COMMUNITY DRUG SUMMIT

HELD AT PARLIAMENT HOUSE
PERTH

TUESDAY, 14 AUGUST 2001

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Summit met at 8.30 am.

The CHAIR (Professor Liz Harman): Welcome delegates to the second day of the summit. We have an opportunity in the next 30 minutes to hear from some of you. You will recall last night that Mr Chaney announced six names of people who had asked to speak this morning. Through no fault of their own, two additional yellow slips came forward after that announcement. They had in fact been handed in on time but in the process of coming through staff, they did not get to us on time. As a result, we do not want to disadvantage those two people - Pam McKenna and Elena Jeffreys. I therefore ask all eight of the now nominated delegates to speak this morning for a maximum of four, not five, minutes and preferably a little less, if possible, for us to complete the 30 minute session in time. While they are gathering their thoughts, I shall deal with a couple of other matters.

We may have some difficulties in accommodating every speaker if we treat the right of reply in these morning sessions as an opportunity for open debate. As a result, we have had a series of discussions. The main opportunities for debate at this stage in the summit are in your working groups where the various points of view are now emerging. They will also occur later on Thursday and Friday when we come to the main debates on voting and recommendations. At this stage, we suggest that the right of reply in these early morning sessions be limited to delegates who need to correct statements made about themselves or their agency services or factual errors of the type with which the scientific advisers might also be able to assist us. If a delegate wishes to have a right of reply to any of the statements made this morning, could they please let one of **The CHAIR**s know after the session and we will arrange for it later in the day. I now call on Malcolm Smith on strengthening what works.

SMITH, MR MALCOLM,
Executive Director, Teen Challenge.

Mr SMITH: Teen Challenge is the largest youth drug rehabilitation program in Western Australia. We have more than 315 centres in 65 different nations of the world. We help young people get out of the drug scene.

I will talk about strengthening what works. We often want to find new methods that work, and we spend a lot of money on trials and testing to find something new. However, we must also look at what works, and strengthen those things. Teen Challenge is part of the Western Australian Network of Alcohol and Other Drug Agencies, the peak body of non-government agencies. WANADA works. On the basis of dollars spent, it looks after more young people and families than other organisations. We need to strengthen WANADA.

We must also strengthen the fences at the top of the cliff. Teen Challenge deals with the young people who fall over the top of the cliff. We need to strengthen the fences at the top of the cliff that prevent our children from falling over and hurting themselves at the bottom. Those fences are the laws of our land. We need to strengthen, not weaken, the fences at the top of the cliff. If we weaken those fences, more children will fall over and hurt themselves. We need boundaries, absolutes and signposts so that our young people can see the clear and present dangers. We need to not weaken, but strengthen, these things. I would much rather that a child had a brush with the law early in his drug entrapment stage than pressed on with the drug scene and ended up suffering from serious mental or emotional problems, cancer of the throat, long-term imprisonment, overdose or death. It is preferable that our young people have an encounter with the fences at the top of the cliff that are designed to protect them and give them an understanding of the dangers of the drug scene; that is, have that little brush with the law. Let us strengthen the fences at the top of the cliff and help protect our young people. If we do not, the enemy will be at the door.

I have been to Portugal, Amsterdam and Lisbon on a couple of occasions. Portugal opened the door a little; now it has opened the door completely. I have been to Lisbon, and seen where, under the great freeways next to the railway tunnel where the needle exchange bus gives out needles, the kids walk around with needles in their arms and legs and defecate on the ground. The Government has built toilets and showers for them, but they do not use them. They just get off their faces. The Portuguese Government opened the door. When the enemy was at the gate, it opened the door and let that enemy come in and create real harm.

Rehabilitation works; it helps young people. Many young people who come to Teen Challenge say they do not want free heroin, free needles or free methadone; they just want to be free. They say, "I want to get my life back together, I want my dreams back, I want my family back, I want my health back. I do not want all these free things." They want their dreams back; they just want to be free.

I have a dream. I want our young people, who were born free, to say no to drugs and stay free. I have a dream that, with our collective help, the young people who have become trapped in the drug scene will be able to walk free again. I have a dream that the young people we are able to set free will be restored to their mums and dads. I have a dream that, with our combined expertise, we will make a great impact on our young people and either keep them free or set them free from the drug scene here in Western Australia.

The CHAIR (Professor Liz Harman): Adrian Hinds will speak on cannabis for medication.

HINDS, MR ADRIAN,
Delegate.

Mr HINDS: The motion is that the Western Australian Government urge the Commonwealth Government to supply cannabinoid medication for strictly defined purposes, through the administration and distribution system used for the pharmaceutical benefits scheme.

We were asked to be innovative. It appears to me that a core of patients are not helped by conventional medication. A baffled doctor will tell a desperate patient to go home and grow cannabis. This is prehistoric medicine. The doctor does not tell me that I have a heart condition that needs digitalis and to go home and grow foxgloves. He gives me digoxin tablets. The proposal is to supply pharmaceutical-grade products through well-developed and proven existing channels. The drugs would contain no particulate matter, no toxic gases, no bug killer and no weedicide or herbicide. It is not a month's supply of roll-your-own for $3.50 and it is not a get-rich-quick scheme for my industry. The market would be small and the product defined as a medicine of last resort. The scheme will fit the system to the patient and not vice versa. In another context last night, Josie Maxted and I discussed patients who do not fit the system.

Both the United States and the United Kingdom allow the supply of cannabanoids in a limited manner. The US supplies marinol - a herbal extract - in a capsule for the treatment of multiple sclerosis and refractory nausea and vomiting that results from chemotherapy - not things people would volunteer to experience. The UK supplies nabilone, a synthetic product. I do not know what it is used to treat. Nabilone is not marketed in Australia but has occasionally been imported for special use. This information was obtained from the national prescribing service last week, but it relates to 1992. It is stated that there is not much interest on the part of oncologists, the results are equivocal and it is a hassle to obtain. I understand that no-one bothers much about it. However, Dr Chesher, a Sydney pharmacologist, has stated that cannabanoids possess potentially therapeutic properties and that the future is likely to be in synthetic versions. One of the problems in the past has been that, because of the shady reputation of cannabis, research funds have been difficult to obtain. However, research continues. An article in the July edition of *New Scientist* states that the

Commonwealth University of Richmond, Virginia, has produced an optimistic report on research into separating the medicinal effects from the other effects. We should accept cannabanoids into our normal systems for the benefit of appropriate patients, to demythologise a demon and to get on with the developmental research to measure interactions with other drugs. I have precautionary and advisory labels for alcohol, milk or antacids and grapefruit, but I do not have one that refers to mixing with cannabis.

The pharmaceutical benefits scheme can handle it - it distributes over $30 billion of product and it readily deals with the derivatives of opium and dexamphetamines. The Commonwealth Government controls the pricing structure and the drug does not need to be subsidised - price recovery is one of its principles. The authority system tightly targets the medication to particular diseases. My industry supplies monthly reports to state and federal Governments on throughput of product. I will leave the debate about the choice of active ingredients, target treatments and treatment systems to the experts. The proposal probably does not fit the preferred model of commonwealth regulatory bodies, but perhaps they could be a little innovative.

The CHAIR (Professor Liz Harman): Mr Hinds indicated that he was moving a motion. We are not accepting motions from the floor at this point. We accept that as a statement in the spirit of the plenary session.

Ms ADAMS: I am a country delegate from Kojonup. I am speaking today to remind delegates that we have an overall problem. I ask everyone to speak to delegates from the rural areas. There are 28 of us here and we have extensive expertise and experience. It is important that that be used in formulating the recommendations.

The minister spoke yesterday about the diversity of Western Australia. It is a huge area that is geographically different, but we face the same problems. Alcohol is our major problem and it has unfortunately led to illicit drug use. The use of amphetamines is rampant. Our communities do not know how to handle them. Everyone knows everyone else in small rural communities. You can go to any community and they can tell you who the dealers are, they can tell you who the people are who are on drugs, but they do not want to be involved because of the fear of retribution. This is our biggest problem. Somehow as a conference we have to overcome this. Our interagency services - health, police and education - are working very, very well. We have some terrific examples. Do not reinvent the wheel; talk to the delegates, and I am sure you will be amazed. These things can be adapted to the metropolitan area; in a way, I think the country can lead. We need representation probably more than we ever have and especially from the powers that make the rules. It is very important. We have technology but we are very isolated.

I will give a quick example of the town I live in. We have a lot of aggressive behaviour with our people attending accident emergencies involving drug-affected or drug-related problems. These people have to be shipped off to Perth. We cannot deal with them in a small hospital that has a 2 x 2 x 2 roster. We have enrolled nurses on at night. We are having a terrible time keeping people in the regional and rural hospitals for this reason: they are not prepared to put up with the abuse that they receive. If an ambulance has to go from Kojonup, it takes two volunteer ambulance drivers, it requires a solo practice GP usually if it is someone who really needs their help, or maybe a health service manager as well, so that is four people on an eight-hour round trip - this usually happens at one or two in the morning - who then have to turn around and do their normal day jobs. These are the issues we are facing.

The other thing is the elderly. I cannot leave them out. A large number of elderly people are moving to the rural areas, but the problem is that they have moved away from the crime scene. They are now petrified to go out at night after five o'clock, so their social interaction in the evenings is really being diminished. Our rural delegates can come up with a lot of issues, so please listen to them. Thank you.

LOVETT, MR TONY,
Delegate.

Mr LOVETT: I would like everyone during their deliberations to come up with recommendations and keep in mind what I raised yesterday, and that is the issue of drugs and alcohol in the workplace, because from my point of view that is a major issue but unfortunately it has not been part of one of the discussion papers. I have unfortunately been in a situation where I have had to go and address the families of people who have lost their lives on the job. I do not say it is directly due to drugs, but a number of other circumstances, although drugs and alcohol are big players in accidents and deaths and all injuries at this time. To give delegates some idea, WorkSafe WA says that a truck driver who drives, for argument's sake, a pine tip truck from Manjimup to WESFI in Welshpool is not supposed to drive any more than five hours without a break. I can tell you now that there are guys out there doing 14 hours a day, and when you see them come into the yard at two o'clock in the morning, glazy eyed and all the fruit, you certainly realise it is not just because they have been up all night. All I ask is that while you are discussing your issues you keep in the back of your mind what happens in the workplace and the social ramifications.

The other thing I have spoken to a number of delegates about is that when a man or a woman is working 12 hours a day and they get home, they do not have the time for the normal social interaction and the quality of life that they should have with their children, and that is one of the big impacts when it comes to the issues we are discussing.

RUSSELL-BROWN, MS ANNE,
Delegate.

Ms RUSSELL-BROWN: I want to speak with delegates today about the particular issues facing young people and my comments will be based on the experiences and practices of my organisation, Mission Australia, which is working with adolescent drug users through the Yirra program and the On Track program. We work with young people up to the age of 18, so here I am speaking more about adolescents than the World Health Organisation's definition of young people to 25. My main thrust this morning is to encourage you to not throw away some of the treatment options that are already available and to perhaps highlight what we know already works and to think about things that could be done a little better.

Our organisation, like Malcolm Smith's, is a member of the Western Australian Network of Alcohol and Other Drug Agencies, which is an important peak body for making sure that agencies are well coordinated. There would be no disagreement that the issues confronting young people are significantly different from those confronting the adult population. Adolescents are particularly vulnerable to their environment, which has a significant impact on their relationships with their families and their access to support services. The problems they confront are multifaceted and include legal, family, health and financial issues. This means that strategies and programs designed to assist young people must be holistic in their approach, and recognise that each aspect is important in its contribution to the success of any treatment. From dealing with young people, we know that some of the things that work are therapeutic relationships - sound, warm relationships - that convey respect, understanding, acceptance, commitment to change and a corrective interpersonal experience. It is important to remember that such strategies and programs require the input of young people in both their design and implementation.

It is interesting to note, from the experience of my organisation, that there is very little difference in the effectiveness of service outcomes between those young people who are coerced into treatment services and those who volunteer. It is a reality for most young people under 18 years of age that even if they claim to be voluntary patients, they have been in some way coerced by family members or other social institutions, because they do not have that much control over their own lives. In saying that we know current treatment options work, we need to acknowledge that because drugs are still a problem there is a perception within the community that current strategies have failed.

Many of the programs that are available are still to be properly evaluated, and they suffer from either inadequate funding or from a patchwork of funding that makes compliance costs of maintaining that funding extremely difficult and makes insecurity of funding a reality. Obviously we need to establish and maintain a continuing overarching strategy that reviews funding levels, looks at such things as competitive tendering and its viability, and assists with compliance for agencies that are meeting the needs of these young people. Much of this is currently in place, so it is really a matter of finetuning rather than revolutionising. This means that current service providers - including my own agency - will have to accept some previously unpalatable remedies. We need to be more accountable and to ensure that the general community knows that we are available. We need, perhaps, to look at something like a code of practice or series of criteria for the delivery of treatment services.

The fight against drugs has developed into not only a battle against the substances, but also a campaign that in order to be successful must acknowledge the need for a set of measures that promote confidence in the sector that is working with our most vulnerable young people.

The CHAIR (Professor Liz Harman): Pam McKenna will speak on "Don't throw out the baby with the bath water."

McKENNA, MS PAM,
Delegate.

Ms McKENNA: My presentation also had the "what works" title but there were too many of them.

Dr Bill Saunders referred yesterday to the framework that was already in place, and I thought that many delegates would be unaware of what services are out there. Although I will not speak in detail, I want to touch on that issue. I am director of Palmerston Association, which provides services from the Albany office covering the great southern region, and from the Mandurah, Rockingham, Kwinana and Fremantle offices covering the south metropolitan area. We have a residential program at Wellard, and our head office is in Northbridge. We are also joint venture partners with Cyrenian House Drug Rehabilitation in the Perth community drug service team at East Perth. However, it is in my role as President of WANADA - twice mentioned already; it is not a conspiracy, honestly - that I want to respond to the concerns that there is nothing out there and the implication that we are starting from scratch. Firstly, I acknowledge that for regional people it is quite likely there is nothing out there and also for people with particular issues. We must look at that in order to develop the best response. However, there are quite a number of great services out there. They are staffed by competent, qualified and committed people who are often underpaid for that work. Those staff are working effectively with amphetamine users in many places. They are working with complex cases every day. People ring up and want to see someone. We do not ask how complicated their case is and whether we should refer them on. Of course, we talk to them. We do not work with drug use only but the whole person and whatever that person brings to the agency.

Non-government services have very sound relationships with each other. A great network is in place. Western Australian Network of Alcohol and Other Drug Agencies is doing that for us. However, we are not perfect. We have 12 community drug service teams across the State, six non-government agencies, 163 residential beds for rehabilitation, plus 10 smaller agencies with specialist services.

We are concerned about a number of gaps and areas that we would like to talk about. The linking of clients across sectors has come up in almost every issue. We would like to see the reintegration or even integration of clients from treatment, including that in prisons, into housing, vocational education and employment; youth-dedicated respite, detoxification and residential care services, and an increase in service options for Aboriginal people. We would like to see the expansion across the State of home-based detoxification services, such as that which St John of God is providing in its pilot project, which is about to run out of funding. We would like the services we offer marketed in such a way that people do feel there is something out there for them. How do we let families who have lost somebody through drug use know that the Palmerston Association is running a bereavement group? They are very difficult to target. We need adequate resourcing for all that we do and for any new initiatives that may come out of this Drug Summit. My list is longer but I want people to stay focused.

JEFFREYS, MS ELENA,
Delegate.

Ms JEFFREYS: As I mentioned yesterday, I have been a drug user for 10 years. I want to challenge some of the points that have been raised, especially those raised this morning by Malcolm Smith of Teen Challenge. People do not have to travel anywhere to see people who are street present and drug users. It is happening in this city. That is why we are here.

When people say that a brush with the law will somehow stop people from drug use, I want to tell people what a brush with the law involves. At the very young age of 19 I was picked up for baking a space cake. I was done for sell and supply, sell and supply, sell and supply, sell and supply, possession with intent to sell, possession, and possession of an implement. This was not just a bump with the law. The police come, grab you and harass you. They search your house and your bag. They take you off in a police car. They take your clothes off, search your cavities, harass you and ask you where you got your marijuana. They want you to dob in all of your friends. When you do not, they keep you there, keep you there and keep you there. You have to rely on someone - anyone on an income - who is prepared to sign for your bail to get you out of the police station. You suffer humiliation, isolation, total denigration, treatment as a second-class citizen, as the cause of problems in society. You suffer victimisation, by not only the police, who are merely doing their job, but also everybody in society, because your criminal record does not go away. A brush with the law is not just an event. It stays with you forever. For the rest of your life you take it with you. It severely tarnishes your decisions.

Why would people move away from a drug-using scene when they have an arm-long list of police charges and no-one in the straight community would want to know them anyway? That perception of drug users is put forward by the mainstream media and some of the underlying currents in this room. If we are to make progress this week, we must not consider drug users as "other people" and realise that we are all drug users; I refer, for example, to the alcohol that was consumed last night. We all tolerate drug use and it is important that we recognise that. On Wednesday and Friday on the steps of Parliament House, drug users will speak out about their experiences. If this summit is committed to change the future of the drug situation in Western Australia, I urge all delegates to listen to the experiences of drug users. Over five days at this summit, we will not have heard

enough from people who are involved in the drug-using community - it is a community. Many of us would like the laws changed concerning drugs that are currently illegal.

The CHAIR (Professor Liz Harman): I thank all delegates for their superb discipline for being here on time. I call on my co-chair, Jade McSherry.

The CHAIR (Ms Jade McSherry): I welcome all delegates back to day two of the Community Drug Summit. Today we will hear from a number of speakers and I begin by introducing Professor Tim Stockwell. Professor Stockwell is a director of the National Drug Research Institute and he will give his presentation on an overview of prevention. Welcome professor.

