COMMUNITY DRUG SUMMIT

HELD AT PARLIAMENT HOUSE
PERTH

THURSDAY, 16 AUGUST 2001

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Summit met at 8.32 am.

The CHAIR (Hon Fred Chaney): We have limited time this morning for a number of speakers. I believe that some groups have been working this morning. I appreciate that some delegates may be a little slow this morning. We need to get as many speakers through as possible.

I wish to advise of the first outcome of the summit. Yesterday, John Harris tabled views about the need for the principles to be more reflective of Aboriginal and islander concerns. The matter is being considered by working group 9. I spoke with the chair of that group this morning. While the group is sympathetic to the views raised, not only with respect to Aboriginals and islanders, but to members of culturally and linguistically diverse communities, it is concerned that with only five recommendations, it is unsure where the matter would fit in its priorities. I have referred the matter to Mr Kucera and he confirms that he is prepared to look at the principles and reword them to take into account the concerns of Aboriginal and Torres Strait Islander Commission delegates and culturally and linguistically diverse communities. That being the case, there is no need for a recommendation to further pursue the matters that have been raised by John Harris in a formal way on behalf of group 3, and which have been raised in other contexts by the delegates. In a sense, this is a first response from government to views expressed at this summit.

We still have 15 minutes in plenary session devoted to speakers. There are five speakers listed, three of whom are from yesterday: Tim Schwass, Sandra Harris and Anne Griffiths. The two additional speakers are Geraldine Taylor and Amber Parry. A further 16 delegates requested to be on the list to speak and have not been accommodated. I acknowledge that and I am sorry but we amended the program yesterday to pick up as many as we could but we have not been able to pick up everybody. I ask Tim Schwass to address the conference for three minutes.

SCHWASS, MR TIM,
Children's Court Magistrate.

Mr SCHWASS: Good morning, delegates. I am a magistrate in the Perth Children's Court. This whole process is similar to a birth: the conception was fun but yesterday the sharp pain of labour hit. Anxiety about the outcome is increasing, and the midwives are about to be tested. Luckily we have three - although we may be down to two. We need to stop worrying and start pushing.

My first point is the parents' involvement in the juvenile justice system. Section 8 of the Young Offenders Act provides that parents should be involved in the sentencing of juveniles. It is my practice to involve parents or responsible adults in a genuine way, because the law requires it and it makes sense to do so. However, the law may not go far enough. It could provide that, in serious cases - for example, where a pre-sentence report is requested - the judicial officer must provide reasons for a disposition contrary to that which the parents think is appropriate. The pre-sentence report could confirm that the parents had the opportunity to come to a considered view and that the author of the pre-sentence report fully discussed the options with them. Difficulties arise when a child does not have an effective family. Family and Children's Services has recently committed to the Perth Children's Court a permanent officer to assist children without a family. That will help.

My second point relates to sniffing. It is an absurdity that sniffing - the use of inhalants - is not an offence when the use of marijuana is. Many of us have seen and know only too well the dangers of sniffing: cumulative, irreversible brain damage, often leading to death. The fact that it is illegal to sniff on government railway property has more to do with dealing with what is seen as a public nuisance than protecting the vulnerable from themselves.

My third point is certainty. I am sure delegates agree that certainty in the law would be a fine thing. Laws that are not intended to be enforced should be repealed. I am confused enough; give me a break.

My fourth point relates to the children of drug addicts. My colleague Sue Gordon rang me on Monday morning, and instructed me to bring this to the summit's attention. She was angry that last week she had sighted a heroin-addicted newborn baby at King Edward Memorial Hospital. A sighting is a necessary formality in a case in which a child is considered in need of care and protection. The mother, who has four other children, all in the care of the State, had been leaving the hospital and returning drug-affected. I rang Sue last night to confirm that I could mention her anger. She told me that she held two ex parte hearings on Tuesday, 14 August. The first case involved a heroin-addicted mother who had been using throughout the pregnancy, including on the day of the birth. The baby was born in a toilet in Northbridge. The mother has shown no interest in the child, who has been made a ward of the State until 18. In the second case, the heroin-addicted mother already had a child who is a ward. The mother has received no antenatal care and shown no interest in the baby. That child also was made a ward of the State until 18. I too am angry. Let us get a grip and do something to help these children have mothers.

HARRIS, MS SANDRA.

Ms S. HARRIS: I address this forum with the simplicity of a mother who has lost a child from drug-related death. Families who lose children from drug-related death not only suffer horrendously but also are often exposed to disgusting discrimination and judgment from a society that has the mentality that somehow our children deserve to die. People think that, after all, they are only dirty little junkies. As such, I urge delegates, when making the recommendations, to consider them appropriately, no matter how sensational they may appear, and address those families that have lost their children. My son could not have cared less about who caused his drug use or why. He did not care about the models for zero-tolerance, harm minimisation, early intervention or whatever. He was simply a 19-year-old kid experimenting with life.

As a mother, I endorse the availability of Narcan. Adam was still frothing at the mouth when he was found. I encourage the implementation of cardiopulmonary resuscitation and overdose training for all children. The irony is that my son was qualified for that and had revived several persons during his minimal life; yet no-one at the death scene could perform CPR. Police officers, ambulance drivers and mortuary assistants must continually be trained in sensitivity and sympathy skills. No parent in this situation should be told by a police officer that this sort of thing does not happen in his family; nor should parents be told that if they want a T-shirt placed on their child for photographs, they should do it themselves. Having come through the back door of our state mortuary, I know that a sign reads, "If you suspect OD, glove up". We who work with the deceased know that we must wear gloves when handling all bodies.

I also call for other community services to understand that alcohol and drug counsellors should be the first referral point for families. Overdose counsellors should be trained in not only counselling for grief and loss but also preparing funerals and recovering bodies. They should have a knowledge of autopsy rights, state mortuary availability and the symbolism and rituals of all cultures. Free ambulance services, emergency department opiate overdose prevention project programs for all hospitals and the continuation of bereavement groups must be classified as best practice and be available throughout the State.

For God's sake, help us save our kids.

GRIFFITHS, MS ANNE.

Ms GRIFFITHS: I draw the summit's attention to issues related to substance abuse among Western Australia's homeless people. Last year, 119 supported accommodation assistance program agencies catered for about 8 700 men, women, young people and children accompanying adults. Alcohol and drug abuse is the greatest single risk factor among the homeless population and is closely correlated to violent behaviour. Indigenous Australians represent 32 per cent of all people assisted. That figure clearly demonstrates the effects of dislocation from culture, substance abuse within families, imprisonment of family members, lack of education and employment opportunities and their own substance abuse problems. Young people under 25 years of age represent one-third of the SAAP homeless population. Half of them - 1 500 - are under 19 years of age. They tend to be multi-drug users. Typically, they have been on a roller-coaster ride of living with friends, squatting, involvement in criminal activities and lack of involvement in education, training and employment. Some are in the early stages of developing mental illness.

Women and children escaping violence represent 28 per cent of the SAAP population. Often they have been associated with drug and alcohol abuse. The services generally do not have the capacity to attend to the needs of these children - often referred to as the "invisible children". In one night, 497 such children were in refuges throughout the State. Typically, they have experienced high instability and mobility, witnessed and experienced violence, witnessed and may have been caretaker for a drug-dependent or mentally ill patient, suffered developmental, attention deficit hyperactivity disorder, health, dental and education problems, failed to develop appropriate peer relationships or engage in sporting or community activities or hobbies, and frequently return to the situation of danger. Without skilled and early intervention, we can predict where this pattern will lead.

Finally, women leaving prison having been sentenced for drug-related crimes, often seeking reunification with their children, need a range of intervention strategies over and above those currently provided. Some have been using drugs since an early age - sometimes as young as 10 years of age - and they have high rates of childhood and young-adult trauma. They are at high risk of death following release - usually within three to 18 months. Many of those deaths are not directly drug related but involve violence or an accident. Integration in the general community is difficult and alienation and loneliness often lead them back into old, harmful environments and networks. We are here to make a difference at this summit, for these people - our fellow Australians - and I hope we can.

TAYLOR, MS GERALDINE.

Ms TAYLOR: I spent many days preparing what I will say today, but now I speak from the heart. I represent women throughout the nation. I come to this place from the National Council of Women of Australia as a mother, a wife, a concerned female, a sister, but not yet a grandparent - I hope that will happen one day. I ask delegates to listen to the voice of women and families.

I have heard some wonderful presentations over the past couple of days. My gut feeling makes me ask what is the basic unit of our society. It is our family. Delegates should look to their right and to their left. Each one of us came from a family unit in which we gained our value and belief systems. I urge and encourage delegates to support the family. I urge support of the family that is drug free

and the family that has come into contact with drugs. There is no division among us. We are the unit of society. I urge you to consider that this conference summit is about human dignity, it is about human worth, it is about bringing together our ideas and working as a family for the outcome of our children. Finally, it is the right of the majority of our society, of the rest of Australia, to have a drug-free environment as our ultimate aim. Slowly, families feel that their values are being eroded. It is the right of the newborn to a drug-free environment in utero; it is the right of a young child to be in a drug-free environment; it is the right of an adolescent to make a choice. It is those early development years that are so important.

Finally, I am so surprised that when money is allocated we talk about performance appraisal, we talk about best practice, we talk about accountability and responsibility to get the funds. What is the best practice for our families? The best practice for our families is to be strong. There is no cost too high to pay for the integrity and stability of our families. Environmental pollution laws are now going through so we do not contaminate our lungs and our bodies. What about the drugs that are available to our youth?

This is a wonderful nation. This is a wonderful State. We are the best in Australia. Let us show the rest of Australia that we have the moral conviction to say “no”, to raise the goalpost, but also accept that families in need who come in contact with drugs are also our brothers and sisters and need to be supported in every way. Thank you.

PARRY, MS AMBER,
Youth Worker.

Ms PARRY: I would like to talk to you as a child of a user. Firstly, I would like to say that drugs are not fun for most addicts. It really surprised me this morning when I opened my newspaper to read that drugs are fun for most addicts. I believe they are not fun for most addicts. I have never been an addict myself, but I would not find it fun to send my children to school without food, I would not find it fun to hock my children’s belongings, I would also not find it fun to nod off on my children’s birthdays, I would not find it fun not to give my children Christmas presents. I would really like you all to think about what we are saying and to think about what we are trying to do here. Drugs are not okay and do not just hurt the user’s life; they hurt the people around the users. Do not forget about the 98 per cent of us who do not use drugs. Do not forget about the community that is affected by drugs every single day. We are not alone in this. I think we should stand up and be counted and be heard so we know there are better ways for people to deal with their problems instead of turning to drugs. Drugs may be fun, but I say to you that is not an excuse for them to use drugs. That is all I have to say.

The CHAIR (Hon Fred Chaney): I thank all delegates for those contributions. Before calling on our keynote speakers for this morning, all delegates would have had on their chairs this morning a set of additional rules for consideration of working group recommendations. We will return to those prior to morning tea after the two panels that we are about to hear. I now invite Dr George O’Neill, who is the Director of the Perth Naltrexone Clinic, to address us on the topic “Using naltrexone - strengths and limitations”.

O'NEILL, DR GEORGE,
Director, Perth Naltrexone Clinic.

Dr O'NEIL: I thank the organisers for this opportunity. We are still improving the work that we are doing and we have a long way to go. In a four-year period, the chance of achieving six months heroin-free has increased from five per cent for a seven-day detox to 98 per cent for a one-day treatment. Oral naltrexone, with carers crushing tablets, doing urine monitoring and retreatments where necessary reached approximately 60 per cent of the population. The more difficult part of the population required implantable naltrexone. Good results depend on integrating a PHREE program. This will be explained in detail shortly, but it refers to the order of treatment: correcting physiology, housing, relationships, education and finally employment. Good results really depend on grasping the opportunity when the addict and his family presents, however it presents and when it presents.

Past expressions "harm minimisation" and "zero tolerance" are outdated. Harm minimisation was derived from the strategies of the 1990s, which were focused on the spread of AIDS, and zero tolerance implies intolerance for much of what the addict represents. The new millennium terms that we would like to promote are opiate maintenance programs and active recovery programs. Virtually all workers agree that goals are not well designed for dealing with addiction as an illness. Active recovery requires efforts for the addict to change and express their feelings honestly. He or she can only achieve this if the community offers them forgiveness, hospitality, optimism and a home where they feel loved. The term PHREE is a nomenclature to indicate the correct order of treatment for addicts - physiology, housing, relationships, education and employment. Much of the treatment is in fact education rather than counselling. Correction of physiology and housing immediately is often associated with rapid patterns of recovery for many patients. Correcting the physiology may be achieved by geographic isolation from the product or by using antagonists, such as methadone, which keep the patient addicted. These antagonists keep the withdrawal symptoms controlled. Prevention of craving and use is more effectively controlled by antagonists, with blockers such as naltrexone. This approach ends the addiction while treatment is maintained. Giving the addict help with artificial housing and helping the family rebuild a home is essential. Self-esteem is the principal relationship to be rebuilt and then the relationship with others. Finally, education and employment are re-established.

This complex graph shows the risk of death from overdose falls consistently for a number of years after detoxification treatments. The attraction of becoming heroin free through residential detoxification is associated with a five per cent risk of death in the first year after returning to the city; that is largely from jails. Active heroin addicts have a 2.5 per cent risk of death if untreated in the first two years after monitoring begins. While oral naltrexone patients have a 2.2 per cent risk of death in the first quarter after treatment, regression analysis estimates a risk of 0.5 per cent by the fourth year following treatment. Methadone maintenance patients have a risk of death of about 0.5 per cent to two per cent. When they cease methadone to detox, their risk of death is at least double this level. This is shown on the graph.

Implant naltrexone patients with a standard 3.6 grams of naltrexone have a risk of death, which is likely to be less than 0.3 per cent. We have seen no opiate overdose deaths in these patients. We have followed patients for 170 patient years in Perth, which represents about 320 patients. Between 1998 and 2001 we have improved the effectiveness of treatment to prevent opiate dependence, simply by delivering naltrexone to the patient in a more reliable manner. This has increased the success rate from 33 per cent to 98 per cent in three years. Although the Americans have talked of developing implants since 1978, the first product did not appear until 1996. In the past five years American implants that have lasted five to six weeks have been available. Australian naltrexone implants lasting three to 12 months have now been designed and produced in Perth. By monitoring

blood chemistry and symptoms, the time to replace implants can be estimated. We have recorded no opiate overdose episodes from naltrexone implants in Western Australia in what equates to 170 patient years.

With oral naltrexone, crushing and monitoring gives excellent results, but where supervision is missing it must always be remembered that the blood level is low within 20 hours of taking the tablet. This contrasts with good blood levels at 200 days after a 3.6 gram implant. In our Australian research on oral naltrexone, John Saunders in Brisbane, John Currie at Westmead and our own group used carers and careful monitoring. All three groups recorded opiate-free success above 50 per cent at six to 12 months. Other Australian researchers using oral naltrexone used no carers, and no blood or urine monitoring, to demonstrate that oral naltrexone is not useful without carers or monitoring. Their results were uniformly less than five per cent at three months.

Since August last year every implant patient has had a guarantee of effective naltrexone delivery for six months or more from the time of insertion. They do not require carers for their naltrexone delivery. Between mid 1997 and mid 2001 the total number of detoxes in Perth increased by 400 per cent to 500 per cent compared to the standard 300 detoxes that the central drug unit performs each year. In the 1997 to 1999 period the death rate started to fall in Western Australia, while the death rates in Victoria more than doubled in a 24-month period. We believe that this is related to the high number of naltrexone detoxes in Western Australia.

Naltrexone implants became available in August 2000, and by October 2000 were being used at the rate of 30 to 40 a month with our most erratic patients. Some of these patients had overdosed 70 times; all were overdosing regularly. We believe the decrease in ambulance calls apparent before the end of 2000 relates to the introduction of an efficient treatment to control Western Australia's most erratic patients. By late February-early March 2001, the heroin shortage started to affect Perth significantly, and the drop in ambulance calls we believe is related to the decreased availability of improved treatment.

In the past six weeks, the old Northam hospital has been reopened to care for recovering heroin addicts. We believe that with appropriate support, we can achieve a world-class rehabilitation centre with the benefits of residential care as well as the protective effects of implantable naltrexone. We can recommend to all residential rehabs the use of implantable naltrexone, especially to protect the addict for his or her first six months back in the city. This should be inserted prior to discharge or preferably at admission. The three-storey building shown here is primarily for accommodation, while the larger building is for activities and rehabilitation.

It is difficult, even for experts in the field, to keep up with the quantity of new information generated from our research work in the past four years. This is the first city in the world in which rapid detoxification with naltrexone has been used almost as much as methadone to control an epidemic. Before 2000 there was a reasonable argument that detoxification might not be as safe as opiate maintenance with methadone or heroin. This is no longer the case. Since the introduction of naltrexone implants we can now argue, with good evidence, that giving up opiates is safer than any opiate maintenance program. Is it not time to question our strategic plans?

Our opiate maintenance programs have grown from 500 to 35 000 methadone patients. This large pool has no quality assurance system to monitor illegal opiate use. As a result, these 35 000 people represent a large opiate dependent pool which is at risk of infecting new recruits. In a high percentage of cases, our addicts under 25 years admit that their dealers are methadone maintenance patients in their thirties or older. It is my belief that we have a secondary epidemic, and we must change the planning.

It is now time to invest in recruiting the remaining 35 000 heroin addicts into an active recovery program. The technology is available, and we must provide the teaching, funding and service. I believe that promoting active recovery programs such as the physiology, housing, relationships, education and employment program, together with naltrexone implants, will change the world.

Certainly there is now strong evidence for the safety and efficiencies of these programs compared with opiate maintenance programs. Active recovery involves mental, physical and spiritual changes by the addict and by the community in which we live. The addict must seek to be honest and to ask forgiveness. The community must offer forgiveness, optimism, hospitality, discipline, monitoring, love, friendship, a home and a purpose.

The CHAIR (Hon Fred Chaney): Before calling Dr Ritter, I have been advised of a request from delegates to suspend question time after the presentations given by Dr O'Neil and Dr Ritter in favour of further statements being made from the floor. I understand that quite a few delegates have a considerable interest in the subject before us; therefore, I propose to allow delegates to ask questions after we have heard from Dr Ritter. However, should questions not continue, I will call on delegates for statements. I intend to give priority to questions and to use any available time after that for statements.

I ask Dr Alison Ritter to address the summit. She is the head of research at the Turning Point Alcohol and Drug Centre in Melbourne and her topic is outlined in the delegates' programs.

RITTER, DR ALISON,
Head of Research, Turning Point Alcohol and Drug Centre, Melbourne.

Dr RITTER: Thank you very much for this opportunity. It is an extremely challenging task to summarise and consider the evidence of all the different treatment options that are available in only 15 minutes.

Is treatment a good investment? The answer to that question is a resounding yes. A number of studies have demonstrated that treatment works to improve drug use and to improve the way in which people function socially and psychologically; therefore, treatment is a worthwhile investment. For every dollar that is spent on treatment, seven dollars is saved. I have been asked whether it would be better to invest money on law enforcement or on supply reduction initiatives. Research on this issue showed that treatment is by far the most effective way to reduce drug use and it is more cost-effective than law enforcement or supply reduction initiatives.

Given that we know that treatment is a worthwhile investment, in what sort of treatment should we invest? I will briefly summarise the three broad classes of treatment for illicit drug problems: drug withdrawal, relapse prevention and substitution pharmacotherapies. I will describe each of these treatments in turn and discuss the various programs that exist within each of these three modalities. I will then discuss the evidence that has been obtained by research.

Some people refer to withdrawal as "detoxification"; it is the same thing. It is most important to know that the goal of withdrawal is to interrupt a pattern of harmful drug use. Withdrawal is primarily a physiological process aimed at removing the drug from the body safely and comfortably. Withdrawal does not change people's drug using behaviour in the long term. Withdrawal can be provided in hospitals, community residential settings, on an outpatient basis and in home-based services.

In broad and simple terms, there are two types of withdrawal; that is, medicated withdrawal, in which someone is given medication to help with the withdrawal process, and cold turkey. Almost every drug user has experienced cold turkey. They know what it is like because they usually have done it a number of times by themselves or with support from their families. Most of the treatment services do not know much about cold turkey and they provide medicated withdrawal. In a moment I will talk about different medication options but first I will emphasise that probably the most important part of a successful drug withdrawal or detoxification treatment is to provide a supportive and calm environment. That is crucial to the success of the drug withdrawal process.

