and looking at the South Australian experience, it may not happen over here, but all the indications are that that is likely to happen. A number of other States still have not gone to that type of legalisation.

Mr LOVETT: Everyone knows that hydroponics is in essence a chemical process, and I am wondering whether marijuana grown by that means would be lined up with traditional marijuana, because it is not natural. Does Western Australia have to go down that track, or can it say that hydroponics, being a chemical process, sits in another spot, and we can flick them for that too?

Mr GERE: It is a very difficult one. What do you legalise? Do you legalise hash and the hash oil that can be made out of a plant, or would you decriminalise just the plant? There are so many different scopes, and they are worthy of debate, but it would be like debating religion. We could be here all day and still not have an answer.

Mr MACKAAY: In a sense, I want pick up from there, with a question for Bill Saunders. You have said that we should finetune what we have, rather than revolutionise. Do you have any comment about some of the matters we have been given for consideration, which go to drug law reform, and the decriminalisation of certain substances in certain circumstances? Do you also have a comment on something that was said by our Swiss visitor this morning, that that country has been able to turn the image of heroin from that of a rebel drug to a loser drug? I notice the slide said "looser drug", so I was not sure about that at the time!

Dr SAUNDERS: I am a utilitarian. My personal morality is, first, to keep people alive, and, second, to include them, rather than exclude them. I am not against drugs, I am with people. My moral belief is that you can only work with people. You cannot rehabilitate a dead junkie. The bottom line is to keep people alive, but as soon as you begin to do this, you move into harm reduction mode, in terms of drug law reform. Prohibition creates the worst of everything, because once the prohibition line is crossed, we do not regulate the market at all. I am a great believer in regulating the market. I would regulate the alcohol and tobacco markets to be much tougher than they are now. I would regulate the cannabis, cocaine and magic mushroom markets as well.

It is not going to happen yet, but I would give everybody, at the age of 18, once they have passed their drug-taking test, a smart card, which they could stick into their pharmacy machine, like an automatic teller machine. They would have an account with which they paid for their drugs. The State would provide the drugs and tax them, and the State would know exactly what everyone was using. One person could obtain only so much in a 24-hour period, just like money. I would make sure we regulated the whole thing, and charged people for it. All the money would go back into treatment services, and we would not have the problems we have now with a huge market of illicit money sloshing around, which corrupts everything. Gambling has been legalised, and prostitution has been decriminalised or legalised. We want more control. I do not think prohibition gives us that control. That is a personal belief, coming from my morality about the situation. Is a community like Western Australia going to do this? Of course it is not.

The CHAIR (Hon Fred Chaney): Although we can carry for as long as people wish to ask questions, it appeared a moment ago that we had run out. Before I call Kelly Sorensen, who was the next person who sought the call - I now see one or two further people - I would like the summit to feel that, if it does not wish to continue with questions, we can break a little earlier for afternoon tea, and start the working groups a little earlier. The groups are vital in terms of the opportunity for exchange. Without wishing to discourage any questioning, I am giving notice that delegates need not feel they have to question if they have run out of matters they wish to raise with the panel.

Ms SORENSON: My question is to Detective Superintendent Fred Gere. Can you explain why prisoners on remand, and specifically drug users, are not entitled to psychiatric care or support until they are sentenced?

Mr GERE: I am sorry, I cannot answer that. Are you directing that question to me in terms of law enforcement? I do not think it is a police issue.

Mr ELLIS: I am the representative of the Department of Justice, so I am probably in the best position to answer that question. Basically, that situation is not correct. A range of health services are provided in prisons. The issue with remand prisoners is that they need to agree to participate in that. They are assessed within 24 hours of receival at the prison. There is a limited capacity for psychiatric care and I cannot excuse that. It is a matter of available resources. Remand prisoners are assessed by medical practitioners. We have been moving to create a full assessment centre process at Hakea, which is the new remand facility that has been combined. We are hopeful that that will improve what have not been good prison services.

Mr MOYSES: I believe Dr Saunders will be right in 20 years and we will operate under that model. I would like Detective Superintendent Fred Gere to clarify his comments about the South Australian situation, which is relevant to the committee that I am on. You were saying that those mini-organised syndicates export product to States that do not have a similar situation to South Australia. Is it for export and not internal consumption?

Mr GERE: The intelligence we have received is that the syndicates are packing up the hydroponic cannabis, normally in a vacuum seal, and distributing it. That has been confirmed. There have been a number of cannabis seizures in the north west of Western Australia. It is being transported there by air and road. I can only go by the intelligence information given to me by officers up there, but all indications are that it came from South Australia. I am also a member of the national crime committee. There are growing concerns about the impact this situation is having in New South Wales, Queensland and Victoria. It is being spread from South Australia.

Mr MOYSES: If all States were on an equal footing, that might not be the problem?

Mr GERE: That is a possibility. Again, you would find that if one State had a power problem for three months or whatever the case might be - I cannot say drought because cannabis is grown hydroponically - there would be supply and demand in each State. If there were a variance, these groups would make money. They do not care what the commodity is. They have utilised the

legislation in South Australia to make money. I do not think that there is anything else in it. It is purely a business to them.