STOCKWELL, PROFESSOR TIM,
Director, National Drug Research Institute.

Professor STOCKWELL: Thank you, Madam Chair. Good morning ladies and gentlemen, it is a pleasure to be here this morning for a session dedicated to the topic of prevention of drug use. I will make two main points. First, I urge delegates to take a broad view about what we consider to be prevention. We must look broadly at the objectives of prevention activities and the levels in society in which we implement prevention strategies. As we have heard from several speakers already, we must consider broadly the types of drugs that are the targets of our prevention activities.

Secondly, if we are to implement the most effective range of strategies in Western Australia, we need strong partnerships between practitioners, policymakers, different people who are affected by drug users in the community and also researchers. Along with other research groups here and in other States, the National Drug Research Institute has attempted to forge such partnerships over the years with schools, police, Aboriginal communities, drug users and health authorities in Western Australia and elsewhere. We have come to the simple view that effective prevention involves many people operating at many levels in many spheres of life. Although the science in this difficult area cannot be perfect, because science in an area involving illegal behaviour has its peculiar difficulties, we are beginning to learn what are the effective ingredients that will make some programs more effective. We are also learning about programs that have little effect and others that may even be counterproductive. Collectively, if we can improve our performance in partnership across these different sectors, it will be possible to make a significant impact on the major social, economic, legal and health problems associated with drug use.

I will make some general points about what is prevention in the drug area. This may be a controversial topic. It is important to be clear about basic concepts. I will then raise two questions of the summit that may not otherwise be raised. I will show delegates a slide that shows the traditional classification of prevention of drug use into primary, secondary and tertiary groups but I will not dwell too long on definitions. However, primary prevention involves preventing a problem occurring in the first place; secondary prevention limits the progression; and tertiary prevention limits the adverse consequences once a problem has developed. I suggest that this model works quite well with diseases - the notion perhaps even of dependence, or that vague notion of drug abuse, whatever that is. It does not work very well with the acute episodes of harm, which arguably constitute the most serious harms in society, by which I mean the spread of blood-borne viruses, drug overdose and injuries, intentional or unintentional.

A more contemporary view from mental health is to use a different set of terms - universal, selective, indicative - that really refer to the level of risk of the group being targeted for prevention. Whatever terms we end up using - whatever classification system - we must face one question that is inescapable: what exactly are we trying to prevent? Is it really any use of drugs? Is it risky

patterns of drug use, or is it serious harms associated with drug use? Is it all of those things? I suggest that we cannot define away this problem by saying that it is one way for the legal drugs and another for the illegal drugs. A simple concept, which might straddle these different definitions and which would be helpful, is to consider prevention in relation to the primary focus of reducing drug-related harm across the entire community, by focusing on reducing risky drug use and promoting less risky patterns of use, including abstinence, by promoting low-risk environments and communities. I note here that for certain drugs we will always want to aim for abstinence. Obviously, that will often reflect our legal systems, but not necessarily.

I should also add - I am sure Professor Silburn will illustrate this clearly - that the antecedents of drug use are very important, particularly the most upstream, earliest prevention focusing on childhood factors. The very exciting work on that suggests that there are clear indications of risk and protection in the lives of young people, at a general level and to do with their family relations and their schooling, and that predicts a whole thrust of problem behaviours, including risky sex, aggression, conduct disorders, smoking, excess alcohol use and use of other drugs.

Some encouraging results from intervention studies suggest that the incidence of these problems in adolescence can be delayed or reduced through targeting some of these risk factors and developing resilience in young children to overcome risk factors. However, although we need excitement and enthusiasm in this area, we must be cautioned, because the results are based mainly on North American research. They are outcome measures in terms of drug use rather than problematic drug use. They are totally silent on the issue of drug-related harm. In fact, the results have been quite mixed. We urgently need model Australian demonstration projects to examine this issue to find out whether there are peculiar clusters or antecedents of drug use that will predict particularly problematic patterns rather than just use. For one thing, we know that experimental drug use rarely escalates into more serious forms of drug use. It is not sufficient to evaluate the effectiveness of our programs by using that as the only yardstick. We must look at risky patterns and actual levels of harm.

One of the models of prevention by which the National Drug Research Institute has been particularly influenced is the systems model of prevention, which was first introduced by Harold Holder, who was formerly the Director of the Prevention Research Centre in Berkeley, California. Essentially, this model identifies the many layers, areas and subsystems of society that impact on drug use and its consequences. In particular, actions in one subsystem may affect another. There are some examples whereby activities in the law enforcement sector have different repercussions on the treatment sector. Activities in the treatment sector can influence the wider levels of drug-related harm in society.

Recent research in New South Wales suggests that contact with drug law enforcement may have some positive outcomes for drug users; for example, they are more likely to enter methadone treatment. However, it may also be associated with riskier patterns of use. Therefore, we need to get the balance right.

There is evidence from the alcohol treatment area that the greater the money invested in treatment services the lower the community level of problems. We know with regard to illicit drug programs that if more money is invested in methadone programs, it will have beneficial impacts at the local level on property and other drug-related crimes. Therefore, we need to think broadly about how the different systems in society intersect with each other.

The systems view identifies the many different levels, from international treaty, national drug laws and jurisdictional issues down to the local community, schools, workplaces, families and individual drug users. It is important that consistency operates across and between the different levels, because there are many examples of how different types of intervention can contradict each other and thereby minimise the optimal prevention that society might achieve. I will illustrate some of

these levels of operation and prevention with some examples drawn from current and recent research at NDRI. Later this week, we will present research on legal options for cannabis.

I make no apology for also mentioning some alcohol prevention strategies; for example, alcohol policy in relation to taxation, and hours of trading of licensed premises. One of our strengths is developing national, regional and local indicators of levels of risky use and harm; the regulation of licensed premises in Aboriginal communities; school-based drug and alcohol programs which are focused on harm minimisation as well as drug use; the management of rave parties; individual injecting practices to prevent the transmission of blood-borne viruses; and examining the wider availability of Narcan among drug users as a means of getting better responses to overdose cases. With regard to the latter, we should not overlook the fact that alcohol and benzodiazepines contribute greatly to the likelihood of heroin overdoses. The issue of alcoholic poisoning and overdose is greatly overlooked. A recent survey suggests that 86 per cent of university students had seen one of their fellow students lose consciousness from drinking too much, and in most cases those students were left to sleep it off. Similar issues exist across legal and illegal drugs with regard to priorities for harm minimisation.

The first question that I raise in that context is: what can we do to introduce harm minimisation to young people and in schools? That is a vexed issue, and people have a real concern that by talking about drug use and harm minimisation we may be encouraging drug use. That concern must be addressed. However, teachers have a demand for this kind of education. They know that many of their students are already using drugs, particularly cannabis, and perhaps ecstasy. We cannot ignore that; the problem will not go away. We have successful examples of harm minimisation projects in schools with regard to alcohol. The school health and harm reduction project conducted by my colleagues Richard Midford and Fiona Farringdon was able to demonstrate reductions in risky alcohol use and in experience of alcohol-related harm, at an estimated cost of $12 per student per year. We are looking at partners in order to trial this approach, with schools looking at perhaps cannabis to begin with, but we recognise that it is a tricky area and we need good research to look at the benefits and costs of such an approach.

The next issue I raise is the reporting by the media of drug issues. This picture from last week's *The West Australian* will be familiar to delegates. Do we need a code of conduct for how drug issues are reported? Is there not great potential for the media to glamorise and model how people do drugs and where they can find them? Is there not also an opportunity for constructive harm minimisation advice to be promulgated effectively through accurate reporting? There are excellent examples and precedents in this area with suicide prevention guidelines for the media and in the reporting of Aboriginal offending. The summit should give attention to these points this week.

I will summarise a few key points that I hope delegates will take with them. Prevention must focus on the major harms and risk factors. As well as focusing on drugs and the risks associated, the means of administration and the setting and use of the individual user, we also need to look at the antecedents of drug use and the wider regulatory legislative and cultural environment. We need consistent and complementary intervention across the entire community and many sectors. We need intervention of proven cost effectiveness. An area we fall down on, time and again, is the timely monitoring of risk behaviour - not just drug use - and actual levels of harm. We need to be able to look at the net effects of our collective efforts to prevent drug and alcohol problems.

The National Drug Research Institute is currently working on two major reviews of what works in the area of prevention. Looking across the wide spectrum of activity I have indicated, the work is being done in conjunction with the World Health Organisation and the intergovernmental committee on drugs. We hope to have the product of the research available in the next 12 months and we hope the continuing efforts in this State to improve and rejuvenate our drug policies will be able to draw upon some of the work that is underway at the National Drug Research Institute. I wish all delegates well and I thank you for the opportunity to speak.

The CHAIR (Ms Jade McSherry): Speakers should be aware that the microphone is in the middle of the table. In order for people at the back of the Chamber to hear, speakers will have to focus their voice toward the centre of the table.

The next speaker is Professor Sven Silburn, deputy director, TVW Telethon Institute of Child Health Research. Professor Silburn will speak on the topic of "Promoting Young People's Health and Wellbeing Using Prevention and Early Intervention Strategies".

SILBURN, PROFESSOR SVEN,
Centre for Development, Curtin University.

Professor SILBURN: For the record, I must state that I am not the deputy director of the TVW Telethon Institute. I think the deputy director would be alarmed if he heard I was. My task is to talk about some of the things that Fiona Stanley presented yesterday and build on some of points about prevention made by Tim Stockwell.

I will talk about three things: why it is imperative for Western Australia to invest in prevention and early intervention; new developments in prevention science; and options for preventing and delaying the onset of drug use and reducing the harm associated with drug misuse.

Why should Western Australia make a greater investment in prevention and early intervention? Our existing clinical approaches face a number of very real limitations. The number of young people with clinically significant mental health and substance use disorders far exceeds the ability of our existing services to assess and treat. We know there are very often problems with compliance in treating substance misuse and that many associated disorders are difficult to treat effectively. The interval between parents seeking help and receiving assistance, particularly at the very early stages of problem development, are considerable. While there are some promising developments, the general efficacy of treatment for conduct-based problems associated with drugs is poor. There are also limitations with our current approach to prevention. Youth, alcohol and cannabis use have almost become "normative". Nearly half of all year 12 students report having used cannabis in the past year. Of more concern is the fact that harmful levels of substance use are commencing at much earlier ages. Current prevention efforts have tended to focus on reducing supply and harm through drug education and treatment, and much less emphasis has been given to demand reduction strategies, as has happened in the United States. It is true to say that there is little effective integration of current prevention that targets the range of associated youth problems. We recently conducted a review looking at the association between illicit drug use and suicide, and it is very clear that increased use of drugs is a major factor driving those increases.

The second theme I wish to talk about is the new developments in prevention science. Over the past decade there has been intensive research around the world directed towards developing an understanding of why an increasing proportion of young people have serious problems with alcohol and drugs. As Professor Stanley outlined yesterday, much more is known of the relative importance of various risk factors that arise during the course of child development and increase the chances of drug and alcohol abuse. Our current efforts to deal with the drug issue are somewhat like providing expensive ambulances at the bottom of a cliff to pick up youngsters who fall off, rather than building a fence at the top to keep them from falling in the first place. Much more is now known about what is needed to build that fence, and understanding the risk factors is probably the most important first step. Equally important, however, is that there are protective factors that can decrease the likelihood of young people developing drug and alcohol abuse problems. It is a question of getting the balance right. Most of the research has been focused on the risk side, but more recently there has been a much more concerted effort to understand the prevention side. We also know that some programs are more effective. When we look at which programs have shown positive results, the ones that work best address known risk factors. They must be able to have an

impact on the target factors, so as to reduce risk, but they must also focus on increasing protective factors. It is important to intervene early, before problems become entrenched, and a community-wide approach seems to be much more effective in avoiding problems of labelling and self-fulfilling prophecies.

There are two broad approaches to prevention. The first is the prevention science model, which tends to begin with identifying a problem, reviewing the information, and looking particularly at the risk and protective factors, and then designing, conducting and analysing pilot studies. Once those have shown promise they tend to then be expanded into larger scale prevention trials, with a very strong emphasis on measuring and understanding the costs and benefits. The process then leads to large-scale, population-wide implementation of processes. In contrast is the community development model, which gives much more emphasis to including the whole community and identifying particularly locally relevant and specific solutions to local problems.

In terms of the risk factors of the youth problems, we have a pretty good idea of what is important, at the community, family and school levels, and also for individuals and the peer group. In terms of the community, we know that communities that are more cohesive, where people feel a stronger sense of affiliation and belonging, have generally lower rates of problems. We know that family dysfunction is strongly related to the emergence of problems that lead to high risks of drug use; and at school, early academic failure, or alienation from or lower commitment to school are also important associated factors. The importance of the peer group in adolescence is critical. There is much more understanding of how that can be addressed, and that early identification of problem behaviour highlights the importance of preventing escalation from an earlier rather than a later stage.

Research conducted in Victoria looking at the community prevalence of the risk factors listed in the previous chart show some interesting findings. Firstly, it is not surprising that the bottom axis of that chart shows the number of risk factors that a young person might be exposed to. The vertical scale of the graph shows the percentage of young people with various problems. The red line reflects alcohol; the purple line, sexual activity; the orange line, marijuana and so on. The graph shows that as the number of risk factors increase, all those problems tend to increase. The risk factors that underlie alcohol and marijuana use are the same risk factors that underlie inappropriate sexual activity, violence and suicide. In a similar way, understanding of protective factors at the community, family, school and individual level has identified some important factors that can be targeted in broad social policies and programs. I will not go through those in detail. Community surveys of adolescents have been carried out in Victoria. They have shown that as the number of protective factors increase, there is a decline in all those problem behaviours.

Professor Fiona Stanley yesterday outlined some risk pathways and made the point that at the downstream end, there is a strong association with and interaction between problems such as depression, alcohol and drug abuse, and suicidal behaviour. Much of our effort has been targeted at the larger circle, outlined on the slide before delegates, which involves the downstream, adolescent period of problems. Much less attention has been paid to the early years of child development. We now know that many of the problems that can be identified in grade 1 or 2 are those which greatly increase the likelihood of subsequent problems, and that something can be done at an early age.

This next slide charts the association between harmful levels of illicit drug use and suicide by showing the percentage of young people in Western Australia in whose blood illicit drugs were detected at time of death from suicide. There has been a substantial increase in that percentage since the mid 1980s.

To stress the importance of parenting, we know that some effective parenting measures make a substantial difference to the likelihood of children continuing to have externalising behaviour problems. These effective parenting measures can be taught to parents. This slide contains data from the Canadian longitudinal survey of children, which has followed children every two years

from the age of four and will continue until those people reach adulthood. Children who started with a similar level of problems at age four were matched with those whose families coincided with theirs in terms of socioeconomic disadvantage and levels of parent education. The only factor that differentiated the two groups - the red line and blue line - was the quality of parenting available to the child. With adequate parenting, there is a steady decline in those problems.

Victoria has invested a substantial amount of money in the "communities that care" model, which is one of the most promising models to come out of the United States. That model focuses on community mobilisation to promote social development. Starting from the premise that the desired outcome is personal success, and to reduce drug use which might impede that outcome, the model examines what can be done to improve the bonding of young people to family, school and community. It promotes those attachments and increases the likelihood that those children will identify with beliefs about what constitutes right and healthy behaviour. To do that opportunities are required for young people to develop positive relationships and the skills that will enable them to be recognised for their contribution to family, school and community, and to reward them when they are. To support that also requires an examination of the norms in the community about opposition to drug use, which means looking at communication within the family, school and community and the messages that young people receive from the earliest age. One of the values of that kind of community-wide approach is that it tends to move the average of what people consider to be acceptable and of levels of substance use.

With prevention targeting whole populations, approaches that are successful in shifting the population distribution of the severity of substance use may require only a small shift in the population mean to make a substantial difference at the right-hand side of the graph, which indicates the proportion who fall above a hypothetical threshold score for being in the clinical range. As Professor Stockwell indicated, prevention is now more recently thought of in terms of indicated, targeted and universal prevention. There are pros and cons to each of those approaches, which I do not have time to consider now.

What are the options for preventing and delaying the onset of drug use and reducing harm? There are a number of promising universal interventions. I mentioned the Communities That Care model and I urge this summit to think about that as a possible option. There are also models in America like Preparing for Drug Free Years, which is a program targeting primary school children that has shown positive benefits in reducing alcohol, smoking and other drug problems. A number of selective intervention programs for people who are already at high risk are showing promising early results in Australia. It is important that we consider the children of substance users. A number of things can be done to target adolescents at early risk of depression. Some of those programs have been shown to be effective in primary schools.

The recommendations that follow from this are: the current drug strategy should be more about more broadly targeted, universal prevention strategies; much must be done to strengthen the links between clinical prevention and promotion services across governments and in partnership with the non-government sector; a substantial investment in training and program delivery resources for prevention is needed; and community education about the association between harmful drug use and increased risk of suicide could be improved. Thank you.

The CHAIR (Ms McSherry): I direct attention now to our next speaker, Mr Bruno Faletti. Mr Faletti is the manager of the Department of Education's school drug education program. He will conduct his presentation on the Western Australian schools drug education project.

FALETTI, MR BRUNO,
Manager, School Drug Education, Department of Education.

Mr FALETTI: I thank both Professor Silburn and Professor Stockwell for setting such fertile ground for this paper. This morning I shall examine the school drug education project in the delivery of early intervention and prevention strategies and the educational context within which that project sits. I mention also that a framework called the principles of best practice has been undertaken across Australia as good practice in drug education. I shall direct delegates to these points in my presentation overview.