Three main classes of medication are used for withdrawal treatment. The first is the set of drugs that alleviate the symptoms. That treatment is called symptomatic treatment, and it includes the drugs clonidine, codeine and lofexidine. That is the most common form of withdrawal management, and we call it "conventional withdrawal". The second class of medication is replacement drugs. They alleviate the symptoms of withdrawal by replacing the abused drug with a prescribed drug then rapidly decreasing the amounts of that prescribed drug. The most obvious examples of replacement drugs used for withdrawal are methadone and buprenorphine. The third class of medication is the antagonist drugs. These replace the abused drug but they do not produce any drug effect. As a result of this the withdrawal symptoms are quite severe. Both naltrexone and naloxone are used in this method, and the severe side effects are managed through sedation or anaesthetic or the co-prescription of other medications. There are other interventions for withdrawal, but there is not a lot of research evidence. Acupuncture, Chinese medicine and other herbal remedies are available, but the research is not sound.

There are a number of different settings, such as home-based, outpatient, residential and hospital. There are a number of different ways in which it can be done; that is, the classes of medication. What does the research evidence tell us about which of these works the best? First, the symptomatic treatment - that is the clonidine and the conventional withdrawal - is much less effective than replacement treatments. Secondly, the replacement drugs, such as short courses of methadone for withdrawal, usually result in further withdrawal down the track. Either people go on to methadone on the longer term and then need to withdraw, or they experience what is called rebound withdrawal. Thirdly, recent research has demonstrated that buprenorphine is highly cost-effective as a heroin withdrawal treatment. In terms of the naltrexone and naloxone withdrawal, there has been evidence that rapid detoxification or rapid withdrawal is quite cost-effective. There is good research evidence to support those methods, either under sedation or anaesthetic. There is limited support for acupuncture and other Chinese medicines.

The following slide comes from the National Evaluation of Pharmacotherapies for Opioid Dependence project. NEPOD is a major research project which has pooled the results of 13 different Australian trials. As delegates can see, this shows the cost-effectiveness of the different withdrawal interventions. I thank Richard Mattick for letting me use this work from NEPOD. The most cost-effective withdrawal is rapid withdrawal under sedation using an antagonist. The second most cost-effective is buprenorphine outpatient withdrawal, and the third is rapid withdrawal under anaesthetic. The two least effective interventions are the ones that we provide; that is, conventional withdrawal. I reinforce the point that the goal of withdrawal is to remove the presence of the drug from the body. It is working towards engaging the person in relapse-prevention treatment. The guts of changing someone's drug-using behaviour is in the relapse prevention and substitution pharmacotherapy, not in withdrawal.

I turn to relapse prevention. This is the second treatment modality. The key goal is to change drug-using behaviour, usually after a withdrawal. Relapse-prevention interventions can occur on an outpatient or residential basis and can be provided in groups or to individuals. There are a number of different approaches to relapse prevention. There are two requirements in relapse-prevention programs: first, changing drug-use behaviour; and, secondly, addressing all the other needs that the person has, such as emotional, practical, social and so on. It is important that we concentrate on the drug-use behaviour, as well as on all the other issues that the person is dealing with. The research evidence tells us that the most effective form of relapse prevention is what is called cognitive behavioural therapy. This focuses on practical aspects for dealing with cravings, high-risk situations and life-coping skills. There are a raft of other approaches, including therapeutic communities or residential rehabilitation; counselling and psychotherapy; supported accommodation, which is less intensive than therapeutic communities; marital and family therapy

and support for parents; and naltrexone relapse prevention. I have not listed it, but self-help should be listed; that is, Narcotics Anonymous and so on.

What does the research evidence tell us about these various approaches? The most basic principle is that the longer someone stays in treatment, the better the outcome. The length of treatment is a very important predictor of treatment outcome. We know that for the residential treatments - that is, the therapeutic communities - most people do not stay.

Most people leave a TC within the first three months. Delegates will not be surprised to know that those who stay tend to do extremely well. The problem is getting people to stay. There is very limited evidence for the cost effectiveness of psychotherapy. There is evidence that family therapy, marital therapy and support for parents, in combination with other treatments, improve outcomes. A number of studies have supported relapse prevention with naltrexone. When a person is taking naltrexone, heroin use does not occur - yes, it is highly effective. The biggest problem, however, is getting people to keep taking naltrexone - keeping people in treatment. Most people stop taking naltrexone within three months, and this treatment is less effective overall than some of the other relapse prevention treatments that I have mentioned.

The third area of treatment is substitution pharmacotherapies. The key goal is the provision of a prescribed drug enabling pharmacological stability while the person makes the necessary lifestyle changes. The main objection that people seem to have to substitution pharmacotherapy is that a drug is still being prescribed. What is clear is that while people are receiving a prescribed drug, they can make significant changes to their emotional life, to their relationships with others, to their ability to contribute meaningfully to society, and to their physical wellbeing. These are vital in recovery. We do not seem to have a problem with substitution pharmacotherapies for nicotine - nicotine gum, nicotine patches and so on. We do not object to them, and we know that they are highly effective.

The types of substitution maintenance treatment are dexamphetamine for amphetamine dependence; methadone; buprenorphine; morphine; prescribed heroin and levo-alpha-acetyl-methadol. Clearly, not all these are yet available in Australia. What does the research evidence tell us about these different pharmacotherapies? With dexamphetamine, we really do not know the answer because there has not been enough research. Methadone is highly effective, and buprenorphine is as effective as methadone. We still lack good research evidence on morphine. The work that has been done in Switzerland, notably, on prescribed heroin has demonstrated that the treatment works. It reduces drug use and improves other outcomes, but there has not been a head-to-head trial of heroin with methadone, for example. LAAM appears to work as effectively as methadone.

Once again, the National Evaluation of Pharmacotherapies for Opioid Dependence project looked at the three maintenance options; that is, methadone, buprenorphine and LAAM. As delegates will see on the slide being shown, there is not a huge difference in retention between the three. There is a slight preference for LAAM, followed by methadone, followed by buprenorphine.

My closing comments will be about comparing drug withdrawal, relapse prevention and substitution pharmacotherapies. How do they compare, and in what should we be investing? First, drug withdrawal does not lead to lasting behaviour change. We need to spend some money on drug withdrawal, because it is an important part of the process. However, drug withdrawal in and of itself does not change behaviour. Secondly, the most significant predictor of success in treatment is length. Most relapse prevention programs do not retain clients. Thirdly, substitution pharmacotherapy treatments are the most cost effective of the three. Clients stay in treatment and change their drug-using behaviour. This may not be a message that delegates want to hear. However, my role is to present you with the research evidence, and that is what the research evidence is telling us. That can be seen quite obviously in the retention in treatment graph that is now being shown - once again from the NEPOD project. There is 44 per cent retention for the

substitution pharmacotherapies and four per cent retention for the naltrexone treatments over the number of days in treatment shown in the graph.

Given the research evidence that indicates that substitution pharmacotherapies are the most cost effective, why do we not invest all our treatment dollars in that option? There are a number of reasons. One thing does not work for everybody. People will want to try different treatments, and different treatments at different points in time.

There are some important social factors. I have talked about the three treatment modalities and the different varieties of these modalities, and I have summarised the research evidence. However, the one essential ingredient that can make all the difference is a sense of connection. When I think about the many drug users whom I have worked with over the past 12 years, the one thing that stands out is that they made a connection with me, with the self-help group, and with someone else. They received unconditional regard, and a sense of being worthwhile and of being cared for. Perhaps it does not matter what we do, which drug we prescribe and which relapse prevention program we fund; what really matters is how it is provided - respectfully, lovingly, and with genuine concern for the person's wellbeing.

Ms BOLDY: Dr O'Neill, it seems that the naltrexone program has a lot of benefits. However, two things about the program cause me some concern. I have heard reports about young patients who have had up to six naltrexone implants simultaneously. I have also heard about the apparent excessive prescription of benzodiazepines as part of naltrexone therapy. Can you comment on that, please?

Dr O'NEIL: If we take a person off one or two grams of heroin a day, or if, as we did last week, we take a person who has been injecting intravenously off 500 milligrams of methadone, that sort of person will need benzos for several weeks afterwards. If we take a person off just the standard $50 or $100 a day habit, there will not be much need to use benzos in the first week or two afterwards. The use of benzos is restricted very much to the very high dose, sudden change patients. I think we work as hard as anybody in trying to get people off drugs and off benzos as much as off opiates, and sometimes in doing so we are almost cruel to our patients, because we are pushing them so hard and fast. I have one patient who has been working with us for over a year now, and we have put in enough implants to bring her blood up to very good levels. She will have six implants, but that will be over a year, and that will give her protection for the next 12 to 18 months. Most of our patients will have just one or two implants per stage. The girl with the six implants is progressing very well, and I am sure she is delighted. I do not see that as a significant problem. The implants dissolve gradually over time and can be designed to dissolve over three months, six months, 12 months or 18 months.

Ms WILSON: Alison, you spoke about making drug addicts feel secure with good counsellors and good backup services. Many drug addicts seem to be in a cycle. Do you ever feel that we should remove them totally from that environment and put them in live-in accommodation, with counselling and all the resources in the one package, because at the moment the services are very scattered and it is very hard for addicts to get the help that they need?

Dr RITTER: There is no question that residential treatment is highly effective for people who are in difficult circumstances - for example, they are homeless, or are hanging around with injecting drug users - and we should have sufficient facilities to be able to accommodate residential services. There is, however, the problem of limited dollars, and whether we should invest in residential services or in substitution pharmacotherapies. It is very difficult. We need to invest in a lot of different options, and I do not know how we can determine how much residential treatment we should provide versus how much outpatient or pharmacotherapy treatment we should provide. Residential treatment certainly works for those people who stay in that treatment.

Ms MORAN: My question is directed to Dr George O'Neil. Keeping in mind the psychiatric illnesses in substance abuse - and at the risk of exposing a pecuniary interest - could you please tell

us of the undiagnosed attention deficit disorders in your naltrexone clients, and whether you think attention deficits have contributed to their initial substance-taking activities?

Dr O'NEIL: I think some of our patients have dramatic attention deficit disorders, that even I can diagnose. We take them off their drugs, and they tell us they cannot concentrate long enough to watch a television program, or even to see a whole advertisement from beginning to end. The doctors put them on ADD medication, and they come in and announce that they have been able to watch a television program right through, and for the first time in their lives, are able to read books. We are seeing very dramatic changes in kids who have been using, initially, marijuana and then opiates from the ages of 11 to 13. We are seeing a significant number of people, especially with implants, doing very well after their ADD is managed. It is very hard for me to give you a percentage, because there are the "grey" ones, which I can only just diagnose, and I agree that they do improve after treatment. I send them along to the psychiatrist saying that I am not sure if they have ADD, and it comes down to much more sensitive testing. All I can say is that there is a significant percentage of ADD that needs to be very carefully assessed in this group.

Ms MARSH: My question is directed to both George O'Neil and Alison Ritter. I would like to address a question first to Dr O'Neil, and then Ms Ritter can follow up. Dr O'Neil talked about the death rate from opiate overdose falling over the last few years. My understanding is that it was basically stable until this year, and the rate in Australia is now falling because of a heroin drought. The death rate in Western Australia was stable, while in some other States the death rate went up. I was interested to hear, Dr O'Neil, that you attribute this stability of death rate to the development of the naltrexone program, because over that period the methadone program expanded considerably, from less than 1 000 people to over 3 500. My understanding is that the overdose death rate on naltrexone programs is generally considerably higher than the overdose death rate for people on methadone programs. Would I be able to have a comment, first from Dr O'Neil, and then from Ms Ritter?

Dr O'NEIL: To calculate overdose death rates in any part of Australia involves a review of the statistics of the registrars of births and deaths. John Capelhorn, in Sydney, went to the trouble of obtaining death rate figures from the registry offices of Queensland, New South Wales and Victoria. He determined that the death rate was around about two per cent for methadone patients. A study was done in Perth, in which the researchers did not look at the births and deaths registry, so they did not actually work out the methadone death rates. It has been quoted in the newspaper many times, as evidence that the methadone death rate is low, but no work similar to Capelhorn's has been done. For the moment, I am relying on Capelhorn's work because he did his job properly. He determined that the death rate was around two per cent. The death rate with naltrexone, over sixteen quarters, comes out at 2.2 per cent in the first quarter after treatment. The death rate after leaving residential services is around five per cent around the world, quoting British and United States figures. We start off with a death rate that is about half of that when people actually clean up. After 12 to 15 quarters - that is, three or four years after treatment - the death rate is down to under 0.5 per cent, which means that cleaning up is really worth the trouble. This apparent death rate has not really been looked at or talked about properly in the Press, because people are misusing statistics.

Dr RITTER: This is a complicated issue and experts will not agree, because anything can be done with numbers. I do not know what the right answer is. However, people are less likely to die if they are in methadone treatment programs than if they are using heroin, and people are less likely to die while taking naltrexone than if they are using heroin. If a person stops taking naltrexone, he is more likely to die than if he had been taking methadone. The actual rates involved and how protective the different treatments are is open to debate. The research evidence is not good enough to be definitive about the degree of protection that methadone versus naltrexone provides.

Mr TOON: My question is to Dr Ritter. I have heard concerns raised many times that substitution and antagonist therapies can precipitate a movement to the use of other dangerous drugs. Is there any evidence of that?

Dr RITTER: There is some evidence to support the fact that people in naltrexone treatment start to use other drugs to gain a drug effect, such as benzodiazepines or stimulants and so on. It is somewhat anecdotal. There was no evidence of that in the research we conducted in Victoria in relation to naltrexone, but international studies have been published on that issue. In relation to methadone and buprenorphine treatment, some drug users continue to use other drugs. Benzodiazepines are certainly used by people in those treatment programs. Whether they use more or less than when they were injecting heroin is a matter for debate.

The CHAIR (Hon Fred Chaney): Thank you, speakers. While the next panel members are coming in, I invite Dennis Eggington to make his three-minute statement. If any other crevices of time are found during the day, I will call Anna-Marie Inglis to make her contribution. We will not waste a moment on the floor.

Mr EGGINGTON: Thank you, Chair. The issue of drugs in prison is a major concern to Aboriginal communities. Here in Western Australia, we hold the infamous position of incarcerating more Aboriginal people than any other State or Territory. The national imprisonment rate is currently 143 people for every 100 000. Western Australia imprisons its indigenous community at a rate of 2 954 people for every 100 000. Of the eight per cent of prisoners who have served 11 or more sentences, 82 per cent of those are Aboriginal people. Studies in New South Wales that compared prisoner health and mortality in 30 of the most depressed local government areas revealed that among prisoners, death rates were twice that of the general community; murder was six times higher; suicide was four times greater; and, most importantly for this summit, rates of death from drug overdose were almost 20 times higher. One study on prisoner health highlighted that 70 per cent of prisoners who participated in the study smoked; 23.7 per cent of females and 20.4 per cent of males had used heroin in prison; and about 33 per cent of males and 66 per cent of females tested positive for hepatitis C antibodies. The major health risks identified in prisons and which have been recognised nationally include mental health disorders and behavioural problems, blood-borne and other communicable diseases, and drug abuse. The nature of drug use in prisons and the apparent continuation after release pose significant risks to the community at large. Failure to understand the nature of the continuing risk and the demand for services as offenders move from prison to the community has been associated not only with drug use, but also with mental health, mortality and morbidity outside prison. As indicated, a significant number will re-offend, continue their drug habit and be sentenced to a further prison term where the cycle will be repeated. Although the drug courts have well-resourced, effective and culturally secure rehabilitation services and a long-awaited detoxification centre will have benefits, delegates must understand that these services alone will not help us overcome this increasing health problem. To understand the complexity of this issue for our Aboriginal community, they must understand the relationship between our peoples and the wider community and the history of why this is so.

In her delivery, Professor Stanley gave us a sound understanding of the pathways that lead to increasing the risk of behaviour that leads to drug addiction. I can tell delegates all of that. The policies of past and present governments, whether by design or ignorance, have directly contributed to or created those pathways. In her book *Broken Circles: Fragmenting Indigenous Families 1800-2000*, Dr Haebich clearly identifies this as a present day problem. While the WA community allows the continuation of what Mr Ted Wilkes called the daily oppression of being Aboriginal, we have little hope of building strong families and, in turn, strong communities.

I urge all delegates to understand that tougher laws, zero tolerance and heavy penalty measures on the disadvantaged can act only to diminish what I truly believe is our special place here; that is, our humanity.

The CHAIR (Ms Jade McSherry): Dennis, your time is up. Could you close on your statement, please.

Mr EGGINGTON: Thank you.

The CHAIR: Good morning delegates and panel members. I welcome the panel on carers and consumers today, which will be chaired by Michele Kosky, Executive Director of the Health Consumers' Council of WA. Her panel members include Rosco Woods, Geraldine Mullins, Peter Walton, Kevin Trent and Michael.

KOSKY, MS MICHELE,
Executive Director, Health Consumers Council of WA.

Ms KOSKY: Good morning and thank you for inviting the Health Consumers' Council to chair this panel on consumer and carer issues, and I welcome the people in the public gallery.

Too often in the complex and challenging issues of illicit drug use the voices of consumers and carers are drowned out. It is pleased that this Community Drug Summit has recognised the ethical and democratic right of consumers and carers to participate. Consumers and carers live on a daily basis with illicit drug use and bring a unique perspective to the matters at hand. Carers and consumers have raised with the Health Consumers' Council a couple of matters to note -

(1) the lack of coordination and integration of health between the public and private sectors;

(2) the lack of confidentiality within and between health services;

(3) an apparent attitude problem to people who use illicit drugs when they try to access mental health services;

(4) a lack of information about the risks and benefits of particular treatment options; and

(5) carers have raised with the council time and again the issue of the lack of information, counselling and support for carers, and the public shame borne by people and their families who use illicit drugs.

Again I extend a warm welcome to our panel members and I thank them very much for coming. I would like to get the ball rolling by introducing panel member Rosco Woods, who is an ex-user.

WOODS, MR ROSCO,
Ex-user.

Mr WOODS: I will begin by stating that I used heroin on and off for more than 20 years. Less than five years ago I became an involuntary patient and placed in a locked ward of Graylands Hospital. I was in withdrawal from heroin, as mad as a hatter and enveloped in a devastating grief where death was not the least attractive option. The overwhelming feeling for me there was one of fear. I was given no empowerment or responsibility for my situation and no say in what would happen to me. I did not know how long I would be there or what the hospital would do to me. I was in fear of an untrained system. Throughout that time some very scary people surrounded me. They were the nursing staff, by the way. Today, I work at that same hospital for the joint services development unit, as an advocate for the people with the co-occurring conditions of mental health

and substance use problems. I have gone from a co-morbid junkie to the fine, upstanding citizen you see today.

I know many dependent drug users, and the drug use is never a stand-alone problem. There is always something else. Sexual abuse, abandonment, family violence and mental health problems are common issues for people like me. Drug use is functional because it deadens the pain. In my transition, the big variation in my existence has become my “perception of self”. Only when I started seeing my life experience as unique and my survival as extraordinary, did I move on. It is all about self-esteem. Self-esteem, of course, comes from within but perceptions develop through societal influence. It is very hard to swim with dolphins when you have the ego of plankton.

I hope all delegates realise that very little they do here over the next couple of days will stop Western Australians from accessing drugs, because society has spawned a generation of plankton. We can, however, help to create a culture change and reduce the harm to individuals and the community by encouraging reforms based on the fact that addicts need help, not incarceration, and support, not castigation. They should not become casualties of an unwinnable war. I know we cannot legislate for culture change, but the delegates at this summit can help begin a shift in culture by basing their recommendations on compassion, empathy and humanity. Thank you.

MULLINS, MS GERALDINE,
Australian Parent Movement.

Ms MULLINS: With regard to illicit drugs, we have all heard the mantra that prohibition has failed and abstinence and zero tolerance do not work.

If people read Single and Rohl’s 1992 evaluation of the national drug strategy, they will understand that there has been no policy of prohibition in Australia since 1987, only one of harm reduction, which means using safely. Hence in Western Australia no government funding has been provided for residential rehabilitation based totally on abstinence. In 1995 the Western Australia Police Service joined with the national drug strategy policy and adopted a policy of harm reduction.