Mr PRIOR: This is a question to Bill Saunders, and probably picks up on a previous question. Under the present legislation that covers mentally impaired defendants going through the criminal justice system, drug-induced psychosis is not considered a treatable mental illness. That picks up on the previous question concerning people on remand who have what some medical practitioners call a drug-induced psychosis. They cannot be referred to the Frankland unit at Graylands Hospital for treatment or rehabilitation. What do you think about the phenomenon of drug-induced psychosis as a mental illness?

Dr SAUNDERS: If one accepts amphetamine use, there is clearly an amphetamine psychosis, which is largely characterised as paranoia. Therefore, if amphetamine users have white car syndrome, every white car is a police car and somebody is out to get them. There is also a delusional syndrome which comes from ice and which I believe will be an even bigger problem. Clearly people get a sort of psychosis which is about broadcasting thoughts, either their own thoughts being broadcast or messages coming into them. Clearly, that is a mental health condition which is sectionable, sanctionable and eminently treatable. It is relatively easy to treat these conditions. We give them a fast-acting anti-psychotic drug, put them somewhere nice and stable and give them tender loving care for a week, good nursing and green vegetables - I am not being totally facetious with that remark - and within a week we can work out what is going on. For some people, amphetamine and other drugs will open their trapdoors and if they have an underlying mental illness, that will come out. However, we can manage that episode in the majority of people who use speed and ice excessively well and it will not return. If they stay abstinent, the condition can be cleared up; therefore, it is manageable. In terms of whether that is referrable to Franklin, I would have to take advice from elsewhere. However, in another role I am also responsible temporarily for what is known as the Joint Services Development Unit, which is a culpability unit that is trying to look at better practice in these very issues. I will therefore talk to the Franklin people at 9.30 in the morning, which is what I am doing anyway, and raise this as an issue.

The CHAIRMAN (Hon Fred Chaney): Before calling for the next question, unfortunately, we have a microphone issue. Could I ask speakers to address the microphone rather than the polite way they are addressing the questioners and we can ensure we have a *Hansard* record of what they say.

Mr DUNCAN: My name is Peter Duncan and I would like to ask Dr Saunders a question related to the last question about amphetamine. It appears that the drug treatment issue is based historically on heroin or opiates.

Dr SAUNDERS: It is alcohol.

Mr DUNCAN: After alcohol, the emphasis appears to be on heroin. From the discussion in our working group this morning were a number of parents who were concerned about amphetamine use and how they would manage it. They are unhappy with the services for people on amphetamines. As Dr Saunders said, do we need a specialist unit to deal with them? We are unprepared when these things happen in the cyclic fashion that they do.

Dr SAUNDERS: This is a current debate. The Department of Health, through the Joint Services Development Unit, currently is considering whether there should be a tertiary specialist service for people who have madness and drug problems - to put it crudely. A specialist service initially appears to be a good idea but the problem is it lets everybody else off the hook. All the psychiatric services will say, "It's not us, go to that specialist unit." The best estimate is that 30 000 people in Western Australia have both an alcohol and drug problem and a mental health condition; 30 000 people cannot be dealt with by a specialist unit. What needs to be done is to develop a specialist tertiary across-the-board service which upskills everyone from Cyrenians, Palmerston and everybody else to better manage some of these conditions and puts in, with some extra money, doctors and prescribers who can manage these conditions well. However, Mr Duncan is absolutely

right - I have seen it in my private practice - that a number of people have been put on, for example, naltrexone and have then shifted over to amphetamine use and have become severely mentally ill because of that use.

There is an argument for having almost non-medical safe houses to detox amphetamine users so that psychotic people can be taken somewhere with medical supervision. Another problem is that the Mental Health Act does allow people to be sectioned and locked up. I would be very wary about bringing in new legislation just for amphetamine psychosis, which has been suggested. Clearly, in the debates, the issue of how to manage amphetamine psychosis and ice-related psychosis better is a current issue. However, Mr Duncan is absolutely right; these things come and go. I suspect we need a service that addresses across the board that whole interface of mental illness and drugs. Some initiatives are currently going on to try to improve things. Once again, there is an awareness of these issues. More money and resources are probably needed to make sure that access is easier.

Mr JOHNSTON: The Ministerial Council on Drug Strategy two weeks ago addressed the issue raised by Mr Duncan. Minister Kucera was part of the group that identified that not enough effort had been made to identify treatment options for those using amphetamines. That group has asked the intergovernmental committee on drugs to come up with some options for it to consider out of session over the next three months. It is a topical issue at the national level of debate.

Mr TAN: My question is to Det Supt Gere. If we were to have a situation across Australia in which the possession of two cannabis plants were decriminalised or legalised, would we run the risk of drug syndicates either moving into heavier drugs such as cocaine or heroin or taking their product overseas?

