COMMUNITY DRUG SUMMIT

HELD AT PARLIAMENT HOUSE
PERTH

WEDNESDAY, 15 AUGUST 2001

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Summit met at 8.30 am

The CHAIR (Ms Jade McSherry): Welcome to the third day of the Community Drug Summit. This morning we will start with Rose Carnes, who will talk about accessibility for young people and youth workers.

CARNES, MS ROSE,
Executive Officer, Youth Affairs Council of Western Australia.

Ms CARNES: I will note a few key points about accessibility that have been highlighted by members of the Youth Affairs Council. It is the peak body for the non-government youth sector in Western Australia and has over 300 members in organisations working with young people, workers across a range of professions and young people. Our substance use policy is based on the premise that substance use is part of our society and drugs of various kinds are part of young people's lives, the society in which they live and the cultures within our society. We believe any comprehensive drug policy needs to ultimately address the full range of potentially problematic substances including aerosols, prescription drugs, alcohol and cigarettes. I urge this summit to give a clear message to Governments to include legal problematic substances in further development of their drug policies. We must be mindful of the language we use in framing our recommendations. Language can very easily include or exclude people. So please be mindful of that fact in framing recommendations, and let us try to avoid the use of industry of profession-specific jargon. This will then allow us to continue the opportunity that has begun at this summit, of active inclusion and participation of young people that moves beyond tokenistic consultation.

The Youth Affairs Council supports accessible options for all young people, specifically those that focus on health and safety, and that includes the health and safety of current users. Not all young people see their drug use as problematic, and not all young people will choose abstinence. We therefore urge the well-managed, well-researched, well-planned consideration, exploration and trial of a wide range of options. Then we can be informed about whether they actually work or not. This would include things such as safe injection facilities, and broadening opiate maintenance options beyond the current methadone program, that has already set a precedent for such trials.

As an ex-teacher, I know how many social issues teachers are pressured to pick up, on top of their core business of teaching. The list seems to grow every year. Over the years this has been exacerbated by the erosion of support staff in schools. There is now no consistency and equity in access to guidance officers, psychologists, chaplains, nurses, social workers and youth workers, all of whom have specialist skills and expertise in specific aspects of a young person's life. If the outcomes of drug education are to be implemented effectively, there needs to be a back-up of multi-disciplinary teams readily available to or working within school communities. These teams need to be readily available, and can increase the access to positive outcomes for young people by offering support, multi-faceted approaches, and addressing issues as well as supporting teachers and one another. I urge the summit to consider that in its deliberations as well. Finally, to be accessible, the services will need to be young person-friendly, with approachable settings and worker, close to transport, 1800 numbers, with a decent fast response time and open at the hours they are needed, which is not necessarily nine to five.

The CHAIR (Ms Jade McSherry): Thank you, Rose. The chair calls on John Harris, who will be talking about summit principles from the Aboriginal group.

HARRIS, MR JOHN.

Mr J. HARRIS: We as the Aboriginal No 3 group want to table some changes to the wording of the principles. The No 1 principle is unchanged. The No 2 principle is the one we want to be tabled in reference to our group. The proposed wording is "Recognition of the range and complexity of causes of illicit and licit drug use, and therefore the need for early identification and the need to take education, prevention, intervention, treatments and law enforcement into consideration."

The third proposed principle is "An acceptance of the need to involve the extended family in prevention or minimising the impact of illicit and licit drug use and therefore promote the health and wellbeing of children." Principle 4 would read "A recognition of the particular needs of young people in dealing with illicit and licit drug use." Principle 5 will have three subsections. The first is "the inclusion and related disadvantage of Aboriginal communities caused by colonisation and its impacts." The second is "The particular severity of illicit and licit drug use in Aboriginal and Torres Strait Islander communities." The third would be "The need for culturally appropriate services for effective cultural skills in the general health and addiction workforce." The change to principle 6 would be to "recognise the special needs of regional and remote communities in dealing with illicit and licit drug use". Principles 7 and 8 are unchanged. The change to principle 9 is "to recognise the necessity for policymakers to use and expand evidence based on illicit and licit drug use and for all programs and services to be properly evaluated". Principle 10 is unchanged.

The CHAIR (Hon Fred Chaney): It is useful for that to be tabled. The chairs propose to take what has been tabled and to discuss with working group 9 its approach to the overall principles and any possible cross-fertilisation that might be possible between now and tomorrow, to see whether that can be dealt with in as positive a way as possible. Thank you, Irene, for acknowledging that.

HAYWARD, ELDER DENNIS,
Director, Noongar Alcohol and Substance Abuse Service.

Mr HAYWARD: Sister and brother delegates, presenters in yesterday's afternoon session raised many issues about Aboriginal life in Western Australia and how that relates to the issue of illicit drug use in our communities and families. I will emphasise a key issue that must be clearly recognised in this summit's deliberations - Aboriginal people have been excluded or have been a peripheral element of Western Australian society for many years. Some would argue that Aboriginal people are marginalised even today. When the men who planned the creation of the Commonwealth of Australia met to look at what should be included or excluded from the new Federation, they left out Aboriginal people. The fathers of Federation spoke less than 250 words when considering how Aboriginal people should be included in the Constitution. In 1890, speaking at the Australasian Federation Conference, Alfred Deakin proclaimed that -

> in this country, we are separated only by imaginary lines, and that we are a people one in blood, race, religion, and aspirations

Even as the colonies decided to join together as a nation, Barton proclaimed -

> For the first time, a nation for a continent and a continent for a nation.

It is no surprise that we ended up with a Constitution that discriminated against Aboriginal people and which was to remain with us until 1967. Successive Australian domestic policies took the view that Aboriginal people were not a legitimate consideration because we were going to die out, so Australia did not need to invest much effort just to soothe a dying pillow. However, we were not

allowed to die on our terms, on our land. When they realised that we were not going to disappear, they segregated us in missions for our own protection. They said we needed to be protected from the bad elements of Australian society. The first meeting of commonwealth and state Aboriginal authorities in 1937 quickly declared that the destiny of the natives of Aboriginal origin, but not of the full bloods, lay in their ultimate absorption by people of the Commonwealth. It recommended that all efforts be directed to that end. Only full blood natives would, they thought, continue what were considered barbarous acts of culture and no matter what they did, they would die out. That was quoted by A.O. Neville. Aboriginal culture was expected to die out. Aboriginal people of mixed blood also presented challenges. They argued that they were faced with the problem of half-castes multiplying. To overcome that, they suggested a policy of treating the half-castes as whites. The distinctiveness of Aboriginal culture was to be eliminated. It would, therefore, eliminate the Aboriginal problem. The assimilation policy was created and inflicted on us. We could join the Australian nation as long as we stopped being black.

Paul Hasluck, a Western Australian, reinforced this view in an address to the commonwealth and state ministers conference in 1961. He said that Aborigines were expected eventually to attain the same manner of living as other Australians and to live as members of a single community. However, to be considered assimilated we had to obtain a licence - sometimes called a dog tag - that said we were civilised and therefore allowed to drink, move around and live off a mission.

Time will cut me short and I will not be able to finish my speech. However, I would like to say that a lot of those issues that were passed onto us have affected us to this day. I reiterate what was stated yesterday, that they still have an impact on us that we feel today.

We should be given the right to determine our own destinies; particularly we need support in alcohol, drug-related and health issues to be able to do so. Thank you.

The CHAIR (Ms Jade McSherry): The Chair recognises Jan Battley who will discuss barriers to treatment.

BATTLEY, MS JAN,
Executive Director, Holyoake.

Ms BATTLEY: Thank you and good morning. I have a few issues about barriers to treatment, the first one being diversity. Yesterday someone used the term “one size does not fit all”. I hope delegates will keep that in mind. We have heard from current illicit drugs users and ex-users. We have not heard much from families. However, I hope in the next two days we will hear from families because it is the same for them: one size does not fit all. We need diversity.

Secondly, as services become more expensive, parts of those services get shaved off and flexibility is lost. Although we do not hear about services closing down, there is a slow narrowing of services, in that a lack of flexibility means fewer people can fit into services.

Another issue is that the way of funding these days is very outcome-based. This enhances accountability, which no-one has a problem with; however, it means that it is harder to say yes to everyone who walks in the door of a service because people must fit into small boxes, which again cuts down flexibility and diversity.

I want to mention two services that are under threat and if they do not exist cannot be used. These are services for adolescent drug users and their families. One is my agency, Holyoake, and the other one is the YIRRA program of Mission Australia. The funding for these agencies comes from the Department of Justice and we have been informed that at the end of September that funding will cease, although we are all working together to try to keep it going. The lack of funding means that

200 adolescents and 170 adults in my agency will not receive a service after 30 September, and the YIRRA service will be severely compromised if the funding cuts go ahead.

I want to mention the register of opiate dependants, to which changes should be made. Currently, all medical practitioners have a statutory obligation to register illicit drug users accessing their services as opiate dependants. The fear of being registered acts as a barrier for illicit drug users. The Western Australian Network of Alcohol and Other Drug Agencies - WANADA - has concerns about the lack of informed consent when illicit drug users are not informed of the consequences of being registered. Illicit drug users are unable to determine if they are registered and when they are on the register there are no clear guidelines for being removed from it. I understand the legislation for this register will identify a few guidelines. However, the negative consequences of being on the register affect all users. This form of discrimination includes reduced access to pain management in hospitals or alternative medical treatment on the basis that people registered may misuse any medication, irrespective of how long they have been registered or whether they continue to use illicit drugs.

I shall quickly mention two other issues. One is after-hours contact. Although some services open after hours, services at which people can turn up and be seen are almost non-existent, if not severely limited. The other issue is co-occurring mental disorders. Consumers and families have expressed considerable reservations about the availability and quality of acute mental health emergency care. This availability and quality must be addressed.

CASEY, MS WENDY,
Coordinator, Kimberley Community Drug Service Team

Ms CASEY: Hello. I am a Karajarri woman from Broome. I am also the coordinator of the Kimberley Community Drug Service Team, an integrated service within the North West Mental Health Service, which is part of the Kimberley Health Service in Broome. We have three offices - one in Derby, one in Kunnunurra and one in Broome. I will share with you some of the ways that mainstream society can work successfully with indigenous people. We are looking at ways to expand services and accessibility for indigenous people. It is important that I share some of the process of that with you.

Our service is a treatment service. Ninety-five per cent of our clients from the Kununurra and Derby regions are indigenous people, sixty per cent of clients from the Broome region are Aboriginal people. That reflects our population base. It is important to remember that we have been working well with Aboriginal people in our areas. Fifty per cent of our team are indigenous people working with indigenous people. That is a key point to our success. Aboriginal people are employed in identified Aboriginal positions. However, Aboriginal people are also employed in generic positions to provide services across the board.

The majority of funding comes from the Western Australian Drug Abuse Strategy Office and one position is funded by the Office of Aboriginal Health. Most indigenous funding bodies provide funding to community-controlled organisations. That is the way it should be. However, that does not mean we cannot be creative about ways in which we can spend money within our services to provide indigenous services. We should not rely only on indigenous funding bodies to provide those services within mainstream society.

One of the keys to our success is the development of indigenous mental health, alcohol and drug policies within the service to ensure cultural supervision. For example, indigenous workers and culturally competent non-indigenous workers work to ensure indigenous best practice is being observed at all times within the service.

The other key to our success is community development work. Community development has not been discussed much in this forum. However, we have been very successful in establishing indigenous remote area local drug action groups across the Kimberley. The reality is we cannot provide clinical services to every remote community in the Kimberley. It is a vast and extensive place in which to travel. However, we can provide support, education and training and work with local people to assist and develop their skills so that they can manage the care of their families in their own communities. That is very much the work we have been doing in some of the remote area communities to the point where remote area Aboriginal community members now provide their own treatment services within their community. This has been incredibly cost effective. There are things we can do in the community that do not cost much money as long as the process is right and we are working with Aboriginal people for Aboriginal people to enhance their ability to take back care, control and responsibility of their clients.

I will conclude by sharing with delegates a saying of my uncle Joe Ro, a senior Yawru man from Broome. Waraja ngarlu wanduna, which means one spirit, one feeling, one mind all working together. There is much that we here today can learn from that saying.

PRIOR, MR JOHN,
Law Society of Western Australia.

Mr PRIOR: I am a lawyer and have worked in the criminal justice system for about 16 years as both prosecution and defence counsel. I have prosecuted drug users, abusers, dealers and suppliers, organised crime figures and people who commit crimes to fuel their addictions. The latter comprises a large group of people going through the criminal justice system. The starting point for criminal justice reform in this area is the Misuse of Drugs Act 1981. The problem is that Act was passed in 1981. In 1981, a green Mitsubishi was a very nice Japanese car, ice was something I got out of my freezer and put in the esky when I went on a picnic, and ecstasy was an emotion that, as a Dockers supporter, I now experience about once a year. The Act needs a lot of amendment. People say that it has been amended, but that has happened only spasmodically since 1981.

I give some examples of constructive things that could be done. The Act presumes that someone possessing two grams of heroin is a dealer. To say that about a heroin addict with a high or medium level of heroin use is like saying that I, as someone who has Cornflakes every morning, am a Cornflakes dealer because I have a box of Cornflakes in my kitchen cupboard. At the other end of the spectrum, the Act deems someone with more than 25 plants of cannabis a dealer by way of cultivating plants. The phenomenon of hydroponic cannabis has occurred. If someone with 24 well-grown hydroponic cannabis plants says they are for his own use, he is not smoking cannabis; it is smoking him.

Many things in this Act need to be looked at. The general public has a problem with the offences relating to drug utensils and traces of drugs, especially when they walk down the street and see shops selling bongs and whatever. I do not know the answer to that, but it is something that should be looked at, as should the decriminalisation of cannabis. I do not know whether it is the answer. The Misuse of Drugs Act is not the only problem. Many other criminal laws touch on drugs. Under the Sentencing Act 1995, a judge or magistrate may apply a sentence of two years jail, suspended for two years, to an offender; however, that is all he or she can do. No other conditions are available. There is no such thing as weekend detention or imprisonment. Those delegates who saw the production the other night are aware that weekend incarceration did Dougie the pizza boy the world of good. That cannot be done in Western Australia. Many things need to be looked at. A person with drug-induced psychosis cannot be referred to compulsory treatment and assessment because the Mental Health Act does not recognise it as a mental illness.

What do lawyers and others who work in the criminal justice system say about it? To use the words of Graham Mabury and the commercial jingoism, "Not happy, Jan". What can be done? Do we wait for parliamentarians and lawyers to introduce law reform? During the five days of this Drug Summit, one addict will die.

The CHAIR (Ms Jade McSherry): Christopher Tan will talk about helping people to help themselves.

TAN, MR CHRISTOPHER,
Concerned Community Member.

Mr TAN: That is a hard act to follow. Unfortunately, I have no jokes. My topic is helping people help themselves. It is something I was brought up to believe. I strongly support the idea. We must understand that to solve drug problems, or any sorts of problems, we should not give handouts to drug users without also trying to get them to help themselves. That will not solve the problem. We need community programs that involve the drug user in their rehabilitation.
Speech Continues...

There has been much talk about the drug stigma during this summit. Most of it has related to ensuring that the drug user is not made to feel worse, because that can cause him or her to sink into deeper depression and make it even harder to get off the drug. That is an important point, but it should be balanced against one of the most important aspects of reducing drug use; that is, early intervention. That appears somewhat contrary to reducing the drug stigma. When I was in school, the message was "only mugs do drugs". There is no point in saying that, if we can see people casually smoking joints in shopping malls. There is no point telling people that drugs are harmful to health when we have easily accessible needle exchange facilities and injecting rooms in public view.

Much has been said about cannabis as a recreational drug. My view is a little different. Just because a drug is illegal and is used on a regular basis does not make it recreational. That is like saying a serial rapist is a recreational sex addict or calling a person with a history of assault a recreational confrontationist. It is political correctness gone wrong. Those examples result in the same effect: they ruin families, harm individuals and the community suffers.

The director of Teen Challenge WA talked about it being better to have a brush with the law than to let these people fall into drug use. Another delegate said that he was a victim of Project Noah - he was caught and cavity searched. Too right! At the end of the day, he did something illegal and there must be consequences. There must be consequences for people to learn that drug use is a bad thing.

Many people at this Drug Summit have told me that they are not drug users and that they feel overwhelmed by all the information being provided by drug users. Delegates who are not drug users should not think their opinions do not matter. That is very important.

Protests will be held outside Parliament House later today and on Friday. One will address cannabis and the other will address heroin. This is the "Community Drug Summit"; it is not the "drug community summit". The protestors do not need decriminalised marijuana or heroin injecting rooms; they need family and community projects to help them get off drugs.

MALCOLM, HON DAVID,
Chief Justice of Western Australia.

Hon DAVID MALCOLM: I feel extremely privileged to be a member of this magnificent group of people dealing with these topics. I am very grateful for the opportunity to share the experience.

At present we have no appropriate facilities for the secure treatment of drug addicts sentenced to a period of imprisonment. There is an important need for such a facility. In one case that came before the Court of Criminal Appeal recently, it emerged that the offender had a substantial history of juvenile crime and drug abuse. He was arrested and remanded in prison to appear before the Supreme Court on a charge of armed robbery. His addiction was so powerful that, when he was offered drugs in prison, he accepted the offer and obtained them on credit. He was unable to pay. Armed people then attacked his parents' house in the suburbs demanding payment. It is very difficult to deal with such persons without the existence of a secure drug treatment facility for drug-dependent offenders. Such a facility would provide the protection that the community demands from repeat or serious offenders and, at the same time, it would focus on the offender's treatment. The emphasis must shift to rehabilitation and treatment. Desirably, such a facility would be a separate prison established for young offenders between the ages of, say, 18 and 24 who for other reasons need to be separated from more mature offenders and the prison culture, including the exposure to sexual assault, violence, as well as the internal illicit drug trade in our prisons. Similarly, a separate facility should be provided for juvenile offenders.

The other topic I wish to address briefly is that of early intervention. There is a great deal of promise in this particular area which needs to be explored much further. A number of parliamentary reports recently - one from the Senate, two from New South Wales and another from Western Australia, making four in total - indicate that studies show that early intervention with dysfunctional families has a major impact upon subsequent career development and antisocial behaviour, including drug addiction. That requires a whole-of-government response, which so far has been very difficult to obtain in actual practice. There is little point in heads of government departments sitting around a table making strategic decisions if resources and personnel are not going to be deployed on the ground and given the opportunity to work together.

The experience that has been obtained from domestic violence projects of cooperative character between the people who work on the ground demonstrates this can be achieved where there is a will and where there are resources. However, there must be not only policy direction from the top but also active demonstration by those in government that they can galvanise into action inter-agency collaboration of a very real and effective nature.

The CHAIR (Ms Jade McSherry): That ends are plenary session. I now invite all delegates in the public gallery to resume their seats downstairs.

The CHAIR (Professor Liz Harman): The theme for today is: addressing the supply of drugs through law enforcement and exploring the effectiveness of harm reduction strategies. A number of speakers today will be available to the working groups later on. I invite Commissioner Barry Matthews to speak on policing drugs in Western Australia.

MATTHEWS, MR BARRY,
Commissioner, Western Australia Police Service.

Mr MATTHEWS: The drug problem is arguably the most significant social issue confronting our community. Whilst it has been estimated that only one per cent of the community use heroin and five per cent use amphetamines or ecstasy, the impact on the community is huge and few members are not adversely affected, directly or indirectly.