Because of our daughter’s drug use our family has been to hell, and we are not back yet. Because of drugs, licit and illicit, our daughter lost custody of her two beautiful babies.

From 1989 to 1993 I was a facilitator of family groups with problems similar to ours. Australia’s national drug strategy on illicit drugs has failed for two main reasons: the belief, particularly among our youth, that illicit drugs are less harmful than legal drugs; and the easy availability of drugs through user-dealers.

The Australian Parent Movement of WA was formed in 1993 to try to combat the deliberate suppression by health professionals of the harm of cannabis and other illicit drugs, and to improve family services. Our aim is to strengthen the role of the family in resisting drugs by the networking of parents, their children and their friends. Our group believes that we must fight for a drug-free Australia. With regard to prevention, we know that effective education does work. The drug law reformists - many in the legal, health and justice professions - seek to replace the United Nations International Narcotics Control Board health policy. They have the explicit aim of liberalising narcotics law and law enforcement.

We have two things we want to promote. We urge strongly that the people of Western Australia, particularly grandparents, demand a successful antidrugs policy with an effective community prevention program equal to the hard-hitting Quit, antitobacco campaign - what is wrong with that? - and to use the media to cultivate a mindset with youth that it is seriously uncool to use any illicit drugs.

Ms KOSKY: I introduce Peter Walton, a concerned bereaved parent.

WALTON, MR PETER,
Concerned, Bereaved Parent.

Mr WALTON: Good morning. The five-minute version of my presentation is available to delegates if they would like a copy. I wish drug use were not part of our lives. I do not condone it, but as long as it exists, our driving purpose should be to keep users safe and alive until they can be free again. My daughter Skye was 17 when she died of a heroin overdose four years ago. She was neither a long-term user nor a criminal, but she had lost her way. She was a warm, loving and much loved person. Skye had spirit. In support of animal liberation she refused to wear her school's prescribed leather shoes. She was an individual. On the day of her funeral some of her friends were approached by a police officer who, seeing a newspaper with her picture in it, asked, "Are you friends of that druggie?" We are dealing with real people, not numbers; they are individuals, often young and vulnerable, whose lives should be cherished. We are failing to give the support and understanding they so desperately and urgently need. We need to see the big picture - not nitpick - and dare to break new ground. By all means punish the non-using dealers severely; harm the Mr Bigs relentlessly; patrol our shores and international gateways with vigour; pursue the agenda of things as long as people like: they won't solve the problem. This is not fundamentally a criminal issue; it is a social and health issue.

There is ample proof that prohibition - hoping that the problem can be legislated away - and zero tolerance have not worked. We need to identify the underlying causes, adopt a holistic response and not fool ourselves that dealing with the symptoms alone will succeed. This would be a far more effective use of resources. We have countless children, siblings and parents in desperate need of support right now. They are on the edge, having been marginalised by our laws and procedures. Skye and others like her should never have perished. I do not know what might have worked for her but I know that the options were too limited. We must have breadth of thinking to encompass a much broader range of possibilities even though some will not fit comfortably. Do not rule out safe injecting rooms and the dispensing of heroin under controlled conditions. Do not rule out intensive mandatory rehabilitation programs. Applaud, not deprecate, individuals such as George O'Neil who are prepared to extend the frontiers of accepted practice. Give our political leaders the clear message that it is time to be courageous; that we have a mess and applying more bandaids is not the answer. Do this and you will have done great service. Ignorance, fear and prejudice should have no place in our thinking and behaviour. We need endless compassion. Please be bold, be brave, and make a real difference.

Ms KOSKY: I introduce Kevin Trent from the Local Drug Action Group.

TRENT, MR KEVIN,
Local Drug Action Group.

Mr TRENT: Good morning delegates. The concept of local drug action groups was developed in 1995 as part of a comprehensive Western Australian strategy against drug abuse. Since then, over 80 local drug action groups have formed across the State in communities as far away as Kununurra, Albany and Kalgoorlie and throughout the metropolitan area and other country towns. This indicates strong demand from the community to become involved in tackling the problems of drug

abuse at a local level. Local drug action groups are a partnership between the State Government and local communities. Any member of the community with the energy and desire to do something about drug abuse, both licit and illicit, can form or join a local drug action group. Each LDAG is supported by one of 12 community drug service teams working within their region.

Local drug action groups also form partnerships with other agencies and organisations within the community, paving the way for a truly collaborative approach to tackling the issues that directly impact on the community. Schools, parents and citizens associations, the police, public health units, family community services offices, local businesses, service clubs, rotary clubs, lions clubs, local governments, youth advisory councils, churches and other sporting bodies all have a role to play in expanding the impact of LDAGs. Issues tackled by local drug action groups include promoting responsible attitudes to alcohol consumption, educating children about the health issues associated with smoking and disseminating information regarding medication issues and the treatment of attention deficit hyperactive disorder. LDAGs also target illicit drug use. The Local Drug Action Group Inc manages the program and provides administrative support to the groups. Seeding grants are available, and each group is entitled to additional funds to conduct programs that highlight issues and provide alternative activities.

If an LDAG finds that glue sniffing, for example, is prevalent in its community, it will act to reduce and eliminate the problem. Members have approached local hardware stores to arrange for such products to be kept away from ready access. In addition, the groups will approach local schools and health workers to alert them to the issue so that children can be educated about the dangers. LDAGs do not provide treatment for addicts, but refer them to the appropriate agencies. The beauty of LDAGs is that they are capable of identifying and addressing local drug issues, and these factors make local drug action groups a real force in the campaign against drugs.

In conclusion, LDAGs represent the fundamental concept of community development. They are a grassroots, bottom-up approach to the prevention and reduction of drug abuse within communities. They are part of a unique and innovative program that involves and empowers the community to act and tackle the issue of drug abuse.

Ms MICHELE KOSKY: Delegates should start thinking of some questions, because we will move onto that next. I introduce the final panel member, Michael from Narcotics Anonymous.

MICHAEL,
Narcotics Anonymous.

MICHAEL: I am a recovering drug addict. I began using drugs in high school at the age of 14, and followed the classic "women's magazine" progression from marijuana to harder drugs. By the time I finished high school, I was using cocaine and heroin. After leaving school, I became a heroin dealer to support my habit. I have convictions ranging from possession and supply to trafficking. Towards the end of 1979, I was imprisoned for conspiracy to import heroin and referred to a long-term rehabilitation program, in which I spent 18 months. Upon release, I discovered the Narcotics Anonymous program and began to attend meetings. I am happy to say that I have been free of all drugs, including alcohol, for 22 years. I have been involved with the Narcotics Anonymous service for most of that time. I have spent the past 10 years with Narcotics Anonymous World Services, which has its head office in Los Angeles. Its primary purpose is to print and distribute information about the service throughout the world. It is found in over 73 countries and translated into over 39 languages. I have done a lot of work over the past 10 years in the South East Asian region and the Middle East.

Narcotics Anonymous operates over 300 meetings in Australia, 25 of which are in Western Australia. It does not have any public opinions on outside issues such as harm reduction, but it cooperates with legislative bodies and governments. For instance, over the past two years it has been heavily involved with the United States' drug court program. That program uses Narcotics Anonymous as its primary after-court service. Over 2 000 drug courts will be operating throughout the United States by the end of this year. We work with other Governments that totally control their health sectors, such as middle eastern Governments. Because we have no opinions on outside issues and we do not accept outside contributions, we do not have problems cooperating with most people. As I said, Narcotics Anonymous is funded solely through member contributions.

Ms ALCOCK: I direct my question to Peter Walton. As a parent who has felt the full devastation of drug use, what is your greatest hope with regard to the outcome of this summit?

Mr WALTON: My greatest hope is that compassion will come through. There should be good information, open-mindedness, patience and understanding, and a preparedness to try new things. Perhaps delegates will shift their previously held positions. I hope they have listened, thought about what they have heard and genuinely moved on to new possibilities.

Mr HINDS: I chaired the public meeting that resulted in the formation of our local drug action group, and have maintained a tenuous contact with it since. I have some concerns. Suggestions that the group cooperate with the lawful authorities was greeted with shock and horror. The group seemed to focus on harm minimisation almost exclusively. I ask this question at the request of concerned health professionals in the local community. Should the local drug action group bus be used to take underage people to parties at which there are 40-year-olds, alcohol and drugs?

Mr TRENT: I presume that question is directed to me. That indicates how the local drug action group is tackling that issue. I cannot speak for that group. If that is a community issue, those concerned should get behind the local group and attempt to influence the direction it is taking.

Ms NEEDS: I congratulate Michael for his courage as a recovering addict. He said he went through the classic women's magazine progression from marijuana to hard drugs, including heroin. I would like to hear his thoughts about that possible progression.

MICHAEL: I can speak only from my own experience, and that was my progression.

Ms NEEDS: Is it a possible progression for others?

MICHAEL: I cannot comment.

Mr HICKS: Am I correct in my understanding that the United States has more than 2 000 drug courts? If so, how effective are they?

MICHAEL: By the end of this year, there will be 2 000 drug courts in the United States. They are operated very differently from those I have seen in this country to date, in that they are part of the corrections system. Therefore, they are closely controlled by the judges and the corrections system. They are not controlled to any great degree by the health sector. People are brought before the court. If, for instance, they have dirty urine they are put back in jail for seven days to think about the situation. They are then brought back to the court. This operated differently to what I have seen here. As far as narcotics and other substances are concerned, our only real involvement is that drug courts send people to our meetings and we sign slips to verify their attendance. That is as far as our involvement goes.

Ms DIMITRIJEVICH: Michael, did you go to school in Western Australia? Did you also use alcohol and cigarettes before marijuana and further drugs?

MICHAEL: I went to school in Sydney, New South Wales, and my first drug was really overproof rum at the age of about 12 and cigarettes.

Mr MEOTTI: My question is directed to Geraldine Mullins. You made the comment before by saying that Australia does not have a prohibition policy. Can you please explain exactly which jurisdictions in Australia have legalised current drugs under the international treaties that we are assigned to?

Ms MULLINS: I am not talking about law being implemented. I am talking about policy and what drives funding, and any applications which are made to the national drug strategy for funding have to have a component for harm reduction. Harm reduction is not prohibition; it is about keeping people in drugs.

Mr MEOTTI: Can you answer the question, please? Which jurisdiction? Prohibition is a legal policy; it is not a social policy.

Ms MULLINS: I am sorry. I have answered the question and that is my point.

Ms TREW: My question is to Michael. If you were given the opportunity of free heroin when you made your choice to enter rehabilitation, what would you have chosen?

MICHAEL: I probably would have chosen the free heroin.

Ms JEFFREYS: My question is directed to Geraldine Mullins. I would like to talk about the drug information that came out of Canberra, the federal Health Department, and direct your attention to the fact that every single document went through the Prime Minister's office to remove all mention of harm minimisation and harm reduction, because that is the Liberal Party federal policy. I really challenge what you are saying, that even harm reduction and harm minimisation is embraced by the Liberal Federal Government.

Ms MULLINS: That is quite an incredible statement for you to make, because our group - or people like us who subscribe to abstinence and prevention - is told every time that it has to have a harm reduction component, so maybe the Prime Minister's office is not getting through to its national drug strategy. I would like to know the date of what you are talking about.

Ms JEFFREYS: It was September 1999.

Ms MULLINS: It certainly does not apply, and has not applied in this State.

Mr DUNCAN: My question is to Michael. I am a member of Narcotics Anonymous, 11 years clean, nothing in my blood. Can you explain what a self-help group is?

MICHAEL: I will explain it this way. When I was an active drug addict, none of my friends ever got off drugs. We ended up on long-term methadone programs. We ended up in prison, we ended up dead. I did not believe anyone could. The first time I walked into a Narcotics Anonymous meeting people were actually there that I had seen on the streets before who were totally into all drugs and seemingly happy to be that way. That was the strongest message I have ever received in my life. I went to a lot of counselling - to anything. I went to counselling to make a bad marriage work and to make my using work, but in the end I had to surrender that. The strongest message I got was from the other people in that room, and that continues today.

The CHAIR (Ms Jade McSherry): The next panel, which is composed of service providers, is chaired by Professor George Lipton, Chief Psychiatrist and General Manager for the mental health division in the Health Department, and Chairman of Next Step Specialist Drug and Alcohol Services. His panel members will include Kathryn Kemp, Peter Osborn, Dr Allan Quigley and Dr Pat Cranley.

LIPTON, PROFESSOR GEORGE,
Chief Psychiatrist And Chairman Of Next Step Specialist Drug And Alcohol Services.

Professor LIPTON: It is a great pleasure to chair this session, which is about the provision of services. We have a panel of four who represent a wide variety of the types of services that are needed for the different individuals who seek that service.

Before I introduce the first speaker, I will make a comment. I have been informed that there has been a lot of discussion about the Mental Health Act and whether people with amphetamine psychosis can be admitted and treated under that Act legally. I can assure you that the Mental Health Act is an operational Act. If people have the signs and symptoms of a psychiatric disorder, and are a danger to themselves and to others, they can be treated involuntarily or voluntarily under that Act. If people have an alcohol or drug disorder, but no signs or symptoms of a mental health disorder, they are precluded from being treated under that Act. There are those who might have both alcohol and drug disorders and a psychiatric disorder, and it would be the nature of the latter that would determine whether they could be treated. However, under the Mental Health Act there is no bar to the cause of the psychosis that is being treated. I hope that clarifies the position.

It is my very great pleasure to introduce Kathryn Kemp, who is the manager of Palmerston Association's south metropolitan community drug service team. Kathryn Kemp trained as a mental health nurse in England before emigrating to Western Australia in 1985. After a brief period teaching nurses she joined the Alcohol and Drug Authority in 1987 as a counsellor-educator. Kathryn moved to Melbourne in 1995 to manage a large non-government alcohol and other drug agency. In 1998 she returned to Western Australia to manage the south metropolitan community drug service team.

KEMP, MS KATHRYN,
Manager, Palmerston's South Metropolitan Community Drug Service Team.

Ms KEMP: Good morning, ladies and gentlemen. My presentation is about broadening the provision of treatment. As service providers, we constantly come up with top-heavy government services that are over-medicalised. We are weighed down with form filling and data collection. We are met with rigid policies and protocols that prevent our clients accessing some services, yet they are meant to assist this process. Yes, we need guidelines but how often do these get in the way when our clients do not fit neatly into the services for which we are funded; for example, complex or dually diagnosed clients.

Services should be systemic. The focus on future policies should be on the big picture not on the individual; for example, considering the sociocultural perspective and making changes at that level. In our service we hear every day "fix this person" or "the drug is the problem". I can tell you that at the coal-face level in our agency and in other community drug service teams we are trying to make changes to the way we deliver services. We are encouraging change in our clients by using a systemic approach, involving other family members and addressing non-drug related issues. We are listening to what they are saying and trying to respond, but we need more help to do this.

Changes need to be made at a strategic and ideological level. Services should be relevant. If they are systemic and address the bigger picture instead of blame the victim, the services will be relevant. Professionals will be trained differently at universities, and alcohol, drugs and associated issues will be not just core units but integrated into the whole curriculum. Services should be coordinated. Perhaps the issue is about not more money but redefining priorities on how the money is spent. There are many agencies out there and we should be working more together. Consumers and coalface professionals should be included in policy making. This is not possible in the present system because of the inequities of pay among different agencies and pay structures. This could

and should be addressed to enhance the services we currently offer and encourage workers in these agencies to work together, not to compete.

To give you a practical example, this is our vision for the southern corridor area. I am using the example of young people because for them the provision of services is particularly poor. I do not have time to elaborate on our vision. Briefly, it is about funding being administered locally and not being centrally based, maybe based at Fremantle and Rockingham with four to five beds shared by Alma Street, Aboriginal health and the Department of Health. It should have a low level of bureaucracy, be non-medical youth friendly, and use well-trained youth workers and local general practitioners. Youths do not want high-profile agencies.

I will leave the rest of my presentation for you to read. I leave you with this: we must stop using the terminology “war on drugs”. If we are to find a solution, we need to know why a generation of people want to live in a different reality. Thank you.

Professor LIPTON: That last question will preoccupy all of you because it is a most important one.

It is now my pleasure to introduce Peter Osborn, who is the Coordinator of Mission Australia’s south east metropolitan community drug service team. Peter Osborn has worked in the drug and alcohol field for the past 10 years. His appointments have included the development and management of residential drug and alcohol services for youth.

OSBORN, MR PETER,
Coordinator of Mission Australia’s South East Metropolitan Community Drug Service Team.

Mr OSBORN: Good morning, ladies and gentlemen. Mission Australia’s community drug service team focuses on reducing and preventing the harm associated with substance use. As a drug service team we want to provide accurate, balanced information and support to individual drug users, their families and the community. We recognise the need for healthy debate about issues, including decriminalisation of illicit substances, safe injecting facilities and heroin trials. Over recent years there has not been a reduction in the supply of illicit substances, although some trends and shifts have occurred, the most recent being the shift from heroin to amphetamines. Further, in the current prohibition climate we have no opportunity to regulate consistent quality, quantity or prices of illicit substances. Those things are determined by the black market and can often result in associated harm to the users and to the community.

However, over the past few years, the provision of treatment for drug users has been broadened and some positive changes have occurred in the delivery of services that have been provided to drug users. We now have comprehensive counselling services throughout the metropolitan area and the country regions. We have a better understanding of local issues and, in that regard, we have better mechanisms for listening to the views of the community. We have witnessed the promotion of drug education in the school curriculum. The cautioning system and the Drug Court that has recently been established means that substance users are now more likely to be referred to drug and alcohol agencies for information, education and counselling support. We are keen for those services to be utilised and expanded.

When it comes to treatment, one size does not fit all. People use drugs in different ways, in different situations and for different reasons; for example, we know that many illicit substance users will use only once or occasionally, and they will never experience problems or seek counselling. We also know that stress and dramatic situations can provoke people to develop varied coping mechanisms. Some people use drugs excessively and detrimentally, while other people in the same situation would find different ways to cope.

To move forward, we must build on the work that is already in place and we must continually enhance our service provision. We must develop better family support services and additional after-hours counselling. In particular, we must focus on treating the individual, the family and the community as a complex set of needs. Multidisciplinary teams must address a person's drug use in conjunction with that person's coexisting issues. We must consider the whole person and stop departmentalising or demonising them.

We need excellent detoxification residential services that do not present the individual with a waiting list. We need a range of pharmacotherapies, along with strong counselling support and the opportunity to access the outreach follow-up services. We must understand that addiction is a process. People who come to our centre for counselling do not want to be dependent, but when they are, it is often hard for them to see a way out.

As with tobacco dependency, we accept that most people will lapse on the first attempt to quit and perhaps also the second or third attempt. However, they are more likely to succeed over time as a product of good support, information, education and counselling. Illicit substance users are in the same boat. They need to be provided with good information and good support services.

Professor LIPTON: It is now my pleasure to introduce Dr Allan Quigley. He is the Director of Clinical Services at the Next Step Specialist Drug and Alcohol Services. He is a medical practitioner with over 20 years' experience in the field of drugs and alcohol as a clinician, administrator, researcher and teacher. He is currently president of the Australian Professional Society of Alcohol and Other Drugs, he chairs the State Opiate Pharmacotherapies Advisory Committee. and is a member of the National Expert Committee on Illicit Drugs and the methadone and other treatment subcommittee of the Intergovernmental Committee on Drugs.

QUIGLEY, DR ALLAN,
Director, Clinical Services, Next Step Specialist Drug and Alcohol Services.

Dr QUIGLEY: Thank you, Chairman. I thought that it might be helpful if I provided delegates with an overview of the clinical services of Next Step. Next Step is a statutory authority of government that provides in-patient and outpatient services from a purpose-built clinic in East Perth. It is one of the few comprehensive drug and alcohol services in the country. A youth clinic is located at East Perth and a small outpatient clinic in Fremantle.

Last financial year, Next Step provided methadone treatment to around 1 000 opiate-dependent people and it provided naltrexone treatment to another 1 000 people. There were some 650 admissions to the in-patient withdrawal unit. This year, we anticipate that buprenorphine will increasingly become our frontline treatment. At Next Step we are developing our capacity to provide multidisciplinary assessment and treatment for all our clients. Our youth service has a clinical team of doctors, psychologists, nurses, counsellors and outreach workers. Most of the clients attending the service have co-morbid drug and alcohol and psychiatric problems. Early childhood neglect, violence and sexual abuse are only too frequent. These young people and their families are in need of intensive support and treatment over months and years.