Mr GERE: Most of the upper-echelon organised crime syndicates have already moved away from cannabis. Hydroponic cannabis was traditionally grown by outlaw motorcycle gangs, which were heavily involved in the industry until 1997, when they took the unprecedented step of moving into powder. The lower levels of organised crime are still involved in cannabis as a money-making venture. The majority of syndicates move with the commodity. Ecstasy is a cash commodity, whereas much of the heroin is sold as a result of receiving stolen property or given on-tick, whereby a seller will give a buyer four or five grams to cut down and sell to his friends for $50 before paying back the money. That does not happen with ecstasy, which is sold on the basis of $50 per tab and cash up-front. That is why many of the organised crime syndicates have gone into the cash commodity or are moving up the tree and now dealing with pounds and kilograms rather than ounces. Decriminalisation may not impact on the major organised crime syndicates as they have already moved up the ladder into heavier drugs, with which they have a better chance of making money.

The CHAIR (Hon Fred Chaney): A number of people have indicated they would like the call. I will call Irene Froyland, Rebecca Bogdanovich and Pamela Wilson in that order.

Professor FROYLAND: I was indicating that I could not hear.

The CHAIR: I am sorry. I ask all speakers to speak up. I am sorry I missed that cue.

Ms BOGDANAVICH: Dr Saunders mentioned a project at Graylands Hospital that caters for people with dual diagnosis issues. Is that project adequate, and are initiatives being developed within a child psychiatric hospital setting for children and adolescents presenting dual diagnosis problems?

Dr SAUNDERS: Next Step's youth service has staff with psychiatric and clinical psychology backgrounds. The Next Step presentation will deal with the youth services issues. The youth service is developing a consultancy model to help other adolescent agencies upskill their abilities to manage alcohol and drug problems. The Health Department funds six pilot projects around the State, and the junior sport development unit has recently started supporting five demonstration

projects. Eleven ongoing projects are trying to better deal with these issues. Clearly, response to young people with alcohol and drugs problems and mental illness problems is not sufficient. I must be careful, because I picked up a sense that some people thought I was defending something that is indefensible. People can always do more. Gaps exist, but I do not think we need to tear down the fabric of what we already have to address them. We need to do more and finetune programs, but we do not need to destroy them. Ms Bogdanovich is right in saying that more could be done in this area, particularly with young people with drug problems and mental health conditions. Those people often have the same core aetiology, or cause, which is often sexual, physical or emotional abuse in childhood. It is often inevitable that drugs will be a solace in those cases. I am afraid that mental illness is also a consequence of those sorts of things happening in childhood. I ran a comorbidity group on Friday morning, and seven of the 12 people in the room, including one of the nurses, had been sexually abused. It is a mistake to distinguish between mental illness and drug problems - they are meshed.

Mrs P. WILSON: I am from "drug city Geraldton". Believe me, there is no shortage of drugs in Geraldton. My daughter is a drug addict. When she was getting in touch with the drug counsellors, she said, "Mum, we know more than they do. They were taking drugs six or eight years ago. Drugs have changed since then. They do not understand what we are going through." Without putting our counsellors on drugs, how can we ensure that they can help?

Dr SAUNDERS: I am 52 years old. I no longer understand what drug users do. When I am out of my depth, I ask them to tell me about it. They tell me about "snow cones" and all sorts of other weird things I know nothing about. In my curiosity, I make an ally of them; I gain rapport and a therapeutic connection. It is not about counsellors being all-seeing and all-knowing. If in doubt, they should ask the users - they always know more than we do. The situation changes very quickly. I learnt a valuable lesson years ago, when one of the psychiatrists I worked with said, "If you don't know, ask the junkies - they know it backwards." I encourage counsellors to be more confident in saying, "I do not know; tell me about that." There is something about getting users to talk about their experience. We ask them, "What is your drug addiction like?" If the counsellor does that, he or she will create a therapeutic relationship. That is what helps people out of the mire.

Mrs P. WILSON: When we got in touch with the group Community Mobilisation for the Prevention of Alcohol Related Injury because our daughter was going through major withdrawal, the counsellors could not come to help. They suggested that we pop her in a bath and massage her and it would be all right. Getting hold of a child going through withdrawal and putting her in a bath of nice, warm water is extraordinarily difficult.

Dr SAUNDERS: It is always difficult to comment on an individual case. I appreciate that when the situation is chaotic like that, people want something done. Much can be done during withdrawal by calming down the person. Many people are frightened during withdrawal, and that fear and anxiety escalates the symptoms. Experienced people can talk down sufferers and some of the best detoxification programs are non-medical.

Mrs Wilson is correct - those involved need ready access to services and good advice. One of the Health Department's co-morbidity demonstration sites is at Geraldton. Hopefully some expertise will be developed and dissemination of better ways of managing this situation will gradually happen. People in situations like that need pragmatic and practical advice. Sometimes we must resort to the Mental Health Act and lock up addicts for a while to keep them safe. To be fair to Graylands Hospital, it does that every day of the week. However, I appreciate that that is not a solution in Geraldton.