The number of heroin overdose deaths in Western Australia over the past four years, whilst relatively stable, is the most obvious effect, particularly on the families of those who overdose. In 1997 there were 83 deaths; in 1998 there were 78 deaths; in 1999 there were 89 deaths and in 2000 there were 82 deaths. Even when one excludes drug offences, there still exists a high correlation between crime and illicit drug use. The East Perth lockup in Western Australia is one of the sites at which detainees voluntarily provide urine samples for the drug use monitoring in Australia project. The proportion of East Perth detainees who tested positive to four categories of illicit drugs were -

amphetamines, 39 per cent of males and 46 per cent of females;

cannabis, 61 per cent of males and 63 per cent of females;

cocaine, one per cent of males;

opiates, 23 per cent of males and 41 per cent of females.

The national drug strategy household survey, which examined drug use in the Australian population, concluded that detainees were 63 times more likely to have used heroin, 16 times more likely to have used cocaine and three times more likely to have used cannabis than the general population.

Illicit drugs impact on the level of crime in five different ways -

1. The supply and physical use of illicit drugs, which of itself constitutes an offence.
2. The development of organised criminal organisations and the commission of crimes to facilitate the activities of illicit drug trafficking.
3 The commission of crime under the influence of illicit drugs.
4. The commission of income-generating crime to purchase drugs.
5. Crime committed against illicit drug users.

There have been a number of studies into the nature of the relationship between illicit drug users and crime. Although figures vary, a conservative estimate is that at least 50 per cent of crime is drug related.

Police invest significant resources into the detection and prosecution of those who use, possess, supply, cultivate, import or manufacture illicit drugs. Historically, police have concentrated on endeavouring to prevent access to illicit drugs. In later years police have also put resources into reducing demand for illicit drugs and minimising the associated harm caused to individuals and the community. This is entirely consistent with our mission of working in partnership with the community to create a safer and more secure society by providing quality police services.

In my presentation, I intend to outline some of the strategies undertaken by the Western Australia Police Service to stop the supply of illicit drugs in the State, to reduce the demand for those drugs and to minimise any associated harm arising from their use.

Most crime is locally based and is effectively policed solely by the Western Australia Police Service working in partnership with the community. This is not the case with illicit drugs in which the cultivation or manufacturing process is often undertaken overseas and the importation into Australia is usually via other States or Territories.

Successful interdiction of illicit drugs requires the Police Service to work closely with a number of other national and international law enforcement agencies. The Western Australia Police Service works closely with the Australian Federal Police, National Crime Authority, Australian Customs Service and other police services within and outside Australia. These collaborative arrangements enable the sharing of intelligence on crime trends, the monitoring of the activities of organised crime groups and the trafficking of illicit drugs throughout Australia. Western Australian police

officers are seconded into some of these agencies for set periods to work on target groups or may be part of joint task forces to undertake a specific operation over days or weeks.

Cooperation is high and this has been evident with many successful interstate and local operations. Over the past two years operations against organised drug syndicates have led to significant arrests and large seizures of drugs. The following are some of them -

> Operation 2 Oscar Delta resulted in the arrest of 17 persons charged with 21 dealing offences and the seizure of approximately 4.5 kilograms of heroin.
>
> Operation 2 Oscar Bravo resulted in the arrest of 15 persons charged with 19 dealing offences and the seizure of 271 grams of amphetamine and 530 grams of heroin. The real significance of this operation was not the drugs seized but that the parties arrested have had long-term involvement in drug trafficking.
>
> Operation 2 Papa India resulted in the arrest of 18 persons charged with 25 dealing offences and the seizure of approximately two kilograms of amphetamine.

At a local level, district detectives also target dealers operating below the trafficking level. This ensures all levels of the illicit drug distribution chain receive attention from police, with successful operations recently in Fremantle, Mandurah and Broome.

The number of interdictions of sizeable quantities of drugs coming into Western Australia and the apprehension and prosecution of the perpetrators is both pleasing and worrying: pleasing in that it indicates we are receiving good intelligence and using it effectively; worrying that despite our best efforts the supply of illicit drugs continues largely unabated, suggesting only a low percentage of heroin is interdicted by law enforcement activities. However, of late there is a scarcity of heroin on our streets, which we attribute to several highly successful operations against major drug syndicates in the eastern States. Drought conditions in some of the growing areas overseas and a decision by some of the drug barons overseas to move more to amphetamines may also be factors. This has reduced our heroin overdose figures, which are currently 27 deaths this year compared to 52 deaths at the same time last year. If past experience is any guide, the availability of heroin will return to earlier levels.

Unfortunately a reduction in heroin supply may be countered by the corresponding increase in amphetamine use, which has already been growing. Results from the DUMA project show higher proportions - 39 per cent to 46 per cent - of East Perth detainees tested positive to amphetamine compared to eight to 28 per cent of detainees at the other sites in New South Wales and Queensland. Amphetamine use poses considerable risks to the community, as users are more prone to engage in high-speed driving and commit violent offences when under the influence. Clandestine laboratories where amphetamines are manufactured pose an extreme risk to the community, the environment, drug users and police. This is due to the use of highly volatile and dangerous chemicals by inexperienced persons in makeshift laboratories. In the last fiscal year we located 20 clandestine laboratories spread over 25 suburbs. Precursor chemicals and specialised equipment are required to manufacture amphetamines. In 1993 an industry code of conduct was agreed by suppliers and police to report the sale of these chemicals and equipment. This voluntary code of conduct still operates but is only partially effective. Police would prefer a legislative obligation to report sales of precursor chemicals and equipment. This approach is currently being pursued by most other States.

Cannabis continues to be the principal illicit drug used in Western Australia, as confirmed by the DUMA project and the illicit drug reporting system. In the past, commercial cannabis crops were grown predominantly in the bush, and ranged from small to large-scale organised cultivations. The current trend is for indoor hydroponic crops. Outlaw motorcycle gangs control many of these hydroponic systems. Once a hydroponic system is set up it can produce at least four crops a year compared to the seasonal outdoor crops. Through improved horticultural practices the quality and

possible potency of plants has increased. This, combined with the ability to grow all year, makes this method of cultivation very profitable and less risky for the growers. Hydroponic cultivations pose additional risks to the community as many growers bypass the electricity meter. This, combined with the humidity of the growing conditions and water on floors, could cause electrical faults, electrocution or fires.

The Criminal Property Confiscation Act, which came into operation at the beginning of the year, will be a powerful tool in the fight against those engaged in the organised supply, cultivation, manufacture and distribution of illicit drugs. It provides the opportunity to target organised crime at the highest level and remove any unlawfully acquired assets. Since the inception of the Act we have applied to the courts to seize or freeze assets totalling $13 million. Some of the targets of this legislation are now seeking to defeat the legislative intent by transferring assets offshore, which poses jurisdictional problems for police. Future consideration needs to be given to how we can ensure the effectiveness of the legislation when the proceeds of crime are outside Australia.

Although we must continue all efforts to apprehend those who traffic in illicit drugs, we are increasingly engaged in harm minimisation and demand-reduction strategies. Through our policies on drug overdoses and needle and syringe exchange facilities, we are supporting treatment and advice strategies for illicit drug users. A significant part of our recruit training focuses on harm reduction, its importance and the vital role which police can, and do, play.

It is vitally important to educate our youth and the community on drug issues to better equip them to make informed decisions on drugs. Through our GURD youth alcohol and drug education strategy, we have trained 305 police officers who visit schools throughout the State and conduct drug education lessons. The lessons have been professionally designed and integrate with the School Drug Education Project.

The GURD program began in 1998 and, to date, in excess of 69 000 lessons have been delivered to 320 schools throughout the State. The program is regularly evaluated. Our latest evaluation shows that over 83 per cent of students enjoy the GURD lesson; 88 per cent of students found it easy to understand; and, most importantly, 85 per cent of students talked to their parents about the visit. From a teachers' perspective, the evaluation revealed that 80 per cent of the teachers surveyed liked the program as a vehicle for educating young people on drugs and they believed that it was appropriate for police to be involved with the education of children about drugs. The survey showed that 80 per cent of parents believed it was a great idea for police to be involved in drug education because (45 per cent) of children take notice of police, and (35 per cent) of children have knowledge of the topic. In addition to the GURD program, trained alcohol and drug advisers and GURD officers lecture to the community on a regular basis on alcohol and drug issues.

Policing of drugs invariably involves users who regularly come to the attention of the police because they commit offences to purchase drugs. Police acknowledge that the community is entitled to protection from drug users who victimise citizens to finance their addiction. For some crime categories, particularly crimes against the person, prosecution and imprisonment may be an inevitable consequence. Less serious offending may permit police to exercise discretion not to prosecute so that treatment options can be utilised to reduce or remove the motive to offend. Only then can we realistically expect a substantial reduction in the level of crime in Western Australia. Police participation or support for some demand-reduction strategies, which are educational or treatment-based, have been criticised by some people as going soft on drugs. Although police argue that their approach is a rational response to a complex issue, we recognise the community holds a diverse range of genuinely held views on a topic that engenders considerable emotion.

We have been involved in a range of initiatives aimed at discouraging the uptake of illicit drug use and that divert minor drug offenders into treatment programs with the objective to reduce the overall demand for illicit drugs. Our cannabis cautioning mandatory education program was first piloted in the Mirrabooka and Bunbury police districts in 1998 and was introduced statewide in

March 2000. It offers first-time persons apprehended in possession of 25 grams or less of cannabis the option of attending a drug education session conducted by a community drug service team in preference to being formally charged and appearing in court. As of 9 August 2001, 1 203 persons have received cautions as follows: 79 per cent of the cautions were for males; 21 per cent of cautions were for females; 70 per cent of all cautions were for people aged between 18 and 24 years; 89 per cent of all cautions were for Caucasians; 5 per cent of cautions were for Aboriginals; 2.5 per cent of cautions were for Asians; 91 per cent of all persons cautioned attended the education sessions; 95 per cent of all persons cautioned had less than 10 grams of cannabis; and 90 per cent had less than five grams of cannabis.

Diversion programs have been extended for persons caught for the first time with small amounts of other illicit drugs. It provides the opportunity of diverting offenders to an assessment centre and to attend two treatment sessions instead of being charged and going to court. This program has commenced as a pilot program in the Perth and Mirrabooka police districts and in the Geraldton subdistrict. Since the program started in December 2000, 26 people have been diverted, mostly for the possession of amphetamines. Once evaluated, the program could be extended statewide.

We are currently unable to divert youth under the age of 18 years to these programs because the Young Offenders Act prohibits us from issuing conditional cautions to juveniles. Consequently, a number of young persons have not been offered the same treatment opportunities. Issues paper 5 acknowledges that treatment does not have to be voluntary to be effective and that every dollar spent on treatment equates to a saving of between $4 to $7 on health and crime costs. In most States, people are given an infringement notice or a caution notice without having to attend an education program or a treatment provider. This approach links to the Drug Court concept of therapeutic jurisprudence and is an example of how our strategies must be complimentary.

The CHAIR (Ms Liz Harman): I ask that the commissioner move to his concluding comments because we are fairly short of time.

Mr MATTHEWS: I will comment briefly on the WA Drug Abuse Strategy Office. It has an effective coordinating approach that allows agencies to act collectively in delivering a consistent message.

I will return to the statement I made at the start of my presentation. The drug problem is arguably the most significant social issue confronting the community. There has been much commitment and investment in addressing the problem, and many dedicated people are trying in various ways to reduce the impact of drug usage. Many of those people are police officers, who see at first-hand the damage that illicit drug use does to individuals and the community. Illicit drugs cannot be viewed as simply an issue of law and order. Law enforcement has a key role in this area, in partnership with other agencies, groups and the community. We welcome the opportunity to contribute to the debate.

The CHAIR (Professor Liz Harman): Thank you. We will now move to our second speaker this morning who is Steve Jackson, from the Australian Federal Police, who will speak on the topic "Beyond National Borders: The International Implications of the illicit Drug Trade in Australia".

JACKSON, MR STEVE,
General Manager, Western Operations, Australian Federal Police.

Mr JACKSON: Thank you very much for the opportunity to speak at this Drug Summit this morning. As delegates will see from the title of my presentation, my job in the next 15 minutes is to provide you with some context regarding the national and international dimension of law

enforcement, and supply and reduction. First, I will say a few words about the Australian Federal Police. The AFP's role is to enforce commonwealth criminal law and to protect commonwealth and national interests from crime in Australia and overseas. The AFP is Australia's international law enforcement and policing representative, and chief source of advice to the federal Government on policing issues. The AFP has primary responsibility for ensuring that the Commonwealth's law enforcement interests are protected.

Australasian law enforcement is developing innovative and exciting new methods to combat the drug trade. One of these is to take the fight offshore. In cooperation with our international partners and through the AFP's overseas liaison officer network, the AFP is actively seeking opportunities to target the syndicates in source or transit countries. Delegates will see on the slide on the screen a simplified diagram of where the principal source countries are for the major commodities in which the AFP is particularly interested. The relationships with our overseas partners are based on reciprocity, both in theory and in practice, with the AFP's mobile national drug strike teams under the national illicit drug strategy contributing to overseas-based operations designed to stop the flow of drugs into Australia.

This tough-on-drugs strategy, as you are all aware, is combating illicit drugs on three fronts: law enforcement; health and rehabilitation; and education. Tackling the drug problem means reducing the availability of drugs in the community. Reducing supply gives us the best chance to treat addicts and to educate future generations about the harmful effects of illicit drugs. This is an innovative approach, and it has many benefits, including the fact that it presents greater opportunities for organisations to arrest criminal syndicate leaders; it returns to law enforcement significantly larger drug seizures; it has greater disruptive effects on the operations of criminal syndicates; it limits the availability of safe havens from which transnational crime syndicates operate; it increases the skill levels of developing law enforcement agencies through working alongside the Australian Federal Police in cooperative arrangements; and it reinforces levels of international cooperation.

Operating offshore is logistically complex and expensive. It is more expensive and complex than traditional domestic law enforcement operations. However, having said that, international law enforcement operations must become more commonplace as the influences of globalisation permeate our region with the increasing ease by which people can undertake international travel and by the ways that modern communication is exploited by criminal groups. Australia must take the fight to the source of the criminality, not wait passively as an easy victim.

The slide now being shown is a representation of some of the more significant importations we have experienced in the past year and year to date. Having made that point about the need to tackle drugs at their source, I must say also that, as many delegates would be aware, we engage successfully on our own shores to interdict the supply of illicit narcotics before they reach our streets. The job of the Australian Federal Police is to tackle drugs before they reach our customs barrier. This slide shows some of our more recent successes.

Australian law enforcement has also played a pivotal role in many of the successes enjoyed by our overseas law enforcement partners. This is a result of intelligence and operational resources being shared on an ongoing basis - a strategy that has reaped benefits on both sides of our customs barrier. The first two acronyms on this slide stand for the Hong Kong Police and the Royal Malaysian Police. The Australian Federal Police is the only international police agency, apart from the United States Drug Enforcement Agency, that the Malaysian authorities permit to work on their sovereign territory. The other acronyms stand for the Royal Fiji Police Force, the Royal Canadian Mounted Police, the New Zealand Police, the United States Drug Enforcement Agency, and the Singapore Central Narcotics Bureau.

These operations are about more than just drug seizures, because they have been complemented by large seizures of cash and, more importantly - this is the point to which Commissioner Matthews

alluded - other proceeds of crime, which is the currency that these drug syndicates rely upon. I will dwell on this point for one moment. Delegates have heard me talk about the creative and interactive ways in which we are taking the fight offshore. That means that we are up against a new criminal environment. Rather than large, standing organisations, the most effective criminal groups are small and well organised, with loosely-formed structures. They are cellular in structure, with "shore parties" of expendable foreigners taking delivery of drugs in Australia and passing them to wholesalers. They, like law enforcement, are well informed through intelligence, capable of forming global strategic alliances, and highly international in their operations. They are capable of using new technologies to good effect, and they often hide their illicit activities in licit activities. Most significantly, they can shift rapidly between commodities and modus operandi in search of profit and to avoid or mitigate the risk to which they are exposed. That again is a point to which Commissioner Matthews alluded in relation to the shift in commodity from heroin to amphetamine-type substances. In a single word, they are flexible; therefore, law enforcement must be more flexible if we are to stay ahead of the game. These features together make detection extremely difficult. I submit this is a fundamental implication of the fight that we are waging against the international drug trade.

Strong international law enforcement cooperation plays a vital role in many Federal Police operations and has been integral to some of our most successful outcomes. The Australian Federal Police law enforcement cooperation program, which is funded under the Federal Government's national illicit drug strategy, plays a critical role in this cooperation. This program is based on the AFP's international liaison officer network. The officers in this network, who are now represented in 22 countries overseas, form the link between countries, facilitating the exchange of information, as well as enhancing communication and understanding by attending international conferences and seminars, and, more importantly, working in a collegiate and collaborative way with our sovereign hosts. The law enforcement cooperation program allows us as Australasian law enforcement officers to build a rapport with international law enforcement agencies, particularly those in which we enjoy a presence. The law enforcement cooperation program has a number of positive implications. These include strengthening the capability of overseas law enforcement agencies to gather information and evidence against illicit drug traffickers; developing a greater capacity to meet Australia's international priorities by being able to more effectively gather international law enforcement intelligence to support our operations; and improving law enforcement infrastructure not only in Australia but also when working to support hosts like the Royal Malaysian Police in targeting international crime.

As my minister, Senator Chris Ellison said that Australia cannot regard itself as a fortress standing alone against transnational crime. It is important for Australia to have a presence in the region and across the globe in order to share essential intelligence on organised crime. So what does all this mean; what are the international implications of the illicit drug trade in Australia? Arguably, from a supply reduction perspective, we are being particularly successful in our fight against heroin. Some significant battles are being waged and, more importantly, we are having decisive victories.

According to a recent Australian Customs Service threat assessment update on developments in the global supply of heroin, there is no longer a global surplus of heroin available to replace law enforcement seizures. It is only now that we are prepared to state publicly that our supply reduction strategies are having a marked effect on the domestic market. More importantly, it is not only having a marked effect on the domestic market; it is having a measurable impact. Rather than providing honey-dripping rhetoric, we have something more tangible to say: we believe there is a drought and there is an undersupply of heroin. We believe that because of the figures. Even statistics available from ambulance services in other parts of the country indicate a drought of heroin on the streets.

We have heard much recent media comment about the so-called heroin drought. I can only underscore what Commissioner Matthews said, and that is that the undersupply in Australia is likely

to worsen before it abates to any significant degree. It will abate; I have been around long enough to say that. The drought will not last forever and it is important for organisations like mine to make sure that we push forward with the strategies we have seen so far.

What will be the impact on Australia? If we accept that we have a heroin shortage, we must ask why. It may be due to international law enforcement intervention like the operation in Fiji I showed earlier on a slide. The operation in Fiji last year netted 357 kilograms of narcotics. There may be environmental conditions, as referred to by Commissioner Matthews. Crop extermination strategies, as currently undertaken in Myanmar, may also contribute. It is more likely to be as a consequence of a combination of all these things. What is certain is that law enforcement cannot rest on its laurels. It must remain vigilant. Neither must we allow the anti-supply reduction debate to prevail at the expense of law enforcement strategies. Our current attitude of a multi-dimensional strategy involving supply reduction, harm minimisation and education is appropriate. We must have a balance.