The adult outpatient service at East Perth, with its high case load of methadone and naltrexone patients, operates primarily as a medical prescribing service. Access to psychiatric, psychological, welfare and other support services is limited. In contrast, the Fremantle clinic provides a multidisciplinary service with good access to psychosocial counselling and support. Recent research has shown that patients attending this clinic for naltrexone treatment are retained in treatment for a significantly longer period than are our naltrexone patients at East Perth. These

findings are consistent with other research that demonstrates the benefit of providing psychosocial support to patients receiving pharmacotherapy treatment.

At Next Step we are committed to monitoring and evaluating what we do and to undertaking clinical research. We aim to ensure that our services are evidence based and cost-effective. We want to provide information to consumers to help them make informed choices. We recognise the chronic relapsing nature of drug dependence and understand that a person's treatment goals will vary over time.

In Western Australia we spend between $2 000 and $3 000 a year per person on pharmacotherapy treatment. Keynote speakers at the summit have advised that in Switzerland around $20 000 per person a year is spent on providing heroin treatment, and that in Sweden the cost of a year's compulsory residential treatment is up to $140 000.

Although we need more information about the cost-effectiveness of our treatment programs, our first priority should be to attract and retain people in treatment. We should set the goal of having 50 per cent of drug-dependent people in treatment. Clearly, there is great scope to invest more in helping drug-dependent people in this State.

Professor LIPTON: Our next presenter is Dr Pat Cranley, who represents the Divisions of General Practice drug focus group. Dr Cranley is a general practitioner who works in Leederville. He has a special interest in drug treatment and has had that interest for over 30 years. He informs me that he has treated over 5 000 people with these types of problems.

CRANLEY, DR PAT,
Western Australian Divisions of General Practice, Drug Focus Group.

Dr CRANLEY: General practitioners are the prime caregivers, the window-front doctors, for drug abuse. After poor training on drugs at medical school, and no postgraduate teaching until the past four or five years, we have been sneered at, hindered or victimised by the Department of Health or medical authorities over the past 30 years; yet we handle more cases than any other agency. I have seen about 4 000 to 5 000 people. I believe there is no drug problem in Western Australia; rather, there are problems being handled by drugs. Drug addiction is not a medical problem but a social one, involving the family, school, sexual abuse, personalities, work, relationships, spiritual and cultural breakdown and mental or physical disease. It affects academics, the wealthy or the poor alike. Large numbers of addicts destroy any medical practice with a loss of normal patients. When we consider the difficulty of treatment, the poor results and the shocking Medicare rebates for addicts, it is no wonder many GPs are not interested. Due to the poor teaching and little public hospital contact with addicts, our students and young doctors are not prepared for this treatment. Agencies and supportive agencies ignore or belittle us.

Other issues include the absence of after-hours emergency and detoxification services, police and confidentiality matters and the social isolation of abusers and their treaters. GPs and community services must cooperate, not compete.

My wish list for this summit includes that abstinence, not maintenance, must be the goal we seek as doctors. It also includes rehabilitation. Prison has never helped an alcoholic or a drug abuser. However, citizens must be protected. I support the Drug Court, voluntary or compulsory testing and counselling. However, in the long term, the best and cheapest results come from residential rehabilitation centres with a sound spiritual base.

My wish list also includes needle exchange. While accepting the possible role of needle exchange in viral control, an independent audit should examine the rise in user numbers, hepatitis C, polydrug

use and the rise in numbers from 79 000 needles in 1989 to 3 200 000 in 2000. Cannabis must be recognised as a very dangerous drug.

Drug testing is also on my wish list. Police time and educational time could be saved if the presence of drugs in blood or urine was accepted as proof of use. However, no child should be expelled from school solely for drug use.

My last point is registration. Labelling people for 10 years on drug registers or justice records for minor drug situations hinders work and career opportunities that are essential for long-term recovery. I suggest that a two to three-year clearance is desirable, rather than drug discrimination, decriminalisation or the blurring of legal boundaries, as proposed by some people.

Professor LIPTON: The session is now open for questions.

The CHAIR (Ms Jade McSherry): Due to time restrictions, I will invite only two delegates to ask the panel questions. Therefore, I encourage delegates who have not asked questions to do so now.

Ms ADAMS: My question is to Kathryn Kemp. Your last statement really helps all of us. Why does a generation of people want to live in a different reality? We have been sitting here for three days - this is our fourth day - and the answer to that question is really starting to test a lot of delegates. They are asking why. We are struggling to find the reason. Could you expand a little on that statement? It was a very powerful statement, and I thank you for it.

Ms KEMP: It was not my statement; it was a quote from *The West Australian* last week, which delegates have probably seen a few times. In the agency in which I work, we are finding that when people come in, the drug use pales into insignificance because so many other aspects of their life need attention. That was my point about training professionals differently and doing things differently. We must have policies that address these issues at a much higher level than the level at which we can address them.

Mr McLEOD: I heard a lot of the panel members talk about models whereby organisations need to work together. Certainly, home-based withdrawal, when a shared-care model is used with general practitioners, is a prime example of that. I wonder whether the whole panel could address the issue of how it sees home-based withdrawal being integrated with residential services, community drug service teams and mental health services, particularly outside the metropolitan area where the services are not so readily available.

Ms KEMP: I would like to respond to that. I think it could be managed very easily. The example that I gave in the last slide was of a community-based program - people in the community taking responsibility. Let us have a non-medical detox facility - somewhere that youth can call in - maybe run by an outpatient, home-based withdrawal service, so that there is nursing cover. In this way money could be saved. Let us have beds funded by joint services. Let us have sharing of the funding. Let us have Alma Street and Aboriginal health providing a bed, and the Department of Health providing two or three beds. These issues are not insurmountable; it can be done.

Dr QUIGLEY: We need to be clear about what we mean when we talk about home detoxification. Most of the people who withdraw from drugs fortunately withdraw from drugs at home. Home detoxification is usually understood to mean the addition of a nursing service, in particular, to visit the person at home while he or she is detoxifying. Front-line detoxification services are incredibly important in this State. We do not have the detoxification services that we need. We need to strengthen the capacity of general practitioners and the community drug service teams to provide detoxification. If these front-line services were linked together better, they would be more able to provide appropriate home detoxification services for people across the State. Next Step has a small detoxification unit in the centre of Perth. However, that service is inadequate to try to meet the needs of people across the metropolitan area and the far reaches of the State.

Dr CRANLEY: Over many years I have had home detox patients. It is possible to do it. However, it would be much easier if we could get assistance from nursing staff, mental health patients and so on. One big problem that needs to be looked at is that the public hospitals will not do anything about people in a desperate state who need detox at hospital level rather than at home level. The home level can be managed, but there is a big difference between stopping a person who has overdosed and then having that person walk out. I had one patient who overdosed seven times in five days and finished up in Royal Perth Hospital seven times. That is a complete and absolute waste of medical care. He should have been kept in hospital and treated as a potential suicide or something else. He was sent home, and he eventually overdosed and died. We had our chance, and we lost it.

Mr OSBORN: We already have home detoxification in the form of the release program that Allan has referred to. It is not only about home detoxification. It is also about getting services out to the community and to individuals in their homes. It provides people with another option or opportunity. We cannot expect people to be on waiting lists for a number of weeks before they can go into home detoxification. That is not absolutely necessary. It is important that we strengthen the models that we have, and it is just a matter of including the detoxification option.

Professor LIPTON: I will not talk about all the models and programs, but what Kathryn has said is very important. We do not have druggies, drug users, drug abusers or drug addicts. We have people who utilise drugs, and who do so poorly or sensibly and who do or do not put themselves in danger. I think everyone on this panel would agree that the focus and outcome of this summit is the people who, for whatever reason or reality, utilise drugs, as human beings have done from time immemorial. Why it is happening in this way now I do not know. This is not a drug summit. It is a summit about people who take drugs and may need assistance.

The CHAIR (Hon Fred Chaney): Before we break, we need to look at the procedural matters that were circulated this morning. This summit is widely representative, and some delegates are extremely familiar with meeting processes, and some less so. For that reason I should quickly explain the framework that has been put forward in this paper. The summit documents that you originally received made it clear that you would have an opportunity to vote on the five priority recommendations in each of the hour sessions which commence this afternoon and run through tomorrow. The three chairs of the summit have had very lengthy discussions with the chairs of the working groups, trying to work out how to maximise the opportunities for full forum participation in that discussion, and for amendment, if that is possible, again given the time limitations. The clear points are that there will be a vote taken on each of the five priority recommendations, so that the working group recommendations on which you have laboured so long and hard will be subject to showing the weight of the opinion of the whole summit. That is a primary objective which has always been part of the summit agenda. To achieve that, we are suggesting one minor re-ordering, which is mentioned there, to put group 9 first, because of its general principles, to deal with the general before the particular.

Then there are rules relating to amendment and so on, which are simply designed to ensure that you have the maximum time possible to consider what amendments, if any, you would like to put forward. That is why they are staggered in time, with the first deadline for the first group we are considering, and then time is allowed over the next day and a half as far as possible. It is then proposed that the working groups would sit in the middle of the Chamber while their recommendations are being considered, so that some limits can be imposed on sharing the time between people in the working groups and those who were not part of that working group. That is the reasoning, as well as to permit the working group to consider whether some amendments might in fact be utterly consistent with their intention. It may well be that delegates have suggestions which actually improve those things, and which are acceptable and therefore do not need a lot of time for discussion.

We acknowledge in these rules that there may well be amendments which we do not get to deal with, simply because time does not permit. That will depend on how many amendments people choose to bring forward. Those amendments will remain part of the record of the meeting, and will be available to the Government, and if, when you take a vote at the end of each hour period, people are unhappy with the recommendation, then of course they vote against it, or they can abstain from voting if that is what they wish.

I think the real decision that we need to make - I am proposing to put two matters for show of hands - is the request we have had from a number of delegates to move from a show of hands on the recommendations to a secret ballot. I do not proposed to invite discussion on that, because in a sense, the discussion is made impossible by the reasons that were put forward for wanting a secret ballot. As in any large gathering, there is not necessarily a balance of power among delegates. Some people are not as used to meetings, others are perhaps in a position where they have funding relationships with other who are delegates, and there are various reasons people put forward for saying that they would prefer to exercise their vote in secret. That, in the view of the summit chairs, is not a matter for the chairs. We think that is a matter for you, the delegates. I am therefore proposing to invite you to indicate, by show of hands, whether you are prepared to have a secret ballot on the five recommendations. The proposal would be that you would each have a ballot paper with five recommendation voting points, to which you would vote "yes" or "no", or choose not to vote. If you are not agreeable to that, we will remain with the existing standing orders, which is a show of hands. I stress we are raising this in deference to the issues which have been raised, not by the chairs of the working groups or of the summit, but by the delegates.

Ms INGLIS: If we are going to change the voting, I would just like to note that, with a show of hands, delegates can immediately see the response that the submissions are going to receive. How soon after a secret ballot would we know the result?

The CHAIR (Hon Fred Chaney): We think it would be very quick, because it is really a matter of just counting 100 ballots on the five votes. I would expect, for example, that by the end of dealing with the second group, we would know the results of the first. That would be my guess. I think there are competing issues here, but it is matter of choice for the summit. I propose to put, from the chair, the notion that we should move to a secret ballot, not on the amendments, by the way, because I think that is simply unworkable, but on the final recommendations. Could I please have a couple of tellers to count the vote, in case it is close? All those in favour of moving to a secret ballot, on the final recommendations, please indicate by a show of hands.

Motion agreed to (57 to 26).

The CHAIR (Hon Fred Chaney): There will be a secret ballot, by the decision of the summit.

Ms JEFFREYS: Will this procedure include abstentions?

The CHAIR (Hon Fred Chaney): Delegates can choose simply not to mark their ballot paper "yes" or "no" and that will be counted as an abstention. If delegates wish to indicate a personal abstention, that is a matter for them in a secret ballot situation.

Ms JEFFREYS: If we are using abstentions, you do not just call for "for" and "against", but for "abstentions" as well.

The CHAIR (Hon Fred Chaney): In a secret ballot, you will either fill in the ballot paper or not. That will be the process.

Ms JEFFREYS: You just had a vote and you did not call for abstentions. That is why I am asking whether you will be calling for abstentions.

The CHAIR (Hon Fred Chaney): We will not be calling for abstentions in the circumstance in which a ballot paper is distributed. Delegates will either fill it in or not. If a delegate wishes, as a matter of principle, to publicly indicate that he or she has abstained on an issue, that is a matter for

that delegate. A second point requires confirmation. We are suggesting that in the interest of hearing as many delegates as possible, a time limit of three minutes be set on speakers, and that there be a distribution of time between representatives of working groups and the balance of the meeting. Do we have the support of the summit for the rules that have been promulgated? Can I have a show of hands? That is clearly carried.

Ms JEFFREYS: If we are going to include abstentions in this process, you do not just call for "for" and "against", but you ask -

The CHAIR (Hon Fred Chaney): The parliamentary process with which I am familiar is that delegates may stand in their place to indicate they have abstained. If you would like to do that Elena, please do so.

Mr LOVETT: Point of order, Chair. Can we just have an abstention box at the bottom of the ballot paper? If there are going to be five ticks, there might as well be one for a person who wants to abstain on those also. This is not Parliament.

Mr PUGA: I think the only way to talk here is to raise one's voice. Please do not forget the victims of crime.

The CHAIR (Hon Fred Chaney): We will consider including an abstention box.

Summit suspended from 10.39 to 11.06 am

The CHAIR: In response to concern expressed by a number of delegates, I spoke to some people in the courtyard where alcohol was being served when a number of delegates were being interviewed. A number of delegates found this a problem and I thought it was inappropriate and said so. I want the summit to understand that the issue is not within the jurisdiction of the summit; it is within the jurisdiction of the Speaker.

I also acknowledge that someone who wanted to make the point that alcohol is a drug that has devastating effects on society and is not part of this summit is entitled to make that point. A narrow point I made was in response to concerns expressed by delegates that, for a number of delegates, the situation was personally difficult and offensive. If I went further than some delegates wished I am sorry, but I thought it was an appropriate response to the concerns expressed to me.

We will now have a session where our rapporteurs have, with enormous patience and dedication, listened carefully to discussions, both technical and expert, from the community and from the heart. They will make some comments that might be of assistance to the summit. I invite Emeritus Professor David Hawks, Honorary Professional Fellow at the National Drug Research Institute, and Emeritus Professor of Addiction Studies, Curtin University of Technology and Associate Professor Richard Mattick to address us.

HAWKS, PROFESSOR DAVID,
Emeritus Professor Addiction Studies, National Centre for Research into the Prevention of Drug Abuse, Emeritus Professor of Addiction Studies at Curtin University of Technology.

Professor HAWKS: To persuade Richard and I to undertake this unenviable task, the organisers of the summit offered us the grand, eloquent title of scientific advisers and rapporteurs, and said that these titles would be prominently displayed on our folders and name tags. Seduced, as one always is, by the French language, we agreed. What does rapporteur mean? In this context, it cannot mean that we will prepare a report of the conference. That would be presumptuous, as we have not been a

part of all the discussions and, therefore, would not be able to reflect the contributions. I have interpreted my brief as to try to identify some of the main themes, emphases and, in some cases, contentious issues. This is my selection, but it need not be that of the summit.

We need to acknowledge the logic of the relationship between supply and demand. If there were no demand for drugs, there would be no incentive to supply them. It would not be economically viable. Similarly, if there were no supply of drugs, demand would go unanswered and, presumably, be diverted elsewhere. The problem is that neither can be guaranteed. We cannot guarantee that either supply or demand will not exist.

I deal first with supply. Various speakers have said that we intercept, at most, 10 per cent of the drugs entering this country, and some would consider that an optimistic estimation. The summit has been told that an international industry is involved in the supply of drugs. It has been told that this industry is highly sophisticated and flexible, very well informed and capable of replacing one commodity with another as required. The summit was reminded that the supply of drugs from certain countries reflects economic conditions in those countries over which we have absolutely no jurisdiction.

We cannot ensure that there will be no supply; nor can we guarantee that everyone - to use Dr Stanley's phrase - will have a better childhood. We may aspire to that, but we cannot guarantee it. The two spokespersons who advocated early intervention would be the first to agree that even if we were to employ all the best methods of that model, we would not be able to guarantee that, given the availability of drugs, everyone would achieve sufficient immunity from the possibility of using them. Despite our best efforts, we could not guarantee that. Therefore, we need to reckon with both impossibilities and be realistic in our aspirations. We need to minimise the harm to our failures; those who, despite our best efforts, climb over, go around or crash through the fence.

The second theme I have drawn is that we have been told we have a crisis. We are seeing increasing indices of problematic behaviour among our adolescent population - suicide, mental illness and learning difficulties. We have the second-highest prevalence of drug use in Australia. We have been told that we are not doing well enough and that we should innovate; but we have also been told that we should not throw out the baby with the bathwater. There are good programs. We have heard about them. We have dedicated and competent people. You are among them. We have good stories to tell. We are widely admired and emulated.

We are told we should act, but we need to act calmly and rationally. We need to evolve, not to revolutionise. We need to learn from other countries, but not imagine that we can merely transpose their programs onto our own with no consideration of the vastly different environment that prevails. Most of all, we should not deceive ourselves into thinking that the solution lies in yet another bureaucratic restructure - however diverting that may be. When we last undertook a major restructuring of services following the recommendations of the Task Force on Drug Abuse in 1995 - the most prominent component of which was the creation of the Western Australian Drug Abuse Strategy Office - we gave as our target to achieve the lowest levels of drug abuse and harm in Australia. The kindest interpretation one can place on that aspiration is that we are yet to achieve it, as several of our speakers have emphasised.

Thirdly, we must reconcile - I appreciate that for many delegates this is a matter of reconciliation - the tension of appearing to offer two contradictory messages: to abstain from drugs but to avoid using them harmfully. They "appear" to be contradictory because there is no logical contradiction. To seek to minimise the harm of using drugs is not contradictory. To abstain from using drugs is to minimise the harm associated with their use. If there is no use, there is no harm; it is to minimise that harm absolutely. However, we do have a responsibility to both populations: to those who remain behind the fence, to use Simon Lenton's very vivid example - the high, razor-wire fence - and to those who crash through it or go around it and find themselves on its lower reaches.

Fourthly, we must commit ourselves to what works, or what can be shown to work. In other words, we must embrace pragmatism rather than dogmatism. We must rigorously evaluate our policies and practices. If we show that idealism is a necessary component of success, let us promote it.

Fifthly, we have been instructed as delegates to give our attention only to the problems associated with the illicit use of drugs. Yet, we have been told repeatedly that to do so without reference to the drug-using society in which we live is ill conceived. Problem drug use, whether licit or illicit, implicates the same risk factors. Alcohol and tobacco are the gateways to illicit drug use and themselves constitute the greatest harm. To separate them from other drugs is both to invite the ridicule of young people - who will see us as picking on their drugs but failing to acknowledge the harm associated with our own use of drugs - and to fail to recognise the commonality in all drug use.

Sixthly, we have been reminded very forcibly by some speakers that we do not yet understand drug use. This is a consequence of our failure to consult drug users. We see it only in terms of its costs and harms. Therefore, we fail to understand that for some users and at some time their drug use is seen by them to be beneficial. That is not to say that it is beneficial to others, as we have also been forcibly reminded. If we do not understand this, we will fail to recognise that for drug use to be addressed, its functions for those people must be recognised and themselves addressed. We need to recognise that at one level, as far as the drug user is concerned, drug use is a rational behaviour. It is something that they have chosen to do for reasons that may be paradoxical to us, maybe unknown to us, but represent for them persuasive reasons. If their drug use is to be assuaged or rendered less problematic, we need to understand that.

Seventhly, another of the tensions we have to contend with and tolerate in one another is that arising between those of us who believe that true rehabilitation will occur only when there is an informed and cooperative consent with that treatment and those who have argued, and indeed argued persuasively, that in some cases compulsory forms of treatment are successful, compulsory forms of treatment which at least initially are not accepted by their users. We were offered examples from Sweden and, more locally, examples at our own drug courts.