I shall mention briefly drug education in the context of our current broader drug strategy; how drug education is implemented, and the look of it in Western Australian schools; the history of the school drug education project; the principles of best practice in drug education; what is currently being done in schools with the school drug education project; a possible future landscape for drug education in our State; and a summary.

Clearly, school drug education fits into what has been described as the prevention and early intervention focus. Although it has been stated this morning that illicit drug use is almost normative in our schools, the latest surveys indicate that in fact 40 per cent of students in secondary schools have experimented with drugs while regular users of cannabis drops down to about 13 per cent. That is a huge difference that I ask delegates to keep in mind when we are talking today. We should not lose sight of the fact that the drugs clearly used by that age group are alcohol, pain killers and tobacco. Research suggests, as has been stated, that early adolescent drug use is associated with an increase in the later risk of drug abuse.

Preventing or delaying the onset of drug use is a worthwhile goal in circumventing future drug-use problems. That is why a prevention/early intervention approach is very worthwhile in a school setting. School drug education sends out a clear non-use message about illicit drugs. We want students to be clear about the social, legal and health consequences of drug use. However, we know - and this also comes from the surveys - that students experiment with illicit drugs, and a small percentage uses illicit drugs on a regular basis. We need a different approach for those students, and to look at strategies that may reduce the risk of problems and harm. It is a complex and tricky problem to address in schools, but we cannot shirk that responsibility. There is no doubt that schools are an ideal setting for many of the health promotion interventions Sven outlined, but we must be cognisant that schools are only part of the picture. The research shows that if drug education is to be effective, it must be an important part of a coordinated approach. This includes initiatives such as parent education, regulatory schemes, public education, social marketing, health service reorientation and general community mobilisation about drug use. In considering the effectiveness of this approach, we need to look no further than the success of some of the long-running state smoking prevention programs and the impact they have had on the prevalence of smoking.

How is drug education implemented in Western Australian schools and what does it look like? The take-home message from this slide is that drug education looks different in different places. That is not necessarily a bad thing. The drug education delivered at Oombulgurri Remote Community School in the north is different from the drug education delivered at Hale School in the metropolitan area and John Calvin School, a church school in Albany. However, we are aware that drug education should embrace a number of basic principles, which I will talk about later. We know from the research that school drug education should be comprehensive and developmentally appropriate and delivered within a health education context. Some of the broader approaches Sven talked about are valid in this circumstance. The teachers, with the support of resources and other people, are the prime deliverers of health and drug education. They have the rapport with the students, the teaching methodology and the chance to follow up. The delegates last night watched an impressive presentation from the Youth For Christ (WA) group, and I endorse that as part of a comprehensive drug education package; however, it is not drug education in itself. We need to

coordinate drug education with outside agencies such as the Police Service, through its GURD program, Life Education Australia and the Health Department. Drug education should have a specific curriculum home, in which certain people in schools are accountable and responsible for teaching it. That is what we consider effective drug education and the way it is implemented in schools. I will talk more about that later.

I provide a potted history of the school drug education project. I am talking about what is already in existence in our State. Delegates and speakers have called for us, in looking forward, to not throw away what works. The school drug education project emerged from the 1995 report on the Task Force on Drug Abuse, which, in one of many recommendations, said that school drug education should be taught in all Western Australian schools. That recommendation was implemented in 1997, and is one of the few truly collaborative projects across Western Australia. It has the support and guidance of the Catholic Education Commission of Western Australia, the Association of Independent Schools and the Education Department. We are a cross-sectoral project; we work across and have the support of all systems and sectors. That is no mean feat. The project is guided by a series of groups - a management group, reference group and task force - which allow the project to consult widely with and receive direction from the community about its needs. We continue to do that regularly.

Our future vision is guided by a three-year strategic plan, which we are halfway through and which will run until 2003, to ensure that the project has a clear goal. The project was recently evaluated by the Curtin University of Technology's Department of Health Promotion. The research found that schools that have been associated with the project throughout the State have implemented the strategies they are exposed to in the training. Things are happening in schools that research has established are effective. The teachers are teaching the things we believe are doing the most good for our students.

The school drug education project was set up to ensure that effective drug education is provided in all Western Australian schools. We work with teachers and schools; we do not work with students. The evaluation found that the strategies we cover with schools and teachers are implemented. A call for more comprehensive research will be encouraged.

How do we know we are providing effective drug education? Research done in this area across Australia in the mid-1990s resulted in the development of principles of best practice - a framework on which schools can hang drug education. Those principles were nationally agreed to and have been taken up by drug educators throughout the country. They are currently being revised by a member of the National Drug Research Institute. There will be refinements, but, in essence, they will remain very much the same. These are the principles we promote in drug education training. Schools are aware of them and, if implemented, they provide the most effective drug education we can provide according to current research and practice.

The principles state that drug education should be taught in the context of an ongoing and developmentally appropriate health curriculum; that is, education appropriate to children at various stages of development. The principles also state that classroom teachers are best qualified to teach drug education using other people and resources as appropriate, inviting input from the community and other agencies. The principles go on to state that we need to teach a combination of the most relevant information and that students should examine attitudes and values - their own and society's - about drug use. They must also develop the social skills to which Professor Silburn referred when discussing protective factors and what we can do. That covers children's decision-making, assertiveness and communication skills, their ability to make and maintain relationships with their peers and how they can set and achieve goals. All of these aspects are taught within a drug education context. The principals tell us that drug education should be based on student needs and the drugs that cause most harm to society. Much of the emphasis in schools is on the legal drugs that cause so much harm in society. Of course, illicit drugs are not ignored.

Finally and very importantly, as stated most eloquently by Professor Silburn, we should look at drug education in the context of a health-promoting school and community. What is said in the classroom should be reflected outside the school, in the home and by the community. We take a holistic approach and encourage that at all times.

The school drug education project is implementing a number of initiatives. We have developed and distributed to all schools a kindergarten to year 12 drug education teacher support package that involves additional teacher training. The package has been picked up by education authorities in South Australia and the Australian Capital Territory and used as a primary focus in schools. It has obviously been well received by teachers and our interstate counterparts.

Our teacher training is central, delivered by a core project team, but we also have regional committees - 16 of them spread throughout the State. I am heartened by the regional people who have said, "Do not forget us", because we have not forgotten them. We have regional committees located in the Pilbara, the Kimberley, down in Albany, in the mid west and the goldfields, and they all provide regional, local, relevant training for schools in that area. As I said, drug issues are very different in the Wingelina remote community school from in the middle of Trinity. So we have committees that work in a very localised way.

We have also encouraged regional drug education networks - and previous delegates have mentioned this - contacts with the police, community drug service teams, local drug action groups, public health units, and other agencies that deliver and support drug education in the region. We have made a concerted effort to ensure that these networks are formed and developed so a very coordinated approach to drug education can occur in those areas.

I now refer to the Leavers Live program. I am heartened to see that Tim Stockwell mentioned the area of alcohol, because in the post-compulsory years it is a big issue, and when students finish year 12 the celebrations on Rottnest, Dunsborough and other places are very well documented. The Leavers Live program looks at trying to minimise the harm that happens when those celebrations occur, both to the community and also to the people partaking in those celebrations. Rottnest 2000 was a very successful intervention.

The last program we are undertaking but a very important one is an early intervention program. Some students' lives are surrounded by drug use. It may not be their drug use; it may be the drug use of their parents, their peers or their siblings. For those people we need an early intervention model and we try to connect those people with services both within the schools and outside of the schools so those people have a point of referral and contact. We also support policy development so that schools are very clear about what action to take should drug use occur in the school.

I will quickly refer to the future landscape. I will start from the bottom. The evaluation of project outcomes: although we have done this in a processed way, we know what goes into the school and reaches the students; we have not done it on a project-wide level and I would endorse any recommendations that help elucidate the directions in which the project should go. We should also look at strengthening our regional capacities, enhancing drug education in the post-compulsory years where it becomes a real problem, examining our approaches to illicit drug use and involving parents in all aspects of drug education.

The CHAIR (Ms Jade McSherry): Our next speaker will be Sandra Collard. She is a parent and a grandparent, and she will be sharing her experiences.

COLLARD, MS SANDRA,
Delegate.

Ms COLLARD: Good morning delegates and a special good morning to my elder. I will share with you an experience I have had as a mother and a grandmother. Life does go on, especially after it is felt that life as we have known it as a close and happy family is suddenly over as we were railroaded on a roller-coaster ride to go nowhere. We were left somewhere in the middle of a real grey area, always shadowed by the unknown of today's outlook on drug and social issues. We had so little faith and trust in a system that did not know our cultural ways, had no idea of who the service providers really were and how they should help us and rescue our injecting drug-using child who was 22 years old.

My son was living in a world of imaginary tales and shadow-boxing. There was no-one else other than him. There was a constant scuffle - yet with whom? He was constantly beating himself up with the use of alcohol and illicit drugs. There seemed to be an everlasting, overwhelming deal of pain that he was trying to confront on his own, and the appalling part about it was that it was slowly starting to destroy the raising of the child we knew he was and the making of him into a person - and that was the person he had to change.

Our son was not diagnosed with an incurable disease, but what happened to him is a big part of reality and life that many families have faced and are now still facing; that is, dealing with drug misuse and as parents trying to help our children and to rebuild our lives. Looking back over the last six or seven years, give or take a few days here and there, his days were filled with drinking and drug use almost every day. Our son was going through bouts of rage and wanting to kill himself. He was angry with himself, at us as a family and the world at large. For the family, life at home was hell, and for him, life was not worth living. The turning point for our son and us as a family surviving on a day-to-day basis was the night that he overdosed through sheer anger and frustration at his life and the pain he had caused us as a family. He, and he alone, had to realise that the path he was on was his choice and not ours, and that until he admitted it, owned it and accepted it as one path of his life, there was nothing we could do as a family to help him overcome his drug misuse.

Our family has always been a close-knit and relatively protective family kinship. When our son turned 18 he was allowed for the first time to go into the city, where he discovered a particular social scene and lifestyle in which alcohol was the in thing. At 20 we noticed his personality, attitude and respect for us as a family change. The nightmare began - a nightmare that lasted four years. It was four years of picking him up off the streets, out of the gutter, and ringing taxis and ambulances to take him to hospital. Our son also had a partner who was a drug user and whose parents were dealers. Their access to drugs and money was easy; they had an easy-rolling lifestyle of drugs and free living.

On the night that changed our son he overdosed and required hospitalisation. I called an ambulance and a family member who was a health worker to help to support me as well as my son as we transported him to hospital. What came next was the healing, and this was the hardest part. It was an experience that I particularly wish to get across.

When our son embarked on his journey of healing we as a family did not know how to do it. We wanted to do it culturally and correctly, so we turned to the Aboriginal Medical Service, the Noongar Alcohol and Substance Abuse Service, Manguri and the Aboriginal Legal Service for information and support. We felt there was very little information available to us about drugs and what to look for. What information was available did not seem to help and was not culturally appropriate. Our son's recovery was a lot harder than just dealing with drugs, for many reasons. There was no culturally appropriate drug rehabilitation service available. We did not know what to do to help our son, and we did not know to whom to turn.

When our son initially sought help we outlined to him that the family was unable to help him unless he wanted to make the change. He had to own it, but we as a family would do it together. We found that mainstream organisations did not understand that they were not working with an individual but with a family. We were often told that the individual is the drug addict and the

services were only for him. The service providers did not want to hear from us as a family. We tried to point out that he was not alone but was part of a family; that we were there to share his problem; that we as a family wanted to fix his problem and we wanted the service providers to help us fix it.

I have only a few seconds left, so I will move to my last point. Such an experience could break down the family, but it brought us closer together. This happened mainly because of our Aboriginal notions, values and beliefs of trust in and understanding of family, and, as we were already a close family, our willingness to share and use the expertise in the family and our Aboriginal community. Unfortunately, I am out of time.

The CHAIR (Ms Jade McSherry): I would like to introduce Tim Harris. He is a sibling of a drug user and he will tell us his story. Welcome, Tim.

HARRIS, MR TIM,
Delegate.

Mr HARRIS: My name is Tim Harris. I have just turned 21. I am the fourth boy of a family of five children. I have a younger sister who is 16. My eldest brother started smoking cannabis 16 years ago when he was 14 and rapidly moved on to using speed by injection; I was five years old. My second brother rapidly followed suit.

I am not sure what age I was when I first became familiar with what was occurring in my family, but I relate agonisingly to the continual chaos. I remember the violence and abusive behaviour that my eldest brother demonstrated - the broken doors, the drug paraphernalia, my mother's grief and sadness, our family's shame at being raided by the drug squad and the massive pain that I experienced as our family unit fragmented and finally fell apart when my parents divorced. I remember feeling many emotions, but I relate mainly to long-term sadness and isolation.

I became a confidante to my brothers and found the secrets very painful. I can remember their coaxing me to experiment. I was around eight when I first tried marijuana. My third brother, Adam, who was three years older than I, was also introduced to drugs by my eldest brother. We idolised our eldest brother. We had been brought up extremely closely and our introduction to drugs so early created a normalcy.

Adam also experimented very early, moved quickly into dependent use of marijuana and then began using amphetamines and heroin. He also created major chaos and violence in our family. There were times when I really hated Adam for what he was doing - the police harassment, the drug squad raids, the brake-lining being slashed on my mother's car, and the continual pain that hung over our family.

When I was 16, Adam died from a heroin overdose. He had just turned 19. The pain was excruciating. I remember the horrendous agony when mum told me Adam was dead, accompanying my family to the state mortuary, having to walk into the viewing room and seeing Adam lying there. My mother encouraged my sister and me to touch him and talk to him. I remember all of us crying. Adam's funeral was the most painful experience. My mother suggested that we all be a part of Adam's celebration of life. I helped organise the music and I was a pallbearer.

After Adam's death, our whole family was thrown into grief. I remember mum suggesting many times for me to go to counselling. I became very depressed and when I was offered meth-amphetamines, it was easier to say yes than no. I became more and more dependent on speed as I became more and more depressed. I found my friends impossible to communicate with. They all

presumed I was over losing Adam and they would not talk about him. People often would ask me how my mum was, but forget that I was really hurting.

My mother was very familiar with my emotional behaviour and stressed regularly her support and continued to suggest counselling. I finally reached a point where I started to plan my own death. My mother intercepted and together we saw a counsellor at Palmerston. The counsellor was wonderful. She recognised my desire to commit self-harm and accompanied me to Fremantle Hospital. I saw a psychiatrist there who suggested my only problem was drug use.

I overcome this grossly low point, but by mid-2000, I was totally dependent on drugs. I was facing a major operation on a massive blockage in the tube of one of my kidneys, and yet I could not see a necessity to stop. After my operation, I started reading all the drug information and books in our home, and realised I had had enough. I tried to detox at home twice, but found firstly, being in a using relationship with a girlfriend and my other friend's continual harassment, made this achievement impossible.

On 21 December last year, I finally tried to access help. I was very fortunate. Bridge House took me straight in and here I received my first serious counselling. I was able to resolve all the feelings I had experienced as a child being affected by drug use. I now realise that this exposure caused major detrimental concerns during my major developmental years; that displaying depression, isolation, an inability to form safe relationships and a fear of change are part of the process that I have endured.

During this period the sibling bereavement group at Palmerston also commenced. Taking advantage of both forms of counselling and group work has been the most achieving procedure in my life. It has allowed me to reinstate my true love for my eldest brother, to realise that he was young and foolhardy, and that for him drug use seemed exciting and cultural. Encouraging our use seemed the appropriate choice.

I miss Adam every minute of every day, but an acceptance of his death is now possible. The plus for me is now being reinstated in my job, having been dismissed previously in a very inappropriate manner. I still suffer from depression and panic attacks, but now have new skills and strategies to overcome these feelings and I am now finally enjoying healthy non-using relationships.

Drug use does affect all persons in a family unit. It is a systemic, family inclusive model, and a roller-coaster ride of emotions, which is experienced and presented by all family members in different modifications and emotional periods right across the gauntlet of grief. We siblings do matter; we do feel; we do need to be respected and have our confidentiality validated. As such, we siblings have a right to be endorsed, a right to know where to access help. We also have a right to be able to access professional counselling, sibling groups and sibling bereavement groups. Thank you.

KURTH, MR NATHAN,
Adult Child of a Drug User.

Mr KURTH: My being here this morning at this Drug Summit is to talk primarily about my experience as a child of a drug user. Unfortunately, that is not exactly what I will talk about because I will go one better and have a yarn about how my life has been affected by the use of drugs by my mother. My first recollection would be of my first foster family where I was placed due to my mother's substance abuse and not being able to take care of me. That is what I have been told. It was a while after I had been in foster care that I realised that I had become a ward of the State. I imagine that I was too young to recall it happening. That was quite a shock to my system. It was tricky to deal with, but I got on with it and it was all right. My life became a bit of a mystery

after I was born because of my mother's substance abuse, which continued after I was born. I was taken into care because she was unable to look after me. The responsibility of raising a child was taken out of the equation on my mother's behalf. I was taken into the Department of Family and Children's Services because she was not able to take responsibility for me or wean herself off drugs. For the best part of 15 years I was brought up in foster care as a ward of the state. I am sure it was not easy for my mother to hand me over to the Government, but it was not a joy ride for me having to live with many different foster families and experience a lot of rejection and fear of commitment at a very young age.

During my early childhood, I had brief contact with my mum when I was placed in foster care. Many times we would go for long drives to Bandyup Women's Prison; however, when I went there, I did not know why she was there and I was never told. The prison was remarkable because it was so big. The first time I went to the prison when I was young, I was surprised and confused about why there were no men at the prison. At the time all I knew about prisons was that men were also held in them.