What are the implications of this heroin shortage? Obviously, simple economic principles dictate that the demand on the streets will be as great as it was before and that the street price will increase. The purity will fall. The health consequences for users will be nothing short of tragic because the dealers will start cutting heroin with more harmful and life threatening substances as it will be in short supply. We must also be on the lookout for all the indicators of major and significant commodity shifts by syndicates. It is far too early to tell what the effect of our recent seizure of 1 000 kilograms of cocaine in Western Australia will have on the market. I will advance a proposition: if last year's statistics are believable - and they are - the global production and supply of cocaine was in the region of 300 tonnes. We seized one tonne, the United States authorities seized 13 tonnes earlier this year and the French authorities seized 1.8 tonnes the week after our seizure. I will let the delegates be the judges of what will be the impact on the domestic cocaine market.

Should we gloat? Absolutely not, but we should recognise that we are making a difference. I said earlier that I was not going to present honey-dripping rhetoric. I will not. These are tangible figures that we have been able to put together based on consultation with overseas drug enforcement agencies as well as health agencies under the United Nations drug control program. You may be interested to know that this international benchmarking study established that, based on quantities of illicit drugs seized per million residents, in 1998 the Australian Federal Police, in cooperation with the Australian Customs Service, was in second place behind the Netherlands for heroin seizures, in fifth place for ecstasy and in twelfth place for cocaine. We will hold that last point for the moment, and see what impact the recent seizure has on that.

What does it signify? The war against illicit narcotic trafficking is not a local or even a national war; it must be waged on the international stage. I will close with a point I made in my opening statement. Cooperation and collaboration is not nice to have; it is a "must have". For many years we have talked about how good it would be for law enforcement globally to harmonise its attack against transnational crime syndicates. That is now a reality. The record drug hauls achieved by the AFP and its partners to date, together with the tangible examples I have provided today, are testament to the resolve that we have on this matter. With this winning strategy, I believe we will win the war.

The CHAIR (Professor Liz Harman): I would now like to call on Julie Wager, who is from the Western Australian Drug Court, and will speak on drug courts in Western Australia.

WAGER, MS JULIE,
Stipendiary Magistrate, Perth Drug Court.

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Ms WAGER: In a traditional adversarial court, when an offender pleads guilty, that offender gives the lawyer instructions to tell the court. That story, those instructions, are usually not supported in any way, and are often contradictory. In a usual adversarial court, the prosecutor will advocate locking the offender up, regardless of the personal circumstances of the offender. In a usual adversarial court, the judicial officer will never have seen the offender before, and after sentencing will never see the offender again. Those are the three separate parts of an adversarial system, and we need those three parts for very good reasons in our law, but not necessarily if a person has pleaded guilty.

Drug Summit Issues Paper No 7 confirms that many offenders are illicit drug users, and that those offenders are likely to re-offend more regularly and more seriously. The upshot of that is that those offenders will appear in court again, probably with a different lawyer, a different prosecutor and a different judicial officer. The penalty imposed will be greater and they will be sentenced by the judicial officer as one of the three separate parts of the adversarial system. They will do their sentence, and when they are released they will be released with limited supports. What is it that they are released to? For most of them, it will be to absolute chaos, because they are released to drug debts, threats of drug dealers, family breakdown, bad relationships, and psychiatric and psychological problems that just have not been looked at. So what happens? The whole cycle starts again.

The Drug Court is different, in that it is not an adversarial court with those three separate parts. It is a specialist team court, and it supports an offender to make a choice. That choice is to make lifestyle changes and to stop using drugs. The Drug Court is open to those who plead guilty to offences that have occurred because of their illicit drug lifestyle. That mainly means offences of burglary, stealing and receiving. The Drug Court does not accept people who are drug traffickers, people who are charged with violent or sexual offences or those who must face long terms of imprisonment. The Drug Court operates in the Perth Court of Petty Sessions, and is presently a two-year pilot program. It also supervises some who plead guilty in the District Court, and there is a Drug Court in the Children's Court, for serious drug-using offenders in that jurisdiction.

Rather than having the three separate parts that exist in the usual adversarial court, the Western Australian Drug Court has a team that works with offenders who choose to participate. The offender is given a traditional sentence - the usual penalty that would apply for the offence - and is then offered a choice between taking that penalty or becoming a participant in the Drug Court program. If the offender chooses the Drug Court option, the traditional penalty will hang over his head throughout the course of that program. During that program, the offender is case managed by a Drug Court team consisting of the magistrate, the police prosecutor and the defence lawyer. They are the three separate parts of an adversarial system. That is where the Drug Court is different, because rather than being three separate parts, those three parts unite to form a team to work in the best interests of the participant, with the assistance of the case manager or the court assessment and treatment service officer. The team meets each week to work out the best possible plan for the participant.

The participant must come to court each week and knows that if it has been a good week, he will be rewarded. That may be through praise, applause or by having a good time in court. However, if it has not been a good week, the offender knows that he must face the magistrate and receive a penalty. That might be through breach points or, potentially, termination of the Drug Court process and the imposition of the set, traditional sentence. Clearly, if the lapse into a drug-using lifestyle is such that it endangers others or the participant, that will inevitably be the result.

Twenty-three rehabilitation providers assist the court. Those services are funded federally via the WA Drug Abuse Strategy Office. Those rehab providers are great. We have a lot of incredibly talented, committed people in Western Australia. I do not say that just because a number of them are here today, but because they work really hard. We must accept that we should not change what

is working. Those rehab providers would accept that drug counselling on its own is not enough. The Drug Court helps and encourages participants to find stable accommodation and to tap into specialist support, such as sexual assault and financial counselling, psychological or psychiatric services and grief counselling, because the lives of most of the participants have been shattered. The Drug Court has been overwhelmed by the enthusiastic and generous support it has received from members of the community. That includes volunteer specialist people such as Parent Drug Information Service representatives. A delegate at this summit is involved in that service. There is also community involvement through the Notre Dame University law school and Murdoch University postgraduate psychology course. Students come to the Drug Court and assist participants. The Murdoch University restorative justice program also works with participants and victims, if required. Although this support is great, it does not reduce the need for holistic support that is well funded. The Drug Court needs those facilities to make the process succeed for the participants. Access to educational facilities, dentistry - there is nothing like two front teeth to give people self-esteem - housing and family therapy services is required.

We must also examine different ways of doing what we do. For example, we conduct urinalysis tests to assess whether a person has been using drugs. We need to consider ways of making these tests less invasive. We need to investigate options that have been used at other places, such as a mobile urinalysis van. Would that work in Western Australia?

The Drug Court program presently runs from four to six months before a person is sentenced. However, we have been promised legislation to allow it to run for up to 12 months; clearly that is desirable. However, at the end of a Drug Court program, successful participants can do something very unusual: that is, look forward to their sentencing day. The reason for that is if people have worked hard and put in an effort, they can be almost guaranteed that immediate imprisonment will not result. They will get a penalty, as there is still clearly a punishment element. However, the court can consider the fact that the risk of reoffending has been substantially reduced and not necessarily lock up a participant.

It is early days yet, but I believe if a few changes are made, the Drug Court could work for participants in the long term. One thing that is desperately needed is the ability to get participants going as soon as they are referred to the Drug Court. We cannot afford a lapse, waiting for appointments to set up something, because while that is happening, chaos is taking over again. Therefore, the Drug Court needs a secure, specialist detoxification facility for the assessment of participants - both men and women. It is not enough to lock up people in prison to detoxify them. Each of our participants needs to be fully checked over psychiatrically, psychologically and physically to determine the health problems the person has so that immediate professional care can start; and also, importantly, find out what licit drugs need to be prescribed so that there is no over-prescription and we have some control over the future of our participants. The Drug Court would then be in a position to set up a program that has a chance of working because it can start straight away. A secure, drug-free facility would be ideal for that purpose.

Another concern is that the Drug Court presently does not have any legislation. Delegates have heard me say that the Drug Court works differently from the usual adversarial court, which has three players, in that we work as a specialist team. However, the Drug Court is required to fit into the rules that have been set for adversarial courts, and we do not quite fit. Importantly, we must be able to offer participants a chance to be honest and truthful with the court without any repercussions. That means that participants must be able to tell the court that they have used drugs, that their lifestyle is a mess, what is happening at home, and that they have been beaten up by a dealer without facing the consequences of further criminal charges or having that information used against them in other proceedings. We also need legislation to make it clear that the funding of, and the court's emphasis on, education, vocation, health and family are just as important as the emphasis on traditional justice methods.

One of the advantages of a Drug Court is that we have a chance to see what may work. I believe that through care should work and should be tried. No doubt, delegates will be given information about that during the summit. If something worked for a person when that person appeared in the Children's Court, then why stop it just because that person has turned 18? If a person in the Drug Court gets on really well with his counsellor then relapses and must be imprisoned, why break that relationship? Why not let that counsellor continue seeing the person in custody and continue being there for him when on parole? We cannot afford to throw away the good work that has been done with each offender and go back to square one, just because a relapse has occurred.

I stated that the Drug Court is a specialist court. I have indicated that as a result of that we need specialist services provided by well-trained professionals. No mention has been made of the money. Clearly, those services cost money. However, I ask delegates to consider that the cost of providing those specialist services will, in the long run, be much less than the cost of keeping repeat offenders in custody. I ask delegates to consider also that the cost of providing those services will be significantly less than the cost to the community, both emotionally and financially, that results from offending.

Most importantly, the provision of specialist services to a therapeutic, specialist court may assist so that unnecessary deaths do not occur. It may mean that people who have potentially so much to offer are allowed to realise that potential.

LENTON, MR SIMON,
Research Fellow, National Drug Research Institute.

Mr LENTON: This paper draws on work I conducted with a team of people, both in Australia and internationally, for the Drugs and Crime Prevention Committee of the Victorian Parliament, which was published in a Monograph available from the National Drug Research Institute. My aims today are to summarise the six main models for drug laws; to discuss the likely impacts of the international drug treaties and conventions on the options; to consider some of the advantages and disadvantages of the different legislative models; and to comment on cannabis law.

Cannabis is the drug for which most variation exists among the models; therefore, I will use it as an example. Firstly, I will talk about total prohibition. Under total prohibition, all activity associated with the possession, use, manufacture, sale or supply of drugs is considered criminal. Such a legislative system currently operates in Western Australia, although since March last year, as has been mentioned, cautions have been issued for first-time cannabis possession offences.

Through the second option, which is called legislative prohibition with an expediency principle, drug-related activities are illegal. However, cases involving possession or use of small amounts are not investigated or prosecuted by the authorities. An example is the system operating for cannabis in the Netherlands. Under the prohibition with civil penalties scheme, drug-related activities are illegal, but under certain conditions criminal penalties do not apply. Instead, a civil penalty such as a fine is administered. Cannabis laws based on this model operate in South Australia, the Australian Capital Territory, the Northern Territory and in 10 States of the United States of America.

Under partial prohibition, personal-use activities are legal but commercial activities are illegal. Examples of this model operate under cannabis law in Colombia, Spain and Switzerland. Under regulation, all cultivation, sale and supply of drugs is to some extent controlled by government regulation. Activity outside the regulated market remains illegal. In Australia this applies to licit drugs such as alcohol and tobacco, as well as to pharmaceuticals. The final model, which gets a lot of Press, is the free availability option. No legislative or regulatory restriction applies to the

manufacture, sale, supply, possession or use of drugs. When we think about it, free availability does not apply to many commodities in our community.

Legislative and regulatory options have other components, such as drug courts and cautioning and diversion schemes. These are often integrated into total prohibition schemes. I will not speak in detail about those this morning. Free availability operates in the Kullu Valley at the foothills of the Himalayas in northern India. Many Indian States prohibit alcohol but allow drugs prohibited in the west. This slide shows a drug researcher squatting alongside some cannabis plants growing on the side of the road. The Kullu region is one of the destinations on the hippy trail.

It is important to consider Australia's obligations under international drug treaties and conventions. Australia is a signatory to the three main conventions, and is bound to have in place systems that prohibit the availability of drugs. However, like the international whaling convention, exemptions are provided for scientific and medical purposes. Interpretation of these laws and conventions differ; however, most commentators agree that civil penalty systems for cannabis, like those in place in South Australia, the Australian Capital Territory and the Northern Territory, are acceptable, as are systems such as those in the Netherlands, in which laws are not enforced under certain conditions. Systems of free availability, regulated availability and partial prohibition would probably be in breach of the treaties as they currently stand. However, we all know that where there is a will, there is a way, and national Governments may be signatories to treaties and choose not to behave within them. Our Government's behaviour regarding the treaties on the Rights of the Child and Refugees is one such example.

I turn to the advantages and disadvantages of some of the main legislative options. The advantage of strict prohibition is that it is the norm in many countries and is clearly consistent with the intention of the treaties. Some conservative policymakers and community members claim that it sends a clear signal that drug use is not condoned. However, much drug research, and research in criminology generally, seriously questions the extent to which this message prevents drug use in the community. Some of our research shows that the consequences for individuals who receive a criminal conviction are great in terms of employment, further attention from the law, problems with accommodation and relationships and a range of other things. The cost of drug law enforcement in the total prohibition system is also large, and was estimated at $450 million in 1992. Finally, total prohibition options rarely recognise the need to treat drugs with different harm profiles differently. As such, the opportunity to selectively apply the law to send to the community messages about the different levels of acceptability of various drugs is lost.

(Prohibition with an expediency Principle)The Dutch have shown that a system of cannabis supply can be established that largely separates the cannabis market from the market for other illicit and potentially more harmful substances. While the system operating in the Netherlands is in apparent conflict with the spirit of the international conventions, which expressly prohibit the commercial sale and supply of cannabis, the Dutch maintain a legislative prohibition. Although it is illegal to supply and buy cannabis, the law is not enforced under certain conditions. This is an example in which a pragmatic approach that permits discretion about whether certain laws are enforced allows the system to work. The system allows drug policy implementation to be responsive to local community needs. The Netherlands experience has shown that, to some extent, it is possible to normalise and culturally integrate not only cannabis use but also, more importantly, the strategies to control use. This slide is an example of a pamphlet available in all the cannabis coffee shops in Amsterdam. It is produced by the Jellinek Institute, which is a very famous drug research and treatment organisation in the Netherlands. The brochure provides information to people when they buy cannabis from a coffee shop. Point 4 states -

> Some kinds of hashish or marijuana are stronger than others . . . So it is important to get some reliable information first about what you are buying.

When a person enters a coffee shop in Amsterdam and sits down at the bar, the guy on the other side conducts an interview. He asks if the person has much experience with cannabis and explains that some varieties are powerful and should be avoided if the user is not very experienced. However, the story from the Netherlands is not all good. Evidence suggests that the growth in the number coffee shops may have resulted in an increase in cannabis use among adolescents. It is important to note that this increase has not been as great as the increase in some other countries, such as the United States. The Netherlands has experienced international pressure from the European Union, the United Nations drug control program, some of its neighbours and, of course, the United States to change its drug policy. The Dutch have resisted that pressure and have demonstrated that it is possible to do so.

The Dutch experience also demonstrates that if the control and wholesale supply of cannabis to retailers is not managed within the law, or some other explicit regulatory structure, problems arise for those trying to run the supply businesses and in respect of the law in general. Infiltration by organised criminals has been evident among suppliers in the Netherlands. The Dutch approach of formalising the inconsistency between the provisions of legislation and its implementation could be seen by some as sending confusing messages about the law. A map is produced showing the location of the different coffee shops in the Netherlands, and it includes many advertisements.

I refer delegates to the prohibition with civil penalties model. The Australian experience indicates that this model is not in contravention of our international treaty obligations. Our research has shown that with regard to cannabis, at least, civil penalties are no worse than strict criminal convictions at deterring use. However, the social costs for those apprehended and issued with an infringement notice are far less than those resulting from a criminal conviction. The civil penalty system in South Australia has been estimated to save about $1.3 million a year as opposed to the cost of a strict prohibition system. Research has shown that about 70 per cent of the public in this State and around the country are in favour of applying civil penalties rather than criminal penalties for the possession and use of cannabis. The use of civil penalty schemes provides an opportunity to structure the cannabis market so that a greater proportion of the cannabis consumed is supplied by small-scale user-growers rather than by large-scale commercial growers with criminal associations.

(Disadvantages) Evidence collected in South Australia suggests that many people have been caught up in the criminal justice net through the expiation notice system because the number of infringement notices has grown exponentially over the 10 or more years since the system's introduction. Surveys have shown that this increase in the number of notices issued is not due to an increase in cannabis use but, rather, to the ease with which police officers can issue the notices and the fact that cautions or informal warnings can no longer be issued. This has resulted in net widening - that is, more people are being caught up in the criminal justice system. South Australian evidence indicates that people who are less able to pay suffer a greater penalty. In addition, only about 45 per cent of fines are paid. Strategies have been put in place to improve that situation, and it appears that small fines and more options with regard to dispensing fines will probably be a help.

(Cautions about cautioning) Some issues about cautioning schemes need to be considered in any evaluation. First, does the introduction of formal cautions result in less use of informal discretion and warnings by police? As such, does it drag more people into the criminal justice net? Secondly, do those who are issued with a caution with diversion to treatment but who fail, end up with a more severe penalty than they would have received had they not opted for a diversion option? Thirdly, what are the implications for further treatment seeking for those ordered to undergo treatment early in their drug-using career? We are aware of evidence indicating that those who undergo mandatory

treatment and those who opt for voluntary referral tend to do equally well. However, we do not know the extent to which early mandatory treatment impedes the willingness to seek treatment later. Finally, the goals of such a program will determine its structure. Questions must be asked about the Western Australian scheme.

(Non-legal factors) Criminology research has produced a number of non-legal factors that are greater determinants of offending than the law. Issues supported by the public are a major factor, as is the extent to which the behaviour is supported by peers. The extent to which individuals see themselves as law-abiding rather than law-breaking is also very important. The extent to which an individual feels engaged with society and a longstanding drug and offending history are also major determinants of crime. The extent to which they perceive the laws that apply to them as being fair is important. The extent to which they are committed to those laws is important; and the extent to which they feel that they are respected in interactions between themselves and police at the time when they were last in contact with police.

In conclusion, as part of the National Drug Research Institute, we have made a submission to the summit - which I hope delegates have seen - which is a suggested new model for cannabis law in this State. It attempts to integrate the best features of the infringement notice systems and cautioning which are available in the different States and Territories, both of which have been shown to be consistent with the international treaties. What is different about it is that it attempts to structure the cannabis market away from large-scale commercial suppliers who buy houses and divert electricity meters and grow many, many plants in the houses, by applying civil penalties to the provision of small quantities, trying to have a market that is largely supplied by a cottage industry rather than the large criminals. Finally, attempts have been made to reduce the net-widening that has occurred in South Australia by allowing police discretion to warn, by having cautioning for a first offence, by allowing multiple payment options for people, and by allowing offences to be expunged after two years so that the criminal record does not stay with them for the rest of their lives. Thanks for the opportunity to talk to you.

The CHAIR (Professor Liz Harman): We will now have 20 minutes of question time. I have a number of points to raise while delegates are thinking of the questions they would like to propose to our speakers. We are grateful to all of our speakers for making themselves available for the working group sessions later this morning. Superintendent Jim Migro will deputise for Commissioner Matthews. Mr Martin Hosek from Switzerland will also continue to be available today but will not be here tomorrow. In all cases, would delegates please continue to use the orange forms to reserve speakers for working group meetings.