Finally, we need to find a coherent basis - a logically consistent and defensible basis - for our policies. We must ask ourselves whether it makes sense to decriminalise the personal use of cannabis but provide only for its criminal cultivation. We need to ask ourselves whether it is logical to provide needles and syringes, but not provide a safe, supportive environment in which they can be used. We need to ask ourselves whether it makes sense to continue to proscribe the personal use of cannabis but at the same time tolerate the targeting of young people by alcohol advertisers and retailers. We need to confront the contradictions in our present policies and recognise that together such contradictions diminish the credibility of those policies and therefore their effectiveness. We need to truly aspire to a whole of government or a whole of community response to achieve that sense of connectedness with society, which Alison reminded us this morning is the essential ingredient of successful rehabilitation. Thank you.

The CHAIR (Hon Fred Chaney): I will revert to the no title rule and call Richard Mattick.

MATTICK, ASSOCIATE PROFESSOR RICHARD,
Director of Research, National Drug and Alcohol Research Centre.

Associate Professor MATTICK: When David and I were talking about the role of rapporteurs, he thought we could present these talks in French. I imagine that at the end of the fourth day you are all a bit tired. I will present my talk in English today and hopefully that will not be so impenetrable.

I would like to highlight some of the controversies, and suggest the need for a balance in the process which will follow. At the beginning of the summit, Bob Kucera made a number of comments about the need for you to consider a range of different treatment options, to consider whether you would support a trial of heroin prescribing, the availability of small amounts of cannabis, injecting centres, diversion and court programs. I may have missed one or two things he mentioned, but they are the ones I picked up, and they are controversial. They have the potential to be very divisive, and that is one of the things I want to talk about. They are unnecessarily divisive because of the way in which they are presented.

Before I proceed I want to remind you that there is a national drug strategy. Australia is admired internationally for what has been achieved. Someone just talked about what has been achieved. We need to be mindful that Australia does a reasonably good job. There are still problems, but things are not black. Supply is important. The Commissioner of Police said that 10 per cent of illicit drugs are seized. Therefore, we need to deal with demand, prevention and treatment. We also need to keep people alive and well while we are trying to get them to become abstinent. That is what harm reduction is about. People misunderstand that. They think it is about legalisation; it is not. The supporters of legalisation like to use it in their argument - potentially for that reason - but harm reduction is about keeping people alive and well while they become abstinent. It is important that people realise that. It is a hard concept to understand. I spoke to David Hawks before, and I said that when this concept was introduced into the drug and alcohol area about 12 years ago, it was one that professionals had trouble understanding; it takes time. In addition, there is a need for a non-partisan and non-biased approach that is balanced and evidence-based.

Jack Johnston said that the problem with the national drug strategy is that it does not stretch the boundaries. That is something you have the potential to do. Through decision making you can push the boundaries here and in Australia. You need to consider whether you want to do that and how far you want to go.

I will deal with this quickly, because this area of the range of treatments is reasonably straightforward. There is a need for education, prevention and what the younger people presented as fun alternatives to drugs. The video we saw at the dinner spoke to us about that. We need brief, early interventions before people get into trouble. We then need to deal with people who get into trouble through residential treatments, medications, and court and diversion programs. All of you have referred - in different ways - to a need to support, respect and show compassion for those in need - that is really important - and to bring an enthusiasm to intervention, which often is lacking in the drug and alcohol area.

I turn now to this issue of trials of heroin prescribing. The community in Australia essentially has been misled. I will explain why in a moment. Before I do that, I want to point out that Martin Hosek comes from Switzerland, which is a very conservative country. As a part of its response to the open drug scene and increasing heroin use, Switzerland has provided injectable prescribed heroin. I am not sure that I am in favour of this or against it. I used to be against it, and I am shifting gradually, but I am not sure. It is a minority option. By that, I mean that only a small proportion of really badly-off injectors come into this treatment. It is not fun. They have to go to a clinic three times a day. They cannot even smoke in the clinic. They can inject drugs but they cannot smoke. It is not an attractive option. It is bait; it brings people into treatment. It is not a long-term treatment. It is not legalisation; it is about bringing people into treatment. Heroin is now perceived as a loser's drug. It is something that old junkies do.

The way in which the Swiss system is portrayed in Australia nationally is that prescribing heroin makes heroin available. The debate is very unsophisticated. When reading the *The Sydney Morning Herald*, *The West Australian*, or *The Australian* it is very rare to get a good idea of what is being argued. If you take one thing from this summit, take from Switzerland the fact that heroin prescribing does not mean free availability; it means dealing with people who have lot of trouble in

their lives because of their heroin use. In that context Switzerland has prevention, residential and outpatient care, harm reduction and supply control strategies. In controlling the supply of drugs, the Swiss get rid of the precursors. They take away the ways in which people can make drugs. They have trafficking control. They deal with organised crime and money laundering. They are not a soft society. Those who know anything about Switzerland know that it is, arguably, a very practical society. They are motivated by having an ordered society and they are very sophisticated. They made this decision carefully. Martin Hosek said that if the heroin trial were sold to the community in Switzerland - one of his colleagues also said this - in the way it was sold in Australia, it would never have been approved. I think you are being misled.

The Swedish system was contrasted with the Swiss system, and there was a bit of a polarisation, which I alluded to at the beginning of my presentation. It is unhelpful to have this polarisation between the two extremes, as though one is right and one is wrong. That was not explicit, but I got the impression that it was a choice between a Swiss system of free drugs and drugs for anybody, which is nonsense, and a Swedish approach. The Swedish approach is conducted within a very strong social welfare system. It is an unusual system, which cannot be easily replicated in Australia. They have a huge financial investment in this system. You could argue that the politicians should do that here. You should tell the politicians that. You should tell Bob Kucera that he should put more money into the system. The Swiss talk about compulsory treatment. However, when push comes to shove - if you ask - it is not for adults; it is for the younger people who are usually male, single and have a problem with heroin.

Sweden has a relatively small heroin problem. There are possibly a number of reasons for that. It could be their system or the fact that they are at the end of the supply route, because Sweden is a very long country that goes very far into the Arctic Circle. They have methadone and, I think, one needle and syringe program. Amphetamine and cannabis use is increasing and alcohol is a problem. The notion they have a system that is fine and works just great is not true; they have problems. One thing I really picked up from Mr Peterson was the last line on the slide: “Do not copy drug policy from one country to another”. We should not feel that we can simply transplant a program that will fix the problem here.

Bob Kucera asked you to think about small amounts of cannabis. Simon Lenton described the two extremes of total prohibition, as we have now, and free availability. Total prohibition involves financial and personal costs. We have heard about the brush with the law from one of the delegates. It was quite graphic and made me consider how much it is intrusive. It intrudes also on the ability to travel overseas. Criminal records affect people’s ability to get a job in some circumstances. The problems are significant. Cautioning already exists. Simon also described legislative prohibition. He said that we could provide infringement notices and not legalise a drug, structure the market to low-level supply and reduce net widening.

Drinking and driving was not a criminal offence in New South Wales, but it is now and has been for a number of years because of the problems it causes. You are being asked to consider whether you want to shift an offence from being criminal to being non-criminal in some settings. Nick Stafford captured it nicely when he told you that he thought there needed to be a better solution than organised crime running the drug industry.

Injecting centres are another way of polarising the debate. The whole debate gets dragged off by people who would like to see legalisation and those who would like to see no drugs at all. It takes over the discussion and stops consensus and balance from occurring. I am on the evaluation committee of the injecting centre in Sydney. I am not sure what I think of it. Members of the evaluation committee were chosen because they did not have any strong views about injecting centres. Injecting centres have been put in place in Europe and in Sydney where there is an open drug scene, such as that in Kings Cross, where there is a lot of public injecting and a lot of problems. The aim is to try to reduce public injecting and needles on the street, to address the

spread of viruses, to provide a treatment entry point and to reduce and manage overdoses. The centres are not about the legalisation of drugs but controlling the problem. They are not about heroin prescribing. It is unfair that newspaper readers would not get that information. We frequently find confusion, with people saying that heroin is prescribed there. The fact is that Ingrid is not prescribing heroin. The injecting centre is simply a place where people can go and inject safely. I do not think that you have an open drug scene yet, but if you do, you need an injecting centre.

I was also touched by the indigenous speakers. Ted Wilkes began by saying that he thought someone needed to emphasise that indigenous people have a future, which is very important. The issues involve self-esteem, poverty, housing problems, lack of meaningful work, loneliness, despair and the quote I wrote down of “nothing to look forward to”. This echoes all of the risk factors that were present in Professor Stanley’s talk and those of other academics who talked about the research in this area. It encapsulates the pressures that drive people to use drugs at a level which is problematic. The indigenous speakers also spoke of the urgent need for resources and relevant programs. Again, that is something you may wish to emphasise to the Government.

Another group was drug users. As David said, you must listen to them and understand the nature of drug use. At the top of the slide I mention dependent heroin use for long periods. Californian authorities conducted a 22-year follow-up program on heroin users. We have not done that here and we do not know what happens. The best evidence is from the United States of America. It showed that after 22 years a little less than a third of heroin users are prematurely dead and about a third become abstinent during that 22-year period. About 40 per cent are recycled in and out of jail, in and out of treatment and in and out of heroin use. It is a chronic long-term problem. It is not something for which there is a quick fix. Another thing I took from it was the issue of drugs in small towns - and in larger cities - concerning boredom, a lack of entertainment and the need to experiment. They are factors that we need to consider.

I return to the framework with which I began. We need to deal with supply, demand and the minimisation of harm. We need to keep people alive. We need to deal with source control - customs and police - prevention, treatment, needle syringe programs, methadone and other approaches. The multi-layered approach is what is needed. We run the risk of polarisation because people want to argue either for legalisation or no drugs. Neither of those options is what anybody really wants. We need a middle ground. Each component is important. The national drugs strategy does not stretch the boundaries. Jack Johnson is the chair of the intergovernmental committee on drugs; it is a senior bureaucratic position. He spoke quite openly about the limitations of the national drug strategy. Delegates have the chance to push the boundaries, but beware: I began with this notion before - people often claim things that are untrue. We have been told for many years that somebody has a cure. It started with therapeutic communities, which came in soon after the heroin problem hit Australia in the late 1960s. Therapeutic communities were going to deal with heroin problems; they are important but they are not the cure that was promised. Methadone was also promised to cure the problem. It is a very important invention; I argued yesterday that it is very powerful. Some people may disagree with that and I am happy to talk about the data. Methadone has saved lives and protected the community but it is not a cure for heroin dependence. Three years ago we were told that naltrexone tablets would cure the heroin problem. We are told today that there is a new approach involving implants that will solve the problem. We should be mindful of what we were told three years ago about naltrexone when we think about implants now. The acceptability of implants to users is likely to be quite low. In the work we have done we have allowed users to choose whether they have naltrexone or another option. Only one in twenty patients choose naltrexone; they do not like it as they are opiate-dependent. They like opiates, they do not like alternatives.

Regarding drug wars and zero tolerance, we need to look at the United States experience. They have not had the successes that we would like to see occur here if we wanted to have a war on

drugs. Again, it is an extreme position. Heroin prescribing and injecting centres are in the same category; they are not going to turn around the problem, they are potentially part of the solution. I think we should seek extra resources; it is part of what we should do. We need to stretch the boundaries and think about what we can do that is different. We should not just restructure what is already here. Stanley told the summit about the need to monitor the impact and the level of success, as is done with road traffic accidents. Tell the Government that you want to know what the changes are and that you want it monitored carefully, but be practical and compassionate and I think you will have the opportunity to show national leadership.

The CHAIR (Hon Fred Chaney): Thank you, David and Richard. Before we resumed, a delegate told me that I needed to remain calm. I found the summing up from the two experts - after what has been a very turbulent three and half days of information and statements - very calming. I thank them both for what they have done.

I remind delegates that we are in the straight now and are about to reach the point when delegates express their views and find out the extent to which the views are shared by others at this summit. The final working group session will now be held and each group is to produce five priority recommendations. Subject to the groups meeting their obligations - I understand they are all in good shape - the recommendations can be collected in the foyer at one o'clock. They will be colour coded. Delegates will then have to respond to the recommendations. I remind delegates of the agreement made this morning; namely, that group 9, which is the first group's recommendations that we will consider, must put in its amendments by 1.45 pm. Delegates have a limited time only, but that is how it must be. Some time has been made available to consider the balance of the recommendations of the working groups. Again, because it is important that delegates have access to this right, I make it absolutely clear that amendments should be lodged - as is stated on the agenda - at the reception desk at the main door. Delegates must be meticulous and make sure that all amendments that they want to be considered are collected. The reception desk is located downstairs in the main foyer. Delegates are responsible for ensuring that any amendments they wish to move are received at the reception desk, where they will be processed in the proper way. A brief period for lunch and a brief period for contemplation of the recommendations made by the working groups has been set aside for delegates, after which we will deal with the substance of those recommendations. Are there any questions before the break?

Mr CRAWFORD: The chairman would be aware that we have already lost 10 minutes of the vital final hour that delegates have to meet in working groups. I ask that the timetable be put forward by 10 minutes.

The CHAIR (Hon Fred Chaney): It is vital that delegates consider the recommendations of group 9 within the time available. I suggest that the working groups do their best to use the time that is available and bear in mind that the real limit is to make recommendations or suggested amendments to the recommendations of group 9. Delegates have some flexibility during the lunch hour and contemplation period.

Summit suspended from 11.41 am to 2.00 pm

The CHAIRMAN (Hon Fred Chaney): Before we commence, because we are moving into a different mode, I will run through a number of procedural points, so there is minimal misunderstanding. I stress that, in relation to the frequency of attendance at meetings, this is a very mixed group. Some people attend a meeting every day; however, for others it is less common. I want to ensure we have a common understanding of the process. A delegate has raised with me a concern about abstaining from voting. Three options are open to delegates on any vote, whether it be a secret ballot or a show of hands. On amendments, there may be a show of hands, although

delegates have decided to have a secret ballot on the final recommendations. The choices are to vote yes, to vote no or to abstain from voting. Each of those is a meaningful choice. I am sorry to say what some delegates might think is obvious, but this has been a matter of some discussion. If, for example, a motion were passed 70-30, that would tell the Government something about the weight of opinion behind that resolution. If, on the other hand, it were passed 40-30, with 30 abstentions, that would deliver a different message to the Government. An abstention is a meaningful vote, or non-vote. I will call for a show of hands in favour of the motion, and they will be counted. Then I will call for a show of hands against, and they will be counted. The difference between those numbers and 100 will be the number of people who have chosen not to vote. In some cases, an individual may have a particular reason for wishing to record in a public way that he or she is an abstaining voter. In that case, the person should simply indicate that he or she wishes that to be recorded formally; otherwise, the number of abstainers will be the only thing recorded.

For the secret ballot, the ballot papers have been prepared on the basis of a yes box and a no box. Delegates should tick whichever box they think is appropriate; or if they do not wish to vote, they should not tick either box relating to that motion. If delegates wish to add some additional force, by all means they should write "abstain" when they are refusing to tick the box. It makes no difference to the way it will be counted. However, the fact is that in the end the count will be announced as so many voting for, so many voting against, and some choosing not to vote for or against a particular proposition.

The second matter I want to address is this new process of people sitting in the middle of the Chamber in their working groups. The reason we have done that is to enable them to confer among themselves in respect of amendments, should that be appropriate, and also to ensure that we have some certainty that those delegates who are not on this occasion part of group 9 get a chance to contribute to the debate on issues in which they have not been closely involved in formulating.

As best we can - this will not be a scientifically exact and precise method - we will try to ensure that the group in the centre uses no more than 20 minutes of the available debating time, so that something like 30-plus minutes is left for the rest of the delegates to contribute to that topic. How group members choose to use that 20 minutes is a matter for them.

Under the original rules that were set out in the printed booklets that delegates received, there is a general time limit of five minutes for the mover of the motion. Today we decided that other speakers would be limited to three minutes to assist the maximum number of people to contribute. A group, such as group 9, could choose to use its whole 20 minutes up front, or the members of the group may choose to scatter themselves through the debate by seeking the call at different points, and perhaps preserving time for a right of reply. If the group uses its 20 minutes and we are getting towards voting time, I would accept the rules we adopted this morning as meaning that there is no additional talking time for that group. It is a matter for group members' judgment and of keeping track of the contribution time of their syndicate.

Our timekeeper will keep a running total. I and my co-chairs do not think we can do that from the Chair and focus properly on what is happening. We will do our best to do this without error. However, I think delegates have already learned that we are all too human, so we will do our best.

I think that is all I wanted to draw to delegates' attention, except to say this: I think we have accepted that our common objective is to get as sensible and meaningful a vote as we can, as an indication of the balance of views within this community summit. The chairing of these sectors will be aimed at helping delegates achieve that as best we can. When we run through this first group, I think we might find that we will want to think about some finetuning. We are moving into a different process, and the chairs will keep a careful eye on it to see if there are any problems with it.

After that long introduction, the hour for group 9's recommendations starts to run. A small number of amendments to what the group is putting forward are proposed. I invite the chair, or such other person nominated by working group 9, to present the group's recommendations and rationale.

Professor FROYLAND: I am the chair of group 9. We were given the task of linking drug strategies to overall social policies. This has the potential to end in a whole heap of soft words that will make no difference to the mums, dads, siblings and children of people who are using drugs and/or having drug problems. We grappled with the challenge of making a difference. I promise those mums, dads and siblings that we are determined to do so. We believe that we must do everything we can to prevent problems associated with drugs, but that, as one of our esteemed speakers said this morning, we also have a responsibility to keep our failures alive. We have attempted to give our Government the tools that it can use to move forward in this area.

All the members of group 9 have proposed and agreed with these recommendations as recommendations that this summit should send to Government. I believe our recommendations are clear. I will not go through each recommendation in detail but will make a few points about the first four recommendations, and one of the members of our group with specialist skills will then comment on recommendation 5. Recommendation 1 reflects our determination that drug policies should be inclusive and recognise the diversity of the Australian community. We believe it is about partnerships between Government and community, and about social policies that are integrated and strong. Recommendation 2 is about social capital - an expression that many of the people in this room know well but many others do not. Social capital is about social networks, mutual support and strengths. We believe that recommendation 2 will give the social capital of Western Australia more guts and strength to make a difference. Recommendation 3 is clear. It is about early intervention and prevention. Recommendation 4 is our attempt to urge this summit and this Government not to lose what has been gained in these three and a half days. Recommendation 5 has some specialist aspects, and one of our members will comment on that.

Hon David MALCOLM: Although estimates vary, a significant percentage of criminal offences are committed by persons to obtain money to buy drugs. These include theft, burglary, home invasion, street muggings and robbery, and armed robbery at service stations, pharmacies, and other business premises, particularly those open at night. Frequently the occasion of being arrested, charged and convicted is a watershed, particularly for offenders, both children and adults, who may be at an early stage in a drug-related criminal career. The sentencing options include the possibility of treatment in the community, but they do not include treatment in a secure institution. The three-strikes legislation in the case of burglary, and any other requirement for mandatory imprisonment, are barriers to the exercise of sentencing discretion where treatment and rehabilitation would be the option which is best calculated to serve the interests of the community and the offender. Even in the case of armed robbery where the maximum penalty is life imprisonment and the current sentencing range set by the Court of Criminal Appeal is six to nine years, subject to variation by aggravating or mitigating factors, in about one in 10 cases an alternative to imprisonment may be justified. In other cases, particularly those involving juveniles or young persons in the 18 to 24 age group, imprisonment or juvenile detention is the only option because of the seriousness of the offence. That can prove to be counterproductive because of the exposure to the criminal subclass and the prison subculture, including the drug culture in prisons, hence the need for secure drug treatment facilities as an alternative to conventional imprisonment or detention. These options need to be available in all courts in all places.

The CHAIR (Hon Fred Chaney): Three amendments have been lodged with respect to these recommendations. Two of those amendments are, as I read them, exactly the same, and were moved and seconded in reverse order by two delegates. I will deal with one of those amendments. The other amendment was moved by Carlo Bellini and was seconded by Anne Russell-Brown. As I understand it, the amendment is to add to recommendation 1, after the words "within an integrated social policy" the words "and that the development of a comprehensive drug policy include consideration of potentially problematic legal substances, such as alcohol, tobacco, volatile substances and prescription medication." Is that where you want the amendment to be, Carlo?

Mr BELLINI: Yes.

The CHAIR (Hon Fred Chaney): Before I ask Carlo to speak to that, because I am trying to develop a process that will allow us to deal with the amendments speedily, I invite the chair of the working group to indicate whether the working group would like to express an opinion on this amendment.

Ms MILLER: We have agreed to the amendment.