When my mother and I made arrangements to meet each other, she often would let me down. We would arrange to meet but she would not come. Wondering why my biological mother would not see me played a big part in my mind. I am still dealing with that but it is all good and I will get through it eventually. At around the time of my birthday she would usually be in Perth and we would catch up, which was good. Other times when I had matured a bit more, I would meet her in rehabilitation clinics. I often did not see her when we arranged meetings, but when we did, it was usually in restricted confinements including the prison or the rehabilitation centres - although she did not often stay for long at those places. It was great that I was able to see her now and then.

Although she did not want to see me in care, I would tell her that I was in foster care because she could not look after me. I am allowing delegates to realise that my mother's substance abuse had more of a hold over her than she had over her son. As much as she could not help to see me in the arms of the Government, she could not help herself to help me. I will finish my yarn with a poem I wrote the other day that is related to what I have spoken about this morning. I call it "Try not to want not". It reads -

I just feel like a kid trapped
trapped on the edge of insanity . . .
Crying for freedom
at the most crucial time.

And when I become aware
of unconditional
"family" love
it gets thrown out
and passed around for
me to try over
and over, not just from
the beginning but
all over the place.
Don't try to hide.
But there's no one I feel
able to confide in.

So I'll resolve a
strike for my independence
and for all my regret.
I'll take a bow for

the people there was
to take me in . . .
Without them I
couldn't share my experiences
with you people here today.

So I don't know if
it's your caper, but if
you try not, more than
likely, you will decide to
want not.

The CHAIR (Ms Jade McSherry): Thank you Nathan. I now invite all delegates to ask our speakers questions.

Ms WILSON: My question is to Nathan.

Mr KURTH: How are you going, Pamela?

Ms WILSON: Pretty good, mate. I can understand exactly where you are coming from. This question is from the heart: did your grandparents have the opportunity to take custody of you, rather than your going into foster care?

Mr KURTH: It is funny you should mention that. My nanna was trying to get custody of me, as far as I remember from reading my files, because after I was a certain age, the department would let me read my files - they were incredibly big. There was some talk in those files of nanna trying to send over money to get me to go over there with her, because the rest of my family, besides my mum, lives in Brisbane. There was talk about doing that and so forth, but obviously it did not turn out.

Ms WILSON: Would it have had a better psychological effect on you if you had been brought up with your immediate family rather than with strangers?

Mr KURTH: Yes, definitely.

Ms WILSON: So you would advocate that all children should be placed within the family unit, where possible?

Mr KURTH: In their own family?

Ms WILSON: Yes.

Mr KURTH: Without a doubt.

Ms CARNES: My question is for Bruno Faletti. One of the criticisms of the drug education program in schools that I have heard - I want to check this to make sure it is accurate - is that illicit drugs are left a bit of a mystery, and when things are left a bit of a mystery they can become attractive. I wonder how the program serves to demystify illicit drugs and to promote harm reduction with regard to illicit drugs.

Mr FALETTI: Thanks, Rose - good question. Illicit drugs are not left a mystery. The way that drug education is tackled in schools is that we look at introducing information concepts and understandings just prior to when research tells us there is likely to be initiation into that drug use. At the very early end when we do drug education with kindy kids, drugs are usually not mentioned at all, but we deal with skills and friendships. However, as those kids get exposed to medicines and passive tobacco smoke, we start to talk about that. When we see that students might come up against illicit drug use through their social network, then we introduce the concepts. We certainly talk about cannabis as one of the key issues. In some schools that is raised in year 7, and in other schools it is raised even in year 6, depending on the appropriateness of the situation. In some instances it is not looked at until high school. Let me assure you that it is not swept under the

carpet; it is raised. As we know, issues about amphetamine use and ecstasy also need to be addressed as students become more socially mobile, have more money and develop wider networks. Therefore, it is not swept under the carpet.

Harm reduction is a very touchy question. I know that Tim touched on it. Teachers are aware and acknowledge that harm reduction is an important part of drug education. However, we must be careful not to normalise illicit drug use. Therefore, teachers are caught in a real bind in how that is done. We tend to take a more targeted and specific approach to students who may have issues with illicit drug use; therefore, we tend to deal with the needs of those students individually. However, we certainly look at broad harm-reduction strategies. We must remember that harm reduction is appropriate for not only the students who may use those drugs but also the friends around them who need to know what to do to reduce the harm if their friends pass out or overdose. Therefore, it is not swept under the carpet. It is a touchy issue, but we address it.

Mr MEOTTI: Professor Silburn, in your discussion you listed drug laws as a risk factor for young people to begin or to continue drug use. On what facts or evidence have you based this assumption, considering the example of the Netherlands, which has a much more liberal drug policy than ours, yet it has about one-third of the usage rate of cannabis among its teenagers? The scientific advisers may be able to assist with a response.

Professor SILBURN: I did not follow the first part of the question.

Mr MEOTTI: You have said that drug law is a risk factor for young people either beginning or continuing drug use. On what fact or evidence do you base that assumption, considering that a country like the Netherlands has one-third the use of cannabis among its teenagers, yet it has far more liberal drug laws?

Professor SILBURN: There is some evidence in the United States, which has compared the rates of self-harm admissions, suicides and road accidents in States that have, for example, a drinking age of 21 as opposed to 18, that a strong message like that has a population-wide effect in reducing the population risks of some of those outcomes. I was talking specifically about that as an instance. There is a real contrast between the Netherlands and Sweden, which have two very different approaches, but one has to look at it in relation to particular substances rather than as a generality.

Ms MORAN: I have a question for Mr Faletti. Do you believe that to have a resident school health nurse in primary schools to provide student support services such as drug education; dispensing stimulant therapy medication for attention deficit children; dealing with bullying, truancy and self-esteem; and identifying learning disabilities, would enhance the outcomes for children and reduce substance abuse in primary schools?

Mr FALETTI: I seen no evidence in terms of reducing substance use, and I have not read of any. However, we would encourage as many support services in schools as would be practically possible. School nurses play an important part in the practical aspects of drug use, such as dispensing medicines and keeping a check on the substances that you talked about, and they also perform an important educative function as a support person in the classroom. Therefore, I would endorse school nurses in all primary schools; and, if that were possible, we would certainly be putting up our hands for that.

Mr MACKAAY: Mr Faletti, you have told us that the schools drug education program is designed according to best practice and that the delivery matches the design, but you have not talked about the evaluation of that program on the ground. Do you know whether it is working? Do you have an evaluation schedule?

Mr FALETTI: The evaluation that was undertaken looked at the penetration of the project strategies. Our aim always was that the project strategies were to provide curriculum, train teachers, help schools develop policies, and encourage parent involvement. The evaluation showed that those things are being done in schools. Tim and Sven also talked about the evaluation in terms

of whether the stuff that goes into the classroom also leaves with the students and goes outside the classroom; and I assume that is what you are asking. That sort of system-wide evaluation has not been undertaken, and we would welcome it.

Mr TOON: I have a question for Mr Stockwell. I have seen some South Australian work that superimposes the prevalence of alcohol use, cannabis use and other illicit drug use across the age range for males that almost exactly mirrors risk-taking behaviour generally among males, which peaks around the early twenties. In this context, where do you go with prevention?

Professor STOCKWELL: The question is, where do we go with the fact that the peak risk group is young males in their late teens and early 20s. They exhibit risk behaviour no matter what we do. It is one of the main reasons that we need harm minimisation and harm reduction. We must recognise that risk behaviour will occur. We have to look at how we can make our environment safer. There is a range of strategies we need to adopt according to the different settings where we know drug use goes on. Earlier I mentioned the overdose rate and the rate of alcoholic poisoning. Those are clear examples where better education is needed. The examples were university students who did not know the dangers of leaving someone to sleep off the effects of their drugs. This is why we need drink driving laws and all the measures that have been discussed. We cannot inevitably change risk behaviour but we can make the impact less costly to the individual and the rest of society.

Ms GRIFFITHS: I thank and admire the courage of the last three speakers in sharing their experiences with us. I have a question for Sven and Tim about early intervention strategies that address the most vulnerable group of children, those that accompany mostly women into crisis care or women's refuges and whose physical or emotional development has been arrested. The children have their education affected because they are transient; they do not stay in areas for long. The children are often returned to the scene of their original danger.

Professor SILBURN: I am not sure of the question. Was the question how does early intervention address those kinds of circumstances? Regarding prevention, there is no doubt that the earlier, the better. It is also true that it is never too late. The circumstances described highlight how critically important it is that every possible effort be made to support the developmental needs of those children. I am not sure how it can be done systematically. I agree with the statement that the children are a high-risk group and they should be highlighted for early intervention.

Professor STOCKWELL: The point I take from reading this powerful and exciting literature about early risk factors and protection is that engagement with a stable family and the education system and subsequently with the workplace is what provides the most protection. We need to identify groups like the one just mentioned for which that is a special difficulty. These people are particularly vulnerable and we need to be as creative as we can in having an effective response to their needs.

Mr LOVETT: My question is to Bruno Faletti. Bruno made a statement that the School Drug Education Project works with teachers in schools and not students. I would like that to be explained further. I read a report of the task force on drug abuse and I noticed a drug and alcohol policy for a school - I think it was in Kalamunda. Was that policy endorsed by the students or is it a policy of the Department of Education and the teachers? I have a few fears about it.

Mr FALETTI: I am not sure of the circumstances of the drafting of the Kalamunda policy, but we do produce guidelines for developing policy framework for schools. In those guidelines we state very clearly, that the more consultative you are the better. If schools include the students in the planning process, it will be so much better, because in the end the policy must be articulated to students, parents, the community and teachers. Everybody must be comfortable, and aware of the policy consequences. There is no doubt that this reveals the warts in the system, but some schools will sit down and write a policy in an hour, and that will be it, while others will go through an extensive consultative process. Most will be somewhere along the continuum between the two.

The best model is the one that is most consultative. That policy was not written by the Education Department; policies are school-based and written by schools on some very broad guidelines. I do not know whether I answered the first part of the question, because I have forgotten it!

Mr LOVETT: The first part referred to your statement that the SDEP works with teachers and schools, and not students.

Mr FALETTI: Yes, that is right. In terms of being most effective in influencing change, obviously the teachers and the schools are the ones that know their students and their community best, so we work with the teachers and we recommend that they use their localised knowledge to do whatever is most appropriate for their school. There is a wide range of policies, from that at a small primary school through to that at a very big private high school. The school assesses what is right for that school and that community, and puts it into that policy.

Mr BOYLE: My question is directed to both Tim Stockwell and Bruno Faletti, and pursues the issue of evaluation. I hope they do arrive at an evaluation that takes into account the opinions and feedback from young people. Drug education in schools is something we all agree upon. I am a father two children, whose year 1 son came and harassed him after the van turned up at his school last week. I actually commended that effort, but my concern is more about the teenage years and the credibility of the messages coming across, especially with the fairly simplistic "Say no" campaigns, and the denial of the fact that the kids are obviously getting something from drugs. Has any research been undertaken that asked young people about the credibility of the messages put across in campaigns throughout Australia and in other countries? It is not an issue of needing drug education, we need the right kind of education.

A secondary question to Tim Stockwell and Nathan Kurth is how would they have reacted to drug education in schools. Have they had any experience of it and have they any thoughts about the kind of messages that might have been useful for them as teenagers?

Professor STOCKWELL: Thank you for that question. As I understand it, your point is the extent to which these programs being offered in schools have consulted with the target group for which they are designed, and take into account the issues and concerns of the students themselves. That will vary enormously. Forgive me if I sound like I keep blowing the trumpet of the National Drug Research Institute, but we are very proud of its school health and alcohol harm reduction project, which essentially is designed around exactly that. It started off with a youth forum, in which we documented the concerns of the young people who were to be targeted about alcohol use. We also trialled the materials and the exercises that were developed to get feedback from students and also from teachers. They had to follow sound educational principles, and we had to weld those two things together. One of the weaknesses appears to be with school-based education programs in the past. Often when they have been evaluated it has been found that they have very little effect,. It appears that they have not been designed in a very smart way.

They have not taken on board feedback about what engages and interests young people and what is important to them. That should be done and combined with sound educational principles. However, many schools do not dedicate time to drug programs. Schools need to make space for them. The basics are to put the program in place and to consult. When that is done, things work. There appears to be evidence from international literature that that kind of consultation, feedback and relevance will engage and affect. I totally support the point you make.

Mr FALETTI: From our perspective, we engage students in focus groups to give us guidance about the things they would like in the K-12 curriculum materials that we develop. The issues that have arisen have concerned the types of drugs adolescents want to talk about and the way that the information is delivered. They want less of teachers standing up and telling them what to do and more of sitting down with their mates and talking about these issues, and having people talk to them from different perspectives. Those things were taken on board and are in the package. The

interactive nature of adolescent drug education was taken on board and written into the package, so that students have a chance to lead the drug education they do in schools.

Mr BOYLE: This question is directed to Tim Harris and Nathan Kurth. Would you have benefited from drug education in your own school life? What is your opinion about drug education in schools?

Mr KURTH: Sorry, I am not sure how to answer your question.

Mr HARRIS: I received drug education in school, but in my family unit, with my brothers and what not, I was told that it was okay, while the education in school said that it was not okay. It is a matter of who you listen to. I made that choice.

Dr MARSH: My question is to Bruno Faletti and concerns harm reduction. How much freedom do schools have to implement parts of the K-12 package and how much is in the package on harm reduction for illicit drugs? You made the point that harm reduction is needed not only for people who are using drugs, but also for their mates. That accounts, in some schools, for a lot of the school population. I know that it is a difficult issue, but could you perhaps talk around the issue and point out how some schools implement it and what guidance teachers or those who provide the education are given to put it in practice. I know that some teachers do not feel comfortable with it, because they do not understand it terribly well. How much is in the package?

Mr FALETTI: One of the key things we do in our training is to talk through the former State policy. I am not sure where the policy sits at the moment, but we discuss the one that was developed and espoused by the Western Australian Drug Abuse Strategy Office. We make it clear that we oppose the principle of drug use, but also that harm reduction must occur for those students with drug use issues. Teachers are aware of and understand the principles of harm reduction. We have evaluated that and know it to be the case. We encourage teachers to raise the principles of harm reduction in the later adolescent years, when drug education is taught in a more interactive way - I hate to use the term laissez faire - which uses a peer-led discovery-learning type of approach. Teachers have the opportunity to discuss scenarios in which harm reduction might be appropriate. Students are encouraged to undertake courses such as the "save a mate" course, in which they learn basic resuscitation techniques. Schools take that on as a big part of the drug education curriculum in upper school, if time is made available. I am sort of talking around the matter and it depends a great deal on a school's stance and policy. However, there is provision for teachers to take on a drug education program and guidance for the things they can do. The will is there but sometimes constraints in a political and policy environment exist in a school. That is as much talking around the matter that I can do.

The CHAIR: (Ms Jade McSherry): Unfortunately, we have run out of time. We will be breaking for morning tea now. I have an announcement to make. Martin Hosek and Torgny Peterson are available to the working groups until approximately 11.30am. After the morning tea break I ask delegates to move into their working groups.

Summit suspended at 10.30 am

Summit met at 1.30 pm.

The CHAIR (Professor Liz Harman): A concern has been raised that a number of people were late this morning. If delegates go back to the last page of the rules they will find clear-cut advice to be on time for sessions. We will close the doors at the time we start and if delegates are late I ask them to move into the public gallery and wait there for the next session so that they will not disrupt other delegates.

I also take the opportunity to say on delegates' behalf to David Mr Moyses, happy birthday.

Before we start today's session, the scientific advisers have three points they would like to address. I invite Professor David Hawks and Associate Professor Richard Mattick to come forward to present them to us.

HAWKS, PROFESSOR DAVID,
Emeritus Professor of Addiction Studies,
Curtin University of Technology.

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

Professor HAWKS: I shall address the first point and Richard will address the other two. An observation was made by Detective Superintendent Gere on Monday, based on South Australian data, that the South Australian experience of decriminalising the personal possession and cultivation of cannabis had led to the syndication of cultivation. The fear was that to move in a similar direction in Western Australia would have a similar consequence. I have checked with my colleagues, and neither they nor I are aware of any evidence to support that view. If such evidence exists, it has not been made publicly available. The Northern Territory and the Australian Capital Territory have moved towards the decriminalisation of personal possession and cultivation of cannabis, and they have not experienced such an effect. One would be hard put to argue that in Western Australia, where all cultivation and possession is prohibited, there is no criminal involvement in the supply and cultivation of cannabis. The case is not proved, although it may be proved. If the decriminalisation of cultivation in South Australia has resulted in the syndication of cultivation, it has been made possible by the regulations, which provide for the possession of up to 10 plants and do not specify the size of the plant. We have heard that hydroponic developments mean plants can grow to several feet. If syndication has been the South Australian experience, the police can do two things to address it: target the people they believe are cultivating for syndication; and introduce regulations, as has been done in relation to pawnbrokers, that require the suppliers of hydroponic equipment to notify police of their customers. I learnt over lunch that many suppliers of hydroponic equipment in South Australia have criminal records for drug use. They would be easy to regulate.

It is worthwhile revisiting the logic of the proposal to decriminalise possession and cultivation of small quantities of cannabis. It is not to sanction such use. Speeding is not sanctioned. It is not legal as a consequence of no longer being dealt with under the criminal law, and it is still a behaviour to be discouraged. The logic is that the penalty for possessing or cultivating a small quantity is disproportionate to the harm associated with its use or cultivation. Decriminalisation is an attempt to bring the penalty in line with the potential for harm. It is important for delegates to remember that what has been done in three States and is being entertained here is not the legalisation or sanction of the use of cannabis but an attempt to try to find a greater proportionality between the harm associated with such activity and the penalties applied to it.