Mr C. BELLINI: Much of the discussion in this session has been about the treatment of drug use and drug addicts. In the long-term strategy of attacking drug use, what is your opinion of analysing its causal origins? What do you believe are the benefits of early preventive intervention?

Dr SAUNDERS: There is a distinction between drug use and psychological dependence. Many people do drugs, but only some become dependent. The question is why some users do not become dependent. The answer is that they usually have more things going for them - they have jobs, homes and relationships and they feel they belong. The people who become dependent on drugs, who use them excessively and who get into a mess with them, tend to use them for psychological solace rather than as a recreational activity. I suspect that, as Professor Stanley said this morning, the ultimate solution is better childhoods.

At the end of the day the best preventive for drug problems is not a drug-specific intervention but making sure people are safe in childhood and also - this is a great ask of government - ensuring that the economic wellbeing of the communities is high. A line taken through Britain plotting deprivation can actually plot the prevalence of heroin dependence, and the two correlate at about 0.9. The more social deprivation, the more unemployment, the more wretchedness, and the more nasty drug there is. At the end of the day, I suppose the invitation to government is to become the ministry of happiness and make governments make us happy. I am sure Mr Kucera could do that quite simply.

Seriously, I think Fiona Stanley was very good this morning when she clearly said, "Look, folks, you can get a bit drug-focused on this; I think you have to be broader and see the overall social structures." Apart from that, we are well aware that we can do a lot of drug education, but there is no difference between people who get drug educated as against those who do not in terms of getting to the problems with drugs. Drug education does not stop people who are using drugs for psychological solace. This is a very good ask for communities. The last jurisdiction I was working in spent a lot of money on parenting programs, support for kids who were not doing well at school and so on, because we saw that as the root solution rather than dealing with drugs specifically.

The CHAIR (Hon Fred Chaney): I thank the panel for what has been a most informative afternoon.

Summit suspended at 3.32 pm

The CHAIR (Hon Fred Chaney): This is a 45-minute session and, because the Chamber will be used for other purposes at 6.00 pm, we will need to finish as programmed at 5.45 pm. We have nine working group presentations which will have a maximum of five minutes each.

LYNCH, Mr Francis,
Chair of Working Group 2.

This is the group supporting families who deal with illicit drug issues, particularly regarding issues for children of drug users and parents and siblings of drug users. We spent some time this morning going through and briefly exploring some of our interests as to why we were here. That was very useful because what we have realised is that that will form part of the discussion for the next couple of days. We will take the common areas from what we have understood about each other in that first session and try to explore them and see where that takes us as part of this process. We will also look at the issues paper in more detail and the questions and see where they take us.

We spent some time this afternoon looking at the definition of "family", and we want to use a very broad definition. We want to look at the issues of legal linkages, whether it is parents being legal guardians for children, or spouses or brothers and sisters - direct legal relationships - but also the broader kin networks, extended family networks, and also going into the broader community that sits around families and how that all links in together. We also wanted to make a plea to the rest of the groups in the sense that every person who uses drugs is within a family, and we would like you to keep that in mind when you are looking at all the recommendations which will finally come up during the last couple of days. It is not just our group that has a watching brief or interest in that. I am sure that all recommendations will impact on how families can be involved. Thank you.

The CHAIR (Hon Fred Chaney): If at the end of the nine presentations there are any minutes left, I will permit questions of the chairs for any point of clarification.

BELLINI, Mr CARLO,
Chair of Working Group 1.

Mr BELLINI: My name is Carlo Bellini and I am chairman of group 1. I must apologise for not being here when I was first given the call; we were printing out the minutes to be tabled. Yesterday we introduced ourselves, and today we set about a brainstorming exercise in the first session, so that all members could raise the issues they believed were pertinent to drug use and young people.

We went around the table and all members of the group were given the opportunity to talk about what they believed we should cover this week regarding young people and illicit drug use. These issues were then further refined and considered in the context of the issues that were highlighted in Issues Paper No 1 on young people and illicit drug use. Our task at the moment is to correlate what we believe are the pertinent issues with the other issues that have been raised in the booklet. Dr Bill Saunders gave a brief presentation on treatment issues, which proved to be very informative. We also looked at overlaps between the different working groups, such as the prevention and early intervention groups. We hope that collaboration between the chairmen of the different groups will increase the efficiency of the Drug Summit, avoid any overlap in discussions and result in high productivity.

Our first task tomorrow will be to correlate further what we believe to be the important issues for young people and drug use, and what is highlighted in the issues booklet. We will then proceed

chronologically to see whether we can provide suggestions that, hopefully, will help young people who are suffering from the effects of illicit drug use.

MAXTED, Ms JOSEPHINE,
Chair of Working Group 3.

Ms MAXTED: My name is Josie Maxted. I have the privilege of chairing working group 3, which is dealing with the issue of illicit drug use among Aboriginal people. Yesterday we started by introducing ourselves. We looked at some of the questions in the issues paper. We came up with stuff such as the way society makes Aboriginal people feel - as though something is missing. People take drugs to fill the void and to feel whole, and the impact of the black history of Australia has contributed to this poverty of aspiration. There is a lack of good data and information on Aboriginal drug use, and we need more action-based research that answers the community's questions. We want good database research. I acknowledge that causes and pathways need to be taken into account. Disadvantage is cumulative.