The CHAIR (Hon Fred Chaney): I will now invite Mr Bellini to speak briefly to the amendment. In other circumstances, when there were many amendments, I would probably put the amendment without debate, if it seemed fairly straightforward. In this case, Mr Bellini, would you like to speak to your amendment and explain it?

Mr BELLINI: The reason I proposed this amendment, is that we are obviously here primarily to discuss illicit drug use, and all its different aspects. However, it cannot be denied that legal drugs also present a major problem to our society. It can be argued that they present more of a burden to society than illicit drugs. While we are here primarily to discuss illicit drug use, these two issues are interrelated and interconnected. How can we fully consider the burden of drug use on society as a whole, without considering both aspects? Statistics show that the use and/or misuse of legal substances accounts for high rates of morbidity and mortality in society. What this means is that sometimes the use or abuse of legal substances can lead to more deaths, more diseases and other problems associated with health, than illicit drug use. There are also other problems. For example, alcohol can sometimes lead to dependence and alcoholism, which has further implications, such as family breakdowns.

I refer to Nick Stafford, a drug user who yesterday addressed us all. He said that it would be foolish for us not to consider legal drug use in the context of this summit. This is the main premise on which I base my recommendation. It was suggested that, in the amendment, the wording refer to only legal substances, and not specifically tobacco, alcohol and volatile substances. The reason I included all these is that sometimes volatile substances are not considered as drugs, but can be abused in this way, resulting in many harmful effects.

The CHAIR (Hon Fred Chaney): The working group finds this amendment acceptable. It extends the notion of a comprehensive drug policy to those licit drugs that also cause problems. Is there anyone who wishes to oppose the amendment? If not, I will put the amendment.

Amendment agreed to unanimously, on a show of hands.

The CHAIR (Hon Fred Chaney): That now is a clause of the motion which is before us. The original motion is still in front of us, and we will still vote for it at the end of this session, but it has now been added to by Mr Bellini's amendment. I understand the second amendment is not accepted by the working group, and it has been moved by Messrs Hallam and Italiano. They may choose who will speak first on the amendment. The amendment is to the first paragraph of recommendation 1, in lines 3 and 4, to remove the words "caused by colonisation and its impacts". I understand that both amendments are to remove those words. Have Messrs Hallam and Italiano decided who will speak first on this matter?

Mr ITALIANO: The amendment was put forward to clarify the intention of the recommendation, and we will decide either to leave it as written or to accept it. We were not sure what working group 9 meant by including those words. Can we have an explanation?

The CHAIR (Hon Fred Chaney): I invite the working group to give an explanation. Joe, you can then indicate whether you wish to persist with your amendment.

Mr MACKAAY: The words used in the first paragraph come from the redrafted principles for consideration presented by group 3 earlier in the week. They pick up that the indigenous community in Western Australia is in a particular situation for a whole range of social factors.

Since they attribute a great deal of the disadvantage that they experience to colonisation, we felt it appropriate to honour their words and to state it at the top of the document.

The CHAIR (Hon Fred Chaney): In the light of that, do you wish to persist with your amendment?

Mr ITALIANO: No.

The CHAIR (Hon Fred Chaney): Does anyone else wish to speak to the five recommendations of working group 9. The way in which this is handled will depend on the degree of contention within the summit on any particular set of recommendations. The early indications are that this is not proving particularly contentious. One amendment was passed and another was withdrawn. I invite any member of the summit who wishes to speak to do so.

Ms BAKSHI: I put in an amendment. This is an opportunity to comment.

The CHAIR (Hon Fred Chaney): You may comment. It is too late to put in an amendment.

Ms BAKSHI: I am surprised that the words "culturally and linguistically diverse" were not used in that first paragraph. Do I need to talk about it?

The CHAIR (Hon Fred Chaney): The minister indicated this morning that he would respond to a request made by working group 3 and a number of delegates from culturally and linguistically diverse groups to redraft the principles to take those matters into account. That was conveyed back to working group 9. I invite the group to respond to your point.

Mr MACKAAY: We initially incorporated culturally and linguistically diverse groups in the text of that paragraph. However, we became concerned that there were numerous communities or groups within Western Australia that we could also name and refer to their special needs. The question may then be asked: Why mention Aboriginal communities? However, we believe that as the first nation of this country, the indigenous community has a particular standing.

Mr JEYARAJ: I raised the matter concerning culturally and linguistically diverse people in this working group. We spent a considerable time on the matter. We concluded that we would keep the other groups aware of the need to address all community concerns.

Mr EGAN: Can the working group explain the import of recommendation 4, which suggests that the -

> government seriously consider all treatment options discussed at this summit, either as trials or expansion of existing programs . . .

How will that relate to other recommendations delegates are to consider which deal with some specific treatment options, including some that are quite controversial? I am concerned about the possibility that if one of these later options that are specific in their terms fails to secure the support of the summit, the way this recommendation is formatted would leave it open to the Government to suggest that the controversial treatment options had been somehow endorsed by the summit because we endorsed recommendation 4. That recommendation urges the Government to seriously consider all treatment options discussed at this summit, which would include anything that any of our visiting speakers mentioned or anything that came up in any part of the record of the summit. It is drafted in broad terms and the adverb "seriously" ahead of the word "consider" especially means that the Government cannot merely look at it and say it was discussed at the summit but did not enjoy majority support; it must give serious consideration to it.

I understand the recommendation is trying to bring together broad questions; however, I seek clarification that can stand on the record so that the meaning of this recommendation does not become a matter for controversy in the subsequent community debate.

Ms MILLER: We carefully considered this recommendation. In bringing it as the up-front and overall policy in policy development, the group did not want to exclude matters that would be included subsequently or include matters that would be excluded subsequently. We understand the

Government will listen to and seriously consider all the recommendations of the Drug Summit so that the discussions at the summit will be a part of its serious consideration.

Ms BOLDY: I suggest the rejection of subsequent recommendations will speak volumes by themselves. If this recommendation is passed and subsequent recommendations on specific matters are rejected, there will probably be another message there for the Government.

Mr TAN: I hear what has been said about this issue. However, there is an issue of mandate. Will this recommendation give the Government a mandate to do basically what it likes to do with whatever was discussed? The wording of the recommendation is very airy-fairy.

The CHAIR (Hon Fred Chaney): I suggest the time for amendment has passed. The answer has been given that the general provision has been made with the understanding that specific recommendations may be made for or against particular treatments. The Government, if faced with particular recommendations about a particular treatment, will have to take those recommendations into account in its serious consideration. It is unchangeable now. However, you are asking the same question as has been previously asked.

Mr TAN: I was unclear about the answer. Does it give a mandate?

The CHAIR (Hon Fred Chaney): It is not open for these people to answer that; it is for the minister to answer. I see that Richard Egan is looking disturbed. What I am saying is if a general recommendation is made - a point already made by the group - which is then followed by a specific recommendation, obviously the specific recommendation would have to receive serious consideration as against a general recommendation.

Mr EGAN: With respect, that in no way meets my concern. Can it be stated clearly by the working group, or anyone else, that this recommendation is not intended by the working group to commend to the Government treatment options that have been discussed at the summit, but have failed to attract support when debated in their specific terms by the plenary session of the summit? What is the intention of the working group who formulated this recommendation?

The CHAIR (Hon Fred Chaney): The working group may choose to respond now or may, if it wishes, exercise a right of reply later.

Professor FROYLAND: We do not want to respond now.

The CHAIR (Hon Fred Chaney): Are there any further points that delegates wish to raise?

Mr BAXTER: I would like clarification of the term “social capital”. I do not understand it and I am representative of a fair few of the poorly educated, simple folk here.

Ms NEEDS: I wish to clarify my earlier question. I do not for one minute question the fact that the needs of Aboriginal communities were considered. My question was not about that. This summit is about over-arching policy, so if the words are not stated, the results will not filter down to where they should. I participated in compiling the issues paper on supporting families and I called the Western Australian Drug Abuse Strategy Office for information. On the one hand, information about Asian gangs and young Asian children is circulated in the media. On the other hand data on those very issues is impossible to find. The needs of Asian people are met through overcoming language difficulties, the provision of more information, settlement and general refugee issues. If these issues are not stated in policy, they do not filter down to the right people.

The CHAIR (Hon Fred Chaney): I invite the working group to exercise the right of reply. I am not seeking to cut off debate, but I do not wish to waste the working group’s time if there are not further matters to be raised.

Mr BOYLE: I will try to clarify “social capital”. I acknowledge that it is something of a buzzword. It is used to try to identify the intangible things in our community on which we do not put a value. We are used to economic terms, such as “economic capital of assets”. However, the

volunteer efforts made by people in our community to coach their under 12-football clubs and to participate in church life or with parents and friends, scouts, Rotary and community groups such as local drug action groups often are not recognised as having a value in our community.

The term has been developed over the past few years in reaction to the economic rationalist approach of valuing only things in dollar terms. A whole movement including Tony Blair and people from other countries, as part of government policy support is trying to support, regenerate and enhance our social capital - those intangible things that we feel are being eroded through either deliberate or accidental impact of other government policies. We want policies not only to identify tangible achievements but also to encourage intangible goals that involve enhancing relationships and valuing key aspects in people's lives that are lacking and causing them to turn to other things for meaning.

Mr MACKAAY: In relation to identifying cultural linguistically diverse communities, one of the key turning points in our discussion about that was a call from people with disabilities to be recognised as a separate community for the purposes of this paragraph. That led to us identifying groups within the community. The list appeared to be endless. I am not sure what more we can do. I do not believe we can take on amendments.

The CHAIR (Hon Fred Chaney): I mentioned at the summit this morning that the group had provided me with a memo that referred specifically to the cultural appropriateness of approaches within indigenous and culturally and linguistically diverse communities, and their special needs for sensitivity. I referred that to the minister, and he has said he will take that up. I announced this morning that it is the first outcome of the Drug Summit. The points raised are being carried forward by the summit on the initiative of groups 1 and 3.

Professor FROYLAND: We have attempted to provide some strong words that the 100 people in this room can use to remind the Government of its commitment to making a difference. We have worked long and hard on these five recommendations - we had as much time as everyone else. We earnestly believe that if the summit accepts these recommendations, each delegate can use them to make a difference with not only Mr Kucera, but also the Government as a whole. Thank you.

The CHAIR (Hon Fred Chaney): The first working group is providing an essential learning experience. We are about to distribute the ballot papers. Four people will act as returning officers, and they will collect and count the ballot papers, which have been initialled. Exactly 100 ballot papers have been prepared and will be handed only to delegates. Someone raised the issue of scrutineers. It is difficult to imagine the need for a scrutineer for 100 delegates; however, one of the co-chairs will be happy to scrutinise the count, if it meets the wishes of the meeting. It is intended that the ballot papers be preserved. Someone asked what will happen to a ballot paper when someone chooses not to vote. He was concerned that someone could add a tick to that paper. If delegates are concerned about that, they can write the word "abstained" in the boxes. Delegates should vote by putting a tick in the "yes" box or the "no" box, or by not ticking any box. People who do not wish to pass an opinion and want to abstain from voting on any one of the five issues should either leave the boxes blank or write the word "abstained".

The CHAIR (Hon Fred Chaney): This is another test. In planning for these sessions, we have assumed the guillotine will drop after 55 minutes of debate. That is, the vote will be taken after 55 minutes. We assumed that a secret ballot of this sort would take only five minutes, but this will be an interesting experiment. We might find that we have underestimated.

We are faced with another learning experience. Only recommendation No 1 was amended. We will try to display the amended recommendations at the time of voting so that delegates are clear about what they are voting or not voting for or against.

Mr LOVETT: Is it possible to distribute all the ballot papers now?

The CHAIR (Hon Fred Chaney): We discussed that approach, and it would be efficient in some ways. However, again, in the interests of openness, it seems insulting for speakers to confront the prospect that people might complete their ballot papers before they have heard the debate. I remember addressing a judge for five days and going away for the weekend, only to have him read his judgment on Monday afternoon. I felt distinctly miffed that he had written his judgment before he heard my argument. I do not want delegates to be in that position.

Mr MEOTTI: What happens if we have 98 or 99 ballot papers? What if someone has not handed in a ballot paper?

The CHAIR (Hon Fred Chaney): That will be one of life's little mysteries. We have life's first little mystery. Is anyone absent from the Chamber? I believe one person is absent, but happily there is one spare ballot paper, which I will now spoil with the agreement of the delegates. It is fair to say that in any gathering of 100 people, at least two believe in a conspiracy about everything. I am trying to be open about everything.

Mr NORTON: Will delegates receive a copy of the amended papers and resolutions?

The CHAIR (Hon Fred Chaney): A complete list of resolutions will be provided by close of business tomorrow. Delegates will have copies of the working groups' recommendations for the purpose of debate. Amendments will be provided in writing and displayed as I have indicated. Even though amendments might not have been dealt with, they will remain part of the record and the fact that they were not dealt with will also be part of the record. That will all be on the record, but tomorrow there will be a list of resolutions passed and not passed, in the form in which they were dealt with by the summit.

We are ahead of time, and I cannot just ask the next group to move in because we have tried to allow delegates time to consider possible amendments they might want to urge. This gives delegates a little more time than we thought to consider that. I suggest that we adjourn and resume after afternoon tea, on time, and that delegates note that amendments are to be submitted - if delegates wish to submit amendments - to groups 1 and 2 by 3.10 pm. There will be a little more time to work individually on those matters.

Summit suspended from 2.46 to 3.20 pm

The CHAIR (Hon Fred Chaney): The outcome of the voting for working group 9 is as follows: voting for recommendation 1, as amended, was yes 92, no 7; for recommendation 2, it was yes 96, no 3; for recommendation 3, it was yes 96, no 2, with one abstention; for recommendation 4, it was 75 yes, 24 no; and for recommendation 5 it was 97 yes and 2 no. There was a 92 per cent or higher majority for questions 1, 2, 3 and 5 and a 75 to 24 vote for recommendation 4.

We will now move to working group 1 - young people and illicit drug use. The one hour will start from now. If the discussion continues for 55 minutes, the vote will commence in 55 minutes. Members of the group have just been handed a series of amendments which they are looking at, most of which are drafting in nature - from my own quick perusal. No doubt they will consider the acceptability or otherwise of those amendments during the course of their discussions, and will advise us as soon as possible whether or not they are acceptable.

I invite working group 1 to commence using its 20-minute allocation and to introduce its five recommendations.

Mr BELLINI: I am the chair of working group 1 dealing with young people and illicit drug use. Firstly, I would like to present an overview of all the recommendations and talk briefly about each one, addressing certain points which we feel are pertinent to each issue and recommendation. The definition we have used when considering young people is between the ages 12 to 25 years.

The first recommendation deals with the diversity of young people. We have considered age, gender, sexuality, socioeconomic factors, cultural, linguistic and educational background, geographical location and levels of risk and ability. I raised an issue earlier in the week that, all too often, young people are grouped in one category, and we do not consider the individual needs and diversity within particular groups of young people. The second paragraph refers to how we believe that young people should be actively involved in the process of designing and implementing policies in areas in order to address the lack of services and facilities that are aimed at young people and illicit drug use. It is also important that, as a group, we recognise that young people who use illicit drugs represent only a minority of the youth population.

Recommendation 2 stems from the idea of keeping young people in contact with the education system. We have emphasised certain areas that we believe are very important, such as increasing access to alternative educational settings and continuing education. We have also addressed issues that revolve around family support, which we believe is very important. We also consider that not all young people have a stable family background. We must consider young people who have been isolated from their families and may not enjoy the support that most of us have. Anne Russell-Brown will discuss recommendation 3 in detail.

Ms RUSSELL-BROWN: Recommendation 3 relates to the requirement for treatment services specifically for young people. The words “youth specific” are very important as adolescents are not just mini adults and need to be given specialist treatment. This recommendation refers to a range of treatment options, from detoxification through assessment, rehabilitation and respite services. The purpose behind this recommendation is to request additional services to those that are now available for young people:

Mr BELLINI: Recommendation 4 follows the principles of prevention and early intervention. We believe it is extremely important to try to prevent young people becoming involved in illicit drug use. We believe there should be continued support for the development of local action groups, and other community service providers with education occurring on four levels including the home, the community, school and on an individual level. Janette Rowe will now discuss recommendation 5.

Ms ROWE: My background is in accommodation. I wanted to talk on this recommendation, because it has not been raised to any great extent on its own. Basically, it recognises that insufficient accommodation is available for young people, particularly those who are under 18. I work with a quite a few young people who are parents at the age of 15 and 16, and they have a lot of difficulty getting housing - as do single young people who are under 16 years of age. People who are current drug users or have mental health issues are often excluded from the supported accommodation assistance program due to their inability to live in a group environment and the risk that they pose to other residents. It is important that their accommodation needs are picked up, but perhaps in a slightly different environment. “High support needs” refers to young people who have something like a borderline intellectual disability. The SAAP sector accommodates a lot of people who fit that category. There are other young people who have behavioural issues but may not necessarily have mental health or current drug using behaviours.

I now refer to the need for access to pre and post drug treatment for homeless young people and also for young people in rural and remote areas. It is difficult for them to travel to Perth to centralised services when there is no pre and post support available in their region. This is often the time that they relapse because no support systems are available to them. For young people who live in rural and remote regions, there is often no accommodation available. A good example of this is in mining towns which do not have spare accommodation. If you do not work in the mine, you are not accommodated. If there is conflict in the family, there is nowhere for those young people to go. In very remote communities there are no options. Culturally and linguistically diverse young people are a marginalised group. They are often socially isolated and have few resources. The issues for young people from indigenous backgrounds have come up in other groups and, I am sure,

will in other recommendations. They are often last on the landlord's list for rental properties, and there is a long waiting list. It is often almost impossible for those young people to obtain accommodation.

The CHAIR (Hon Fred Chaney): Six amendments, two of which are included on one sheet of paper, have been submitted. They are in the main small in terms of the number of words. A number are essentially drafting amendments and have been accepted by the working group. I will therefore put those amendments before you first, to see whether there is any concern about their acceptance. The working group wishes to have three amendments explained by those people who are moving them.

The first amendment is to recommendation 3. The amendment to the second line is after the words "supervised youth specific" to insert "medical and non-medical". The recommendation would therefore read -

> The Community Drug Summit recommends the establishment of holistic, accessible, supervised youth specific medical and non-medical detoxification . . .

That is apparently acceptable to the working group. Does anyone have a problem with that amendment and want to have it explained? If not, we will regard that amendment as having been accepted. The amendment will be incorporated in the motion.

Amendment agreed to.

The second amendment is to recommendation 4. The third dot point reads "forming of partnerships with key stakeholders including police, members of the community" and so on. It is proposed that it should read "forming of partnerships with key stakeholders including GPs and other community health workers, police, members of the community" and so on. The amendment therefore is simply to insert "GPs and other community health workers" in the list of people with whom partnerships will be formed. Does any delegate have any problem with the acceptance of that amendment? It does not mean that delegates accept the motion but that they will vote on the amended motion. That appears to be okay.

Amendment agreed to.

The third amendment that is acceptable to the working group is to recommendation 5. After the dot points it reads, "The options should include a continuum of care". The amendment would mean that it would read, "The options should include a well-resourced continuum of care . . . " That is again acceptable to the working group. Does anyone have a problem with that? If not, those three amendments are incorporated.

Amendment agreed to.

Another amendment is to recommendation 1. In line 3 it is suggested that instead of using the word "regarding" before "age", it should read "recognised with respect to age, gender, sexuality" and so on. That is moved by Moira Sim and seconded by Greg Duck. That again is acceptable to the working group. Does anyone have a problem with that? That amendment is incorporated.

Amendment agreed to.

Moving again to recommendation 4, Michelle Rosenberg and Mary West are suggesting that we insert after the word "including" in line one of the third dot point some further additional words. We have already inserted "GPs and community health workers". They are proposing that after the word "community", we insert the words "ensuring participation reflecting the diversity of regional populations".

Does the working group have a problem with those additional words? It would then read -

> forming of partnerships with key stakeholders including GPs and other community health workers, police, members of the community, ensuring participation reflecting the diversity

of regional populations, all levels of government, small business, education and community agencies.

That is also accepted; does anyone have a problem about that?

Amendment agreed to.

Ms WILSON: What about "rural"?

The CHAIR (Hon Fred Chaney): I do not think we can do that from the floor. The implication would be covered. The general direction of the resolution is the critical aspect. We are looking for wide partnerships and you have just broadened the motion considerably. I am sorry but we cannot accept further amendments.