I have a couple of other points. Some delegates have been raising questions during the past few days about how the voting process will occur on Thursday and Friday. The chairs would like delegates to be aware that we spent some time last night in a very constructive discussion with the working group chairs and facilitators and will be continuing that discussion with them this evening in order to give delegates some more advice tomorrow. Could delegates please let their chairs or facilitators know if there are any particular concerns they would like them to be aware of as part of those ongoing discussions.

Mr EGAN: I have a point of order. Will the chairs make a decision on voting or will the Drug Summit make a decision on the method of voting?

The CHAIR: The chairs will be discussing the issue again this evening with the facilitators and the working parties. We already have some rules that were agreed to by some delegates on Sunday afternoon and we will be working with those for the time being. We will come back to the meeting tomorrow and discuss how far we have gone in enhancing those rules if we believe that there is, as a result of issues raised by delegates, a need to consider them again.

Diane asked a very interesting question of the technical advisers. We have taken that on notice and they will be responding to her later during the summit. I think that will challenge them a little.

I now turn to the summit delegates and seek questions.

Mr CHANG: I have a question for Mr Jackson. With the obvious increase in the general commodity traffic from China, likewise with the increased inflows of ecstasy tablets from Indonesia and Holland, I would like to know what you have in place or your agency has in place or Australia has in place to protect the drug flow of heroin and the ecstasy tablets from these two countries.

Mr JACKSON: We have in place a number of strategies, both domestically and overseas. Obviously, as a police agency, we rely on intelligence from our overseas counterparts. As I said in my presentation, we have liaison officers - certainly in the countries you alluded to. We are privileged to have a senior liaison officer in Beijing, and officers in Indonesia, Hong Kong, Malaysia, Thailand and Myanmar. There is a recent initiative to have an officer on the other side of the world in Colombia. We are conscious that we need to work out ways to keep a handle on the flow of narcotics, and whether we are doing the right thing or not. As I said in my presentation, we would not blindly pursue a strategy at any cost. We will be big enough and bold enough to put our hand up and say that it did not work, and it is time to look at something else. We very much rely on international cooperation to identify whether we are assessing and analysing the flow issues correctly.

Mr MUDGE: My question is to the Commissioner of Police and the representative from the Australian Federal Police from the perspective of a victim of crime, and it relates to the higher echelons of people who bring the stuff into Australia and distribute it. Without negating that you have been successful in what you are doing, what will it take to be more successful than you have been - other than money, resources or other activities? What will it take for the law enforcement agencies of Australia, and in particular Western Australia, to be more successful? Fortunately, the stuff that was stolen from me has been recovered. The people who took it have been dealt with by the court system, but the dealer who urged that person to steal my stuff is still dealing. That person is still in my street; and is a real threat to the people in my street.

Mr JACKSON: We will not gloat and say that our strategies have won the war, but clearly we have had some decisive victories. Your question is valid, and I will allow Commissioner Matthews to answer it from a state perspective. In relation to the national and international perspective - I will simplify this as much as I can - for every major transnational crime in the world there is a local crime somewhere. It is the local crime that has the consequence of interfacing with the victim. It does not matter whether it is 1 000 kilograms or 10 kilograms of cocaine; I am not too interested in the commodity because each commodity has its own destructive effect. There are a number of things we can do to be more successful. In Western Australia, for example, I have only 142 federal agents, and not all those people are sworn federal agents. In order to police a State the size of Western Australia the expectation is that we push offshore. We look at ways that we can operate in Bali, Indonesia, Malaysia and Fiji; we must rely on the community. That is why the working relationship with state and territory police services is extremely vital and, I have to say, very successful. We want community support. It is arguable whether we would have been as successful as we were in the recent cocaine seizure without the great work that the community did for us, not only in the lead-up but also during and immediately after the operation.

The second thing that we need in order to ensure greater success is continuing international political support. My simplistic, pragmatic view on life is that if we can take these drugs out at source, we will not have a problem on the streets. The Myanmar Government has allowed the Australian Federal Police to operate on its sovereign territory. It is a delicate situation - as it is in Singapore, Malaysia and China - because of the death penalty issue. That is a delicate dimension that agencies like mine have to track. If we can continue to push crop destruction strategies in bilateral and multilateral negotiations with foreign countries, that will be very useful. That, together with community support, is my long and convoluted answer to a very good question.

Mr MATTHEWS: If I may take a little more pessimistic view, it is estimated that law enforcement probably seizes about 10 per cent - it might be 20 or 25 per cent. If we took the most optimistic figure of 25 per cent - no-one has suggested that we interdict that amount - we would have to be four times more successful than we are now. To my knowledge, nowhere in the world has anybody ever managed to do that, no matter what the penalties or the number of police. The reality is that we will be only partially successful in interdicting on the supply side. We need to use strategies well on the demand side for harm reduction and to reduce demand. The problem is that even if we are successful - for example, if we were to argue that we have been successful with heroin - people who are driven by addiction will move to substitute drugs. They will make drugs in home bake or they will move on to amphetamines or something else. People engaged in this at all levels are very ingenious and will go to considerable lengths. Australia is a free trading nation, and that means tremendous numbers of containers and people come into our ports every day. It is not possible to check and search every container and person. Drugs will still get through no matter how effective the agencies. We need a holistic approach and not merely concentrated efforts on the supply side. I do not suggest that the Australian Federal Police should do that. We need an approach that encompasses a whole range of strategies, so we can attack the issue at all levels.

Mr MEOTTI: I direct my question to Mr Matthews, although it could probably go to the Federal Police. Do you feel that a law enforcement approach that encompasses removal of criminal sanctions for the personal use and possession of some or all illegal drugs, coupled with a strong supply reduction strategy, as previously outlined, that is targeting the top-end criminals, drug dealers and traffickers, will ultimately result in better outcomes for reducing the harm of the social cost of criminal convictions etc, as well as a better use of limited police resources?

Mr MATTHEWS: One of the things that is perhaps worth mentioning is that every year 1 500 people in Western Australia die from tobacco-related diseases and 330 from alcohol abuse. There is a regulatory approach to both of those drugs, but they cause considerable harm. As for law enforcement, alcohol involves minimal policing but it is a significant resource because of the harm it occasions, whether as a result of traffic crashes or crime. Shifting drugs out of a criminal environment into a civil environment may resolve one side of the problem by taking the organised crime aspect out of it to some extent, but it may increase the level of harm through greater availability and so forth. A number of States in America decriminalised cannabis. Some of them have reversed that. I do not know the reason for that, but it is certainly a question that needs to be examined. There is a lot of evidence around the world for why that should be. I am sure that others could give the answer to that.

Ms ALCOCK: My question is directed to Julie Wager. Drug courts are a fantastic innovation in our fight against drug abuse. To what extent is there provision for the families of young offenders or any offender to become involved in the drug court process?

Ms WAGER: I preside over the adult court only, so my comments will only relate to adult offenders. In the usual adversarial system that I was telling you about, it is very important that the lawyer receive instructions only from the client, and that the client's version of events go to the lawyer and there is confidentiality in that process. After a plea of guilty has been made, the situation can change because parts of the charge are no longer challenged.

It has become clear that support services must be provided to parents, and that is why I referred earlier to the Parent Drug Information Service. At our court, a group of volunteers, including Paula Marii, has been trained in the procedures of the Drug Court by the court assessment treatment services, the prosecuting sergeant, the defence lawyer and me so that they are aware of what happens at the Drug Court. In that way, if a parent presents himself or herself in a state of crisis at the court to the lawyer or to the case manager's office, that person can be referred by telephone to one of those people. Some of those people have experienced their children being drug users and,

tragically, some have experienced the death of their child. That means that those people are in a position to give support on the phone and to provide information about follow-up procedures.

As Jan Battley said earlier, a number of agencies are available for parents, and we must keep it that way. If anything, the resources available to parents and extended families should be expanded. That is the direction in which the Drug Court is headed. The parents and the families of those affected need a voice and support given the stress and distress from which they suffer.

The CHAIR (Professor Liz Harman): I inform the summit that we will not satisfy all of the interests on the floor to ask questions. I have been given notice of three additional questions and I know that many more delegates want to ask questions. I call on Sandy Moran.

Ms MORAN: My question is directed to Julie Wager. Can you tell us whether, in the case of recidivist juvenile substance abusers, a comprehensive paediatric developmental report obtained prior to sentencing would identify underlying mitigating influences in that recidivism including attention disorders, Tourette's syndrome, learning disabilities or developmental delay?

Ms WAGER: I preface my comments by saying that I am a magistrate who presides over an adult court. I deal only with people who are 18 years or older. As I have stated, a Drug Court in the Children's Court is presided over by the president, her Honour, Judge French. A juvenile justice model is followed in the Children's Court, and reports are obtained. I do not think that any of us would confidently say that those reports are so thorough that all of those needs are investigated. There is room for more information to be provided to the court and for those problems to be picked up so that early intervention programs can be provided to children.

I refer to a point I made about through care. It would be great if that sort of intervention occurred at an early stage for young offenders and for that information to be made available later in the event that that person continued to offend. A problem we have in the court system is that reports are obtained for juvenile justice but they do not flow through to the adult system; therefore, we must obtain the reports all over again. When considering the provision of reports from the Children's Court to the adult system, we must consider the need to balance human rights issues and civil liberties issues. Is it fair that a report that was obtained when a person was 13 years old is still on a file when that person is 25 years old? It is a complicated area, and more support and investigation must occur at an early stage.

The CHAIR (Professor Liz Harman): I will take a final question from David Moyses and invite other delegates to take advantage of the availability of the speakers at the working group sessions.

Mr MOYSES: My question is directed to Simon Lenton and it concerns an interesting report that we will refer to later in the committee. Earlier, Simon touched on an interesting area on the relationships of drugs and the harm attached to them.

I noticed that the report of the independent inquiry on the Misuse of Drugs Act in England, which was handed down last year, specifically noted this point; that is, the relationship of some of the drugs and whether we are sending the right messages. Is it possible that by placing drugs such as ecstasy and LSD in the same class - as the authors of the report believed - as cocaine, heroin and amphetamines that are able to be injected, we are sending a message that ecstasy and LSD are obviously being used by a lot of people without too many harmful effects, so they can go on to the next one? Therefore, the gap is not big enough to send a message that if people go on to the next one, they are taking a big step.

Mr LENTON: One of the problems with prohibition, as you alluded to, is that there is a fence. I refer to Malcolm's comments yesterday about the fence and the cliff, because they were quite powerful comments. Having done research in this area for seven years and having been involved in treatment for 15 years, I have a slightly different view of the fence. I think it is probably a three-metre high fence, with electrified razor wire. The cliff is probably about 100 metres wide, but the fence is only about two metres long. That is because only one to two per cent of people who use an

illicit drug in this State, or in many other places, get apprehended for that. What happens is that a lot of people get around that fence. It is not as long as we like to think it is. Rather than a cliff, I see it more like a set of terraces. The first terrace is very wide, and it is only a short step down to that terrace. On that terrace are 300 000 Western Australians every year. They are Western Australians who choose to use an illicit drug at least once in that year. Therefore, lots of people are down there. Sure, there are big crevices and big pot-holes - there are lots of places to come to grief. However, when a lot of those people look back at that fence, what do you think they see? I believe that one of the things they think is that the people who built that fence are stupid, because many of those on that terrace just walked around it. The second thing they think is that the people who built that fence want to hurt them, because many people in their midst have scars and burns from coming up against that fence. Therefore, a lot of those people down on that terrace spend a lot of time looking back at that two-metre long fence, and they do not look around at some of the hazards and harms that they are likely to experience down there. That is a real problem.

Many people who would seek help from general practitioners, school counsellors and so on are frightened to do so, because they see those people as representatives of the system that built that fence up there. That is a real problem. Yes, there are real problems with the fence as we have it, and not being able to differentiate between some of the illicit drugs that people use is one of them. Thanks for the question.

The CHAIR (Professor Liz Harman): Simon and Malcolm have left us with a very graphic image for morning tea. However, first, I ask delegates to thank all our speakers.

Summit suspended at 10.33 am to 1.30 pm

The CHAIR: (Hon Fred Chaney): I invite Dr Alex Wodak, Director of Alcohol and Drug Services, St Vincent's Hospital, Sydney, to give his presentation.

WODAK, DR ALEX,
Director, Alcohol and Drug Services, St Vincent's Hospital, Sydney, and Drug Law Reform Foundation.

Dr WODAK: Australians, as Mr Howard noted, like to feel relaxed and comfortable. Most Australians now and then use drugs of one kind or another to feel relaxed and comfortable. Mood-altering drugs have been consumed in virtually all cultures past and present, and this is likely to continue for the foreseeable future. Drug consumption rises and falls over time. Individual drugs go in and out of fashion. We understand little of this process. However, we are able, if we allow ourselves, to manage this problem well. We cannot stop some young people from being silly, but we can stop many young people from being dead; and it is almost invariably the politics of drug policy that prevents communities from protecting their young people from being harmed by drugs.

This talk has five parts: how effective is our current drug policy; how can we better understand the present; how can we best reduce the problems drugs cause; how can we get better outcomes from drugs in prisons; and what stops communities from getting better outcomes from drug policy. How effective is our current drug policy? The most important indicators of a drug policy are deaths, disease, crime and corruption. Australia had six drug overdose deaths in 1964 and 958 in 1999. HIV is still under good control among injecting drug users in Australia, and this public health triumph was achieved by harm reduction. If HIV ever spread extensively among injecting drug users, there would probably soon be a major epidemic in the general population, with huge health,

social and economic costs. There are almost 11 000 hepatitis C infections a year among injecting drug users in Australia, and many young people each year develop severe social, physical and mental health problems which are attributed to drugs. Drug-related crime is also common and apparently increasing in Australia, and two state royal commissions during the past 14 years have concluded that drug-related police corruption was common and linked closely to attempts to enforce our drug laws. Many parents are worried about drugs, and there is much anxiety in the general community about this issue.

How can we better understand the present? Our official national drug policy is harm minimisation. The current definition of harm minimisation consists of supply reduction, demand reduction and harm reduction. How well do these components work? Let us start by considering supply control, as this is the basis of current policy. Supply control is increasingly recognised as having major limitations. It is very expensive, although it is not easy to find out exactly how much Governments spend on drug law enforcement. Prohibition is relatively ineffective, as the National Crime Authority noted just last week. Death, disease, crime and corruption have been increasing in Australia for many years. The purity and availability of street drugs have been increasing and prices have been decreasing for several decades. This year, however, heroin has been scarce in Australia, although many believe this is just a temporary phenomenon. Prohibition is often counterproductive. For example, in Australian prisons the penalty imposed for a positive urine test is the same for both cannabis or heroin. Cannabis use can be detected for up to five weeks and heroin can be detected for only two days. Rational inmates inject heroin rather than smoke cannabis. Harsh laws often, inadvertently, produce terrible outcomes. Our current policy is based overwhelmingly on drug law enforcement. According to the most recent authoritative estimate available, expenditure by the Commonwealth and State Governments in 1992 in response to illicit drugs amounted to $536 million. Of that figure, 84 per cent was allocated to drug law enforcement, six per cent to drug treatment and 10 per cent to prevention and research.

Concern about increasing drug consumption is growing because there is an increasing range of drugs available, increasing numbers of young people are using drugs and street drugs are becoming cheaper. Purity is also increasing.

There are three major empirical limitations of supply control. The first is geographical redistribution, also known as the push down-pop up problem. If police crack down on drug traffickers in Fremantle, drug traffickers pop-up in Subiaco. If they crack down on drug traffickers in Subiaco, traffickers pop up in Nedlands. The second limitation is demographic redistribution. If Parliaments pass draconian legislation against adult traffickers, children start trafficking. When police crack down on Lebanese drug traffickers, Samoan drug traffickers pop up. When police crack down on Samoan drug traffickers, Romanian drug traffickers pop up.

The third limitation is pharmacological redistribution. Drug prohibition drives out less dangerous drugs, which get replaced by more dangerous drugs. Bulky, smelly opium that could be smoked was driven out of Asia, and in its place came almost odourless, and far more damaging, injectable heroin. Over a decade ago in Western Australia, increasing amphetamine use was linked to a scarcity of cannabis. Some cannabis dealers started supplying amphetamines when cannabis became scarce. Supply control is not cost-effective but treatment is. One study found that for each dollar spent there was a 15c benefit for cocoa plant eradication for the United States, a 32c benefit for interrupting cocaine trafficking between South and North America, a 52c benefit for improving United States customs and police, but a $7.46 benefit for each dollar spent on cocaine drug treatment. Yet, 93 per cent of United States government funding was allocated to law enforcement and only seven per cent was allocated to drug treatment.

In practice, the relationship between the intensity of drug law enforcement and drug prices is often poor, and drug prices are often poor predictors of drug consumption. Economic theory might suggest that falling prices for drugs result in increased consumption but, in practice, it often does not work out that way.

Alcohol prohibition in the United States is a clear warning of the high social costs of ignoring powerful economic forces. There are also major theoretical limitations of supply control. Enough heroin, cocaine and cannabis to supply the entire world's demand can be produced from a tiny area, only twice the size of the Australian Capital Territory. If authorities cannot ensure that maximum security prisons are drug free, how can we ever make our communities drug free? Every time authorities increase the penalties for offences or increase the chances of detection, they unintentionally give drug traffickers a pay rise.

The prices of drugs increase 200 to 500 times when they are transported from Asia to Australia. The more severe the penalties, the steeper the drug price gradient, and the steeper the gradient, the more willing some traffickers are to take risks; more traffickers, more drug use. The Achilles heel of drug policy, based on supply control, is that increased risks lead to higher prices, and higher prices attract more traffickers. When demand is strong enough, a supply, legal or illegal, will virtually always emerge. The conclusions of this are that the effectiveness of supply control is very modest. Prohibition has often made things worse. There is still a role for drug law enforcement, but we have made the mistake of relying too heavily on supply control and not enough on health and social interventions.

Research shows that drug education, although worthwhile, only achieves modest benefits. Only 27 per cent of youth campaigns in a recent international study achieved a reduction in drug use. The size of the reduction in consumption was only 3.7 per cent, and even this small benefit dissipated rapidly over time. Drug education is worth doing but it is important to keep our expectations realistic. The Rand study I referred to earlier showed a $2.60 benefit per $1 spent on drug education for cocaine, in the United States. In public health, we have to remember that small benefits from multiple interventions are often useful in aggregate. There is certainly a role for drug education.

But drug treatment can have a huge impact on drug demand. First, we have to attract and retain a large proportion of drug users in treatment, and second, we should particularly target severely dependent drug users, as they probably drive drug epidemics. As the drug Czar in the recent film *Traffic* reminded us, we need to start thinking "outside the box". Could a greater emphasis on early childhood interventions reduce the demand for drugs? Could a sustained improvement in youth employment and educational opportunities reduce the demand for drugs? Should we shift from our current approach - which tries to increase costs of using illicit drugs - and instead emphasise benefits of non-drug use?

Let us look at harm reduction. Attempts to reduce drug-related harm usually succeed, while attempts to eradicate drug-related harm virtually always fail and are also often counter-productive. It is far better to aim for and achieve modest targets than set out to reach utopian goals and fail to attain them. Harm reduction for drugs is basically the same kind of approach that we use generally in clinical medicine and public health. Often the choice is between two less-than-ideal alternatives. Do we prefer needle syringe and methadone programs, on the one hand, or an HIV epidemic, on the other? Do we prefer reducing the adverse consequences of drug use or reducing drug consumption; harm reduction or use reduction?