Imprisonment will not stop people from using drugs, as there is more drug use in prisons than perhaps outside. That was identified by the Butler study in New South Wales . We need more rehabilitation services, and treatment and prevention services that are culturally secure and regionally accessible. We want good skills for Aboriginal workers. We want the dual diagnosis of this problem to be recognised, because it impacts on Aboriginal access to services. We had a look at some of the questions and the way we could address them.

CRAWFORD, Mr IAN,
Chair of Working Group 4.

Mr CRAWFORD: I am fortunate to be chairman of the group dealing with prevention and early intervention strategies, including school, parent and public education and action in local communities. Our first task was to be guided to some extent by Issues Paper No 4, because we felt it presented a lot of good material. Having had the opportunity to study that in-depth, we were able to list a number of priorities from that issues paper with which we felt we should deal. We have listed six priorities that we wish to deal with this week. I can go through those subjects if you wish, Mr Chairman.

The CHAIR (Hon Fred Chaney): I am in your hands, Ian. The advantage of doing that, is that it may cross-fertilise discussions.

Mr CRAWFORD: The six issues that we listed on the whiteboard were as follows: first, empowerment of families and communities through consultation and communication; second, management, administration and coordination as an overarching subject; third, workplace and secondary prevention through education in schools, early school intervention in public, compulsory and private schools, parents, risk and protective factors being enumerated; fourth, decriminalisation of cannabis; fifth, rehabilitation; and sixth, removing profit motives. Today we have struggled with the first item, which is families. That will obviously be a core subject for the summit this week. We feel that it is a vital subject. We had some examples of where in the country a new concept called Smart Start had been introduced with a great deal of success. Three government agencies were asked to cooperate with the communities in those country areas. They even approached families in those areas at the birth of a child in order to give them a foot in the door, as it were, for later discussion and some type of influence. We have found that the topic is all-engrossing. I am

not sure that we have totally finished with it; in fact, I think we have a question on notice for tomorrow's session.

BATTLEY, Ms JAN,
Chair of Working Group 5

Ms BATTLEY: I am the chairperson of group 5 dealing with the treatment and reintegration of drug users into the community. We have a very diverse group that I think reflects all of the stakeholders who have come to the summit, which is a good thing. It will be a difficult task and it is a big task.

We found first of all that we had a lot of overlaps with other groups, some of which we are merely noting and others of which we will make particular mention. Our general mandate is to look at new and innovative strategies. These are in no particular order and include examining gaps, and looking into systems, services and resource allocation, other options and continuous improvement. We have started to discuss some items but they are very embryonic. We will thrash them out over the next couple of days. We are sure to come up with others. They include such things as pathways into treatment from other interventions like needle exchange and diversion programs. These are merely headings. They also include reintegration and support following treatment, which is a big issue.

Issues have been flying around, like the extent of duplication and the question of whether it is really duplication; for example, is there diversity in giving people choice? We grouped some issues under the heading of coordination. A big issue is making it easier for people, whether they be users or family members, to access services. Some of the ideas we have been discussing include a single portal. We already have the alcohol and drug information service and the parent drug information service lines but I am exploring that further. Other issues include better promotion and collaboration between services. There are some fairly diverse views on that. We will look at the issue of single agency accountability in the whole field and the need for continuous improvement

As has been said here, services have improved and many ideologies have been broken down, so there are not the strong differences there were. Other matters have improved such as family-sensitive practices, but obviously there are gaps. Work with people who are culturally and physically diverse obvious has a gap, and there are others.

We must consider strategies to make treatment available immediately to users when it is sought and needed because that is when their motivation to quit the drugs is at its highest. Delegates must also consider whether increased resources are necessary to achieve realistic outcomes without providing an open wallet.

McKENNA, Ms PAM,
Chair of Working Group 6.

Ms McKENNA: Our group is addressing the issue of broadening the provision of treatment for drug users through other human services including health, justice, welfare and youth sectors and integrating that treatment with specialist alcohol and drug services.

Like all working groups, ours is diverse, but it also has the benefit of five regional representatives. Three representatives were born in the country and one is a service provider in a regional area. Delegates will hear a great deal about the lack of service provisions in the regional areas. We have brainstormed and come up with an eclectic group of issues. Predictably, those issues go across

most of the other issues being considered by the other working groups. We will lobby delegates and take on board some of the issues they will raise and follow through on some them.

We began considering issues about prisons including the continuation of care for prisoners and their families before and after their release. We examined the lack of resources provided to the care system within prisons and the lack of integration of community-based services to meet the needs that have not been addressed or integrated within the prison system.

The working group examined the issue of drug-free prisons. Funding processes need to be addressed because the tendering processes currently mitigate against local ownership and against the smaller agencies. Those delegates who have experienced the tendering process would know what an onerous task it is. They would also know that the larger agencies have an advantage over the smaller agencies. Funding agreements must require agencies to perform against shared-care models.