The other amendment to recommendation 4 is in dot point 3 - the list of people in partnership - the key stakeholders - which, at present reads, "GPs and other community health workers, police, members of the community . . . all levels of government, small business, education and community agencies". It is suggested that the words "drug users" be inserted. That would mean that drug users become part of the group of key stakeholders who are brought into partnership. That is the meaning of the amendment. Is it one for which the working group requires an explanation?

Mr BELLINI: The only problem we see is with the definition of key stakeholders. Will the proponent explain the reasons behind the amendment?

The CHAIR(Hon Fred Chaney): I invite Michelle Rosenberg to speak.

Ms ROSENBERG: Following from Nathan's talk yesterday, we believe that the key stakeholders in working out drug resolutions for people who use drugs are the users themselves. That is the point we are trying to make. We believe that when working out policies and framework and whatnot for them, they should be the first people consulted because they know what they are talking about.

Mr BELLINI: We accept that.

The CHAIR (Hon Fred Chaney): The working group is prepared to accept that as within the spirit of the resolution. Is there a problem with that? If not, we now have a series of amendments.

Amendment agreed to.

Mr EGAN: If we had been able to see the foreshadowed amendment beforehand, I would not have had a problem with including "drug users". I am concerned, in any context, about including a reference to drug users as key stakeholders without including references to the family members of drug users and several other groups that balance that emphasis. It is somewhat out of place with the other things mentioned on this list, and it would distort it in a particular direction that I have concerns about.

The CHAIR (Hon Fred Chaney): The position is that the movers of the resolution have accepted that.

Amendment not agreed to.

Mr BELLINI: Would it be possible to include "drug users and their families"? Is that acceptable?

The CHAIR (Hon Fred Chaney): If it has the leave of the summit. In my view, the leave of the summit can be refused by any member. A point has been raised that the working group has responded to, and it suggests that the amendment include "drug users and their families". Is leave be given for those additional words to be added? If leave is given the additional words are added. Thank you.

Amendment agreed to.

The CHAIR (Hon Fred Chaney): The next amendment is to recommendation 1, and it is moved Wendy Casey and Josephine Maxted. I am sorry that I have not looked at this amendment before.

It states that "indigenous" be inserted after "sexuality" in the third line of the first paragraph. A disorderly interjection from my left tells me that it is covered by the word "cultural". I ask the working group whether they agree to this amendment.

Mr BELLINI: We will accept that amendment.

The CHAIR (Hon Fred Chaney): That amendment is accepted. Do any delegates have a problem with that? I can say from the Chair without being too interventionist that, at worst, it is a belts and braces amendment. A series of amendments have now been accepted and slightly modified by the floor by leave. I invite any discussion and debate on recommendations 1 to 5, preferably from outside the group so that they can hear what the other delegates have to say.

Amendment agreed to.

Ms ADAMS: I will make some favourable comments about recommendation 5. The community of Hyden has provided an excellent example of what can be done for single youth. That community had a lot of problems with youth suicide because of the town's isolation, and it was hard to get the youth to stay in their community. They tried to have a holistic community. Theirs is an example that should be recommended to the Government for its consideration. They have put in place a program that works very well. I am the type of person who thinks that if something works well, it should be promoted, especially in the rural and remote areas. That program should be considered.

The CHAIR (Hon Fred Chaney): Thank you Judith. I have had an attack of conscience in respect of rural and regional areas - it is unusual that the Chair should have an attack of conscience, so enjoy the moment. The question of leave did not occur to me. I will ask that *Hansard* include the question that was raised with respect to rural communities as well as regional communities. In fairness to the members of the summit who raised that matter, the question was within the spirit of the resolution. I am sorry that I was not thinking quickly enough in response to the previous point. Thank you very much Judith.

Ms BOLDY: I want to make reference to the addition of medical and non-medical detoxification treatment programs in recommendation 3. This issue has had a great deal of coverage at the summit this week, but not all delegates will be aware of the situation. Currently, there are no specific medically assisted residential detoxification facilities for young people in Perth. My amendment to add the words "medical and non-medical detoxification" is meant to indicate that we support an expansion of non-medical detoxification facilities and the introduction of medical detoxification facilities. I understand that the previous Government was prepared to ensure that medical detoxification facilities were established, but that has not happened for obvious reasons.

Mr MACKAAY: I have a question about recommendation 5, about which Janette Rowe might like to comment. The fourth dot point states that young people "need access to pre and post drug treatment". Does that mean pre and post drug treatment support? Otherwise I do not understand what the term "pre drug treatment" means.

Ms ROWE: It refers to pre and post drug treatment. If rural young people want treatment for their drug use and they need a facility in which to live, they must come to Perth because those facilities are not available in rural areas. The majority of those people would not have family or support in Perth; therefore, they need somewhere to stay. Often the refuges are full. Sometimes those people are above the age range of people who are admitted into those facilities. The majority of Perth services are limited to people under the age of 18 years; however, people who seek those services might be 19 years of age or older.

Young people who come to the city for detoxification or drug treatment, which is fairly intensive, end up either on the street or in unstable accommodation. Sometimes they relapse even before they begin the treatment and other times they relapse when they come out of the treatment before they can get home; that is a crucial time.

Ms WOODS: I express my concern that the delegates working in the young people's group have not acknowledged the existence of children aged under 12. There are drug babies and young people who have been neglected. There are all sorts of children under the age of 12 who are not being addressed in this forum.

Ms CARNES: That is a fair enough question and I acknowledge it. As Carlo mentioned at the beginning, we have taken the definition of young people to be those aged from 12 to 25. We debated that as a group. There are a few reasons for that. First, the issues paper that we were sent noted that as the definition. The World Health Organisation's definition of young people is also for those aged 12 to 25. That is the common age range for service provision for young people. Those younger than that are more inclined to be labelled children. It is a fair enough comment. Children from different cultures may experience some of the issues at the age of 10, whereas those from mainstream cultures may experience the same issues at the age of 12. Again, it is not necessarily a perfect outcome. It may come up in some of the other treatment options and so on. We did that because it is the standard definition of young people.

Ms WOODS: I was in the treatment group and we specifically did not address that issue because we felt it was part of the young people's format.

Ms ROWE: The issue that you are talking about has been picked up by one of the recommendations of the family group.

Mr CHANG: In relation to recommendation 4, I ask the working group to rephrase the opening sentence.

The CHAIR (Hon Fred Chaney): Mr Chang, can you address your concerns rather than simply ask the sentence to be rephrased? It is late to make an amendment. Can you explain to the group what you are concerned about?

Mr CHANG: My concern is with the phrase "early intervention programs for young people to inform policy and practice on a whole of government basis". I do not know what the working group is referring to.

The CHAIR (Hon Fred Chaney): Are there further queries of that sort? As I understand it, Mr Chang's inquiry simply asks for an explanation of what is meant by "whole of government basis" in that part of the resolution. Are there any other matters that delegates wish to raise before I call on the group to exercise any right of reply?

Having made the apology a while ago, can I have the leave of the meeting to suggest that we include the words "rural and" where the word "regional" appears in the earlier amendment. It is made on the same basis as the other change. My comment then was that it was within the spirit of the amendment, given the mover. I suspect that "rural" and "regional" were within the meaning of it. Any member at the summit can cut me off simply by saying no. However, will it meet the summit's intentions if we include the word "rural" as well?

Hon David MALCOLM: On the condition that it includes both.

The CHAIR (Hon Fred Chaney): I think we will have leave to follow Chief Justice Malcolm's suggestion as well.

Ms INGLIS: I live in a rural and remote area and we also need to put "remote".

The CHAIR (Hon Fred Chaney): Does the word "regional" not cover the remote areas? If there are more suggestions, I will close this off because I am being disorderly.

Mr BELLINI: For completeness, our group feels that "regional", "rural" and "remote" covers all aspects.

The CHAIR (Hon Fred Chaney): We can be this untidy only when there is a lot of goodwill and not a lot of substance in the points. It has been suggested by the group that we talk about regional,

rural and remote areas. Does any delegate object? If not, we have now made that amendment. Are there any further matters delegates wish to raise?

Ms CASEY: I have just realised something about the word "indigenous" in the amendment. I really hate bad grammar. I do not know if it is too late to change that to "aboriginality", rather than "indigenous", because it does not fit with the sentence.

The CHAIR (Hon Fred Chaney): This relates to an amendment to which delegates have already agreed and which was agreed by the working group, and is in the interests of better grammar. Does anyone have an objection to replacing "indigenous" with "aboriginality" in line three of recommendation 1? If not, that change is made.

I am building up huge trouble for the Chair with this process - I understand that. However, I stress that this is possible when we are simply sorting out shades of meaning when there is no disagreement within the group. If an issue is really contentious, we will have to follow a stricter order of debate.

If there are no further points, I will invite the group to respond and to make any closing statement it wishes to make.

Ms RUSSELL-BROWN: In response to the delegate's question regarding recommendation 4, which refers to policy and practice on a whole of government basis, I indicate that the purpose of including "whole of government" was to include all those areas that have input into young people's lives. That would include health, education, family services, the justice system, police and so on. The spirit of that statement is to ensure that there is no polarisation and that it is coordinated and interrelated service delivery for young people.

Mr BELLINI: In conclusion, I would like to say that this week has been difficult for this group for a number of reasons. The main reason is that our topic overlaps so many others. Young people fit into families, into prevention and into treatment. However, my group and I feel that we have come up with five priority recommendations for young people. When we examine the illicit drug problem that our State faces as a whole, it is important that we consider young people as an amazingly important group in the overall solution to our problem. As young people grow up, they become adults in the community. They then become the leaders. We must start early to try to address the illicit drug-use problem. My group feels that it has taken a step towards doing that. We implore all delegates to please accept the recommendations that we feel are positive steps towards solving, or attempting to solve, the illicit drug-use problem in our State.

On a concluding note, I first thank and congratulate my working group for working so efficiently and for getting on together so well. I also congratulate and thank our facilitator, Paul, who has helped in the organisation and workings of the whole group. I also thank and congratulate again all the other delegates who have helped us, talked to us and given their opinions on young people and illicit drug use. Without their opinions and the valuable workings between all the groups, it would not have been possible for my group to come up with its five recommendations.

I also thank the summit organisers and the chairs for running the summit so efficiently. Thank you. I hope we make a difference.

The CHAIR (Hon Fred Chaney): I ask for the distribution of the ballot papers.

Hon David MALCOLM: As a result of the amendment to recommendation 1, adding "rural" in the third dot point - "rural, regional and remote communities" - there is now an inconsistency between that recommendation and recommendation 3. The third line of recommendation 3 refers to "both metropolitan, regional and remote areas". Should not "both" be deleted and "rural" be added before "regional"?

The CHAIR (Hon Fred Chaney): Can that amendment be made with the leave of the summit? I do not know whether the clerks, who are valiantly trying to keep up with this, have kept up with it. I

think the position is that in recommendation 3, line three, the word "both" should be deleted and the word "rural" inserted, so that it reads "metropolitan, rural, regional and remote".

I have been told by my co-chair that Hansard is having difficulty picking up and identifying some speakers. This means that a delegate's splendid contribution may have been attributed to someone else. I again ask delegates to give their name as they speak, and then they will get the credit.

Mr LOVETT: When we talk about "remote", does that include Christmas and Cocos Islands?

The CHAIR (Hon Fred Chaney): That raises very difficult constitutional questions, but my understanding is that in respect of some areas of administration, Western Australia is the appropriate administering authority; however, in respect of some other functions, it is not. I assume that in those areas for which Western Australia is the administering authority, as it is for education in the Cocos Islands, then whatever is relevant will apply. I ask delegates to complete their ballot papers.

[Ballot papers collected.]

The CHAIR (Hon Fred Chaney): I thank group 1 for its presentation. We now move to the next group.

The CHAIR (Hon Fred Chaney): We now move on to working group 2, which dealt with the issue of supporting families to deal with illicit drug use. I note that we are starting this session at 4.05 pm, so we will have until 5.05 pm if required. A substantial number of amendments of a relatively minor nature have been put forward and they will no doubt be addressed in due course. I invite working group 2 to address their recommendations.

Mr LYNCH: Our group looked at issues concerning how to support families in which a member, such as a child or sibling, was involved in drug use. We have not had a good chance to look at all the amendments that have been put forward, so we will be a bit on the run as we go through this session today. I will preface the discussion today by saying that the group used an extremely wide-ranging view of the family. We wanted to ensure that "family" was interpreted by the summit as those people who are legally connected, such as mothers, siblings, grandparents and children, but also those people who are connected in other ways, through other types of relationships, to particularly ensure that kinship and extended family networks were recognised. We will take the opportunity to go through each recommendation briefly and to explain the rationale behind them before dealing with the amendments.

Mr EASTWOOD: The first recommendation is for the Western Australian Government to consult media interests to facilitate the development of a code of practice that aims firstly to minimise sensationalism in the reporting and treatment of drug issues, and the portrayal of stereotypes in the media, and secondly supports a positive image of youth and families. We draw the attention of delegates to the educative effect of the law and the media. We wonder just how many young people who have a non-conforming attitude or intention have been led down the drug-taking path by the glamorising or sensationalising of these activities in the various forms of media. We would like some positive efforts made by our friends in the media to present a positive image and to tell the good stories, rather than concentrating on the negative aspects of this issue all the time.

Ms BAKSHI: The second recommendation comes from the position that healthy, well-supported communities are necessary for healthy families and that well-supported families are necessary to grow healthy children. These recommendations have been influenced by some of the points raised at the summit by Professor Sven Silburn and Professor Fiona Stanley.

Father BACZYNSKI: Our third recommendation is to acknowledge that services are doing the best they can with what they have and that they provide excellent services. However, extra funding is essential for agencies so that they may continue to grow and provide support services to families. There is a tremendous and immediate need for wide-ranging and user-friendly information. The

availability of comprehensive information is desperately needed in rural and remote areas and must be indigenous and culture friendly.

Crisis accommodation has been covered to some degree in the second part of our recommendation. Experts have stated that sufficient beds exist for crisis accommodation for families in Western Australia. However, in reality all agencies are strapped to the boards for funding and there is simply not enough crisis accommodation.

There are places available for respite for families. However, often a moderate to high cost is involved that family members more often than not cannot afford. We would like to see more government funding where necessary. Again, detoxification centres are strapped for funding and large amounts of government funding are required to maintain current facilities and open new facilities. Detox centres do not necessarily need the presence of psychologists and doctors but, rather, the presence of people who have had experience - people who have walked the walk and can talk the talk.

Bereavement was covered appropriately this morning by a three-minute speech on the topics of assistance and information, the grieving process and immediate in-home assistance. There is also a need for families to have facilities for identification purposes, funeral services and grieving and for growing purposes after the shock of a death. We also covered compulsory rehabilitation, and the words "where appropriate" are recommended.

Ms ALCOCK: I shall speak to recommendation 3. We have heard from speakers about the resulting trauma for the whole family when children are removed from their natural parents because of drug use. Families of drug users, especially parents, are gradually developing a public voice and recognition for their need for support. Children, especially young ones, have no such voice and we have a responsibility to speak for them. The removal of children from their natural parents for any reason is a matter of grave concern to our society. However, we have a responsibility not to leave children in a situation when their wellbeing and safety cannot be guaranteed. However, simple removal of a child does not guarantee his or her future emotional wellbeing. It is vital to give children ongoing counselling and support to meet this need.

It is also imperative for carers to receive the same degree of support that is needed. This applies especially to grandparents, who are increasingly becoming surrogate parents to avoid seeing their grandchildren being put into care. Not only are they struggling with the demands of being born-again parents, but also with trying to understand their own child's drug use; or, worse, grieving the death of that child. The essential aim must always be reunification of the family, and parents must be offered all possible support to allow that to happen. Presently there is only one residential service where mothers may live with their children while undergoing treatment. Places are limited, and because we feel that this is by far the most desirable option, we ask that those places be increased to allow parents to stay with their children so that families can remain intact. That is all behind recommendation 3.

Mr HINDS: The community drug summit recognises that family members of a drug user are often involved in helping the person access services and can be a key resource to assist his or her recovery, but can be marginalised in the process due to narrow interpretations of privacy and confidentiality considerations.

We recommend that the Western Australian Government engage all relevant stakeholders in a process that reassesses privacy and confidentiality issues to maximise the involvement of family members and significant others in the service system, while acknowledging the rights of the individual.

What motivated me to raise the matter with my group was a visit by a harm minimisation training team to my town with the message that it is now appropriate for me as a service provider to supply needles and syringes to teenagers as young as 13 years of age. As a father, this was of concern. A

13-year-old buying needles and syringes clearly has a problem. If it were my child I would want to know so that I could address the matter. However, I am bound by confidentiality and a breach of confidence is considered to be professional misconduct.

Raising this issue produced a huge interest and the service providers in the group spoke of their frustration with the system in which providers are attempting to do their best without all the information they need. The barriers to information are perceptions and protocols of privacy in other services. There are obviously many of what the chair of a health department committee calls "war stories", in which needy people fall through the cracks. Difficulties are compounded by the reaction that I call "when unsure shut the door". My experience is not limited to one example.

Appropriate family members also need to have sufficient information to help them deal with family problems. The federal Government is now revising some privacy laws. There is now an opportunity to reassess privacy and confidentiality issues to optimise communication for the benefit of the less fortunate.

The CHAIR (Hon Fred Chaney): The working group has 10 minutes of its time left and a substantial number of amendments to deal with. The amendments, which will be addressed by the group in a moment - I am trying to save time - raise a number of issues of substance. I think one of them relates to the introductory words of the chairman of the working group when he referred to a broad concept of family; that is, multi-generational and beyond that version of family. That is touched on in the existing proposals, but at least two amendments also seek to make that more clear. Another substantial issue relates to whether there should be mandatory code of practice, although different words are used in two amendments. I am intervening to ensure that the working group has ample time to respond. I am asking it to husband its resources so that it has a chance to respond to the points in the amendments.

Mr LYNCH: One of the amendments for recommendation 1 seeks to change the word "youth" to "young people". We have no problem with that.

The CHAIR (Hon Fred Chaney): That amendment is moved by Rose Carnes and seconded, so it is accepted.

Is it in order that I read the various amendments, some of which will require debate and some which will not, so that we will not be left with no-one to reply. John Prior has moved an amendment and Denis Eggington moved a similar amendment to add the word "mandatory" before "code of practice" in line 2. Denis's amendment is to add "enforceable" to make it "new enforceable code of practice". As I am going through the other amendments, delegates may want to decide which amendment they want to put forward or each person may want to pursue his amendment.

The next amendment, as has already been outlined, is to replace "youth" in line 4 with "young people". We have already been told that is acceptable. Does anybody have any concern about that change? If not, we will adopt it. Recommendation 2 is amended by substituting "youth" with "young people". Phillipa Boldy and Amie Frewin have recommended that the word "families" in line 1 be replaced by "those". The explanation is that the amendment will recognise more people than stereotypical families. I think the intention is for a more inclusive expression. In light of the working group's earlier comments, it might want to pick that up.

The suggested amendment to recommendation 3, which has been moved by Danny Ford and seconded by Mary West, is to include after "range of services" in line 4 the words "Aboriginal and non-Aboriginal". The idea is for a range of both Aboriginal and non-Aboriginal services.

Rose Carnes has suggested an amendment to completely reword the first dot point of recommendation 2 to read -

> Adopting effective, grassroots community development programs that enrich community cohesion, promote social inclusion, encourage and recognise culture diversity.

It is a more descriptive version of the existing dot point.

The suggested amendments to paragraph 5 are to substitute "widely" in line 3 with "appropriately", substitute "adequately" in line 2 with "according to need", and insert after "CALD" "queer".

A series of amendments have been suggested, and I invite the group to indicate which, if any, of those they wish to support.

Ms ROSENBERG: Can someone explain the word "queer"?

Ms JEFFREYS: The queer community represents gay, lesbian, transgender, bisexual, intersex and transsexual people.

Mr LYNCH: We have accepted the amendment to the first recommendation to substitute "young people" for "youth". Someone has moved an amendment relating to mandatory or enforceable codes of practice. Our view was that a mandatory code of practice was not possible; such a thing would require legislation, whereas codes of practice are agreed. I ask for clarification from the proposer of the amendment.