The paramount objective of drug policy should be the reduction of drug-related harm; that is, the reduction of health, social and economic costs of all mood-altering drugs, without necessarily reducing consumption. Harm reduction is an effective, safe and cost-effective policy for all drugs, and it can happily coexist with supply control and demand control. Abstinence is a special subset of harm reduction. It is the most effective option, but it is also the least feasible.

How can we best reduce the problems that drugs cause? Firstly, we have to distinguish clearly between the costs of drug use and the costs of drug policy. Most "drug-related" deaths, disease, crime and corruption are in fact due to prohibition. Heroin prescribed by doctors and dispensed by nurses is relatively safe. Heroin distributed by criminals is often very dangerous. Second, we need

to adopt an outcomes focus. We will never achieve our targets if we do not know what our targets are, or if our targets are unrealistic in the first place. There never has been and never will be a drug-free world. It is much better to aim for a certain silver or bronze medal than risk everything for an impossible gold. Drug policy should aim to benefit drug users, their families and - let us not forget - all other members of the community.

We must treat drug problems primarily as a health and social issue. This means increasing funding for health and social interventions to the level currently enjoyed by drug law enforcement. We must recognise that there is an important supportive role for drug law enforcement, and we should maintain penalties for the unauthorised production or sale of large quantities of all mood-altering drugs.

Fourthly, we must recognise the great value of drug treatment. We should aim to recruit and retain two-thirds of drug users in treatment. This will require expansion of the capacity of the drug treatment system, broadening the range of options and improving the quality of drug treatment to the level of all health care services. We should also target severely dependent drug users as a top priority.

Fifthly, we must recognise that medical research is the key to improving long-term results. We must respect due scientific process. The heroin prescription trial for treatment refractory and entrenched drug users must proceed. For the time being, Mr Howard prefers to lie on the road, rather than jump on the steamroller.

Sixthly, we must base policy on evidence. All major policy innovations, whether for law enforcement or drug treatment, should be carefully evaluated before they are implemented widely.

The seventh point is that the law of demand and supply must be respected. Whatever else drugs might be, they have a market. The choice is between taxing and regulating cannabis, which accounts for one per cent of Australia's economy, or preserving cannabis as a monopoly for criminals and corrupt police. Drugs like heroin and amphetamine should never be sold commercially. Those drugs could be prescribed to selected individuals if rigorous research showed that this was both effective and safe.

Finally, we should recognise that drugs are all of a piece. Harm reduction should not focus on illicit drugs and turn a blind eye to legal drugs.

How can we get better outcomes for drug problems in prisons? Prisons are an expensive way of making problematic people worse. Keeping someone in prison for a year costs about $60 000. Zealous attempts to reduce drugs in prison might reduce the frequency of drug use, but might also increase the dangers of each injecting episode. The heaviest-injecting 20 per cent in the community -

The CHAIR (Hon Fred Chaney): Can you please bring your remarks to a close, as we have limited time.

Dr WODAK: Certainly. I will go to the conclusion. Efforts to get better outcomes from drug policy for the whole community are based on a belief that people who choose to use drugs remain our sons and daughters. Half a century is long enough to judge that a drug policy based on trying to arrest and imprison our way out of trouble has failed and can never be effective. The most important step for reducing harm in the future is to accept that drug use is primarily a health and social issue and that the major factor impeding progress is fear.

The CHAIR (Hon Fred Chaney): Before calling the next speaker, I apologise to our distinguished speakers for keeping a tight limit on their contributions. It seems unfair, but that is the way the summit is being conducted. I now invite Dr Joe Santamaria, who is the president of the Family Council of Australia, a consultant physician, and former director of St Vincent's Hospital in Melbourne, to address the summit.

SANTAMARIA, DR JOE,
President, Family Council of Australia; Consultant Physician and Former Director, St Vincent's Hospital, Melbourne.

Dr SANTAMARIA: Thank you, Mr Chairman. The title of my paper is "The case for sanctions in the field of drug abuse". Sanctions are a provision of any law that imposes a penalty if that law is disobeyed. Fundamentally, it is a measure to protect the common good, and it constrains the liberty of a person to act in a particular way. To break the legal sanction must attract a penalty that deters, such as a heavy fine for exceeding the speed limit or the loss of a drivers licence for a drink-driving offence. In other words, sanctions are imposed to limit the number of people who might behave in a certain way or to behave in such a way repetitively. The drugs that are currently illegal to use or to produce and distribute are called mind-altering drugs. They are known to produce harmful effects in the individual and the wider community. Because the individual is a member of society and, more particularly, because his or her drug-taking behaviour impacts on the family, the local community and wider society, the community exercises a right to protect its members and to prevent the widespread use of such drugs.

The community can be harmed in a variety of ways. Families are often under great stress and the local community is often subjected to so-called aggravated, drug-related crimes. Consequently, the community is particularly concerned with the number of people who use such drugs in a repetitive way and the number who begin to use such drugs. This is the question of the incidence and prevalence of such drug use or, more simply, the dimension of the social problem. Sanctions, therefore, set out to control the number of drug abusers and to contain the size of the population who use mind-altering drugs in a non-therapeutic way.

Sanctions also set out to establish social norms. We see such instances in the compulsory wearing of seat belts and crash helmets, in the drink-driving laws, in the prohibition of smoking in public places such as in restaurants and aircraft, and in many workplace safety regulations. Some people might argue that social norms can be achieved by education alone. However, the track record, as Dr Alex Wodak pointed out, of such an approach without the imposition of sanctions as well has been poor. In the field of drug abuse, a lenient policy has always resulted in a blow-out of drug users.

However, the imposition of sanctions alone without complementary measures does not reduce the problem overnight to zero. It requires intelligent education, reinforcement, attention to other social and personal factors, adequate treatment facilities to complement the thrust of legislation, and community support for the vulnerable and the afflicted. Sanctions may also have to be applied in accordance with the provisions of international agreements. Australia is not only a signatory to the international conventions on drug abuse, but also has ratified the conventions of 1961, 1971 and 1988. According to those conventions, each ratifying nation is required to ban the non-therapeutic use of a range of mind-altering drugs and to impose and reinforce appropriate sanctions. Both heroin and cannabis, for very good reasons, are listed in the prescribed substances. As our knowledge about these drugs has developed, nations have become deeply concerned about the impoverishment of their societies, the economic costs of treating the addicted and the social costs when such drugs are used widely.

In fact, sanctions are an integral part of public health strategy. We see repeated evidence of this in workplace safety regulations, in the sale of alcohol and cigarettes to young people, in the control of road accidents, in the handling of food and in the control of drug abuse. We can observe that the object of these punitive nudges is to establish norms of behaviour that will enhance our quality of life and protect the public from harm. We talk a great deal these days about primary prevention and early intervention, which is in fact a form of secondary prevention. We are investigating the

features and factors that identify an at-risk population. We talk also about protective factors that identify those who are unlikely to get into trouble. The Australian Institute of Criminology is currently involved in research in Victoria into the implementation in Australia of the project known as "Communities that Care". The aim of these programs is to reduce the size of the at-risk population and to strengthen the protective factors that enhance a person's resistance to unacceptable behaviour. These are, however, long-term projects in primary prevention.

In the here and now, however, we are faced with the issue of an epidemic of drug abuse in our country. Despite this well-known fact, we have insufficient treatment services available to deal with the casualties of drug use. Although I have serious reservations about some services that are currently available and the large expenditure on services that I believe are not justified by their outcome evaluations, in the context of this paper we should use the measure of sanctions to divert patients into treatment programs. This is known as therapeutic jurisprudence.

During the last Clinton Administration, the Director of the US National Drug Control Policy, Barry McCaffrey, advocated a move from the criminal justice system to treatment programs for the genuine drug addicts and for first-time offenders. This type of approach was also promoted in the strategic directions document of the Commissioners of Police of Australasia and the South Western Pacific regions, which was released in May 1999. However, neither advocated the removal of sanctions on the recreational use of the mind-altering drugs. Their emphasis was on demand reduction and harm prevention, and the call for adequate services for the rehabilitation of genuine drug-addicted persons.

The principle of early intervention is important in any drug strategy. While sanctions are directed towards demand reduction, there should be a provision to divert the drug user into programs of rehabilitation under the surveillance of appropriate officials who monitor compliance and progress. This requires a range of measures to meet the requirements of the apprehended population and this is very diverse. Some will not be addicted but will be at risk of becoming regular and dependent users. Others will be more firmly addicted and socially marginalised, and many will be in between. This will require quick induction into assessment and treatment, and priority should be given to detoxification and long-term abstinence-based programs.

Early intervention should aim at discouraging continued drug use, especially by the young and immature. However, a problem will arise when the apprehended addict has committed serious crimes. There is a strong argument for the establishment of a dedicated drug court assisted by competent assessment advisers with power to adopt coercive measures against purely addicted persons who have committed serious crimes. It is important to move the drug addict out of his current milieu, known as the drug subculture, which encourages the continued use of drugs and delays the entry into treatment programs. This can be done by using the power of the courts to commit people to detoxification centres, followed by longer-term rehabilitation in drug-free therapeutic communities. It should be remembered that the cognitive functions of the brain remain dysfunctional for some weeks, if not months, during which time efforts should be made to establish rapport, based on caring for the addict and winning his or her trust for what we have to offer. Here we can learn from a variety of programs such as Community Encounter, Teen Challenge, Odyssey House, Victory Outreach, the Benelong Program and the facility known as San Patrignano in Italy. These can be adapted to the Australian culture but they already have a track record in several countries.

In conclusion, I draw delegates' attention to the fact that many of these strategies are already in place in Western Australia. I suggest that they should consult several papers on the web site of this summit meeting particularly the following: They are "Coercing Offenders Into Treatment: a comprehensive statewide diversion strategy", presented by Terry Murphy, Executive Director of the Western Australian Drug Abuse Strategy Office, in October 2000; a ministerial statement of 1 July 1999 by Rhonda Parker on a visit to Sweden, Switzerland and Italy; and the June 2000 submission

by Western Australian government agencies to the federal committee of inquiry on substance abuse. I have given the summit a submission on drug strategy, which I am sure is available on request. Finally, I table a document from the United States Department of Justice entitled "Sentencing and Corrections - Issues for the 21st Century" and released in May 2000.

Thank you, ladies and gentlemen; thank you, Mr Chairman.

The CHAIR (Hon Fred Chaney): Mr Nick Stafford will speak on "A Drug User Perspective On Our Current Laws".

STAFFORD, MR NICK.

Mr STAFFORD: I have been asked to talk about the issue of law enforcement, and drug use more generally, from a drug user's perspective. I am incredibly nervous and I left my paper at home, so I have a couple of things to work with. I am concerned that I am the only keynote speaker who is speaking as a drug user. When societies come together to discuss drug use, drug users are often left out of the picture. It is impossible for me to represent all drug users in Western Australia or Australia. All I can do is talk about some of my experiences.

I am 36 years old, and I am on the methadone program for the second time. I have used heroin on and off for about 17 years, and I have also used marijuana, amphetamines, LSD, tobacco, alcohol and, to a lesser extent, ecstasy and various pills. I first developed a dependency around the age of 25. Through counselling at that time, I began to understand that my dependence on heroin and other drugs was mainly an attempt to manage depression and anxiety, both of which first surfaced when I was about 15. At that time, I also learnt that my mother had been dependent on Serapax, or benzodiazapine, for a number of years, and tobacco for about 15 years - that was obviously more apparent to me. I am proud to say that she has recovered from both. Her father, my grandfather, was dependent on alcohol from his mid 20s until his death at the age of 65, and his wife, my grandmother, died from throat cancer after smoking cigarettes for many years. I come from a family with at least three generations of drug dependency and mental health issues.

During the past eight years I have worked in the alcohol and drug field, mainly in needle exchanges and as a peer educator in four States. I have run programs dealing with coming off methadone, have produced overdose prevention information and have assisted countless people to home-detoxify a family member. Over the years, I have spoken to thousands of people about their drug use.

I have always thought that if people want to come up with solutions or responses to a problem, they must develop a clear understanding of what they are trying to discuss. Trying to come up with solutions before clearly understanding the problem is a good recipe for stuffing up. I do not think our culture has a good understanding of drug use. A lot of good stuff will come out of this summit; however, it will not come to any good understanding of drug use, partly because it has pulled illicit drug use out of the whole context of drug use in our culture. It really concerns me, because it appears that the only drug users in our country are those who use illegal drugs. That is not the case. In fact, the majority of us are drug users. The majority of our police, parents and politicians are drug users. More importantly, the majority of people here and in Australia generally do not experience any problems as a result of their use of recreational drugs. They enjoy them, they bring benefits to their lives, and they increase their quality of life.

I have not read it in the literature about this summit, but the same is true of people who use cannabis. The majority of people who use cannabis in this country do not experience problems as a result. They are not dependent, they do not experience problems, they use it occasionally, they

enjoy it, and that is it. A very small proportion have problems. Delegates can use the information in the booklets to calculate how many people use cannabis and then refer to the treatment section to see how many seek treatment. The figure is .05 per cent of cannabis users. The same can be said about amphetamine use. The majority use them occasionally, recreationally and safely, and do not experience any problems. The same can be said about ecstasy and alcohol. Can the same be said about tobacco and heroin? I do not know. Those substances appear to be different, because there is a much higher rate of dependency among their users.

After hearing all the things that have been said at this summit, one could mistakenly believe that every person who uses those substances is addicted or will become addicted. That is not true. That belief masks the reality of what is going on in our culture. The people who do become dependent do not do so because of the drug; they become dependent because of what is going on inside them. My family is a good illustration of that. Even though I have been dependent on heroin on and off for 17 years, it would be immature and absurd of me to blame heroin for my dependence. I am to blame; I went to the drug and took it dependently to try to cope with my depression, anxiety and so on. Whenever I hear someone say that this drug stuffed up his life, I think, "Take some responsibility. That drug did not jump up at you. It sat there on the desk and you could have walked out of the room. You decided to take it and, after having taken it, liked it and thought that it was okay, and with underlying issues unresolved, you became dependent." Interestingly, if delegates were to observe a drug treatment service for a month, they probably would not hear much about drug use. Those involved talk about the issues inside themselves; they talk about many other things.

For some reason people do not want us to know that some people use these drugs recreationally and safely. When did that start? I have traced it back to America at the beginning of the last century. Anyone can undertake this exercise. Harry J. Ainslinger managed to convince people that a person who smoked marijuana would become a sex-crazed maniac who would kill, steal and generally run amok. He managed to get its use prohibited. When it became obvious that that was not true, he came up with a beautiful idea. He whipped it out of the air - absolutely no research was undertaken. He said that using marijuana would lead to heroin use. That is a myth. I understand that decriminalisation of the use of marijuana was suggested a few years ago in this State. The then Premier - Richard Court - responded, "No, because cannabis is a gateway drug to heroin use." Incredible! A theory that had no validity whatsoever when it was invented is used 40 years later or whatever by a Premier to knock back a very sensible proposal. I cannot think of a better example than that to show that we think very unclearly about drug use. Another one would be that we are all here because of some of the deaths that have occurred due to drug use. It is an incredible tragedy that people die, and will die. What is the number one killer among the drugs in our society? Tobacco. How hard is that to get? It is available at every milk bar across the country.

If I were an alien coming down to our planet and I dropped in and had a look at you all sitting here today concerned about drug use in our culture, and tobacco and alcohol are not even on the agenda, I would just think you were totally and utterly mad. Of every 100 people who die, 80 die from tobacco-related illness, 16 from alcohol abuse and four from all the other drugs - and those first two drugs are not even on the agenda. It seems absurd; and there is a reason for that. This is what the majority of people I know who use drugs unproblematically in our society would like me to say to you: the focus is placed on illegal drugs so that the majority of you who use alcohol do not have to look at your own drug use. It is a way of scapegoating. We have one particular little group of drug users and we can all sit here and moralise and we can all blame them because they are not here to defend themselves. They are not here to say, "Hey, wait a minute, what about you?"

Again, the use of drugs by people under the age of 18 frightens the hell out of me, and I wish it did not occur at all. It is just horrible. What is the number one drug that is of concern to young people? Alcohol - the number one - but we are not here to discuss it.

Another thing really upsets me about the way we deal with drugs; say young people have some real trauma inside them from a family break-up, abuse or whatever, why do they go and use a drug to deal with that? It is because they cannot seem to find another way. These are people craving for something to deal with this intense pain. How on earth did we get to the point of letting people down like that, where the only option they seem to think will work is a drug? How do we respond to them when they grab that last straw to try to cope with life? We label them a criminal and we bust them and try to put them in jail if we can. To me that is barbaric.

Look at myself: dependent on heroin - heroin the big evil drug. Heroin was probably the first drug that was ever in the bloodstreams of people here who were born before 1954, when their mothers were given it during childbirth. Heroin is from the opiates family of drugs, and they have been one of the most brilliant drugs in the history of mankind. They have solved so much suffering, they have saved so many lives, they have done so much good. They obviously have a dark side. We know that people have been using opiates for at least 6 000 years, and you can imagine that people have been dependent on opiates for probably 6 000 years or more. How are we going to deal with that? You would think we would have learned something better in 6 000 years than what we currently have.

I feel as though I have a medical condition; I have an opiate dependency, but first and foremost I am a criminal and my medical condition is a crime. In a sense, I am not just a criminal but I myself am the crime. Twenty-four hours a day I am a living, walking crime. What impact does that have on my life? I am still here. I have worked all these years. I have never committed crimes to support my habit, I have always done it with my wages, but I have probably spent a couple of houses on heroin. I do not have a house, I own basically nothing but a guitar and a cat, and I do not really own her. Of course, it is not just me who has suffered, our whole economy has. Surely we can come up with a better way than letting millions of dollars sink into organised crime. I know we are not going to change the laws out of this. I hope that you will come up with some really good ways of improving treatment and some of the education stuff we do. I do not understand why everyone here does not accept that, although this is a difficult situation, we must come up with a better solution than to let organised crime run our drug industry. Fair enough, you can call it a temporary measure until we come up with something better, but I do not hear that. I hear people saying that this is how we will do it forever. We will let billions of dollars walk offshore every year, while people like me have to try to manage.

What do I think of the treatment that is available? Because it occurs within this criminalised environment, I have not experienced treatment. For me the methadone program is chemical parole; it is legalised opiate addiction. At the same time, if you have ever wanted to know what legalised opiate use would be like, all you need do is to look at the methadone research; it will tell you. Legalised opiate use will give you reduced cases of hepatitis C and blood-borne viruses, improved health, improved family relationships, improved employment, improved financial health, less crime, less corruption and less cost. We are not going to change the laws right now, but can we at least try to involve people like me in the discussion and try to look at a proper, serious alternative to this mess that we have now?

The CHAIR (Hon Fred Chaney): Thank you, Nick Stafford. I now ask Dr Ingrid van Beek to address us. She is the medical director of Sydney's medically-supervised injecting centre.

VAN BEEK, DR INGRID,
Medical Director, Sydney Medically Supervised Injecting Centre, Kings Cross, NSW.