The communication and relationships between agencies are major issues, particularly for the responses that we would require of them. Accessibility, response and availability of services are also major issues. Shared-care models could respond fully and there should be no buck-passing between agencies. If we banned buck-passing, we would solve many of the issues. The working group would require the professional development training of the workers whose agencies respond, and it would require those workers to be accountable. Ongoing support, not just tokenism, should be provided by those agencies.

Accessible information must be provided to parents and carers. Often we hear that no services are out there, and that may be the case; however, people may not know what services are provided. Co-morbidity should be addressed as a systemic problem, not a diagnostic problem. The benefits of shared-care models that have been developed elsewhere - for example, the Victorian model - to provide services to indigenous people should be examined. Resources should be dedicated to staff development training and staff training should be linked to strategic directions. The working group believes that team rules should be developed across the bureaucracies; existing services should be marketed so that people are aware of what services are available; existing services and systems should be built to capacity; and that people who use drugs should not be stigmatised. The working group will explore how general practitioners in the front line, and also the pharmacies, can be used to greater effect. There should be a greater emphasis on recruiting people into treatment who use drugs.

The CHAIR (Hon Fred Chaney): Thank you Pam. Group seven.

MEOTTI, Mr JASON,
Chair of Working Group 7.

Mr MEOTTI: I am Jason Meotti, and I am fortunate enough to be the chair of our working group which is considering drugs and law enforcement, including the consideration of the most appropriate legal framework for illicit drugs. We are examining diverting drug users into treatment and treating the most serious offenders in prison. Our group includes a diverse spread of representatives. It has representatives from the justice system, including an administrator, a prison officer and a representative from the police force. It also comprises a representative from the Chinese community, a couple of parents of drug users and a person who has a criminal conviction for a drug offence.

Effectively, we have tried to break down the issues into five key areas. From what I have heard already, our issues will overlap with other working groups. It is fundamental that the use of drugs and related harm should be considered primarily as a health and social issue, notwithstanding the

need to respond to other criminal behaviour or to protect the community from violent crimes. However, we must recognise the complexity of the relationship between drug use and criminal behaviour.

We feel that it is important to lift the burden on policing that occurs through criminal sanctions on personal use, and that this emphasis should be shifted to high-level suppliers.

The last four key points under matters for consideration were considered most relevant for this group. However, it was also considered important to consider how to intervene more effectively with younger users, including those within the juvenile justice system. The criminal justice system should be more sensitive to and inclusive of the needs of parents and other family members.

We identified a number of issues for discussion. We will look seriously at the review of the Misuse of Drugs Act 1981, and in particular the onus of proof regarding possession for personal use supply; and legal responses to personal use and possession of drug paraphernalia, including smoking implements and used syringes. We will also look at the review of the Sentencing Act 1995 - the options are far too limited at present.

From a policing point of view, we will look at the discretionary capacity of police; police resourcing targets; diverting resources from a focus on personal use offences to organised criminal activity; enhancing the skills of police through better recruitment and education; building capacity for police to develop responses and protocols with other key stakeholders; and a review of police powers; for example, a review of the tolerance of traditional legal pillars that may be an impediment to effective policing of high and illicit drug suppliers, such as the ability to use the right of silence to advantage to avoid providing an explanation for criminal behaviour. We will also look at diversionary options and drug courts. However, it was noted that increased diversionary options need to be matched with increased access to treatment and skilled staff.

From the corrective system point of view, we will consider drug-free units in prisons and/or stand-alone drug-free prison facilities; treatment in prisons; therapeutic units within the prison system to deal with people's addiction problems once they are in the criminal justice system; and harm reduction strategies in prison, including needle exchange, availability of bleach and so forth. With criminal justice, we will look at the fact that cautioning is currently not an option. We will also examine compulsory treatment and engaging significant others - by that we mean parents, spouses, siblings and even children - within these options. Once again we get to the point of diversion or coercion for treatment. That must be matched to increased access to treatment options and enhanced skills staff.

Another key area I would like to take up with the other chairs is that there may well be situations in which legal issues need to be examined in response to certain suggestions. I will use the heroin trial as an example - I have not heard it mentioned yet. We may need to look at changing some laws to allow certain treatment options. Those types of things may need to be examined.

MARSH, Ms ALI,
Chair of Working Group 8.

Ms MARSH: I am fortunate to be the chair of working group 8, which is dealing with reducing harm to the community and individuals caused by continued drug use. My comments now are about issues that came up this morning and this afternoon. Some concern was expressed in our group about the limitations of the principles and matters of consideration that were given out and about the timing of their presentation to delegates. We noted the principles as a summary and useful guide, but decided not to be limited by them. The group also agreed to include discussion on alcohol in the context of its relationship with current illegal drug use, because polydrug use is a very

important issue, particularly in the harm reduction area when we are talking about overdose and a lot of other harms as well.