Mr PRIOR: From a legal perspective, there is probably something in Francis Lynch's argument; however, I am referring to a broad policy perspective. I apologise to those in the media. This amendment is not meant to be a slight on the reporting of this summit. If the Press wants to write a nasty story about me, it may. A code of conduct implies a guideline, and I do not think that is strong enough. Making such a code of conduct mandatory would send a stronger message to the media. It would imply sanctions and highlight the importance of the issue.

I say that because, with the greatest respect, the media are likely to say that it is answerable to the Press Council and that journalists do a responsible job. As Graham Mabury said on Monday, the media can do a lot better.

Mr EGGINGTON: Graham Mabury upset us. I am not sure how many people taking illicit drugs, or any other drugs for that matter, would go to sleep with Graham Mabury. Those on LSD who already think they are in bed with Basil and Barra might.

I have worked with the media enough to know that the code of practice, from the Australian Journalists Association up to the Press Council, has no teeth. We want something from the Government to pull them into line and to enforce the code. If my seconder is happy, I will support the change to "mandatory".

Mr PRIOR: I am happy with Mr Eggington's wording.

The CHAIR (Hon Fred Chaney): I ask delegates to decide which amendment they wish to pursue.

Mr EGGINGTON: I prefer the word "mandatory", as long as my seconder agrees.

Ms MAXTED: Yes.

Mr LYNCH: Our group accepts that, but we have misgivings about whether it is possible.

The CHAIR (Hon Fred Chaney): The word is accepted by the working group. Does anyone object to its incorporation?

Mr FERGUSON-STEWART: Again, I make my comments with the greatest respect to the media - the highest level of government in the land. I have always been under the impression that a code of practice is, by definition, mandatory. Therefore, stating that it is mandatory is oxymoronic. I do not have a problem with its being mandatory. However, if we include that word, we should change the term "code of practice". I do not think we can have a mandatory code of practice.

Mr MEOTTI: It is the Government's responsibility to sort out the implementation, not ours. I do not wish to pass the buck, but it is up to us to come up with resolutions and up to the Government to do with them as it sees fit. We should not constrain our recommendations on the basis that what we

suggest might be too hard or impossible to do. We must make the assumption that it can be done, but it is up to someone else to do it.

Mr CRAWFORD: We can have three codes of conduct: voluntary, industry or mandatory. The summit is talking about a mandatory code because such a code would be enforceable. It is important that we get this wording correct. Whether or not Bob appreciates it, the word "mandatory" would force some action by the Government.

The CHAIR (Hon Fred Chaney): Notwithstanding the point Mr Ferguson-Stewart has raised, the issue is clear. The expressions "voluntary" and "mandatory" are used with respect to codes of conduct, in which case the word "voluntary" is redundant. However, the meaning is clear enough for us to decide whether we want to go with a mandatory or a voluntary code. Those in favour of amending the resolution by adding the word "mandatory" in the place indicated please raise your hands. Those against. I do not propose to take an exact count, but there is an overwhelming vote in favour of the amendment. Anyone may call for a count if he or she believes it is important.

Amendment agreed to.

The CHAIR (Hon Fred Chaney): The next amendment suggests replacing the word "families" with the word "those" in recommendation No 2.

Mr LYNCH: I would like to hear from the mover. I am not sure that is the intent of the amendment.

Ms BOLDY: I suspect that what I have written there has been misinterpreted. I was referring to the second dot point under the second recommendation on the copy we have, which says "the challenging of the stereotyping of families." My proposal is that it be amended to "the challenging of the stereotyping of those who are affected by drug use."

The CHAIR (Hon Fred Chaney): I am sorry for my misreading of your amendment.

Ms BOLDY: Obviously not only families are stereotyped in that way. For example, if a drug user is stereotyped there are repercussions for the family as well. I suspect that if we worded the recommendation "those who are affected by drug use", it would encompass both families and the others who are also stereotyped.

The CHAIR (Hon Fred Chaney): The chair of the working group may have a slightly different view.

Mr LYNCH: We will accept that.

The CHAIR (Hon Fred Chaney): Does anybody object to that being accepted? If not, then that becomes the motion.

Mr MACKAAY: I understood Phillipa to mean replace the word "family" with the word "those".

The CHAIR (Hon Fred Chaney): Is that acceptable?

Mr LYNCH: Yes.

Ms BOLDY: And only in that particular part of the recommendation; not at the beginning, where it has also been added.

The CHAIR (Hon Fred Chaney): Yes. The word "families" should be reinstated in line one. Is that acceptable to the summit?

In terms of wording, I take it that the Carnes-Boldy motion is that the first dot point in recommendation 2 be removed and replaced by "adopting effective grassroots community development programs to enrich community cohesion, promote social inclusion, encourage and recognise cultural diversity". Does anybody wish to speak to that?

Ms CARNES: The main thing I want to make clear from the start is that I am familiar with the Communities That Care program; and I think it is a brilliant program. I do not want anyone to think

that I do not think it is a good program. My only concern with that dot point was that in saying we would adopt a grassroots program such as that, it implied that it would be the same program adopted throughout the State. A couple of things went through my mind. I do not want us to exclude other possible good models and programs. I am thinking of the principle that was passed on to us by the Government about ensuring good value. It may sometimes be necessary to have a look at a range of models and programs that may achieve the same thing without it being so costly. I do not want to knock Communities That Care; I just want to keep some options open.

The CHAIR (Hon Fred Chaney): The working group is conferring on that. Again, this is not an issue of deep division, it is an issue of particularity as against generality. Effectively, what is being sought is the removal of the specific reference to that particular program and leave the balance. Is that acceptable to the working group?

Mr LYNCH: Yes.

The CHAIR (Hon Fred Chaney): Is that acceptable to the summit? Recommendation 2 is amended accordingly. We will move on to recommendation 3, in which we have the proposed amendment to insert the words "Aboriginal and non-Aboriginal" after the words "appropriate range of services" in line four. Was that Danny Ford's resolution?

Mr FORD: Francis, you and I are well aware that the incidence of removal of Aboriginal children from families is still quite high even today. Around 30 per cent of kids in foster care are Aboriginal. That fact deserves to be highlighted in your recommendation.

Ms FARMER: Our group had a lot of discussion around this and I also put that point across. However, the group did not want to acknowledge that we are a multicultural society. We felt better about the words "culturally appropriate" being accepted than Aboriginal and non-Aboriginal. We felt it would disadvantage the high populations of Asians - maybe Vietnamese groups - throughout the State

The CHAIR (Hon Fred Chaney): The words "culturally appropriate" do not appear in the resolution.

Ms FARMER: We thought of those words afterwards.

The CHAIR (Hon Fred Chaney): Danny, the working group is asking if it could insert the words "culturally appropriate". Would that be satisfactory to you?

Mr FORD: Not necessarily. I think you will find that very few children - I may be speaking out of turn here - are removed from core families because of drug abuse. There may be some, but the percentage would be small. I think you will find that approximately 70 per cent are from non-Aboriginal families and 30 per cent from Aboriginal families. That is why I do not think that "culturally appropriate" covers that.

Mr EASTWOOD: I suggest that we say, "a range of Aboriginal, non-Aboriginal and other culturally appropriate services".

The CHAIR (Hon Fred Chaney): This again is a matter on which the discussions are struggling towards a common view that is more a matter of expression than substance. Do I have the leave of the summit to insert the words that have been suggested which are, "an appropriate range of Aboriginal, non-Aboriginal and culturally appropriate services"? Is there any objection to that wording? If not, that will become the motion. Thank you.

Let us move to paragraph 5. Michelle Rosenberg has moved a couple of amendments. One is to remove the word "adequately" in line 2 and to replace it with "according to need". Could I have the working group's response to that, please?

Mr LYNCH: Yes, that is fine.

The CHAIR (Hon Fred Chaney): As no-one objects, we will make that amendment.

The other motion from Michelle relates to line 3, and is to replace “widely” publicised with “appropriately” publicised.

Ms FARMER: We have an issue with this, as “appropriately advertised” might not be considered appropriate by some groups in the community. It may not be as widely publicised as some groups would want it to be. The view in our group was to have a wide distribution of material to ensure that everybody who needed it could have access.

The CHAIR (Hon Fred Chaney): Michelle, having heard that explanation, do you wish to proceed with that amendment? You are perfectly at liberty to do so.

Ms ROSENBERG: The reason we came up with “appropriately” was the fact that as we have seen in the past four days the media chooses what they want to put in the newspaper. I do not know whether some of the stuff that has been in the paper regarding drugs - or even in the media in general - has been appropriate. It is widely publicised, but is it appropriate that it needs to be in the paper?

The CHAIR (Hon Fred Chaney): My understanding of this part of the resolution is that it is the obligation on government to publicise and not the media coverage. I think this recommendation relates to the Government’s obligation to make the service known.

Ms ROSENBERG : All right.

The CHAIR (Hon Fred Chaney): I think that is a different point. Michelle, are you happy to withdraw that amendment?

Ms ROSENBERG: As long as my seconder is happy.

Ms RUSSO: Yes.

The CHAIR (Hon Fred Chaney): If any mover or seconder wants, it is entirely okay to push on with an amendment. I am simply trying to facilitate the spirit of the meeting.

The CHAIR (Hon Fred Chaney): Elena has moved after “CALD” the addition of the words “and queer”, so the recommendation would read “CALD and queer issues.” Would you like to speak to that, Elena, so that the group may have your views?

Ms JEFFREYS: The slogan of the National Union of Students sexuality department campaign is, “In some countries they kill their young, queer kids; in Australia we let them kill themselves.” This is a sad reflection on the enormous rate of youth suicide that has been attributed to sexuality, especially in rural and regional Australia. Homophobia contributes to high-risk behaviour. Prejudice, lack of role models and no comprehensive education on sexuality, apart from heterosexuality, play a huge role in the identity crises that many young people go through. It is no surprise that young people are picking up drug habits and developing drug problems. For this reason it is important to include a recognition of queer issues in this motion.

Evidence shows that information is not targeted at young, queer people. Services not catering for them can be a barrier for queer people entering rehabilitation. If people would like further reading on that, Dr Rob Cover from Melbourne University has recently released the results of a study about queer identity and suicide. It makes specific links between suicide and the time young people are developing their sexual identity. At that time, they are most vulnerable to picking up drugs and developing drug problems. That is why helping queer people and their families deal with these issues will make a real difference.

The CHAIR (Hon Fred Chaney): As seconder, Ali, would you like to speak to that motion or reserve your right to speak?

Dr MARSH: I will reserve my right to speak.

Mr DREWETT: I am deputy mayor of probably the most diverse town in this State, Vincent. I find the word “queer” totally offensive and derogatory to the gay and lesbian community. I have

many friends in those communities. We should not be labelling them queer. I have a personal friend who is an openly gay male. He likes to be referred to as such. He does not like to be called queer. In this instance, we must recognise those people in our community. They are members of our community who offer a wide range of benefits to our community. If we are to recognise them, let us recognise them with a name with which they wish to be recognised.

Mr TAN: Maybe a better way of putting it, which perhaps will not offend anyone, would be by the use of the words “and sexuality issues”. That would remove any stigma.

The CHAIR (Hon Fred Chaney): I was talking to someone over lunch about the difficulties with terminology in many of these areas, including the areas of disability, changing attitudes and importance of the attitude of people who are being described. I do not pretend to know what the position is and I do not wish to put a view forward on it from the Chair. However, if delegates can think of a word which is satisfactory and which would leave us with the issue of substance rather than the terminology, I would appreciate it because it would be helpful to the summit. I do not think that what has been said is against the spirit of what you are trying to do, Elena, but is rather expressing concern that it may give offence to some elements of the gay community.

The CHAIR (Hon Fred Chaney): Are you happy to have “sexuality issues”, which was Christopher’s suggestion? I am not sticking to strict standing orders as it seems to me to not be a problem of substance, only a problem of expression.

Ms JEFFREYS: Can we include “gender and sexuality”?

The CHAIR (Hon Fred Chaney): The movers have suggested that the words “gender and sexuality issues” be inserted. It seems to me that it is not going to the substance of what has been moved, but to its expression. Is there any objection to that? If not, that is the amendment. I have not asked the group whether it is acceptable.

Mr WATKINS: One idea about terminology, although not necessarily about substance, could be the term “gender identity”. It covers all the issues.

The CHAIR (Hon Fred Chaney): Another comment in relation to descriptions - “gender entity”. Has the working group had a chance to consider its attitude to the amendment?

Mr LYNCH: We do not have a problem in principle with the term “gender and sexuality”. We are concerned about how many groups we have to continue to put in. In principle, we do not have a problem with that. We are worried about excluding other groups. “Gender and sexuality” is accepted.

The CHAIR (Hon Fred Chaney): I encourage the summit delegates to not be too hung up on matters of fine detail as against matters of substance. Where there are matters of substance, everyone is entitled to be very hung up.

Mr EGGINGTON: I suspect this situation will come up repeatedly whenever there are lists in various recommendations. It would be unfortunate if we adopted an ad hoc approach to this question. I am concerned that this list can expand. The disability question could easily be raised here and would have just as much claim - probably more in terms of the percentage of the population - to be acknowledged. Religious questions could also be raised that cannot be subsumed under the acronym CALD. The group that worked on this recommendation, in the context of the intense thought they put into it, thought to highlight two particular matters - indigenous and CALD. Unless there is a very pressing case to be made as there was, for example, by Danny in relation to Aboriginal children and separation - and a particular minority group is intensely affected by a point at issue - I have great concerns about us endlessly expanding lists.

Dr MARSH: Eleanor explained that there are enormously high suicide rates among young people with those issues. There is a particular issue to be made in this instance. It is the same with

indigenous people. They have enormously high rates of death among their young people. This issue is extremely important in this context.

The CHAIR (Hon Fred Chaney): I have been assuming that the amendment was to go at the end of the recommendation. It may be that it is meant to go where there are brackets - halfway down. I am advised that is where it is meant to go. A number of viewpoints have been put and the group is still conferring. After having those two exchanges, I would like clarification of its position.

Ms MILLER: As some resolutions will be passed tomorrow, I wondered whether it would be useful to have a small group of people meet overnight and consider how we could put a proposal to the summit to make sure that we include people in the relevant times. Otherwise, as Richard said, we may have this debate on every issue. The debate started when group 9 gave its presentation and it is still continuing. None of us wants to exclude people and we recognise there is a need to include people in specific areas. Would it be possible to form a discussion group of the chairs from each working group, or other people who would be happy to be involved in that discussion?

The CHAIR (Hon Fred Chaney): I will be happy to accept the proposal that a group be formed of the chairpersons from the working groups if it were the will of the summit. Before these resolutions were put, I was about to make the point that I thought that the chairman of working group 2 made a most useful introduction that referred to the broader family. Putting aside for the moment the issues related to gender and so on, which I accept are important to many delegates, the notion that the drug problem affects siblings, parents and grandparents seemed to be an important part of that group's presentation, which is not fully reflected in the recommendations. I know that everything was done under time constraints, but there is grounds to believe that these issues will be repetitive and that we may usefully address them quickly. Is there a sense within the summit that that would be useful? Rosemary Miller suggested that the chairs might consider the issues to avoid us doing this on a sequential basis.

Mr EASTWOOD: By definition, listing different groups of people who should be considered in our deliberations leaves out others. It is like having a bill of rights; once those rights are listed, people debate what has not been included. We have tried to make these recommendations general so that it is possible to apply them across the board to everyone in our community. Once we introduce lists of different groups in our society that have not been included, we could go on forever. As has been mentioned by members in our group, there is a high suicide rate among disabled people and other groups including the elderly and people in the country. We are making a rod for our own backs if we keep doing this.

Mr MACKAAY: I wonder whether we could have a preamble ahead of the entire set of recommendations, which refers to these issues, that could be crafted by some or all of the group chairs.

The CHAIR (Hon Fred Chaney): In the interests of the rules that were adopted this evening, I will proceed to deal with these recommendations as they are. We will have to deal with Elena Jeffreys' proposed amendment, which is in slightly different form than it was originally. In terms of the practices we have adopted, there are a series of papers on which recommendations could be made. If some delegates wish to work on an overall statement, the chairs of the working groups will cooperate. However, I think that is a matter for the delegates, and not a matter for the direction of the Chair.

I thought the chair of the working groups said that they would accept this addition; however, as it is entitled to do, the work group has not expressed a unanimous opinion. What is the position that we should adopt for the working groups? I refer only to Elena's proposed amendment.

Mr LYNCH: As I understand it, working group 2 acknowledges the intent of the amendments, but I think there was some concern about excluding other possible groups. It should go to the floor.

The CHAIR (Hon Fred Chaney): In those circumstances, I will put that to the vote because we are running out of time, otherwise it would not be put. All those in favour of inserting in that brackets section reference to culturally and linguistically diverse gender and sexuality issues please raise your hand. We have dealt with a substantial number of amendments, including some of real substance. Those against, raise their hands. The result is 67 in favour and 33 against.

Amendment agreed to.

The CHAIR (Hon Fred Chaney): The motion is now amended. Of course, it is not carried; it will be put in a few moments. Does the group wish to exercise any right to further comment on the resolutions before they are put?

Mr LYNCH: I commend these recommendations to the summit. We must do as much as possible to ensure that the Government and the community realise the impacts that drug use has on the wider family of the drug user, particularly on children, parents, grandparents and siblings. By agreeing to these recommendations, we can ensure that message is heard.

The CHAIR (Hon Fred Chaney): I ask delegates to tick the relevant box. If delegates are abstaining, they should not tick any box. Some people are drawing a line as opposed to a tick. It is being treated as a formal vote, but we ask that delegates tick the appropriate box. If they wish to abstain, they should follow the alternate process.

A point of order has been raised, and I am not sure I have it absolutely clear. I understand that what was on the screen when delegates voted by show of hands was “gender identity and sexuality”. In fact, in the course of debate, the word “identity” was removed. It should have read “gender and sexuality”. Because I cannot see what is on the screen behind me, it is a little difficult. I still seek clarification. I have no recollection of the word “identity” being inserted.

Dr MARSH: It actually read “and gender identity and sexuality issues”.

Ms JEFFREYS: When you read it, Mr Chairman, it read “gender and sexuality”.

Mr TAN: When we voted on the amendment, it did not say “gender identity”.

DELEGATES: Yes, it did.

Mr TAN: Okay, I am sorry.

The CHAIR (Hon Fred Chaney): If it was on the screen, I rule that that is what delegates voted on. Will delegates please cast their votes. Are all votes in? We want no voting scandals!

Mr MEOTTI: I have a point of order. I was under the impression that we would get the results from previous sessions -

The CHAIR (Hon Fred Chaney): Would you stop taking the words out of my mouth, Jason?

Mr MEOTTI: I am sorry. I thought we would get those results before we voted on the next round; that is all.

The CHAIR (Hon Fred Chaney): No. The voting on the recommendations of working group 1, “Young people and illicit drug use” was that in each case 97 people voted. On recommendation 1, the voting was 94 yes; 2 no; 1 abstention. On recommendation 2, the voting was 96 yes; 1 no. On recommendation 3, the voting was 96 yes; 1 no. On recommendation 4, the voting was 96 yes; 1 no. On recommendation 5, the voting was 95 yes; 2 no.

I thank delegates for not only the discipline they have shown but also their goodwill in permitting some flexibility. I want to emphasise that tomorrow we will have a couple of issues on which there are likely to be strong feelings. We will need to follow a strict order of debate to reach a conclusion on them. The co-chairs and I are really grateful for the spirit in which the discussion has been conducted. We will endeavour to deal with those difficult issues in the same spirit and to allow such flexibility as will enable the true will of the summit to be evidenced.

I ask the chairs to have a brief meeting with the summit chairs - not nearly as long as previously. Those papers that delegates did not have are available in the morning tea area.

I remind delegates that there is a staggered series of times for the submission of amendments. That has been done, as I said before, to maximise delegates' opportunity for input. For working group 3, the time limit is 5.30 this afternoon, so those delegates who wish to submit amendments to working group 3 need to do that before they go home this afternoon. For working groups 4 and 5, the time limit is 9.00 am tomorrow, so delegates should attend to that early. The time limit for the remaining three groups is noon tomorrow. The summit will resume at 9.00 am tomorrow, so delegates will need to come in a bit earlier if they wish to put in amendments for those various groups.

Does anyone wish to raise anything before we leave at an earlier time than was anticipated? If not, I declare the summit adjourned until nine o'clock tomorrow morning.

Summit adjourned at 5.05 pm