Dr VAN BEEK: That is a hard act to follow. Thank you Nick. I am here today to talk about the role of medically-supervised injecting centres, and also about their limitations. By way of

background, 47 injecting facilities have been established in four countries in Europe in areas in which open drug scenes had developed, in association with the concentrated supply of drugs in red light districts and/or at major railway terminals since 1986. This is not by any means a new initiative that has started in Sydney, and by no means is it unique. The establishment of medically-supervised injecting centres in the European context acknowledged the need for a balanced approach to manage public health and public order issues that arise from street-based injecting at a community level. We know from the evidence that people who inject in street-based situations are more at risk of drug overdose and the transmission of blood-borne viruses. Street-based drug use is also associated with reduced amenity at a community level from things such as discarded syringes and so on.

There have been a significant number of homeless, injecting drug users dwelling in the Kings Cross area since the 1970s. Since the early 1990s a proliferation of illegal shooting galleries has cropped up in commercial sex premises right in the heart of Kings Cross. These facilities originally were set up to sell space for casual commercial sex, often with street-based sex workers, who also frequently injected drugs. Increasingly, they were used also to accommodate injecting, and from 1990 solely for the purpose of injecting. After a while, however, these facilities not only provided a space to inject but also began to integrate services to include the provision of sterile syringes and also, in some instances, to provide the drug. In those instances, across time, there was also the involvement of the local police. The Wood Royal Commission into the New South Wales Police Service revealed that much police corruption was associated with these facilities that had developed in Kings Cross, in part, to address the issues of street-based drug using.

In the final report tabled by Justice Wood, who led the royal commission into the New South Wales Police Service, he recommended that consideration be given to the establishment of safe, sanitary injecting rooms under the licence or supervision of the Health Department, and that the Drug Misuse and Trafficking Act 1985 be amended accordingly. This recommendation was made in the context of the harm reduction approach, specifically as an extension of the needle syringe program. In particular he said -

> At present, publicly funded programs operate to provide syringes and needles to injecting drug users with the clear understanding that they will be used to administer prohibited drugs. In these circumstances to shrink from the provision of safe, sanitary premises where users can safely inject is somewhat short sighted. The health and public safety benefits outweigh the policy considerations against condoning otherwise unlawful behaviour.
>
> [Quotation not verified.]

The then New South Wales Premier, Hon Bob Carr, accepted the recommendation and established a parliamentary committee to further investigate the possibility of establishing such a facility under the licence of the New South Wales Health Department. However, he also required that there be bipartisan support for such an initiative. A bipartisan group of politicians, 10 in total, spent several months investigating this option. Despite the testimony of literally hundreds of experts and people from all sections of the community, including drug users, police, people from health authorities and various business and residents, and despite the majority of those testimonies being in favour, the committee voted against the recommendation by six votes to four.

From a state perspective the issue of sanctioned injecting centres had been dealt with. However, from a Kings Cross perspective we continued to have street-based drug use, made all the worse by the closure of the illegal shooting galleries in the area, which displaced both drug dealing and using back onto the streets. Whereas it had been hoped that the Wood royal commission would solve to some extent the drug using problem in the Kings Cross area, in fact, people felt it more because the activity moved from indoors back onto the streets. We were back at square one, and needed to look again at how we would manage the problem; how public policy might somehow at least be able to

pick up the benefits that the illegal shooting galleries had, such as providing clean syringes 24 hours a day, seven days a week, and moving the activity off the streets.

In April 1999, 12 months or so after a group of people got together in Kings Cross to address this very issue, a civil disobedience exercise took place at the Wayside Chapel in Kings Cross, which is an organisation run by the Uniting Church, and which has a long history of addressing issues of social importance. It was never intended that the facility would provide an ongoing service. The hope of the exercise was to place the issue of injecting centres back firmly onto the agenda for the May parliamentary drug summit which was held some weeks later in New South Wales. It succeeded in that regard.

One of the 172 resolutions that were passed - I emphasise one of 172, and people can certainly be forgiven for thinking it was the only one passed judging by the attention it has received - was passed by the summit with an overwhelming majority of support from all the parliamentary and non-parliamentary delegates. The resolution was that the Government should not veto proposals from non-government organisations for a tightly controlled trial - I emphasise tightly controlled trial - of medically supervised injecting rooms in defined areas, where there was a high prevalence of street dealing in illicit drugs, where those proposals incorporated options for primary health care counselling and referral for treatment, provided there was support for this at a community and local government level.

A resolution of the New South Wales Parliamentary Drug Summit recommended that -

> Any such proposal should be contained in a local Community Drug Action Plan that was developed by local agencies, non-government organisations, volunteers and community organisations.
>
> These should be submitted to full public and community consultation processes and preferably a local poll. They must be part of a comprehensive strategy for local law enforcement, health, community and preventative education initiatives.

To cut a long story short, it took us two years to reach the point of opening the doors of such a facility. I am sure that even people in Perth were aware of some of the delays. Finally, the New South Wales Supreme Court endorsed the licence that the Uniting Church received to conduct this trial. On May 6 we opened the premise at a location in the heart of Kings Cross and we are now neighbours with the various strip clubs and so on that previously had provided such services.

The aims of the Sydney medically supervised injecting centre include: first, the reduction of fatal and non-fatal drug overdoses. I emphasise that this is not only about saving lives so that people can recover to address their illicit drug use over time, but also to reduce the non-fatal drug overdoses. Sometimes I think that we do not appreciate the health and social consequences of non-fatal overdoses. Secondly, to reduce the transmission of blood-borne infections. Earlier I alluded to the fact that risk behaviour is at its greatest when people inject in backstreets with poor lighting and when pressure is placed on them to finish quickly because of the risk of being caught. Thirdly, it is important to improve drug users' access to relevant health and social welfare drug treatment and rehabilitation services. By engaging drug users in a facility that is staffed by health professionals, they can be made aware of what options are available should they choose to use them. Fourthly, to reduce the public nuisance associated with street-based injecting, which I referred to earlier, including discarded needle syringes.

A law exists regarding self-administration of illicit drugs in which the possession of used syringes can be used as circumstantial evidence to charge a person. In those circumstances it is difficult to institute a one-for-one type of needle syringe exchange. When users inject in the streets, inevitably some needle syringes are left behind.

Where should these types of facilities be located? Already today during interviews with various media organisations I have been asked in which part of Perth I think we should set up this type of

facility. I am quick to say that I have worked in the area of Kings Cross for over a decade and I regard myself as having a good sense of the situation there, but I do not in any way believe that I am knowledgable about the Western Australian situation. In principle, I suggest that, as has been the situation in the past, that type of facility should be located in a place where there is a high prevalence of street-based injecting that is associated with fatal and non-fatal drug overdoses in the population.

In the year 2000, surveys among drug users in Kings Cross show that 32 per cent of users had last injected in a public place; nine per cent had last injected in illegal shooting galleries - some illegal shooting galleries still exist- 49 per cent had last injected alone, which means that the user has a greater risk of overdosing; 71 per cent of the users in the area surveyed would have preferred to use an injecting centre for their last injection. The most recent data we have about where drug overdoses occurred - unfortunately this data is quite old - shows that 10 per cent of all overdose deaths in Australia in 1996 were in Kings Cross. That is comparable to the total number of overdoses in Western Australia. In 1999 more than 50 per cent of ambulance call-outs for drug overdoses in the area were within 100 metres of the facility.

It is important to locate those facilities not only where there is a high prevalence of street-based drug use associated with overdoses, but also where there is community support. We have very strong community support in the Kings Cross area. Despite that, a lot of effort was required to get this facility across the line. One would certainly not want the community to feel ambivalent about it. We undertook four polls between 1997 and 2000, which showed increasing support for such an initiative in the backyard in Kings Cross. We also had the luxury that all local, state and federal government members of Parliament who represent the area strongly supported the initiative. Overall, bipartisan support at a state level would be ideal; unfortunately, we do not have that.

I turn to the recommendations. These facilities should not be stand alone. They should be integrated with other health and social welfare services, in particular the needle syringe, primary health care, counselling, drug treatment and rehabilitation services to ensure a holistic, comprehensive approach. They should complement, not replace, the range of harm-minimisation strategies at a state and national level. They should be carefully monitored and evaluated.

Finally, from the most recent data regarding activity at the injecting centre in its first three months, I anticipate, as has been my experience when establishing services for this community, that there will be a slow and steady increase. We expect to see increasing numbers in about six months. We have registered over 831 individual drug users in the first three months, despite being under a lot of media and political scrutiny. We have ongoing registrations, which is particularly important from a public health point of view. It indicates that we are not just looking after the one cohort across time; we are continuing to recruit. Of the 831 drug users, we have made 258 referrals, of which 45 per cent have been in drug treatment and rehabilitation. We have managed 36 overdoses of heroin and cocaine in the three months. Presumably, they were overdoses that would otherwise have occurred in unsupervised situations, and it would have been down to fate whether or not an ambulance arrived in time.

CLARKE, ASSOCIATE PROFESSOR HARRY,
Reader in Economics, La Trobe University, Melbourne.

Associate Professor CLARKE: I am the odd person out this afternoon, because I am not a doctor and I am not part of the drug industry. I am an economist and a policy analyst. I will give delegates my perspective on this issue and summarise some of my work. I have looked at various harm minimisation schemes. Generally, I will outline what I think is a good public policy perspective on

illegal drug control. The general argument I will put forward is not very controversial; that is, sensible harm minimisation needs to be coupled with a pursuit of drug abstinence policies. I do not see harm minimisation and abstinence policies as alternatives. The two things must go together. Targeting either of the objectives by itself will worsen the achievement of the other objective. The economic view of drug use sees drug users as pursuing objectives - whatever they are - subject to various constraints or costs. Among these costs are things like the current and future prices of the drugs they use, such as heroin; the current and future penalties they expect to incur through using these drugs; and the health and overdose risks they face, which are contingent on their use. There are general social costs of using a socially disapproved-of substance. Policies that seek abstinence by increasing user costs alone promote social costs. Dr Wodak talked about these issues. If we aim for abstinence alone and try to eliminate drug use entirely, we will create crime and health costs. Similarly, I think that pursuing harm minimisation alone will reduce some of the user costs of usage, but it will promote usage. Therefore, it will worsen this abstinence objective.

Generally, it seems to me, therefore, that there is some kind of trade-off between these sorts of positions; that is, pursuing harm minimisation and pursuing abstinence. Extremists on each side of the debate often assume away the side of the debate that they do not want to consider. For example, harm minimisers often claim that their policies have weak, adverse incentive effects. I do not believe this. I think that the evidence on price sensitivities and other things that is coming out now suggests that these incentive effects are strong. Policy trade-offs seem to me to be real, and their implications for social choices are important.

Four current features of the Australian heroin markets concern me. Apart from a recent shortage and a blip in prices, heroin prices are now quite low. Secondly, evidence is now coming out, particularly from the United States, that there are high price sensitivities in heroin demands. If heroin prices fall, usage tends to increase strongly, as does participation in the use of heroin. Thirdly, community accessibility to heroin in Australia is high. A number of studies have looked at this accessibility issue. Finally, generally community tolerance of use, if not sale, is increasing, and the resolve to prosecute people for the use of heroin is waning.

Generally, it seems to me that if harm minimisation policies continue to gain public support, without understanding the adverse incentive effects that they have, the potential is for a much worse heroin problem. I apologise that the slides being shown are out of sync.

My argument generally is that, like most people, I favour abstinence, but I agree that it will not be achieved. Unfortunately, abstinence is now being pursued mainly by supply-oriented policies. I agree with Alex that these are generally not good policies. They raise prices and increase health and crime costs.

Penalising use, or encouraging users not to use, promotes abstinence with reduced heroin prices, and to that extent it creates less social harm. Therefore, it has always seemed to be a good principle of policy that users, not suppliers, should be the main target of the drug control effort.

I want to discuss this idea in relation to a number of specific policies at which I have looked, and some empirical work I have done in looking at the costs of these policies. One policy that has been discussed widely is the public provision of heroin to addicts. This eliminates the addict's need to rely on crime and reduces overdoses. It means that casual users still cannot access free heroin; hence they continue to rely on illegal supplies. Therefore, the claim is that harm can be minimised to the people who are addicted, while sustaining pressure on supplies. It seems to me that that is a fallacious or oversimplified argument, because this policy has effects on the user costs facing new users of heroin. First, by eliminating addicts from the market, it reduces current prices facing new users. If all addicts in Australia did not demand heroin, prices would collapse, because currently those addicts demand most of the heroin that is used. Free heroin for addicts means lower future prices for current new users. To the extent to which new users are forward looking, they will react to the expectation that prices will be lower in the future, should they need to be supplied, by

increasing their current use. Finally, the policy seems to convert risky and socially ostracised heroin use into a state-managed health problem. All these things reduce the user costs of using heroin and provide incentives for use.

In 1999 I costed this proposal. I cannot go into the details now because it is quite a long study. However, it seems that if one accounts for these effects, the proposal costs more than it saves. Reduced user costs expand new user numbers, future addiction and future treatment costs. Therefore, in simple cost-benefit terms, I do not think that is a useful policy to consider. We can restore the value of the policy a bit if we couple public provision with intensified penalties that try to offset these adverse incentive effects. This will discourage new users and encourage addicts to participate in legal programs. Again, the general argument is that we need to couple harm minimisation policies with policies that will offset the adverse incentive effect on new users. This will work provided the authorities can more successfully prosecute illegal users, and that is a big "if".

Another policy that we have just heard about is safe injecting rooms. This policy is not dependant on being able to more successfully prosecute illegal users, because it leaves heroin illegal but enables safe administration; so the risks are essentially reduced to zero. This policy also leaves heroin prices high and does not reduce the price component of user cost, but it does reduce the risk that is a component of user cost. However, if heroin users are risk averse, as psychologists and most people in the community tell us, then heroin use will be higher if use is less risky. This has some troublesome implications for the way we think about heroin policies. The unfortunate implication is that if we accept this line of reasoning and say we do not want to have safe injecting rooms because they will reduce risk, and this will reduce the user cost that faces addicts, then the logical extreme is to then say: why not increase the risk? For example, we might want to delay access to medical care in order to increase risk, but provide incentives to reduce use. That is a bizarre argument, and I am certainly not advocating that. However, if we reject these harm minimisation schemes on the basis that they have adverse incentive effects, then we need to consider the question of the size of the risks that we want to have.

Generally, safe injecting rooms have three cost effects: they reduce abstinence by lowering the risk of use; they have ambiguous effects on harm, because by reducing risks, overall harm is reduced, but by expanding demand, more people are exposed to lower risks, and it is not clear how that will wash out; and it is costly policy. I have done some empirical work on this matter, and with conservative assumptions about risk, modest weight placed on induced new user numbers relative to overdose deaths, and capital cost comparable with that of the Swiss safe injecting rooms, my studies likewise reject the case for safe injecting rooms. They are a bad deal; they cost more than they save. The same analysis can be applied to proposals to supply Naloxone to users or their families for use in the event of an overdose and so on. I have not studied Naloxone in detail, but a worthwhile study must again account for its potential adverse incentive effects; and that is generally the point I am trying to make today.

The methadone program is the most important of the treatment programs. Methadone enables three sorts of harm minimisations: it limits the need for users to rely on crime to finance their addiction; it gives users a secure supply of drugs and thereby reduces the social costs that Alex talked about; and because it deals with addiction without giving users a high, users say they gain a less drug-focused life. A methadone policy has similar effects to the two policies that I have just discussed. Firstly, it mimics, as Nick has said, the policy of just publicly providing heroin to addicts. We are giving them just methadone, not heroin, so in that sense it is the same as the public provision policy. It also has a similar incentive effect to safe injecting rooms if we regard methadone as a safe treatment; and there are some questions that we could raise about that. The adverse incentive effects of a methadone program parallel the two treatments that I have just discussed - safe injecting rooms, and the provision of legal heroin to addicts. Methadone, by destroying an addict's demand for heroin, will put downward pressures on prices, and that will self limit the success of that sort of

program. If methadone reduces risk and provides a backstop in the event that heroin becomes unaffordable, this will again reduce the users' costs and increase their demand for heroin.

I turn now to drug use prevention policies. I think heroin use is irrational. There is a philosophical debate about that, but I think it is. So the question is whether users can forestall use by providing better information? If they can, then you get rid of this trade-off. You can advance both abstinence and harm minimisation in one hit. That is an unfortunate pun, I guess. Fear arousal and straight information do not seem to work in providing information, but skill building and other things are useful. The difficulty is that you do not know what triggers will initiate heroin use for particular individuals, and since the range of such triggers is broad and off-setting them expensive, in my view incentive-based policies generally out-perform fashionable trigger policies. So, I will stick to the incentive view that I will adopt.

Joe talked about legal sanctions; I think their importance is understated in current debates. Firstly, heroin prices have fallen strongly over the last decade or so. Therefore, if you are trying to evaluate the effects of enforcement policies, the relevant counterfactual is whether heroin use would have been greater without enforcement, and in my view it probably would have been. There are severe statistical causality issues in most of the studies that have been done here. I am quite unconvinced, and in fact usage has fallen in some countries in which stringent penalties have been imposed. I am not going to throw out legal sanctions. There is still a case for retaining this component of policy.

It seems to me that the two important ideas I am trying to put forward are that harm minimisation stimulates demands by new users, so it performs best if it is accompanied by hefty penalties directed at new users. Drug control policies must balance abstinence and harm minimisation. It is a cliche, but I think it is true, that there are no simple solutions. I do not think I have any simple solutions. There are very awkward compromises and the gains you get by trying to work out these compromises ideally might not be that great. It seems that the best sort of compromise from my public policy viewpoint is to try to pursue harm minimisation among addicts, but to retain strong penalties for illegal users. This has two effects. It drives addicts into safe and controlled use, but offsets the incentives for new users to increase their consumption of heroin.

The CHAIR (Hon Fred Chaney): Thank you very much Professor Clarke. After an hour and a quarter of intense information input you have an opportunity for a few questions. I call Elena Jeffreys.

Ms JEFFREYS: I would like to start by thanking the speakers for their contributions today. Some really enlightening papers have been presented. I would like to question and challenge some of the conclusions drawn by both Dr Santamaria and Harry Clarke. As both of you were presenting your papers, I was under the impression that you were endorsing a rational addiction thesis. I do not think, Professor Clarke that you actually were doing so, because at the end of your presentation you said that you thought heroin addiction was irrational. I would like your comments on that. In the light of the 1998 Makkai research from the Australian Institute of Criminology, based on a group of Australian drug users, which shows very clearly that there is no evidence that legal barriers stop people from using drugs that are illegal, I would like to know from both Dr Santamaria and Professor Clarke, the sizes of their research groups. How many users did you talk to in coming to your conclusions?

Dr SANTAMARIA: Firstly, I carry out my research fundamentally by reading research papers and information that appears on the Internet. It is the current situation as I see it. Having worked in the field of alcohol and drugs and the associated field of road safety since the mid-1960s, I have no doubt that sanctions have played a legitimate part in reducing the size of the problem that we were setting out to tackle. I believe that sanctions exercise both a moderating affect on the behaviour of people and reduce the size of the drug-using population. Secondly, all the evidence that I have read in the literature and on the Internet has pointed to the fact that we should discourage intravenous drug use. The level of harm is now so great that we must realise that the use of intravenous drugs is

creating most problems, such as death from drug use and the transmission of hepatitis C. The containment of HIV-AIDS is partly related to the size of the injecting drug user population in Australia, which has always been small. It cannot be compared with overseas populations, in which the base population used when looking at the spread of HIV-AIDS is somewhere between 10 and 20 per cent. Australia has never had a population of that size.