Associate Professor MATTICK: A question arose about whether drugs law affect initiation into or the ongoing use of illicit drugs, and we thought we should address that. The prima facie role of laws is to deter use. Some might say that drug laws provoke use by encouraging young people who want to rebel to rebel against those laws.

The issue of looking across jurisdictions to determine the effect of legal sanctions must be considered very carefully. There are a number of methodological reasons why this is a difficult area to address confidently, and delegates should be cautious about accepting arguments that the rate of drug use in different countries relates to the laws of those countries. Many differences occur across the countries. These include the ways in which data is collected - whether by questionnaires or interviews - and the questions asked of the participants. In Australia itself, the questions differ between the national household survey, general population surveys and specific technical and further education and school surveys. It is difficult to make competent conclusions about rates of use. The age groups surveyed vary across settings, as do the settings that are assessed, such as schools, TAFEs and the general population. Further, drug availability, purity, price and acceptability of drug use will vary across countries. For those reasons, David and I believe we should be cautious about drawing strong conclusions about the relationship between legal sanctions in different settings and the initiation or ongoing use of drugs. Another factor is absence of evidence. This does not mean the evidence of absence of an effect. Although drug laws may exert marked effects, one should not conclude that based on the information available.

I turn to the issue of the potency of tetrahydrocannabinol in cannabis plants and the cannabis smoked. An increase in potency has been mentioned on a couple of occasions. I am concerned that delegates are clear about the extent of the increase. The New South Wales opposition leader stated that there had been a ten to twenty-fold increase in the potency of delta-9 tetrahydrocannabinol in cannabis. Our centre looked at that issue and the evidence is that that is not true. Results have not been collected in any systematic way in Australia. It is not possible to say with any confidence whether there has been an increase in potency. However, data has been collected in the United States for the past two decades. That data has demonstrated a minor increase of about one per cent from 3.3 per cent THC to 4.4 per cent. The New Zealanders have also collected and analysed data over two decades and they have demonstrated that hydroponically grown cannabis plants have a THC content of between six and eight per cent. Therefore, we are not experiencing a ten to twenty-fold increase; it is only a doubling or an increase of one-third.

It is possible that the THC content has increased. Professor Stanley suggested that one outcome of the summit should be the introduction of monitoring. If delegates want credible information about the nature of THC content, we could simply collect samples from seizures on a regular basis. The process need not be expensive or extensive - 100 to 200 samples a year would be sufficient.

Finally, cannabis smokers will extract different amounts of THC from cannabis based on how much they need.

The CHAIR (Professor Liz Harman): I thank the technical advisers. These comments are made in response to points brought to our attention by delegates seeking clarification. I thank them for their contributions.

McSHERRY, MS JADE.

Ms McSHERRY: On being announced as a co-chair for the Western Australian Drug Summit I felt privileged to be able to represent youth on such a sensitive issue, and one that has become a real problem in today's society. Having been addicted to drugs for six years of my life, I am well aware of the issues that surround the drug epidemic. I was once a high-performing state athlete.

However, during the early 1990s, I was lured into the drug scene by experimentation with marijuana, lysergic acid diethylamide - or LSD - and ecstasy. At that time, drugs were not really discussed and did not appear to be at the forefront of community concern. Therefore, I never understood the real harm of experimenting with them. Within months, my curiosity increased and I began to inject amphetamines. I thought I was enjoying this until I began to reap the consequences of my inexperienced drug use.

Having been involved in drug-related crime, I faced the justice system for the first time and decided to try to quit drugs. However, during this vulnerable time there was a large amount of heroin on the streets, and it was not long before I began to use it. Shortly after using it I became addicted, and I continued to use daily for the next four years. Throughout that time, I went on and off methadone a number of times and I was involved in and charged with a number of drug-related crimes. I escaped death from overdose and I attended in-patient and outpatient counselling. My immediate and extended family were greatly affected by my drug abuse. At 22 years of age, I booked into the Teen Challenge WA rehabilitation centre. I went to the centre weighing 42 kilograms; my hair was falling out and I found it hard to eat. Drugs had affected my life.

I have been free from illicit drugs for two years and I know I will never become dependent on them again. I now work with young people in the program, helping them to get free from drug addiction. I also work with people outside Teen Challenge. I go to schools and tell students about my experiences with illicit drugs. Having had such exposure to the drug scene, both as a user and now as a counsellor, it is quite evident that the drug problem is growing rapidly. The first-time users are getting younger and the number of overdoses has increased. As with the previous speakers, you will hear the voices of the youth today and hear their views on the drug problem. It encourages me to see how the young people of today are standing up to be heard and standing up for what they believe in. On behalf of the chairs, I welcome these speakers.

Our first speaker is Sandra Spadanuda. Sandra is a representative from the Youth Affairs Council of the WA drug forum.

SPADANUDA, MS SANDRA,
Representative from the Youth Affairs Council of WA Drug Forum.

Ms SPADANUDA: I am here today representing the outcomes of the pre-drug summit youth forum held last month coordinated by the Youth Affairs Council of WA. Approximately 60 participants took part in the forum, with the target group being young people, those who work with young people, and YACWA members. On the day there was a range of different participants and a huge range of opinions. However, there were a few core issues that we all agreed on. The most common issue all forum participants agreed on was the need to introduce a range of strategies. We need to remember that one size does not fit all, and the holistic and cross-portfolio approach is essential. Generally, focus tends to be on either treatment or rehabilitation at one end of the scale, or prevention and education at the other, and there is a plethora of approaches and needs in between the two.

We need to value diversity in order to create unity. After all, what unites us is far greater than what divides us. We need to focus on similarities, not differences, and respect and value difference. We need to take a multifaceted approach where we are acknowledging our diversity and where education is the key - education that is part of our lifestyle and that is integrated into our local communities; to start education at a young age and to provide realistic, accurate and practical education; and education encompassing relevant information and allowing people to make their own choices.

One important point which came out strongly from the forum was to ensure education did not demonise drugs or drug use. It is a commonsense approach recognising that people use drugs and will continue to do so. Simply telling young people not to use drugs or to stop using drugs is unlikely to be successful. Young people tend to respond in a more positive fashion when drug education messages recognise and respect their ability to make decisions.

The forum expressed particular concern for the need to ensure that emphasis is less on what drug a person is taking and more on the how and why they are taking it. This is why there is a need for workers to accept a substance user as a person. Not all young people want not to use, and in this case harm reduction strategies need to be utilised.

We cannot assume that all young people using substances have a problem. Not all substance use automatically leads to addiction or criminal tendencies, nor does it automatically lead to participating in a drug culture. We must build up the positives of young people and the individual and not focus on fault. It was clearly agreed on by the forum that there is need for a range of treatment options, options that reflect a growing diversity of needs. When we are considering young people, we need to look at establishing programs that are young people specific and at the same time reflect their diversity of needs. What works for one young person will not necessarily work for another. It is also about accessibility. There is a need to create a space that is easily accessible to young people and that is free from prejudgment. It is also important that young people be involved from the start in designing, developing and implementing services and treatment programs for other young people. As Western Australians, we have a choice at this point to decide what kind of society we want, what assumptions we want to work from and what values we want pursued.

We need to acknowledge and accept our diversity; we can celebrate the richness of this diversity as a community. If we believe there is one solution to this problem we are wrong. There needs to be a range of answers that are continually reviewed. As we continue to work on solutions we need to be responsive to the changing needs of the members of our community.

The CHAIR (Ms Jade McSherry): The next speaker is Paul Dessauer, who is an outreach worker for the WA Substance Users Association.

DESSAUER, MR PAUL,
WA Substance Users Association.

Mr DESSAUER: Good afternoon ladies and gentlemen; I would like to thank you all for inviting me along today. To introduce myself briefly: my name is Paul Dessauer and I am 35 years old. Until three or four years ago I was very much a part of the drug culture. I have spent between 10 and 15 years of my life as a poly drug user and dealer. Until about two years ago the Australian Taxation Office had never heard of me. I would never have envisaged that I would be standing in such sumptuous surroundings; this is a surprise. I do not want to spend a lot of time talking about myself, because we do not have much time today, but I want to explain where I am coming from and why I wanted to talk to you today.

I have used a wide variety of illegal and legal drugs in my life. I have had several different drug habits. I have used heroin and amphetamines in quite destructive, problematic and habitual fashions at various times in my life. Every time I have had a drug habit it has been different. That is one point I want to stress today: there is not a drug problem in Western Australia; there are hundreds of thousands of people who have problems with illicit drugs. As long as we talk about "a drug problem" we are missing the point, because we are talking about it as one separate issue in isolation.

I used to be a drug dealer. I used to sell drugs to support my drug use. I am not necessarily proud of that, but I am not ashamed to stand up and say that either. When people do not earn a lot of money there are only three ways in which they can support a serious drug habit: they can work in the sex industry, sell drugs or thieve. I chose one of those options. When we think of drug use in black and white, simplistic terms it is easy to say that if we stop the suppliers and the dealers, the problem will go away. We have been trying that for about 100 years now and it is not working.

We need to look at why so many young people in our society want to take drugs in the first place. The issues papers for this summit are full of facts and figures. We are told that over 51 per cent of Western Australians have tried an illicit drug at some stage in their life. That supports what Sandra said about a lot of people's drug use not being problematic. Obviously, the majority of people in our society experiment with drugs as they are growing up. Most people do not have problems with it and grow out of it. Some people go to ridiculous extremes, as I did for a few years. However, some people can still come out at the other side as well. The point I am trying to make is that there are lots of different people in our society who are all using different drugs, in different ways, for different reasons, at different times in their lives.

Another point that Sandra made, which I would like to stress, is that we need a wide variety of approaches and wide-ranging strategies that are flexible and adaptable and that allow us to treat the individual - to look at the individual's whole life. Anyone who works in the treatment sector will have seen the same story over and over again: someone who has got all sorts of problems in his life is taken away to rehab and is cleaned up over a few weeks, but is then thrown back into exactly the situation that provoked the substance use in the first place. It is a pointless exercise. It destroys the self-esteem of the person involved and it messes around with their families. We need to look at why these people want to take drugs in the first place.

If I tried to tell you everything I know about youth and illicit drugs in my remaining 30 seconds or so, I could not. I could not tell you everything you need to know even if we had 30 years. You need to talk to as many people as you can and talk to the young people. There needs to be more of a dialogue between the people who set the policy and the people whom the policy affects.

We must look at the social reasons that kids take drugs. Kids take drugs to be accepted. Kids do not care that they might end up in jail. Kids do not care that they might have liver cancer in 20 years time. Kids care if they fall over and look stupid in front of their friends tonight. If we look at the way in which advertising has been used to control alcohol consumption over the past few years, we see that many advertisements are focused on making kids think about keeping control of their substance use rather than trying to abstain from it completely. We need youth-specific services that are developed with youth involved. They must be holistic services and not treat substance abuse in isolation. They must be pragmatic, client-based and credible. Kids must believe what they are being told.

Prohibitionist propaganda does more harm than good. When I was growing up I was told that if I smoked marijuana I would go insane, I would rape my sister, burn down the house and kill my parents. When I found that marijuana was not the drug that I had been told it was, my respect for the people who had told me that just disappeared. After that, I did not believe anything I was told about drugs. I was probably much more casual about getting into hard drugs than I should have been, because I did not believe anything that I had been told about them.

I do not want to detract from our time for questions. Please use the time that we have to ask questions. I would like delegates involved with youth issues to look at five submissions made to the Drug Summit. They are submission 237 from the Western Australian Network of Alcohol and Other Drug Agencies, 262 from the Hills Youth Centre and the Swan View Youth Centre, 325 from the Palmerston Association, 432 from Mission Australia and 445 from Trinity Youth Options. These people are dealing every day with young kids who are having problems with illicit drug use.

Please read these submissions because they address much more than we can possibly touch on in the time we have today. Thank you very much.

WAIHI, MS KAMILA,
Youth and Advisory Council, Northampton.

Ms WAIHI: I am from a small country town, about 45 kilometres north of Geraldton, called Northampton which has a population of approximately 2 700 people. I have resided in a number of small country places and also spent 10 to 12 years in big cities. Having spent most of my teenage years in country towns, I realise illicit drugs are readily available to youths and others. Although drug use in smaller towns is on a smaller scale, it is still very much of an ongoing problem. As the professors said this morning, children start using at a much earlier age - from 10 to 11 years old - as happened with me with smoking. Having spent my youth in rural communities and big cities, I know that youths do not realise the madness that they can get into and the consequences. I want to use my experience to aid youths of today and their issues. As part of my local drug action group and from what I have witnessed with the group in the past 15 months, I have received feedback and know the expectations. I want to share my experiences and help make it easier to deal with drug issues.

Why do we want to use drugs and why do drugs make us feel better? Is there a system or some form of education that can help our self-esteem and eliminate drug use? We do not know the answers; however, we must answer these questions to help our youth. This summit is a part of that process and hopefully we will be able to do that after this week.

I will state the three main serious drug problems that face rural youth. I have spoken to members of my community and to the local police, who also agree that they are serious issues. First, binge drinking and its consequences are big issues in rural areas; secondly, the dependency on marijuana, which can lead to all sorts of other things; thirdly, slowly but surely chemical and prescription drugs are increasingly filtering into smaller towns - it is happening.

Drug use is becoming more of a problem because we do not have the resources available to support and accommodate the fast-paced youth of today. Boredom is an issue for people in rural areas, particularly for people between the ages of 13 and 18. Where do we put these little adults who are no longer children? There is no provision for their entertainment. In other words, they neither fit in with their parents' social activities nor with the younger community. They are in no man's land. Those people have no solace. Where do we place them? Generally, smaller communities do not have swimming pools, cinemas or skate parks. Smaller communities do not have the same recreational facilities that larger cities have to offer - not that I want to make too many comparisons. It is often expensive to travel to places that have those facilities.

How do we improve the morale of the youth in rural areas and solve some of the issues they face? When I was a teenager, it helped to have places to go to, including youth centres and educational facilities, and it also helped to have youth workers and counsellors around me. By "educational facilities", I do not mean only books and pamphlets, but also places in which to talk to people and to stay with your mates. I have not seen any places that have those types of facilities without the backing of a major corporation. Where can we go from here? Can the Government help provide those facilities?

The PANEL CHAIR (Ms Jade McSherry): Thank you Kamila. Our next speaker is Johanna Somerville. She is a representative from the Department of Community Development and the Office of Youth Affairs drug forum.

SOMERVILLE, MS JOHANNA,
Representative from Department of Community Development and Youth Affairs Drug Forum.

Ms SOMERVILLE: Good afternoon ladies and gentlemen. I am here to talk about the findings of our research on young people's views on drugs in Western Australia. Allow me to give delegates a brief introduction on how our data has been gathered. We collected and analysed it over a four-week period from mid June to mid July 2001. The data was obtained in four separate ways: a questionnaire was distributed to two schools; a workshop was held by the goldfields and south west regions Youth Advisory Council; eight focus groups were held; and one half-day forum was held by the Office of Youth Affairs in Perth.

There were 355 young people involved, mostly between the ages of 12 and 17. My main point can be expressed through a simple quote obtained in our research. It states -

> People think that everybody takes drugs, but they don't. You read the newspaper which says that 43 per cent, or something like that have tried marijuana, but really there is only a very small percentage that have actually done drugs.
>
> [Quotation not verified.]

That quote supports a belief in the misconception that the majority of young people today are engaged in illicit drug activities. A recent Western Australian school survey shows that most young people have never tried illicit drugs and that only a minority had used these substances on a regular basis.

I ask delegates to look at the graph that is being shown. Most young people are not using illicit drugs. If you take nothing away from my presentation, at least remember this: those young people have the secret of success because they have done it. This will help us all to tackle the drug problem. I am here to share with you what they know.

Our data has been collected from a wellness model; that is, from youths who have generally not used illicit drugs. There is a value in speaking to those who have used illicit drugs, and most people today will speak to you about that. However, I am here to offer a different view. The most interesting thing found in our data - it came up in all the focus groups, forums and questionnaires - was the importance of family. Having a supportive and encouraging family, who show young people they care and spell out to them clear values about drugs and other issues at a young age, was seen as the most significant factor in not only preventing illicit drug use but also helping young people achieve their life goals. This type of parenting style must be strongly supported. When it is not available within families, alternative encouragement and support should be available and provided.

Most importantly, values that view illicit drugs as bad must be developed in young people. In illicit drug education in schools, it was fascinating to find that most youths believed it started too late and that it should really begin in year 7 in preparation for high school. They also wanted drug education to be more realistic and meaningful, not just facts and figures. Those who felt they benefited from their drug education often spoke about guest speakers, including former drug users. The key issue for the majority of young people is not addiction but, rather, experimentation. More information must be provided on how to handle this.

When the young people spoke on drugs and the law, many were in favour of harsher penalties for drug dealers, but believed a more compassionate and treatment-oriented approach should be used for drug users. In terms of their thoughts on the summit as a whole, some were sceptical, saying that they doubted that the Government was really interested in what they had to say. I hope you will prove them wrong.

I have shared my thoughts and feelings with you. Now it is up to you to act on them. I hope these strategies that are based on what works will help you all to tackle the sources of the problem. Many Western Australian youths are sceptical of this process. Prove them wrong. Ask me the questions and get involved. I have a lot more to share with you. Thank you.

The PANEL CHAIR (Ms Jade McSherry): Delegates will notice in their booklet that Erica Simpson was to be our fifth speaker, but she has withdrawn. However, she will be available during the afternoon tea break if any delegates would like to speak with her.

The CHAIR (Professor Liz Harman): I ask delegates to again thank our panel members for their courage and frankness. They are now available for questions from the floor. However, I will make one point before we start questions; that is, on my rough count, some 50 per cent of delegates have not yet taken the opportunity to use the plenary session to ask a question of or make a comment to the speakers. Please feel encouraged that the summit is interested in all viewpoints. If you would like extra encouragement, I am giving it to you now. Would anybody like to ask a question?