The group also expressed concern at the absence of parliamentarian involvement, given the role that appeared to play in the success of the New South Wales Drug Summit. We noted that issue. We had a fair bit of discussion about how we would progress, and decided initially to limit discussion to questions posed in the issues paper. However, because we are aware that there is a lot of crossover with other groups, we decided that we would liaise with other groups and ensure coverage of all relevant issues - ones that we wanted to look at in addition. We also had a query about to whom the recommendations would be addressed - the summit, the Government, the Premier, or whatever.

One thing on which we agree is that more targeted resources are required; that is, resources that are used in the best way possible. We started at the beginning of the issues paper and looked at the definition of "harm reduction". Our group comprises a broad range of people with different backgrounds and emphases, and that became very evident when we were talking about harm reduction. We agreed on a definition of "harm reduction"; namely, "strategies aimed at reducing harm for individuals who continue to use". However, we also wanted to place emphasis on the community aspect, because a harm reduction strategy will be truly effective only if it also reduces harm for the community. There was some discussion about the relationship between harm reduction, demand reduction and supply reduction, and where the limits should be drawn. We came back again to the importance of liaising with the other groups to sort out what they would be dealing with so that everything would be covered, and also so that we would not be duplicating the work of other groups in the limited time that we have. Our group also expressed a lot of concern about the limited access to treatment and other resources in rural areas. We also had some discussion with Jack Johnston and Martin Hosek, which was very useful. The key issues that arose for us today were deciding where to draw our boundaries, and the importance of liaison.

FROYLAND, Ms IRENE,
Chair of Working Group 9.

Ms FROYLAND: I will attempt to represent the views of group 9. Our group has the task of linking drug strategies into overall social policies that are addressing the underlying causes of many other problems. We had to read the title of our issues paper a number of times, but that is okay; we are quite good at reading. We started the day by looking in some detail at the principles. We did this not because we wanted to nitpick but because this seemed like a good starting point. We made some strong recommendations about additional words that we believe it is important to add. The first principle was about a commitment to finding as much common ground as possible. We thought it was important, particularly in our group, that in developing strategies to tackle the issues we not only found, but also promoted, the notion of common ground. In other words, we wanted to take a more active and strong approach, and not just identify but actually promote. The second principle was recognition of the range and complexity of the causes of illicit drug use and, therefore, the need to take into consideration education, prevention, treatment and law enforcement. We wanted to take a whole-of-community approach to that matter. We were quite moved by this morning's speakers, and we believe we should take a whole-of-community approach rather than focus just on the drug user or supplier, or the people who are supposed to solve our problems. We believe those two additions are very important, and we recommend them to the attention of delegates.

We also discussed in some detail principle 9, which was about the need for evidence-based decision making. While we applaud Professor Stanley's introduction and we all agree on the need for

evidence as opposed to passion, we want to remind delegates of the difficulties of measuring human behaviour and the need for inclusiveness of process and outcomes.

We embrace the notion of evidence-based decision-making but we caution that we are dealing with complex human behaviour and the last thing we want is an approach along the lines of "The evidence says this can be done in this way, in 10 treatments, and you have had your 10 - see you later." We are concerned about that.

We consider that these are important points we want to present. We addressed our task, which is to link all the strategies and thinking of the other groups and of people not represented here, such as groups looking at other crimes and other social problems. We have begun that and were feeling quite good about it, but I now feel we are back at the starting point because, having heard the other groups, I realise that we have to link it all. Some of them have already started doing it, but where do we start? We are a strong group and we believe we can do it. It is an awesome task but we will spend tomorrow working on the relatedness of the problems and the linkages of the solutions.

The CHAIR (Hon Fred Chaney): Would any of the delegates like the groups to expand or clarify any of the presentations?

Ms PARRY: Group 6 mentioned education and information for carers and parents. Could that include the children of drug users? Could it be in the same package?

Ms McKENNA: Yes.

The CHAIR (Hon Fred Chaney): Everything is functioning well here today except the acoustics. Any other questions or clarifications?

Group 8 asked the minister to give it some guidance. It was not intended that it should be a limitation in any way. The interpretation placed on it by group 8 is the intention of the organisers of the conference and the minister. Other groups should not be concerned about any notion of limitation; it is not the intention. Only group 8 specifically addressed the point. I reiterate that it is not a matter of contention.

Mr HICKS: Our group invited three speakers to attend our session and we found it most useful. We asked them questions that we were not able to ask in the forum. I encourage other groups to invite speakers to their sessions.

Mr TAN: I am not sure who will answer this question, but there is actually a topic 11 listed here, and there is no group for it. We have all had a lot of trouble defining our boundaries of discussion in terms of recommendations. What actually happens to topic 11? Is that discussed a bit by everybody as an overall field?

The CHAIR (Hon Fred Chaney): Which topic 11 are you referring to?

Mr TAN: Zero tolerance and a drug-free society. It has not been given a group or anything, and it has been put in as a topic. We do not know which group should be discussing this topic, or which should not.

The CHAIR (Hon Fred Chaney): Would Dr McCotter like to explain?