Ms JEFFREYS: Professor Clarke, how many users did you talk to in coming to your conclusions?

Associate Professor CLARKE: You actually changed the question. I would like to answer the original question first. The only part of the rational addiction model that I believe in involves some kind of forward-looking behaviour; users think about the future when they are making current usage decisions. I do not believe they accurately forecast the future or that they are perfectly rational. I think that they are irrational in the sense that there are better ways of achieving their objectives and because users do not engage in the search for information that one would expect of a rational person embarking upon a risky activity.

I tried to make conservative assumptions for the point that I was trying to make. I assumed that, in most of the harm minimisation schemes, if the scheme reduced mortality by about 50 per cent, the demand would rise by 10 per cent. I thought that was a conservative assumption. It would be hard to reject that figure on a priori grounds. Those assumptions gave the adverse findings on those schemes.

Mr EASTWOOD: It is nice to have a question from the back bench. I will preface my question to Dr Santamaria by saying that we know cannabis is the most complex of all illegal drugs and contains at least 61 cannabinols, of which delta-9 tetrahydrocannabinol is not the most dangerous for many organs in the body. I am bemused by the idea of making cannabis more available and that decriminalisation will help the situation. I do not think that it will make the drug any less dangerous. What is your opinion of the outcome of policies that have sought to decriminalise, legalise, condone or normalise the use of current or previous illegal drugs such as tobacco, alcohol, cannabis and heroin? Some of those drugs have already been legalised. Does the normalisation process make the drugs less dangerous or does it increase their use and create or exacerbate the problems and damaging health effects of those drugs?

Dr SANTAMARIA: Mr Chairman, I had difficulty in ascertaining the question. I have a hearing defect.

The CHAIR (Hon Fred Chaney): I was having a little difficulty and my hearing is acute. Lawrence, could you please restate your question?

Mr EASTWOOD: Dr Santamaria, because of the dangerous nature of some of the drugs we are talking about, do you say the normalising, legalising or decriminalising of their use will make the drugs any less dangerous?

Dr SANTAMARIA: The historical evidence is that if that sort of behaviour is normalised, decriminalised or made legal, the size of the using population must expand. That was shown at the end of the nineteenth and the beginning of the twentieth centuries; in the period immediately after World War II when the Japanese used amphetamines; in Sweden; and in the United States in the 1960s and 1970s. When the policy of normalisation is adopted, the size of the drug-using population increases, which results in increasing numbers of people who become chronic users and in increasing social problems.

Dr MARSH: My question is addressed to Associate Professor Harry Clarke and to Dr Alex Wodak, both of whom I would like to respond. Harry Clarke said that supervised injecting facilities increased demand because they were regarded as reducing the risks associated with drug use. One clear fact that comes out clearly in the research on this issue is that when the use of one drug decreases, the use of another drug increases. We heard Nick Stafford's talk in which he said there were many underlying issues that drive a lot of people to drug use and that people will use

something. I would like Associate Professor Harry Clarke to respond first to that demand issue and to the balance of it all.

Associate Professor CLARKE: Clearly, abstinence policies alone drive people into using substitute drugs that are dangerous. Interactive effects with heroin, benzodiazepines and other drugs are causing lots of deaths. The positive feature of abstinence policies is that to some extent they reduce the likelihood of those sorts of substitutions and therefore reduce social damage, social costs and so forth. I say that reducing the risks provides incentives for use. I believe Dr Marsh's point is correct.

Dr WODAK: Mark Twain observed that what you know that is wrong causes more trouble than what you do not know. With due respect to Professor Clarke, many of the things that he said he knew, in fact were assertions and assumptions, and I believe many of them are wrong. The research on injecting rooms in Europe referred to by Dr van Beek is fairly limited in quantity and quality. We do not know what has been the effect of supervised injecting rooms on the incidence of drug use. However, in some countries, such as the Netherlands where supervised injecting rooms have been established, injecting-drug use in fact has diminished since that time.
Speech Continues The situation is very much more complicated than the very simplistic notions put to the summit. However, Dr Marsh raised a good point in her comment that cross-substitution across different drug classes is far greater than we assume to be the case. Usually that is not even mentioned as a possibility.

I refer the summit to a paper published by the National Bureau of Economic Research in Cambridge Massachusetts on the raising of the minimum local drinking age for alcohol. It was increased during the 1980-88 Regan presidency from 18 to 21 years and introduced by each State at a different time. At about the time a particular State raised the minimum legal drinking age from 18 to 21, alcohol consumption in that age group fell, but cannabis consumption rose. The net effect was a reduction in road crash deaths. We must consider the possibility that all interventions can have unforeseen, unintended consequences that are sometimes positive and sometimes negative. The situation is very complicated. I think Dr Marsh made a very important point that often when we push down the use of one drug another drug pops up in its place.

Dr VAN BEEK: An assertion was made that injecting centres will make heroin use less risky; therefore more people will decide to take it up because drug users are rational in that way. Presumably, that argument could be extended to cigarettes. It is about as likely to affect increased drug use as the availability of lung-heart transplant operations will encourage a 15 year old to start smoking. From talking to young people, the presence or absence of treatment programs or life-saving procedures does not factor at all. When we heard from Nick Stafford about what affects the decision to take up drugs, that was not mentioned. The issue of what message injecting centres might send will be a subject of the evaluation.

Mr HAMILTON: Dr van Beek, while I was in Sydney in late July you were getting publicity about the $4.5 million spent at your centre. At that stage I think four or six people had been saved from overdosing. What could we do with that $4.5 million towards providing good rehabilitation to addicts?

Dr VAN BEEK: The $4.5 million that was cited was very misleading. It included all the start-up costs and all the costs associated with a two-year delay in establishing the service. The recurrent costs associated with running the service are for employing eight staff, four nurses and four counsellors under state award rates. The use to which we can put four nurses and four counsellors, eight hours a day in terms of treatment and rehabilitation is extremely limited. There is also the issue of diminishing returns. If we want the best value for our dollars we must diversify expenditure. A cost benefit analysis of treatment and rehabilitation facilities shows that they do not perform very well; they feel good. Methadone programs outstrip them by a long shot. However, I still think to judge the Sydney medically Supervised I injecting Centre on one month's figures of

four overdoses is rather spurious. I urge that we wait for the 18-month cost benefit and cost effectiveness analysis, which will also be part of the evaluation of this trial.

Ms BAKSHI: Nick, will you please comment on the statement among some of Dr Clarke's comments that heroin users are irrational people?

Mr STAFFORD: I do not believe that is the case. It is a difficult issue that involves very many people. A person's decision to try heroin for the first time involves so many factors that I would not know how to decide whether it is rational. Dependency changes the way people think about it. The first thing a dependent person must do is maintain a regular supply so that he can function in his daily life. For me, that is so that I can work. I consider that I manage my heroin habit in a rational manner and in a way that keeps me safe, allows me to work, prevents me from overdosing and protects me from diseases. It is so complex that I do not think I could even begin to explain it.

Ms WEST: Does Dr Santamaria think heroin has a place in palliative care?

Dr SANTAMARIA: No. Heroin is converted into morphine when it is taken into the body. In palliative care, morphine replaces heroin. All the palliative care physicians I have spoken to say that, in the context of drug abuse in Australia, morphine is the drug of choice.

Mr LYNCH: Ingrid van Beek mentioned that the centre made a number of referrals during its first three months. What type of referrals were they? Have some of the people registered with the centre wanted to use the counsellors with a view to ending drug use?

Dr VAN BEEK: Of the 831 attendees, we have made 258 referrals, 45 per cent of which were to detoxification and other types of drug treatment. That is a significant achievement. The only way in which the injecting centre is likely to increase the population of drug users is by keeping a few more alive. I make no apology for that. We have also referred people into health and social welfare services, where it is likely they were further assessed and possibly referred into treatment. We are pleased by the high rate of referral, which reflects the fact that because the service is not pitched as a health service per se, it appeals to people who have not yet identified in the course of their drug use that they have health or social issues - in many instances they do not have such issues. However, this facility allows us to make contact with these people sooner. We are able to address their drug use and hopefully prevent them from becoming, in some instances, street-based, homeless drug users who have lost their social supports and spend half their time in the prison system. An important objective of the facility is to reach this additional group of people. We are pleased to say that, at this very early stage, a substantial proportion of the people we are talking to have not previously spoken to health professionals about their drug use and are extremely receptive to the information we are conveying. As a result, those people are open to referral at an earlier stage, when we know these sorts of things work much better.

Mr B. JONES: There has been a lot of talk about making marijuana more accessible for recreational-type use. I do not know whether someone from the panel or the scientific advisers will be able to answer this. What are the harmful effects of marijuana, both physically and mentally? I have heard a lot of talk, but I have not heard any scientific evidence to enable me to make a value judgment. How will marijuana affect me?

The CHAIR: (Hon Fred Chaney) The scientific advisers may want to make some comment. However, we should give the panel members - in particular, the medical practitioner - an opportunity to respond to what is essentially a scientific question.

Dr WODAK: (Dr Wodak) The answer is long and complicated. To cut a long story short, the health effects are divided into mortality, disease and morbidity. The effects on mortality are clear - there is as yet no reported case in the scientific literature of death due to cannabis. There is general agreement about that. Morbidity is more difficult to encapsulate. However, in general terms, the effects are modest. They are not nonexistent - cannabis can cause some harm. Whatever the harmfulness of cannabis, there is not much we can do about it. So many units per kilogram are

consumed and that is its harmfulness. The larger question is how we want that market supplied. Do we want it supplied by criminals or in some regulated way? Either way, it will still be harmful.

Mr B. JONES: I want to know what harmful effect it will have on me or my family. I am not interested in whether the drug lords supply it. I am not a drug user; I have never taken cannabis.

Dr WODAK: A number of effects are possible, a number are probable and some are certain. We cannot go into the long list of debatable and possible effects. Most people accept that some temporary mental health problems occur. Debate is ensuing about persistent and permanent problems. Very few people believe that is the case. A stronger case can be made that it causes damaging effects on the lungs and argument is continuing about whether cannabis leads to lung cancer. The balance of opinion is that it does not. Concern has also been raised about the effect of cannabis on driving skills. This has been researched in laboratory tests by measuring the reactions of people working on a computer and outside the laboratory with people driving on race tracks. Epidemiological studies have also been conducted. The jury is still out on that issue. However, the majority of opinion is that the effect on driving is modest, if any.

We must not lose sight of the fact that the controls we place on cannabis also have significant financial and social costs.

The CHAIR (Hon Fred Chaney): That does not address the question asked. I suggest that Mr Jones talk to our scientific advisers and raise the issue with his group.

Dr SANTAMARIA (Dr Santamaria): I would be happy to speak to Mr Jones later. We must address certain issues not only in respect of cannabis but also all the other mind-altering drugs, including alcohol and tobacco. Most of the early problems associated with the use of cannabis are not physical. The same applies with alcohol and tobacco. Physical complications usually manifest themselves years down the track. The major complications with cannabis are its effects on a person's higher centres of function; that is, his cognitive functions - his ability to learn, to remember, to perform tasks and to function in his ordinary, everyday life and in his workplace.

It is the effect on skills and behaviour and cognitive functions. The other problem with cannabis is that it is a drug that is slowly excreted. Unlike alcohol, which is excreted fairly rapidly, cannabis is very slowly excreted. Consequently, if you take cannabis fairly regularly - say, every five or six days - the chances are that the cannabis level in the body is increasing all the time and it is particularly likely to increase in concentration in the brain, which is one of the fatty tissues of the body. That is where cannabis is actually stored.

The early features are, as I say, not necessarily physical. We also have to remember that we do not know what is the average dose that a person takes. We do not know what level of cannabis in the blood or in the body affects driving skills. We know that in relation to alcohol because we have been able to carry out those studies; we have not been able to do it with cannabis. The other thing is that the cannabis people use today is much stronger than that they were using in the 1970s and the early 1980s.

Mr RALLS: I am not sure to whom I should put this question. Has there been any research into the effects decriminalisation has had on other issues such as road trauma, health issues and education? Someone mentioned that its effects on driving is moderate, but if its effect is moderate on road trauma, health issues and education, putting those together will give the big picture.

Mr STAFFORD: I do not understand the question.

The CHAIR (Hon Fred Chaney): What is your question?

Mr RALLS: Has there been any research about the effects of decriminalisation on those other issues? If it is decriminalised, does it have effects on road trauma, health issues - such as cancer and so on - and also education?

The CHAIR (Hon Fred Chaney): I think the question is whether there is any scientific evidence that in those countries in which the use of marijuana has been decriminalised - and we were given some examples of that earlier - it has affected road accidents or road issues. Is that a fair summary of your question, Jason?

Mr RALLS: Yes.

The CHAIR (Hon Fred Chaney): If none of our experts can help us, then we should move on.

Dr WODAK: There was a paper by Eric Single, which reviewed the international literature on cannabis consumption in relation to the alteration in legislative approaches to cannabis. The general conclusion was that liberalising or indeed restricting this did not necessarily have the effects people anticipated it would. As far as I know this is the only paper still in the literature on this subject, so I think that is the limit of our knowledge.

Mr LOVETT: I would like to put my question to Nick Stafford. Firstly, I congratulate him on his submission and his courage for being here. I have to say that his was the best speech we have heard from anyone so far; it did not assume anything and it was good to hear from someone who uses. What got me about your speech was that you said you have still been working while you have been on methadone or heroin. You may have enlightened the rest of the people at this summit. Would you agree with a statement I made the other night that, in essence, there are people who use all sorts of drugs in all sorts of manners and then there are alcoholics? I can go to a hotel and have a couple of beers, whereas another bloke will drink all day. You can go to work and do all your normal stuff, and then there is an addict.

Mr STAFFORD: I see what you are getting at, but I do not think it is that simple. There is a lot of functional drug use in the sense of people trying to deal with internal things - whether that is abuse, trauma or whatever. I do not agree with this theory that some people are addicts. I think you learn to be dependent, and you use dependency as a method of coping with life. I do not believe in this view either that once an addict always an addict. It is not possible to treat drug addiction, it is only possible to recover. I do not think there is any end point for recovery; you learn to manage. You learn to deal with your life and to manage your drug use. There is this conception that everyone who is dependent is totally out of control and unable to manage their drug use. For many people - not for all - this is not true. I am quite capable of buying a gram of heroin and splitting it up. I know that I have this much money and this heroin has got to get me through five days. I will break it up and use it, so that I can function during my day. I know that if I had to pick up my methadone once a month I would be totally capable of managing my doses for a month instead of having to be on parole and go in every day.

Mr COE: My question is to Dr van Beek and relates to the injecting facility. Am I correct in saying that it is still under the banner of a pilot program?

Dr VAN BEEK: It is an 18-month trial. The legislation allows it to operate for only 18 months.

Mr COE: In light of that, could you describe to the summit the reaction from the community in general at the beginning compared with the reaction today, now that you have had an opportunity to look at the statistics and other data?

Dr VAN BEEK: The Kings Cross community is a fairly unique community and we could not have hoped for a more suitable community to pilot the first injecting centre. It is a relatively young, middle class, well-educated, progressive community with a good understanding of the complexities of drug use issues and the courage to agree by and large to pilot something like this in its own backyard as indicated by those polling results. It is also a somewhat transient community as most people do not settle in Kings Cross for life. People go there knowing what they are buying into and, also, should it get too much or should they reach a stage where they want to settle down with kids and a dog, they are financially and socially able to move elsewhere. In that way it is different from lower socioeconomic communities in which people do not have those options.

We have enjoyed strong support from the community. However, there was a small group of people who were opposed for a range of reasons. They felt a lot of anxiety before we opened that the world would not be the same once we were operating. That is even though the Kings Cross area for decades has been a major drug supply source and has been, arguably, the centre of the sex and drugs industry in this country. We were coming from a low baseline, and even if one of objectives of the facility were to lower amenity - which it was not - that would have been a great challenge to achieve. Since we have opened, the fact that nothing shocking has happened to date, has reassured, in particular, those people who were doubtful, and those people who wanted to give it a go but were anxious. If anything, the already high underlying support in both the residential and business community has increased since the results have been communicated. The experience so far is that drug dealing patterns have not shifted.

There has not been any of the expected congregation in the immediate vicinity, which was one of the concerns. We have yet to see the results across the State but it would seem that there is an increasing willingness to try new things.

The CHAIR (Hon Fred Chaney): At least a dozen people are seeking the call. I have already noted Dennis Eggington, Father Paul and Messrs Hicks and Hinds. We will clearly not get through that list in the time available. I want to invite Professor Mattick to make some comment on the matter which Elena raised. There is a sense of disappointment when people cannot ask their questions. I am sorry, but time will run out.

Mr EGGINGTON: Dr Alex, we do not want any more taxes and we do not want any more deaths. Can you give us a ratio of which we should be advising government of how much money should be diverted from the law and justice budget into the health budget to be able to start to turn around some of these issues?

Dr WODAK: First, I reject the notion that we should be cutting the law enforcement budget. Even if it were advisable to do that, in politics it is setting the bar too high; it would be unachievable. I do not think that we should be doing it anyway. In round figures it is a very important question. We are probably talking nationwide of several hundred million dollars to get treatment to the level that I talked about. In Switzerland the budget for illicit drugs is about 1 000 Swiss francs a year per capita for a population of seven or eight million. That roughly goes half and half to drug law enforcement and drug treatment. Their costs are probably a little bit higher than ours because of salary costs. However, we could extrapolate that to Australian conditions. There would be some likely savings in Australia from having a much smaller prison population. Bearing in mind, as I have said before, one inmate costs $60 000 a year, we would not have to reduce the prison population by very much to produce savings similar to the cost of the expansion of drug treatment services. It may be that by spending several hundred million dollars more on drug treatment, the cost would entirely be met by reduced outlays on corrections.

Mr STAFFORD: My understanding is that we currently collect about $8 billion to $9 billion in alcohol and tobacco taxes. We spend less than one per cent of the total budget on treatment. If we are making money out of drugs, we must deal with the problems. We must change the community attitude. If we are going to collect that amount of money, we should spend as much of it as we bloody well need to to provide treatment for everyone who needs it. What is left over will be a bonus, but first and foremost we must cover the damage that is caused.

The CHAIR (Hon Fred Chaney): I invite Professor Mattick to make a comment in response to the clarification request made by Elena.

Associate Professor MATTICK: The effects of cannabis on functioning are acute, as Alex said. They include anxiety and paranoia sometimes found during the use of cannabis. There is a disruption of cognitive function and coordination at that time. There is some evidence that psychosis may occur, not be caused by the use, but triggered in individuals who are already susceptible to psychosis. The chronic effects of long-term use are that dependence can occur,

which was not mentioned by any of the speakers. It occurs in relatively few people, and fewer than for alcohol, nicotine or opioids. Cognitive impairment through long-term use can occur and respiratory function is affected. Physically, bronchitis can occur. There is also double the rate of lung cancer through long-term use. Those are the effects of cannabis smoking.

Professor Clarke mentioned something about the safety of methadone maintenance treatment. I am not quite sure what he meant, but methadone maintenance treatment is a very safe intervention for those who use it and take it appropriately. It is an opioid that can cause death if diverted, but methadone treatment is associated with reduced HIV risk and an increased life expectancy. People do not die if they stay on methadone treatment.