Mr WOODRUFF (Mr Woodruff): My question is to Sandra. It is interesting that in the past couple of days most of the discussion has focused on dependent drug use and problematic drug use. It was interesting to hear you talk about young people whose drug use does not fall into those categories but is more on a recreational, experimental level, or is less problematic. What sense do you have of the proportion of young people who fall into that latter category; that is, their drug use is neither dependent nor problematic?

Ms SPADANUDA: The outcomes that I presented today came out of that forum. The people who work with young people, and the young people who were at that forum, presented that view to us as well, and that was something that we generally agreed on that day.

Ms ROSENBERG: Johanna, were your questionnaires and workshops purely metro-based?

Ms SOMERVILLE: Some of the questionnaire was given to schools in the metropolitan area. We held one workshop in the goldfields and south west, but the eight focus groups were done generally in the metro area.

Ms BOLDY: Johanna, you mentioned that there was strong support for introducing heavy penalties for drug dealers but taking a more compassionate approach for drug users, yet Paul said that he was involved in both drug use and drug dealing and that he was dealing in order to support his habit. Can you comment on the dilemma that presents?

Ms SOMERVILLE: It is interesting that when young people were asked about that, they had nothing to say. They were stuck on that dilemma. They had a very polarised view: drug dealers, harsher penalties; users, a more compassionate approach. However, when asked what they would do about people who are dealing and using, they did not know what to say. In my opinion, if people are dealing drugs in order to support their drug habit, then we need to get to the root of the problem, and that problem can be fixed only by taking a compassionate approach.

Mr HICKS: Johanna, we heard this morning that 40 per cent of schoolkids experiment. In light of the statistics that you have given us as well, that brings home to me the need to address this matter at the experimental stage. What options were borne out of your data in respect of how we can nip drug use in the bud at the experimental stage?

Ms SOMERVILLE: If we want to nip it in the bud and take that approach, young people need to be given the view that drugs are bad and the experimental use of drugs is bad, and that is done mainly through the families. Once young people have reached a certain age, schools can educate them and tell them. However, families also need to be educated, and parents need to be told that they must tell their children from a young age that drugs are bad, and be a good role model for them and not use drugs themselves, so that by the time their children get to school they will know this and, therefore, will not experiment.

Ms CARNES: Johanna, I would like to clarify the target group of people who were involved. Did it involve Aboriginal people, people from multicultural backgrounds and homeless people - the more marginalised groups - or was it largely a fairly conservative population?

Ms SOMERVILLE: It was largely a fairly conservative population, to be perfectly honest. The main ages were between 12 and 17. In the rural workshops, there were a few Aboriginal people; I am not sure of the numbers, because I do not have that information with me.

Ms INGLIS: I have a question for Jade and Paul as they have used drugs for a number of years. Do you think it is possible to keep using drugs in a harm-reduced way or is the only way to stop using drugs completely?

Mr DESSAUER: It depends on the individual and the circumstances. I have used drugs in what I considered to be perfectly reasonable and under control ways but there have been other times when the drug I used was the focal point of my day, every day, for 24 hours a day, for several years. That is obviously not a good way to live. The question cannot be answered with a simple yes or no. Once a person has used a drug habitually for a long time, it is very difficult to use it recreationally without falling back into familiar old patterns of use. I cannot take opiates, otherwise I will develop a heroin habit very quickly. It is something that I have proved to myself repeatedly over a number of years. It is a lesson I have learned. I agree with a lot of what Johanna has said, but saying that having the right family background will insulate kids against drug use is just not true. I went to a state primary school and a private high school. I will not say which school it was. I had a very good upbringing. The only drugs my parents took were a small amount of port at Christmas and Bex powders. I was brought up with a very strict attitude toward drugs. I think that attitude contributed to me going as far as I did because when I was young I rebelled against everything that I had been taught. I was not protected by having a strict upbringing. I find it hard to believe that some people think that telling someone the truth is hurting them or could possibly hurt them. The better informed people are, the more control they have over their own lives and the better informed their choices are. The best thing you can do for someone is to educate him - on any issue.

Ms McSHERRY: Could you please repeat the question.

Ms INGLIS: Is it possible to go forward using drugs in a reduced manner than they were used before or is total abstinence the path for people who have problems with drugs?

Ms McSHERRY: I do not wish to give my opinion on that. Once I began to experiment with drugs, it gave me the sense of having no fear about the drug scene. I remember when I was young that I had a picture in my head where I was fearful of drugs, drug users and drug pushers. My picture of a drug user or addict was someone who was on the streets and that a drug dealer was someone that I was scared of. Once I began to experiment, my ideas about that changed completely. I found that a lot of my peers were drug dealers and a lot of users were my friends in the schoolyard. Once I started experimenting with drugs, I found that I wanted more. That is my experience. I lost control of what my limitations were. Like Paul, I grew up in a good family. I had big dreams; I was racing overseas with athletics and I was a disciplined person. Once I started to use drugs I lost sight of where I was going and I wanted to have more drugs. Once I became addicted to heroin I just wanted more. When I was an addict I tried very hard and I struggled every day to not use heroin. That went on for between four and five years. There was no control in my life as I had lost it when I started to use heroin. That is how it was for me.

Mr DESSAUER: If I can just make one more point about one of the problems dealing with really young people with problematic drug use. It is very easy for Jade and me to say that we can see what problems we have had with drugs, because we have done it for quite a few years. Most people, when they first start using either heroin or amphetamines, which are the two big ones that people use habitually, are having a great time. They do not experience all this pain and misery that we are talking about. They feel fantastic every day. When you are really young, it is a ball, it is great fun, and it can be for a couple of years before you start to fall over. When you meet someone

in that stage, and you tell them, "This is going to destroy your life, you do not want to do this", they do not believe you. They cannot see that far ahead.

The CHAIR (Professor Liz Harman): We have three questions at the moment in our queue, and I will not call for any more until we have moved through those.

Mr MOYSES: I was originally going to ask Paul about drug education, because it seemed to be in contrast to what Johanna was saying, as in educate them and tell them the truth, and do not just say they are bad, which sounds very much like our Prime Minister's line to me, which does not seem to work. You have clarified that a little bit. With the aspect of dealing, and being a dealer, could you clarify a little bit more who dealers are, and what might deter them? Did punitive action by the State deter you from dealing?

Mr DESSAUER: Nobody sets out to commit any criminal activity thinking they are going to get caught. That is the first thing. One hundred years ago people could get hung for stealing a loaf of bread, but if someone was hungry enough, or their family was hungry, they would go and steal bread, and assume that they would not get caught. It does not matter how strong the penalties are. If the person does not believe that the consequence will be a result of engaging in that activity, they will do it anyway. Young people, in particular, are not scared of that sort of punishment. It is not something they think about. Jade made a really good point. Until she encountered the drugs, she was scared of them. Once she realised that it was just her friends at school who were buying and selling drugs and taking them - people who were around her socially - she was not scared of them any more. Instilling fear into people only works until they have some direct evidence that contradicts what was used to scare them, and once they have that evidence, they do not believe anything else you tell them about drugs. As a result, you have lost any chance of being credible with that kid. If you tell them the truth from the start, they know that you are someone they can talk to who is not going to lie to them, and who has their best interests at heart and wants to tell them the truth. Kids are used to being lied to, talked down to, and having their opinions disregarded. Most kids who have problems with drugs have a whole stack of other problems as well, and to work successfully with them, you have to build a trusting relationship. You cannot get people to trust you by lying to them. It is that simple.

Mr MOYSES: And with dealers -

The CHAIR (Professor Liz Harman): David, can I not have a follow-up at this stage, but take the other questions that are waiting.

Mr MOYSES: I had not actually finished my original question.

The CHAIR (Professor Liz Harman): Okay then, let me take it, but I will encourage you to be quick.

Mr MOYSES: It was more the duration for which people engage in dealing. My experience is with short-term dealers.

Mr DESSAUER: Many people who come into contact with the criminal justice system on sell or supply charges are just small-time, gutter-end-of-the-spectrum user-dealers. The people who really make a lot of money out of drugs are the people who never take them, and quite often they never even see them. They pay other people to do all the dirty work. There are people like that who I consider to be quite evil, and who make a lot of money out of other people's misery. I do not think I was one of those people. My girlfriend and I used to use around $100 000 worth of drugs every year. That is quite a lot of money as far as I am concerned, but I did not get to hold any of that money. That just went straight through my hands and up the food chain. I never ripped anybody else off, I never robbed anybody, or stole anything. I never pushed drugs on anybody. I was selling drugs to people who were just like me; they were all my peers. They knew exactly what they were doing. They were people who had educated me in my own drug use. I do not have a problem with that. I would not do it now, but I am a different person from the person I was four years ago. In the

last two years I have been working at the WA Substance Users Association, and I was working at George O'Neil's clinic for a year as well. I have started to find a way to generate an income for myself that uses the same skills and knowledge, but in a more legitimate fashion.

Ms THOMAS: Jade, thank you for sharing your experience with us, and for chairing the summit. When you were taking drugs, did you go to Teen Challenge Perth voluntarily or were you taken there?

Ms McSHERRY: I sort of knew about the Teen Challenge program for a couple of years before I decided to stop using drugs. I had to go to court to face some charges and that helped make the decision for me to go to Teen Challenge. I had come to a critical part of my life, at which point I was either going to end up in jail, in a coffin or in a psychiatric ward. That was crunch time. I was basically given an ultimatum to rehabilitate or to go inside.

Mr ELLIS: My question is directed to the three people who indicated that they were drug users in the past, and is specifically about the impact of the criminal justice system post-arrest. My question does not specifically relate to the police, but to the courts and any follow through that may have occurred. I would like to know your personal experiences, because some people believe that there is a positive impact from involvement in the criminal justice system. I am concerned that it has a negative impact upon people.

Mr DESSAUER: I do not have a criminal record. I was never charged for dealing drugs. I was charged for possession of marijuana in Queensland, but that was as far as it went. Erica Simpson, who was to speak during this session, will be available this afternoon. She has a lot of knowledge about this issue. I encourage you to seek her out and to talk to her about that issue. The only thing I can say is that several of my friends have been in jail for drug use or for crimes that they would not have committed if it had not been for their drug use. Jail is not a very nice place. I have known one or two individuals in my life about who I would say the world is a much better place for them being in jail. However, for the majority of the people I have known who have been in jail, it has not done them any good. One of the reasons is that our jails are overcrowded. When you hear estimates that between 30 and 90 per cent of inmates are there for drug-related offences, we must ask if there is another way of dealing with that.

Ms McSHERRY: I will go back to the point Paul made earlier that when people commit crimes, they do not intend to get caught. Crime was an outlet for me to get money to support my habit. If I had not been an addict, I would not have committed crime. That was an outlet for me. Having faced the courts a couple of times, I think a brush with the system towards the end made me realise that I had to choose my destiny from that day on.

Ms BOGDANOVICH: My question is to Jade. How important was support from both within and outside your family while you were overcoming your drug addiction? How long did you need that support?

Ms McSHERRY: During my years in Perth when I was using drugs, I tried to detox a number of times. The amount of support needed was enormous. Your parents, sisters or brothers, or even your grandparents, who see something like that going on in their family, need the support as much as the addict. For me to be free from my addiction, I had to leave the whole scene, because it was causing too much stress on my family, my workplace and my life. The support needed among the community and within the family group is huge.

The CHAIR (Professor Liz Harman): I suggest that we are close to the changeover in the sessions at 2.30 pm and I know that a number of people have not been able to ask questions but do have an interest in having answers. I invite them to use the panel members, if and when they are available, during the sessions for the working groups. I thank the panel and now call on my co-chair Fred Chaney to resume the Chair.

The CHAIR (Hon Fred Chaney): Delegates, as you know from your program, the next hour consists of a presentation from Ted Wilkes followed by a session chaired by Pat Dudgeon and supported by the panel listed in your programs. I hope to be a bit more tidy and orderly than I was the last time I worked with Pat Dudgeon, when I walked from the podium having taken all her notes for the day with me, which I found when I got back to the office. I hope I do not do the same to you today, Pat. I invite Mr Wilkes, if he is ready, to address the summit.

WILKES, MR TED,
Director, Derbarl Yerrigan Health Service.

Mr WILKES: Thank you very much for the welcome. I am very honoured to be here. I have called the title of my paper "Drug Issues Can be Black and White . . . Working Together".

Since 1829 systemic historical oppression has been the norm for indigenous people in Western Australia. Throughout history we have always fought against this; however, it appears, from a losing position. This Drug Summit must conclude that for indigenous people to have a future, access to and the use of substances and drugs for the purpose of escaping from the ongoing pain of oppression must cease or at least be diminished considerably. Being indigenous can mean living with drugs, be it from a distance or from within; more often than not it is from within. If indigenous people have not used drugs themselves, someone in their immediate or extended family has and continues to do so. This can, to a varying degree, result in the breakdown of family units, ultimately impacting adversely on the whole indigenous population of Western Australia. This might be a bold statement to make. However, all dysfunctional indigenous families in Western Australia are impacted on by drugs; whether they be licit or illicit is of little consequence.

Alcohol and cigarette smoking continue to decimate indigenous families. It is little wonder that mums and dads are powerless to defend their families against illicit drugs and substances that are so easily available in today's world. If a child sees its parents and elders inhaling substances or drinking alcohol on a regular basis, the child's destiny and opportunities are restricted from the start. Some people still believe, as it appears do most conservative politicians, that individuals are responsible for their own poverty. Many people living in Western Australia play on this notion, for it surely allows them to deny Western Australia's true history. Poverty and all its consequences are products of a society's history. Indigenous people in Western Australia are extremely concerned about the increased use of drugs in our community.

The national action plan on illicit drugs clearly found that social exclusion can be both a cause and effect of ill health. It is highly relevant to actions in the illicit drugs area. Increasing evidence points to the links between low socioeconomic status and social integration and illicit drug use, juvenile crime, suicide and mental illness. People who are homeless, living in poverty or inadequate, overcrowded housing, have few employment prospects and low self-esteem and suffer from racism, bigotry and the ignorance of others are extremely vulnerable to drug use and dependence. That does not include the physical and emotional exploitation of children and youth by those in our community who prey on the young and innocent and encourage drug use.

Is it in the interests of any indigenous person to tell the world if he has smoked cannabis, tried speed, heroin, crack or ecstasy or had a go at methylated spirits, paint, shoe polish, cheap wine, hairspray or a cocktail of prescription drugs? I think not, unless he has had enough or wants to be a statistic. However, some important facts and notable variations must be considered. New ideas and, therefore, proper planning for future generations are needed. The south west and larger regional centres of our State, particularly those on or close to the coast, are vulnerable to most illicit drugs. Cannabis is commonly used throughout most of these regions and centres, often in conjunction with alcohol and cigarettes, although it is also combined with other illicit drugs.

Indigenous users are aware that drugs are an expensive habit; however, they have little control over the dealers who set the price and control the moods of their young and/or vulnerable clients by manipulating them with enticements such as starter packs and quick fixes. Once the bunny is in the trap, the price goes up, and the bunny must find the money. That is when hock shops, used furniture stores and people who buy goods for cash with no questions asked become increasingly important. Some families have lost thousands of dollars as a result of sons and daughters or brothers and sisters stealing from them to feed their habits. This burden must be shared by the whole community, because once the family runs out of resources and can no longer be exploited, the broader community is targeted. As the director of a large Western Australian Aboriginal community-controlled holistic health service, I can report that very few culturally appropriate options are available to indigenous clients or families seeking help with drug issues. We are all susceptible to drugs, but we must recognise that Aboriginal people are even more susceptible.

I recently asked Mr Denis Hayward, a colleague of mine at the Noongar Alcohol and Substance Abuse Service and an expert in the alcohol and substance abuse area, for at least three points to make at this summit. The first point is commitment. Government agencies and key stakeholders must make a renewed commitment to Aboriginal programs aimed at addressing identified needs in the illicit drugs health area. The second is priority. Funding priority for Aboriginal programs must be given to Aboriginal service providers over non-Aboriginal service providers. The third point is resources. Increased funding to address the lack of resources for Aboriginal people and to establish and maintain Aboriginal services such as detoxification units, safe houses, shelters and clinical support services must be given the utmost priority. There is a lack of accommodation, particularly emergency accommodation, and youth facilities for Aboriginal people. These are urgently needed.

As I have titled my paper, drug issues can be black and white, working together. Resources can be shared; however, for programs to impact positively on our indigenous community, indigenous people must be in control of the effort and the resources needed to ensure that that effort is positive and successful. This does not preclude the imperative of proper partnerships and the harnessing of good intent.

It is important to understand that regional variations exist. Perth is the drug gateway to the indigenous community. For indigenous people, urban living brings with it a multitude of social issues. The social and emotional wellbeing of indigenous people in Perth and larger regional centres will invariably impact on the next generation. It does not augur well, and some families could be devastated by drugs. Clearly, Australia is divided regarding tolerance to drug use. This presents a scary scenario to those of us who work to diminish the adverse impact of drug use on individuals in the first instance, but, more particularly, on our society as a whole.

It goes without saying that initiatives promoted at this summit will have their knockers, and I have no doubt that my statement and perhaps my involvement will create some controversy. There appears to be a lack of commitment by government and society to a real partnership with the indigenous communities of Western Australia.

Indigenous people still shy away from mainstream services, and that is unlikely to change simply because government makes a policy. Some people may say that these are my perceptions, but most of my indigenous colleagues agree that these are more than perceptions.