Dr McCOTTER: Basically, what we did is put together all the submissions that were espousing zero tolerance, and a drug-free society in a file and gave it a number 11. Originally, when this process started some months ago, we had nine topics, and the nine topics are reflected in your nine working groups, and of course we produced nine issues papers. When we embarked upon the community consultation process, we got about 241 or 242 submissions recommending a zero-tolerance position, and we put them all together, so that they were easy to access. We also created a number 10, which was essentially a general category, where people were making submissions about all sorts of things that did not actually fit neatly into the nine. So there were nine issue papers, nine topics, nine working groups, but two additional files of material which is general or specifically about zero tolerance.

Mr TAN: My only issue is that, by the way that it is structured here, no groups specifically can really talk on this at all.

The CHAIR (Hon Fred Chaney): That is not correct. There are a number of groups which, if they wish to, could pick that up as part of the material that they are considering.

Mr TAN: So we are allowed to -

The CHAIR (Hon Fred Chaney): Yes, it has not been put there to exclude it. I understand that all of those documents have been available for access by delegates. They are there for the advice and guidance of delegates, and within the groups that look at legal issues, for example, that might be an issue they wish to pick up, or even social issues groups may wish to pick it up.

Ms FARRELL: There has been some discussion about the voting process that is proposed, coming up to the recommendations. There is some feeling that some people may be intimidated, for one reason or another, with the open voting process. Has any consideration been given to secret ballots, so that there is perhaps a truer reflection of people's intent?

The CHAIR (Hon Fred Chaney): So far consideration has not been given to that matter, but the decision was that there would be voting in an open and public way, as we earlier indicated. If there is a view among delegates that that creates a difficulty, that is a matter that we as chairs should be prepared to address.

Ms FARRELL: I personally do not have a problem, but it has been raised, and perhaps people might want to consider it overnight, and perhaps the chairs might want to revisit the issue tomorrow, to see what the general feeling of the summit is in that regard.

The CHAIR (Hon Fred Chaney): That is an excellent suggestion, and I remind you that at least one delegate has raised the issue of abstention, for example. Clearly, abstention is more difficult in a secret ballot situation, so there may be a number of considerations delegates wish to take into account. I do not think it is a matter for the chairs to impose a view on this summit, and we can revisit before any question of voting actually arises. I think, on procedural matters, where we have had some indications of intention, that is not likely to be a problem, but I think you mean on the substantive issues.

Ms FARRELL: Yes, when we are voting on the last Thursday afternoon and Friday, where, maybe for whatever reason people feel that they cannot vote with their true intent, particularly with the media coverage, and other people watching and all of those sorts of things. It would be a shame to end up with outcomes that do not necessarily reflect the whole process we are going through.

The CHAIR (Hon Fred Chaney): We might have a chance to discuss that with the chairs of the groups before the open forum.

Ms FROYLAND: I will respond to the previous question. We are one of the groups that will be looking at the question of a drug free society. It is one of the questions for consideration in our booklet, and we have dot pointed it. It is not our main consideration. I urge all groups to look at that issue.

The CHAIR (Hon Fred Chaney): It was indicated that the chairs would consider requests for statements to be made in the plenary session each morning. There have been six requests, which means all those who have requested a right to speak at the plenary tomorrow morning may do so. The requests have come from Malcolm Smith, who will speak on the subject of strengthening what works; Adrian Hinds, on cannabis for medication; Judith Adams, on rural issues; Tony Lovett, on drugs in the workplace; Anne Russell-Brown, on resourcing and coordinating treatment; and Greg Duck, on what works everywhere - treatment across cultures.

There has been a request from the Aboriginal medical service for it to video the Aboriginal panel tomorrow afternoon. The video would be used for internal, training purposes. The chairs can see

no possible objection to that, given that the summit is already being recorded. It will not add to the exposure of delegates.

I apologise to delegates for not being able to join them at dinner tonight. I am hosting a function for a visitor to this State and I would be adding to the divorce statistics if I did not co-host that event.

One of the delegates raised a concern about acoustics with me. As often occurs during conferences such as this, some side conversations are taking place while people are speaking. On a couple of occasions this has made it a little difficult for delegates to hear. I ask delegates to avoid side conversations that will impede other people hearing the discussion.

Mr MEOTTI: I think working group 5 has been given the issue of heroin trials to consider. I did not hear that mentioned. Is that something the group is looking at and discussing?

Ms BATTLEY: Yes, we are. We have put it in our preliminary report.

The CHAIR (Hon Fred Chaney): On the face of the reports that the chairs have given this afternoon, you all appear to have made extraordinary progress in dealing with significant issues that the summit is to address. I note how many refer to the cross-fertilisation that they want to occur and think must occur, and to the intention, outside the formal process, to engage in exchange. In terms of producing proposals for voting later in the week, that sort of thing is likely to be very productive. That is a positive element of the reports we have heard this afternoon. Thank you all for your attention on day one. Have a wonderful party tonight and I will see you in the morning.

Summit concluded at 5.45 pm