Summit suspended at 3.30 to 5.00 pm

The CHAIR (Professor Liz Harman): Welcome back to the final session for today. I will pass on a couple of messages before we begin our changed order of proceedings for this afternoon. First, the parliamentary staff have requested that delegates please not turn up the volume on their microphones because the sound resonates through all the microphones, which causes problems with the sound system. If delegates are having difficulty hearing the sound system, Philip has some earphones. Will those who want earphones please raise their hands.

Secondly, a number of people have said they would like to spend some of tomorrow's lunch time working in their groups. We are unable to arrange for lunch to be taken out of the main dining rooms and sent to the rooms in which the groups work. However, we could organise a schedule that allowed some groups to take lunch at 12.30 pm, and others to be staggered throughout the lunch time to avoid the queues. We might ask Denzil to organise that. The schedule will not stop delegates going to lunch when they want to. We might arrange for groups 1, 2 and 3 to have lunch at 12.30 pm, and then groups 4, 5 and 6 at another time.

Mr EGAN: On a point of clarification, the program presently says that there will be a distribution of recommendations over lunch, with an hour's reflection starting at 1.00 pm. Can you clarify when we will have the full set of 45 recommendations in our hands to enable sufficient reflection time on the recommendations as a whole?

The CHAIR (Professor Liz Harman): I will provide that clarification first thing in the morning, because we will be meeting with the working group Chairs this afternoon. We will be able to get some clarification from them as to exactly when the recommendations will be available. I expect we will try to get them as early as possible so delegates have as much time as possible to consider them.

My co-chair, Hon Fred Chaney, has been talking to the members of the groups about the fact that we were being overwhelmed by the yellow forms coming into the main centre. As a result of that, we have changed today's proceedings. Instead of having group reports, tomorrow morning we will hear from a number of delegates who put in yellow forms. I will call out a number of delegates, who will have the chance to speak for no more than three minutes. Paul Baczynski, Brad Jones, Willhemina Farmer, Paula Marii, Sandra Harris, Amie Frewin, Mathew Ferguson-Stewart, Sandy Moran, Louis Puga, Dr Moira Sim, Stephen Norton, Tim Schwass and Tony Italiano. If delegates are not able to speak when their names are called, they should indicate that and we will move on. I call Paul Baczynski.

BACZYNSKI, FATHER PAUL,
Catholic Archbishop Coordinator; Cross Roads Community Drug and Alcohol Rehabilitation Centre.

Father BACZYNSKI: Good evening, everyone. Thank you, Madam Chair. I am Paul Baczynski from the Cross Roads Community Drug and Alcohol Rehabilitation Centre, the Catholic Church organisation that is helping the addicted. First, there is a definite pole here of harm minimisation or zero tolerance. That is probably why this summit has come about. I am impressed with the way those two camps are not putting on their academic vocabulary boxing gloves, because we must come together on this issue from a spiritual perspective. We must focus our energies, talents and time on ways that can truly be holistic. As I come from a spiritual perspective - the Catholic Church - we must look at things from a moral perspective; hence, I have a zero tolerance attitude. However, I would like to pull down a few false barriers between the harm minimisation and the zero tolerance attitudes. For example, the groups that I run in Fremantle for addicted people, their families and friends focus on the fact that our long-term goal for addicted people is that they stay and live a life that they are in control of, rather than the drug being in control of them. People who regularly come to our groups regularly fall down between our group sessions. We do not say no to them at the door. We encourage them with great love to keep going, to pick up their cross, to pick up the pieces and to bring their life back together again.

Zero tolerance or a holistic approach has many benefits worldwide, which we have not heard here. I will share a couple briefly: San Patrignano is an Italian-based program which, along with two or three other European-based, long-term rehabilitation programs, has had wonderful success for many decades now - between 80 and 90 per cent. We are talking about a 30-month rehabilitation with no relapse for three years. That is a positive statistic. It works very well. Can the State not look at something along these lines; that is, arts and crafts centred, human development centred and spiritually centred for the whole person?

Likewise, non-government organisations such as mine that ask for no money get very little airplay, especially here at this summit at the moment. I would like to encourage everybody to try to come together. We can build a better society, but we need to keep off the academic boxing gloves between the harm minimisationists and the zero tolerants, and come to a good, strong understanding of how we can help our youngsters. Thank you.

The CHAIR (Professor Liz Harman): I invite Brad Jones to speak on a father's concern.

JONES, MR BRAD,
Youth Category Experience and Concerned Parent.

Mr JONES: I am a concerned father. I came here to learn and to participate in this conference. I want to make four main points. A lot of people do not use drugs. We need to be careful about the message we are giving to them. The decisions that we make here could change the balance in the community. The people who do not use drugs have a right to believe, as well as to live, in a drug-free community. As we heard on Tuesday, the majority of people in the community do not abuse drugs, and their views need to be respected. Let us not send the wrong message to people in the community about drugs. Let me give an example. I appreciate that free needles should be available to people. However, I also think of the message that I am sending to diabetics who have to pay for their needles. Are they less important? They have an affliction as well.

My next point is that the information and the facts and figures that have been used in this summit are very confusing for me. I am just a dad. I will sum up.

The CHAIR (Professor Liz Harman): Brad, there are a lot of dads out there. If you want to speak, speak.

Mr JONES: The community statistics that have been given here are very confusing. There needs to be a basis of understanding whereby simple people can understand what is being talked about here. We need to have stuff that people can comprehend - something against which to evaluate it. I have had a lot of trouble understanding a lot of the information here; it is very misleading. I would like to be able to make really good, educationally based decisions on well-founded information. I have not been able to do that. We need to have a national strategy on information so that it is always judged by the same criteria and is understandable by the people.

My next point is about how we evaluate our strategies and how well they are going. They are all evaluated in so many different ways that I do not know what evaluation to accept. There needs to be a base point whereby everything is evaluated in the same way, so that people can make simple decisions.

The CHAIR (Professor Liz Harman): Thank you, Brad. I will get you to make one more point.

Mr JONES: My last point is that the major concern for me, as a dad, are the roles in society; that is, what influences me and my children. The biggest influence I can have on my children is as a role model in the way that I live my life. I do the best I can, and a lot of other dads and parents do the best they can. The message that I want to give is that the other influence that affects our children and us as a society is the television and other media programs. I do not want those things to dictate the values of our society. I want families to dictate the values of our society. Families have a lot of worth and a lot of love to give to their children. However, in a drug-related situation, there is a lot of love that families are unable to give.

The CHAIR (Professor Liz Harman): We all applaud the courage of those who have come forward. I now call on Willhemina Farmer to speak on hope from a grandmother's perspective.

FARMER, MS WILHEMINA,
Southern Aboriginal Corporation.

Ms FARMER: I am 37 years of age. I am speaking as a mother, a grandmother and a sibling who has lost a brother and a sister-in-law. Most of my life has been affected by issues to do with drugs. I am also speaking as a former user; I have not used for 16 years. I am not speaking as a senior public servant who has been involved in policy for nine years. I have listened over the past few days to all the issues and debates with regard to the drug issue, and I feel that it is being painted as a rosy picture that is glorified and that suggests that drugs are okay. I do not want to put down any of the people who have shared their views; I respect their opinions, and the facts and findings from their research. I heard all the figures quoted at length, but they were so cold, because I and so many others are still hurting from the devastation and pain. What I hear is in such contradiction to my own life skills experiences. I am saying to you now that drugs are not okay, and the impact of drugs on individuals, families, communities and societies is devastating. We need to bring some balance and moral values back for future generations. Drugs are not okay. I do not even understand the term "recreational drug use", because people are still playing Russian roulette with their life and with the lives of other people who are a part of their life.

My daughter continues to use drugs, and I will do everything possible to love her and keep her safe. I will also not accept that it is okay for her to have drugs in her life, in our home, and in view of her

sibling, family members and her daughter. I chose to take my daughter to court for custody, care and control of her daughter, because there should be no compromise to the rights of that child. I once again repeated the history that I had gone through. Yes everyone has choices, but when a family member is so unwell, the welfare of children must come first, and the needs of other family members must be taken into account. When I started using, I had no idea of the type of ride the merry-go-round would take me on. That ride was to last for six years. I had no idea of the losses associated with my children being removed from my care, and the issues that will continue to affect their lives across generations because of my inability to mother them. Without knowing it, I chose to give up the privilege of rearing my own children. They and I will never regain what they and I have lost. My son was 11 months old when he left my care. He now 18 years old and I still have visions of the 11-month-old bundle that I handed over because I chose to screw up. I chose to use and I chose to deal. I chose that lifestyle. I also chose to lose my children and family to get what I wanted out of life. Once we start on this road, it is hell getting off it, and it is hell for our family and loved ones. Others will always be in control of the stopping and the starting. I live every day of my life fighting the enemy - myself. Please let us do what we can to stop people getting on the merry-go-round in the first place. Let us make recommendations that will give children, my grand-daughter and other grand-daughters a future with hope, not one that is about accepting drugs.

MARIL, MS PAULA,
LOCAL DRUG ACTION GROUP.

Ms MARIL: I am a parent volunteer with the Parent Drug Information Service, and also co-convenor of a local drug action group. I became involved with these organisations because of my own child's addiction. I have been involved with the Parent Drug Information Service for a year, and the local drug action group for four years. Prior to that I was looking for help for myself and my child. Within those four years I have seen changes happen, and help has been made available for myself and my child. It saddens me to hear that Holyoake is one of the services that may soon be non-existent. It is the only service that has been able to reach my child. As a parent volunteer, I hear parents with the same concerns as myself, and it saddens me that there are no resources out there to cater for and cope with some of the needs of parents, especially those dealing with mental health issues, children going through the justice system, and, of course, living with an addict. It has been hell, because my child had her own child, and I have had to take custody of him from when he was three months old. My concern now is for my grandchild and other children in his situation. It seems that I am hearing that it is up to the drug addict to make some choices to get help. It is up to me to be the voice for my grandchild, and that is why I am proud to be here and hopefully to make some changes for his generation.

The CHAIR (Professor Liz Harman): I now call on Amie Frewin.

FREWIN, MS AMIE,
Alcohol and Drug Council's Prevention and Education Reference Group.

Ms FREWIN: Thank you, delegates. I did not have much time to prepare today, so I will present as much as I can. I wanted to talk about some of the unique challenges facing young people in rural and remote communities, as I am from the south west. Most young people do not have access to services after hours. Many cannot even physically access services because transport is a barrier. Even if they find a service that suits them, they will not necessarily be looked at or referred to it

because of competitive tendering, competition for money and bums on seats. That is, of course, if they can get over the initial stigmatisation of getting through the front door of a treatment service in a small country town.

Stigmatisation is a huge issue in country areas, and I will share a personal story of something that happened when I was at school. One of the highlights of upper school was going to a camp down at Walpole. I was involved with a number of different groups within the school. A number of students were bringing marijuana to the camp. I, being the nice person, got caught up in the middle, by literally passing a foil from one person to another. I was taken off the camp on the second day, my parents paid $700, which was not returned, and I was branded a drug user and almost accused of criminal involvement in trafficking. That was the extent of my involvement. I then had go back into that school and face the stigmatisation of teachers and my peers during that time. That was very hard to overcome. I could have used that opportunity to go either way in life.

The service I work for has an at-risk focus, and I really want to challenge you with what that means. My typical client is homeless and jobless, has a mental health issue, probably has an eating disorder, is a victim of abuse, has low literacy levels, and did I mention that they have a drug problem? What am I doing to assist these young people? Not much on a budget of $50 000, which includes outreach. What kind of problems do they present with? Not alcohol, because I am funded by the national drug strategy, and can only put down illicit drug use as a primary presenting issue, even though we know that alcohol is a major issue in rural communities.

Dr Alex Wodak said earlier today that one of the biggest obstacles to moving forward is fear. I want to know what it is that we fear. If we trial something, perhaps it will work. I fear what will happen if we do not make some major changes. I urge delegates to look at how these changes will be implemented. The community does not have a good understanding of the jargon used in the drug and alcohol area. What does the term "harm minimisation" mean to the community? I went to a meeting late last year in a small town at which a motion was passed to bring in corporal punishment for those who commit drug-related crimes. The punishment meant by that was public floggings. That community thought that it was the best way to go. In summary, country people, and especially young people, have specific issues and a number of barriers to accessing services. I hope we can come together to address those issues.

FERGUSON-STEWART, MR MATHEW,
House Master, Guildford Grammar School/Youth Leader.

Mr FERGUSON-STEWART: As David Malcolm said today, we are greatly privileged to be here. However, great responsibility comes with great privilege. I will talk about the great power we have as delegates to this summit and how we must ensure that we do not fall too far into the trap of imposing tyranny. John Stuart Mill, in his profoundly influential essay "On Liberty", which showed great foresight in predicting the rise of tyranny in Europe before Nazi Germany became a reality, warned of the tyranny of the majority. As we know, Nazi Germany gave majority support to anti-Semitic policies. Those policies would be totally reprehensible to everyone here today. In this summit, delegates have the power to democratically give majority support to recommendations that may in turn be adopted by the legislators of this great State. Even if we democratically reach a majority decision, that does not make us right. Winston Churchill once said that democracy is the worst system there is, except for everything else we have tried. In making decisions this week, we must take great caution, because what we decide as individuals with a predetermined frame of reference may impose a tyranny on other people. Being part of a majority does not make us right or righteous. For us to decide that the use of drugs should remain illegal imposes a tyranny on those who want to take drugs, but just as significantly, for us to decide to give money, for example, to a

free heroin trial imposes a tyranny on the long-suffering taxpayer. It is likely that it will be impossible for us to avoid imposing any tyranny on some part of the community, so we must carefully choose where to impose tyranny and where to allow liberty to flourish. We must be careful that tyranny remains the less preferred option to liberty, to ensure that we do not fall into the trap of tyranny as did past regimes such as Nazi Germany. We must minimise our imposition on society and the taxpayer as we try to minimise the imposition of drug use. We must not add to the feelings of disenfranchisement and alienation from democratically elected Government and democratic processes that are already felt by many individuals in our community. I ask delegates to please remember that being part of a majority does not make a person right. Delegates have been granted the power of tyranny. Please use that power responsibly.

MORAN, MS SANDY,
Concerned Community Member.

Ms MORAN: The "National Mental Health Strategy 2000", a commonwealth report, stated that 11.2 per cent of children in Australia had attention problems; three per cent had depression problems; and three per cent had conduct disorder. Twenty-three per cent of the children with one disorder qualified for a second disorder. Approximately 40 to 50 per cent of attention deficit folk will have some substance abuse issues. People with disabilities have significant vulnerabilities, one of which is substance abuse. There are no significant public sector services for families of attention deficit children in this State. This is surely a part of early identification and intervention. There is no public education or professional development of educational or health care providers on developmental disabilities. ADHD folk die from non-diagnosis of their condition, and substance abuse is just one form of the damage that is done to these vulnerable people. Many disabilities are hidden, but their impact on peoples' lives can be devastating. People with disabilities like attention deficit hyperactivity disorder, learning disabilities and Tourette syndrome are among the most discriminated against minorities in our community. Their disability is hidden. Please consider their needs in this debate.

PUGA, MR LOUIS,
Justice of the Peace and Concerned Community Member.

Mr PUGA: I am a concerned community member and I am speaking like one. I am totally confused because I did not know all these services were available to approach and to talk to. I am totally confused because there are so many government agencies and people involved in helping us, the community. Sometimes we do not know where to go. We make a couple of calls and nobody answers the phone. I do not know where the agencies are but they are there for us.

I have many points but I am roughly talking to those who are here: do not forget the families and do not forget that we come from very far away countries. We have our religious, moral and educational values. We teach all those values to our kids with one thing in common; that is, do not do drugs because they are evil; do not drugs because we know they will always be with them; and do not do drugs because we do not want our kids to do drugs and please keep it that way. We try to keep them away from drugs. We know they are there. Maybe tonight the news will touch on drugs. I pick up the telephone and I do not have any telephone numbers. People call me for help - I am a justice of the peace as well - and I do not know where to go and how to approach the agencies. The money is there - funds, funds, funds, money, money, money, duplication, duplication - and people

in the community are saying there is nothing there. I do not know if that is true but I am totally confused because I did not know the agencies were there. Thank you.

The CHAIR (Professor Liz Harman): I shall ask Moira Sim now to speak on the role of general practitioners and then I will turn to Stephen Norton and Tim Schwass.

SIM, DR MOIRA,
General Practitioner,
General Practice Divisions of WA Ltd.

Dr SIM: I am Moira Sim of General Practice Divisions of WA. About 90 per cent of the population consult a general practitioner on average six times a year. We are highly accessible, we are geographically spread and very diverse. We are probably the most accessible of health care providers. We are one of the few services that are open on Saturdays after 5.00 pm. We have no criteria for entry to our services and we see people who fall in between the groups who turn up and say, "I don't know where to go because nobody will accept me." We see the members of a family differently way from the way in which other service providers see them. We have primary responsibility for each person in a family who consults us. The person who uses drugs therefore is the primary person and everybody else is secondary.

We are a very untapped resource. We use commonwealth funds so that we are not competing for the same pool of funds, and we have a proven role in brief and early intervention. The general practitioners in WA now provide the majority of community-based methadone services across the State, and 90 per cent of the people who use those services are very satisfied with them, one of the major reasons being that they can walk into a general practice and there is no stigma about going to see a GP. It is not like going to a drug clinic and being marked as having a drug problem, which is very helpful to people.

General practitioners are very aware that until about 10 years ago there was no education at all on drugs in their undergraduate years. About 10 years ago that started to change, which means that doctors are now coming out of university who have had some drug education; therefore, attitudes are changing. Young general practitioners have different attitudes and they recognise it is very difficult to work in isolation. They are, therefore, developing a number of initiatives towards working with other people in multidisciplinary teams. For example, in Bunbury a local GP said that he was having trouble on his own trying to look after people who needed methadone. As a result of an approach to his local division of general practititioners, we now have a multidisciplinary team of four GPs willing to take on the work with a community drug service team, mental health and Next Step.

When the summit considers its recommendations, I ask it to please consider the role of general practice; it is an untapped resource, which sees a large proportion of the population.

NORTON, MR STEPHEN,
Senior Prison Officer.

Mr NORTON: I am a senior prison officer at Casuarina Prison. I deal every day at work with offenders who have drug related problems. I do not represent the Department of Justice, these are my personal views.

Over several days, drug-free prisons and drug-free units have been discussed here. I strongly endorse that concept; it is desperately needed to deal with the drug problem in the prison system.

Prison officers need better education in drug addiction and in the problems prisoners have, so that they can better deal with them. As I said, we deal with them daily. We are not people in the community who see them on an hourly basis; we live with them.

If the summit considers anything, it should consider what a syringe can be used for - that is, a weapon - and the effect that can have on prison officers, nurses, educators etc who come into jails. I understand fully the issue of blood-borne communicable diseases and I can relate closely to that issue, but I have concerns. Everyone takes a risk when they walk into a jail. The fact that a syringe can be used as a weapon is a major issue.

I feel very privileged to be at this Community Drug Summit. I hope that, in five or 10 years or however long it takes, if the community feels it is not taking the right direction on drug issues, another meeting like this will be held so that we can again point the Government in the right direction. Thank you.

The CHAIR (Professor Liz Harman): I apologise to Willhemina Farmer because my voice overrode the beginnings of her statement. I invite her to correct the record when it comes out tomorrow. Thank you for today's proceedings.

Summit adjourned at 5.38 pm