Table No 1 refers to illicit drug-related charges dealt with by the Aboriginal Legal Service of Western Australia. The table illustrates that drug-related charges are on the increase within the indigenous population. The alarming statistics regarding the increase in manufacturing or dealing and trafficking in drugs should alert us that some indigenous people are now accepting that to be involved in exploiting other human beings - whether they be indigenous brothers or sisters - is acceptable and, in fact, normal. It is not. Indigenous leaders must be given the power to initiate positive interventions. Identifying many of those in our community who are manufacturing and trafficking is not hard. We are a close-knit community, but there are concerns about the safety of

individuals and families who are involved in illegal activities around drugs and those who may disclose certain information to the authorities. What I am saying is that, to a degree, there is little trust in the police and others in authority to do the right thing. Dare I say it - there appears to be a buzz in the indigenous community that some police are complicit; that is, they are involved in drug rackets, could not give a damn and they definitely could not care less if the person involved is indigenous. Again, these may be seen as my perceptions, but I believe that most of my indigenous colleagues agree with me.

My recommendation is the establishment of a special unit comprising Aboriginal police officers and police aides working to a combined committee of Aboriginal and non-Aboriginal leaders to identify appropriate interventions in the indigenous community.

A major concern to indigenous Western Australians is the availability of drugs in prison. Suffice to say that there is a drug culture in prisons. Indigenous Western Australians are disproportionately represented in prisons; hence we must promote appropriate alternatives to the current regime. Aboriginal medical services and indigenous drug services should be allowed to work in close partnership with the Department of Justice and the Police Service to develop strategies and to monitor and evaluate the situation.

I believe that the use of cannabis in the indigenous world is entrenched, as it is in the broader community. I have taken the following information from issues paper No 3, which addresses illicit drug use among Aboriginal people. The percentage of people who have used any illicit drug is higher among indigenous than non-indigenous people, but fewer indigenous people have used illicit drugs other than cannabis. Concern has been expressed by indigenous people across the State about the widespread use of cannabis. In many communities it is reported that its use has become normalised and it is now used in remote communities where, until recently, it was non-existent.

Given that cannabis is an illicit drug, I believe that this summit should discuss whether it should be decriminalised. Indigenous Western Australians will have little or no power to prevent its misuse if we do not make appropriate interventions regarding its supply and use.

Amphetamine use orally or intravenously has been reported by substance misuse workers in Perth and large regional centres throughout the State. Reports from Port Hedland, Kalgoorlie, Broome and Geraldton suggest that amphetamine use may be related to the proximity of these communities to mining, fishing and hospitality industries, in which the rate of use of amphetamines is high.

Illicit drug use is less common than other methods of taking illicit drugs. Nevertheless, the 1994 national survey of drug use among indigenous people found that two per cent of urban indigenous people acknowledged injecting drugs compared with 0.5 per cent in the general urban population. I have real fears that this percentage is on the increase. I have seen many instances and heard many stories to not say to you today that the indigenous community of Western Australia is being devastated by illicit drug use. To come to grips with the problems that arise from drug use, we have to understand that its use is a symptom of something lacking elsewhere. I will point some of these out.

Education: Let us revamp the education system so that it can inform our children properly and keep them at school longer. Indigenous Western Australians are missing out. If we fix this, we fix up some of the issues around drug use.

Housing: We need more and better houses for indigenous people. If we fix this, I believe we fix up some of the issues around drug use.

Employment: We need more jobs and meaningful forms of income for indigenous people. If we do this we diminish “nothing time” and improve self-esteem. One would think that this would impact positively on drug issues.

Media: Indigenous stereotyping by the media continues unabated. We are told not to believe everything we read and hear, but if it is constant, then it eventually sticks. Indigenous people are

not lazy, unintelligent criminals; we are quite the opposite. We do, however, need to seek assistance to help us through. More understanding and compassion from the media would go a long way toward diminishing drug use and dependency. I could go on and on, as there are many social issues impacting on indigenous Western Australians. Our job is to make these positive, as drug use and dependency will only increase should we not.

Hard drugs and soft drugs: is there a need to make distinctions? In the indigenous community, the impact of drugs is felt across the board. Our own diversity means we will have different views on what is hard as opposed to what is soft. The impact on our physical and emotional beings, however, is clearly different depending on which drug is being used. I see the devastating impact of volatile substances, such as paint and petrol. I see the destruction -

The CHAIR (Hon Fred Chaney): Your time has expired.

Mr WILKES: I conclude by saying that our society today should not condemn those who have been drug dependent; rather, we should embrace them as fellow Western Australians. Exclusion will only be detrimental to our effort.

The CHAIR: We now have a panel which will be chaired by Pat Dudgeon who is Head of Aboriginal Studies, Curtin University of Technology. Her panel members include Alex McIntosh, Senior Project Officer, Compari Midwest Community Drug Service Team, Geraldton; Dawn Bessarab from the Curtin University of Technology; and Joe Collard, youth worker from the City of Gosnells.

DUDGEON, MR PAT,
Panel Chair,
Head of Aboriginal Studies, Curtin University of Technology:

Mr DUDGEON: We are very fortunate today to have here three members of the Aboriginal community from a diverse background and I am sure they will give important and different perspectives. I introduce Alex McIntosh who has actually worked in the youth drug and alcohol field for the past six years. I also introduce Dawn Bessarab who has had more than 12 years' experience working with Aboriginal families affected by drug and alcohol problems, especially in the areas of child protection, family support and community development. She currently lectures on Aboriginal issues at Curtin University, while also studying for her doctorate. Finally, and not least, I introduce Joe Collard, an indigenous youth officer employed by the City of Gosnells who has also worked in the Ministry of Housing, human services and child protection. Joe has five siblings, one of whom is an amphetamine user.

I would invite questions to our panel and our keynote speaker after the entire session is complete. We will have ample time for questions and answers. The panel will commence with Alex McIntosh.

McINTOSH, MR ALEX,
Senior Project Officer for Youth with the Compari Midwest Community Drug Service Team.

Mr McINTOSH: Good afternoon to you all. My name is Alex McIntosh. I am a Yamatji man of the Badimaya people from the Paynes Find-Mount Magnet area, and I am proud to be here. I am the senior project officer for youth with the Compari Midwest Community Drug Service team. Compari is based in Geraldton and services the mid west and Gascoyne region. My career began by

chance when I answered an advertisement for an administrative traineeship through the College of TAFE Perth central campus. Before I could commence my traineeship, I had to find an employer who was willing to have me on the job for only 75 per cent of the week as the other 25 per cent would be spent in the classroom. I thank Holyoake, the Australian Institute of Alcohol and Addictions in Northbridge, the agency that took me on. As my administrative knowledge and skill level improved, so did my desire to learn all about the programs that were on offer within the agency and how I could adapt them to assist Aboriginal people and youth in particular. I soon found that I had a flair for working with youth, and Aboriginal youth in particular. Needless to say this did not go unnoticed by the coordinator of the adolescent program at the time. Unfortunately, the 12-month training period came to an end and with funding constraints, the probability of securing more funding to create a position on staff for me were virtually zero. Thus I was reluctantly let go, but not before obtaining employment with Victoria Park youth accommodation as a support officer. This is where I really started to wear different hats. The range of issues affecting young homeless people is strikingly similar to those affecting young people with alcohol or drug problems. I have acted in the roles of carer, social worker, welfare officer, teacher, alcohol and drugs counsellor, relationships counsellor and housing manager - just to name a few. In late 1999-early 2000, I was offered a full-time position at Compari in Geraldton, which I took joyfully.

During my contact visits with communities in the mid west region, it became clear to me that drug use is as diverse and widespread as the people are. The issues that I raise have been voiced to colleagues and me by concerned members of the communities within the mid west region. It is hoped by many that my relaying this information to you will assist in alleviating, if not containing, the spread of illicit drug use within the rural regions.

Observation and community information reveal that alcohol and other drug use by juveniles is beginning at a much earlier age. The ages that have been mentioned are early preprimary with eight to 10-year-olds, and early high school with 13 to 15-year-olds. Communities attribute this to the lack of support offered to youth in rural and remote areas, parental neglect and that youth have nothing positive to look forward to - by that I mean in the way of education, employment, housing and, more importantly, financial security.

A contributing factor to the parental neglect issue is the increasing interest in the use of marijuana among young Aboriginal mothers. The reason for the increase, as explained by a young mother in Meekatharra, is the fact that the females can see how many males in the community have turned to alcohol as a means of finding solace. The males often overindulge and as a consequence are the perpetrators of domestic violence disputes. As the women do not want to be seen in the public eye as being intoxicated, they have taken to using marijuana. As a consequence of this move by the females, the males have taken to using marijuana as well. With this trend comes a whole new set of issues. Two reports have come in from communities such as Mullewa and Geraldton of Aboriginal males in their late twenties to early thirties who have attempted suicide due to cannabis use and the confusion that is experienced when the poly drug affect of mixing cannabis with alcohol comes into play. The parental neglect caused by the introduction of marijuana use has inadvertently added to the increase in juvenile crime and youths' general lack of knowledge about socially acceptable behaviour.

I have a whole lot of issues in front of me that I would like to address, but I will leave you with a thought. Isolation and the feeling of being isolated can have a huge bearing on the wellbeing of any community. I ask you to consider the rural and remote communities when policies, procedures and programs for the introduction of new services are implemented. After all, one day the people living in the remote regions of Western Australia will inevitably end up being our next-door neighbours. Thank you.

BESSARAB, MS DAWN,
Curtin University of Technology.

Ms BESSARAB: I am quite privileged to be here. I am a Bardi/Injabandi woman. I am Bardi from the Kimberley and Injabandi on my mother's side, who is from the Pilbara. As I have only five minutes to speak, I thought that I would focus on two key points. These points come from my working experience over the past 12 years and from speaking to other Aboriginal workers who have worked with families affected by drugs and alcohol.

The two points I would like you to consider at this forum are, first, a holistic approach when working with Aboriginal families. What do we mean by this? This term is bandied around a lot and spoken about a lot, but do we know what it means to be working with a holistic approach, and do we actually do it? My understanding of working with a holistic approach is that we need to not only consider the physical and chemical dependence that an Aboriginal person has on a particular drug or substance, but also look at the emotional, psychological, social, spiritual and political relationships of that person not just to family but to the wider community and the Aboriginal community. Although it is not possible to explore these dimensions in detail, I raise them at this forum for you to think about, challenge and discuss how and why this approach can and should be integrated into treatment programs for Aboriginal people.

The nature of Aboriginal people's existence in this country has been based on a political struggle for recognition of their rights as a people, their rights to land and their rights to equality of services. A holistic approach needs to consider this in the context of working with individuals whose drug use may be the tip of the iceberg out of the depth of other issues that arise because of who they are - Aboriginal people. People have talked about social exclusions. Even though we live in the year 2001, many Aboriginal people still feel and are still excluded from the wider community.

The second matter I want to talk about is family and kinship systems. Because of the nature of Aboriginal kinship systems, family is often defined as broader than the nuclear definition of western family structures, which is mum, dad and the kids. Consequently an individual located in an Aboriginal family relates to a large group of people, not only brothers, sisters and parents but also aunts, uncles, cousins and grandparents. All these people have an impact on an individual's life, and some to varying degrees have different relationships of respect, trust and authority. That means that if we work with only the individual without considering the role that the rest of the family plays in the individual's life, treatment programs may not work or may be ineffective.

Family members need to be identified and included in any treatment program, so both the counsellor and the family can acquire an understanding of what is happening to that particular family member who is drug affected. It may be that different members of the family will play a different role in the recovery process of the individual, and provide different types of support in assisting the individual to get through and over his or her addiction. It is important to assist the member who is identified as having a drug problem, and to get the member to identify family members who can provide positive role modelling and support and who are drug free. Otherwise, often the drug-affected person returns to the old network because it is all the person knows and he or she is not strong enough to resist using drugs again and falls back into a drug pattern. Often many other family members are also drug affected. It is important to get them to identify other members of the family who are not drug affected. Sometimes the person does not see that because all the person sees is the group that he or she is working with or mixing with.

Treatment programs need to be culturally designed so that they work with Aboriginal-world views because, even though the effects of drug use are the same for Aboriginal families as they are for non-Aboriginal families, the way in which people respond is different because of cultural factors and historical experience. The way that they make meaning of those things is also different. We need to recognise that. I often hear people say, "Well, it is no different for Aboriginal families than

it is for white families." We must consider that the Aboriginal experience in this country has been different, and that is what makes it different for Aboriginal people.

Unless those matters are recognised and considered again, programs will not be affected. I ask the non-Aboriginal organisations that are represented here who have Aboriginal clients, what training do they offer their staff about cultural awareness? Do those organisations have an Aboriginal staff member in their agencies? When designing programs, do those organisations include Aboriginal people? Do they consider talking to Aboriginal people about what they think must go in a program that works with Aboriginal clients?

COLLARD, MR JOE,
Youth Liaison Office, City of Gosnells.

Mr J. COLLARD: Good afternoon, my name is Joe Collard. I am a young indigenous Western Australian of Dutch and British descent. I am currently employed at the City of Gosnells council as an indigenous youth/liaison officer, but I am here today as an indigenous person. I cannot express the views of all indigenous persons on the issue of drugs, as it is too diverse for any one individual to address.

I have not taken illicit drugs. My mother and her extended family raised me. I first noticed the problems of alcohol, cannabis and solvent abuse within the indigenous community when I was in primary school. I have four brothers and one sister. Today, one is an amphetamine user, one is in the WA Police Service, another is doing a traineeship, one has an extensive criminal record and the other is a university student. Illicit drugs affect many Western Australian families across the board in one way or another. I have noticed the availability of drugs including heroin and amphetamines has become more easily available. The quality of these drugs has become the new surge.

What is the cause? The contemporary expansion of drug use is a warning signal of the weaknesses and faults in our society including loneliness and despair. Otherwise, why should a significant number of talented, privileged people prefer drugs to the reality of the present day? Why do some people get hooked? Numerous other factors contribute to increasing drug abuse including disillusionment, depression and lack of purpose in life. Additionally, economic problems, including unemployment, and poor parental examples contribute to increasing drug abuse. Long-term illicit drug use will no doubt cause mental illness, and indigenous people already top the statistics. This addition has only one means to their end; that is, the criminal justice system in which indigenous Western Australians are also over-represented.

Illicit drugs has been the root cause of so many indigenous families suffering from domestic violence, crime, family feuds, prison, unemployment and the loss of cultural identity. What is the solution? To say that there is no solution would be a pessimistic outlook on society. Positive changes can occur through a process that includes every level of government and ongoing community involvement and dialogue. Drugs are not only an indigenous problem but also a problem for the community as a whole. Much thought must go into this. The whole of the Australian community is watching this summit and it has many critics; delegates, prove them wrong.

The CHAIR (Hon Fred Chaney): Thank you panel. At the end of this discussion, Pat Dudgeon will sum up the discussion. In the meantime, there is time for questions.

Mr CRAWFORD: I direct my question to Ted Wilkes. Ted, if I heard you correctly, I think you said that culturally, there were few things that an Aboriginal person could do to counter drug taking. If that were the case, would you agree that it is a major problem? Surely the key to any response must be culturally based.

Mr WILKES: That is a very good question. There is no doubt that Aboriginal people throughout history - I will refer to history without trying to make remarks about history all the time - have lost so much culturally. Throughout the southern parts of Australia, in particular, Aboriginal people are trying to reinvigorate our culture. Through what I call "harnessing good intent", if the resources are provided by the mainstream community to the Aboriginal community so that our efforts can reinvigorate our culture, we will get there. I do not mean to fob it off. It is an answer in which I could ramble on for a long time. However, it is all about resources. We must get in the resources and get proper understanding from the authorities. When we talk about culture, there must be law-makers. There must be law-makers in the south west among the Nyoongar people; that is, indigenous people who can assist the police and other authorities to do the right thing.

Mr COE: Ted, I picked up your points about the word "culture" as well. I noted that you said there appears to be a lack of partnership with the Government, and that Aboriginal people tend to steer away from mainstream services. An important point on which I picked up is that indigenous leaders must be given the power to deal with the problem within their own community. I take it you are referring to Aboriginal elders - along that line, anyway. For the purpose of this summit and for the benefit of delegates, will you perhaps elaborate a little on what you said about giving powers to the Aboriginal leaders to deal with these problems in the important role they play and, more importantly, to extend that role further within the Aboriginal community?

Mr WILKES: That follows on from the last question. As a director of a pretty large health service, I know that the resources we receive are given in good faith. However, they are never enough. It is all right for me, as one person, to say that I can use all those resources in a beneficial way for our community, but one can do only so much. Aboriginal leaders throughout the south west and the rest of Western Australia are crying out for this resource base. It is just not happening. We know that we have the commitment, but in some instances we need the learning. Therefore, it is a matter of providing the resource through the education system too. I mentioned that if our kids stay at school longer, we will end up with an intelligence that will allow us to take these resources and do with them what the rest of the community wants to be done; that is, to make sure we harness the good intent and start to decrease illicit drug use. We cannot do that effectively unless the rest of the community - the mainstream community - recognises that we are equals. At the moment we are still viewed as not quite equal to the rest of the community. I am not too sure whether that is a true statement on behalf of all Western Australians. However, in the main, most mainstream organisations still treat us in a subordinate way. Until such time as they recognise that we are equals and we are able to use those resources - the motor cars and the phones etc - we will not get too much further down the track. I have been told that I must keep my answers short, so I had better finish there.

Ms MILLER: My question is to Dawn, and Alex may be able to answer as well. It has been brought to my attention by Aboriginal people that the number of Aboriginal juveniles entering our juvenile custodial services is very high. Are any resources allocated for the diversionary stuff that happens within the wetjala community? When young white kids come before the juvenile justice scene because of their illicit drug use, or whatever problem, they receive a community-based order. Is there an appropriate matching service for Aboriginal youth? Secondly, is there an appropriate diversionary service for Aboriginal juveniles in regional and remote areas, so that people who come into contact with the justice system are cared for near their own communities?

With regard to services in the mid west region, I will read to you what was said to me before I left -

> The absence of male-specific health providers has an impact on the alcohol and drug consumption among Aboriginal males of all ages. In a lot of cases an Aboriginal male will not access health services because they may not be culturally appropriate. More Aboriginal health workers and health professionals are needed to address the issue. Training in alcohol and drugs for Aboriginal people should be easily accessible and maybe even delivered

within the community requesting it. The need for male and female Aboriginal health workers to be educated in issues that affect both genders, agencies, and their accessibility are a big issue with people in the Murchison area. Aboriginal people in the mid west find it amusing how people in Perth can complain about not being able to access a service because it is in a suburb on the other side of town, but get enough complaints together and you get a new office established in your area. What about the people who have to travel hundreds of kilometres to access such services? Not enough thought is give, to the time it takes rural people to get to their appointments, the amount of money they have to spend on keeping the appointment, and finally the likelihood that they may have to stay over in a different place for a period of time. Although the agencies are advertised on rural television, the majority are still inaccessible; and, through the media, the advertised agencies seem to be giving the impression that they only assist people from the wider community.

[Quote not verified.]

The CHAIR (Hon Fred Chaney): The question related also to diversionary services. Do any other members of the panel, or any delegates, have specific knowledge about the availability of those services?

Ms BESSARAB: No diversionary service comes to mind. That is not to say there is not one; there may be one that other people in this room are aware of. However, if we have to think about what diversionary services there are, that indicates that they are probably scarce and there are very few on the ground, if any, otherwise we would have thought of some names. The only program I can think of for young people - and it is only for young Aboriginal males - is one in the south west called the Lake Jasper program. I know from talking to some of the people who have worked with that program that some of the things they have done with young Aboriginal youth have led to a real turnaround in some of those young people's lives. However, as Ted mentioned earlier, resources are the key, and we do not get enough resources to enable Aboriginal people to set up culturally-appropriate programs to work with our youth.

Mr MEOTTI: Ted, I noted with interest your comments about the legal aspects of drug use, particularly in Aboriginal communities. Do you think any changes could be made to the drug laws or to the Criminal Code in Western Australia to tackle or improve the situation for indigenous people? Is there a role for tribal law within Aboriginal communities as a way of addressing illicit drug use?

Mr WILKES: Yes. I will answer the second question first. There is definitely a need for traditional law and what we call customary law to be invoked in our communities to work alongside the mainstream law systems, and Aboriginal elders in those communities have been waiting for this opportunity to do that. In fact, in many cases they do that anyway, but they get into trouble because they are invoking their laws, and the Aboriginal people then have to go in front of the white man's laws and they sometimes get a double whammy. As I have indicated, marijuana use is entrenched in Aboriginal communities. I would also like the delegates to discuss the potential to decriminalise cannabis use. It is so entrenched in our community that we have little chance of controlling its misuse, given the current regime and the way it operates. It is up to this summit to really get its teeth into discussing what to do about that matter. Our communities are devastated not only socially but also physically. As we have heard from places like Meekatharra, there are physical health concerns about the use of cannabis, but there are also social concerns, because it costs so much to buy it in the first instance, and it then costs so much socially to accept what happens when people become polydrug users and use cannabis in conjunction with alcohol and cigarettes. The actual burden of cost is so immense to our community that we have to do something about it. I ask that, in some legal context, it be undertaken. There are hard drugs in the Aboriginal community that we cannot deal with at present. We need the mainstream community to offer us proper ways of

negating the potential for heroin and amphetamines to creep further into the indigenous community and devastate us even more.

Mr J. HARRIS: Dawn talked about Lake Jasper, a culturally diverse place. It is a very successful program that is run on cultural lines with Aboriginal people. Unfortunately, they do not have the resources to update and take more young people into the facility. That is always the issue.

The CHAIR (Hon Fred Chaney): Could you please form a question.

Mr J. HARRIS: The bottom line is that there is a lack of Aboriginal cultural places. It is as simple as that.

Mr ITALIANO: My question is to Joe Collard. I have been a partner with Joe in the southern districts local drug action group. Could Joe tell us of the difference he has made since joining the City of Gosnells, and in particular, with indigenous youth in the area and the programs undertaken to achieve changes.

Mr J. COLLARD: I have been with the City of Gosnells for three years. I started as a trainee at the local pool - the leisure world centre. From there I got involved with youth services. I studied while doing youth work. I was then put on full-time work. I am funded by Safer WA and the City of Gosnells. I look at things in a holistic approach as I am the Aboriginal youth/liaison officer. You have to look at things in a holistic way. When I deal with young Aboriginal kids, I know there must be something wrong at home. For example, there are five or six kids that regularly come to the youth centre. The kids have no food at home - nothing. I feel for them but you can only do so much. We have conducted heaps of programs. Earlier this year we held a family camp for Aboriginal kids. They were invited to bring a significant family member to the camp. The camp was opened up to the wider community in order to help with reconciliation. We held an Aboriginal cultural youth forum with Tony Italiano a few months ago. It was sponsored by the local drug action group and the City of Gosnells and the Department of Education. Chris Lewis and a number of other role models attended. We got them to pump in the good positive stuff. Whenever there is something in the local newspaper I generally put my face straight on it and put the positive stuff out straight away so that it combats the negative. I try to weigh the positive against the negative. I do not like to give myself any glory but things are working in the City of Gosnells.

I believe that it starts from local government, and, if you have a good team to back you up, and a good council, things can improve. Gosnells is a good council, but there are some councils nearby that need to pull their weight and lift their game a bit. I believe that the City of Gosnells is moving ahead in a lot of areas. I hope that answered the question.

The CHAIR (Hon Fred Chaney): I apologise to you, Tony, for misnaming you when I gave you the call. I will take one further question before I ask the panel to sum up.

Ms ROSENBERG: I am not sure who can answer this question. In my work with indigenous children, I find that many of them get sent down to detention centres, and, even if they have not previously been using illicit drugs, not including cigarettes, they come back with a severe drug problem. Do you find that even with city kids being sent to detention centres?

Mr WILKES: I will have a crack at this one. I have just noticed my colleagues are trying to decide who will answer, and I would like a little bit of help from them. From the perspective we see around us, it is certainly true that we are very aware and wary of what happens inside prisons. When our juveniles go into prisons, we always discuss whether or not it is a good thing. This summit really needs to understand that these are genuine concerns of indigenous people. We see our kids go into prison and into juvenile institutions, and they come back with some other ways of looking at life, which are not necessarily good ways. Some of the role models they run into in prison are not very positive, and some of the ways that prisoners do their business are not the ways we do it on the outside. You must understand that some of these institutions are not a safe environment for juveniles. Inside some of these institutions are hard-core juveniles who have learnt

the tricks of the trade, and they pass that information on to people who are not necessarily hard-core themselves, or who have just been in for a little while. That is really a concern for us. I would just like to open this up, if some of the other members would like to answer.

Mr DUDGEON: I think the issue was about detention camps, rather than places like Nyandi or Riverbank. Would there be any difference between detention camps and other institutions? They would be more monitored.

Ms BESSARAB: In my experience in working with a couple of families, that was the case for some of their young people who went in. They may have been using marijuana, and I do not know if they were drinking alcohol, but when they came out, as Ted said, they were a little bit smarter and started getting into car stealing and those sorts of crimes. Their drug use had escalated a bit and they had graduated to amphetamines. I do not know if that is the case for all the kids, but I know that in a couple of families I work with that was certainly the case for a couple of their young members. After the first entry into the system, it was a constant revolving door with one particular young person. As I said earlier, when you are dealing with young people who are using drugs, usually the family systems that they come from have broken down, and there is heavy drug use there, so the young people go back into that. When this young man came out, the family was also using drugs, so it compounded what he had picked up in prison, and made it a lot worse. That it why I think it is important to consider a holistic approach, because you cannot just look at the individual and the chemical dependency in isolation. You have to see how that is connected to the way the individual relates to his family, where that family is located in the community, what its history is and how that impacts on their experiences and meaning-making. It is a whole range of things.

The CHAIR (Hon Fred Chaney): Thank you very much. I now invite the panel chair, Pat Dudgeon, to sum up the discussion.

The PANEL CHAIR (Mr Pat Dudgeon): Thanks, Fred. Basically, this is a short summary, just taking down the main points of each of our speakers, including those of our keynote speaker, Ted Wilkes. Ted said that the drug problem among indigenous people is widespread and part of the issue of poverty and powerlessness. Few culturally appropriate programs are available to Aboriginal people, and there is a general lack of resources across the board. He also said that other social issues must be addressed in the treatment of drug use. One of the important points he made was that cannabis should be decriminalised.

Alex McIntosh spoke from a rural perspective and said that drug use is as varied as people are. Rural drug use has different aspects. He spoke about young mothers in rural towns who are tending to use cannabis rather than, or with, alcohol and that males are following this trend. This has led to increased neglect of children.

Dawn Bessarab made two points. Her first was that a holistic approach must be adopted. That means that the land, history, and emotional and social wellbeing of indigenous people must be taken into account when dealing with any issue, and particularly those involving drug treatment approaches. Her second point was that family networks must be a part of any approach. Any approach needed to go beyond the individual and this was critical in drug treatment.

Joe Collard related his own experiences and noted the change in the type of drug abuse that has occurred in his own time among his indigenous peers. He looked at the issues behind drug use. He asked that delegates and all those involved in this community drug summit use this event to make some significant changes to the way things are at the moment.

Thank you panel members and our keynote speaker.

The CHAIR (Hon Fred Chaney): A number of delegates have made the point to me over the past couple of days that it is important that the Aboriginal voice be heard at this summit. Distinguished

Aboriginal delegates are, of course, involved in the summit, but this panel has been an anticipated session. We thank panel members for their contribution.

Summit suspended at 3.28 pm

Summit met at 5.00 pm.

The CHAIR (Hon Fred Chaney): I invite Carlo Bellini to report on behalf of group 1.

BELLINI, MR CARLO,
Chair of Working Group 1.

Mr BELLINI: To commence I would like to say that we very much value and commend all the young people who talked to us today. They gave group 1, dealing with young people and illicit drugs, further insight. The youth forum this afternoon depicted the essence of our deliberations and discussions in today's group sessions. We heard from young people how we need to recognise the diversities within youth. Other delegates raised the issue that young people must be involved at the start of designing, developing, implementing and evaluating services and programs. That is one issue that group 1 believes is the essence of working with young people. I was very happy and proud to hear that our group represents young people. Our group consists of about five young people, so we have representation from a good spectrum of youth.

We would like to enforce and emphasise one aspect that arose today; that is, all too often youth is grouped into one category. We talk about young people but we do not recognise that young people span all ages. Young people can be categorised as babies, children and youths up to the age of 25. In specific reference to drug use and young people, we must categorise youth and consider each specific unit within that large group. In addition to youth being age-specific, there are major diversities in regional, urban, rural and remote groups. There are also ethnic differences. We must appreciate those diversities when considering prevention, early intervention and drug treatment strategies for young people. There is also a diversity within drugs and the drugs that young people take. Our group is also considering that aspect. It is essential that this summit results in some positive outcomes regarding illicit drug use and young people.

After discussing and appreciating the importance of defining youth and the diversities within youth, we talked about the other topics we thought were extremely important when considering young people and illicit drugs. I have already addressed the first topic of young people and their concerns. We also addressed the topics of regional and remote areas, treatment, prevention, education, community and accommodation. We went around the table, and everyone presented their opinions on the points they thought the group should consider when preparing its recommendations. We have now done that for all the topics, and tomorrow we will prioritise those points and formulate recommendations.

Our group is working together fantastically, and has great functionality. The old fable of the tortoise and the hare springs to mind - we are getting there, but it is a slow process. Although it is difficult to deal with important issues, we are making progress, and I hope the next few days will be very productive.

LYNCH, MR FRANCIS,
Chair of Working Group 2.

Mr LYNCH: Group 2 is discussing supporting families, particularly children, parents and siblings of drug users, to deal with illicit drug issues. This morning we spent time reflecting on and trying

tease out a bit more from the first session. Three of the speakers - Sven Silburn, Tim Harris and Nathan Kurth - spoke to us, which added to our deliberations.

We then focused on the topics raised in the issues paper for group 2. We spoke about the stereotyping of drugs in the media and the issues surrounding that. That stereotyping often has a negative impact on the families of people who use drugs. It has been raised two or three times during the summit that some sort of code of practice for media reporting should be developed. We believe that would be useful, and we would like to see it pursued in some way. Families often feel stigmatised or marginalised because of the way drug issues are reported.

We also looked at accessibility to treatment or information services, which is another issue that has been raised in a number of ways during this summit. Families often do not know where to go to get information and are unaware of what is available to them. In a sense, it is a perennial issue; however, some focus needs to be given to that. We should continually try to create better ways of giving information to parents, siblings and other people associated with a person using drugs. Associated with that is the need for researchers to publicise information as well as gather it. The group looked at ways of ensuring information is widely published. One of the questions in the issues paper referred to the extent to which services employ family-sensitive practices. Such practices may need to be pursued with more vigour. It is early days, however, and we probably have further to go.

Another issue is the extent to which we may need to evaluate current services.

Our group had a major discussion about language. We sense a polarity in discussion about harm minimisation and zero tolerance. When families are trying to access services, sometimes the debates and what can be seen as polarities can affect families and the people trying to assist. We see a great need for diversity of service. We must empower people to be able to choose the type of service they want. However, sometimes the language creates issues in its own right. Perhaps a tolerance about the diversity is needed.

The last issue we addressed - we will discuss it again tomorrow - relates to balancing individual rights to privacy and the desire on the part of people around the user to be involved in service provision.

FORD, MR DANNY,
Chair of Working Group 3.

Mr FORD: Delegates might be surprised that I am speaking as the chairperson of the working group today. Our group is addressing illicit drug use and Aboriginal people. We elected two chairpersons - the other being Josie Maxted, who spoke as chairperson yesterday.

Our working group was very happy with the panel this afternoon, because it covered many of the major points that we want to get across to the delegates at least once in the five days we are here. Delegates will note clear statements in the introduction to our issues paper. The summit is discussing illicit drugs, but alcohol, prescription drugs, solvents and tobacco do more harm to the Aboriginal community. We are grappling with the terms “illicit” and “licit” drugs, because focusing on only one narrows discussion of the impact of drugs on the Aboriginal community. We want the broader issue addressed.

One of the principles refers to family. We want to ensure a much broader definition of family.

The other issue missing from the principles that the Aboriginal group would like to see included - we will argue this point later - relates to the disadvantage that the Aboriginal community suffers as a result of colonisation. Ted Wilkes made those points today.

Our group has also discussed the prison situation. Many of our young men and women are in jail as a result of the use of drugs. Should jail be the solution? Evidence indicates that when Aboriginals go to jail they use drugs much more frequently. That question must be addressed.

Ted Wilkes referred to disadvantages suffered by Aboriginals as a result of colonisation and so on. It becomes an intergenerational issue. We have heard many stories from young people today about falling into the cycle of drug use. However, for Aboriginal people it is actually an intergenerational cycle, and we are very keen to get that point across. Yesterday Graham Mabury painted a fairly simplistic picture of the media's role in portraying drug use by Aboriginal people - not just Aboriginal people but the media's role in sensationalising these types of issues - and Tim Stockwell today refuted that by saying that especially for indigenous communities the media does play a huge role.

One of the things that our group will be pushing is the early intervention and prevention and education type strategies.

I will now put forward some comments made by our group today. We are thinking that there just are no intervention and prevention services for the Aboriginal community - if there are you can count them on one hand. Maybe I am being simplistic in that sense, but there certainly are not a lot. There is a need to ensure respect for regional variations because of culture, remoteness and other factors. Strategies need to be comprehensive across the continuum, such as early identification, intervention, treatment, rehabilitation and ongoing support et cetera. We are very keen that there be partnerships with the mainstream services. There is demand for drugs. The value base of Aboriginal communities needs to be supported so we can go forward with strengths that promote social cohesion. We are very keen to return to looking at the strengths approach. We need to look to these cultural foundations as a means of healing the impacts of history, colonisation and disadvantage. We need to look at community support for education, and the promotion of respect and acknowledgment of the efforts of the working group by the Government, the public and the media - and do not sell our efforts short, especially the working group. We need to mobilise the non-Aboriginal community in support of our efforts and values where black and white are working together to promote a more civic society in Western Australia.

CRAWFORD, MR IAN,
Chair of Working Group 4.

Mr CRAWFORD: I am chairman of the working group on prevention and early intervention strategies, including schools, parents, public education and action in the local community. Today's subject addressed the demand for drugs by mobilising our communities, and the examination of prevention and early intervention strategies and what works. That was aimed squarely at our committee and we felt that we were very topical.

I feel very fortunate to be with a group of people who are totally cooperative. We are all leaning in the same direction and, although we have moments of disagreement, the end product is that we are looking forward to the betterment of this problem facing the summit this week. It is important to stress that the group I am involved with is very positive.

We attack our problem by throwing ideas up onto a whiteboard, no matter how disparate they are. We discuss them and we gradually pare them back to some sort of recommendation. We are in that process now. That has enabled us to arrive at three or four recommendations at this stage; but of course they have not been totally finalised and polished into the presentation that we would like to make towards the end of the week. However, I will run through the matters that we have alluded to which are important and which we will be dealing with finally towards the end of the week.

This is the proposed wording: we recommend that the school drug education program receives extra ongoing funding to conduct comprehensive evaluation, focusing on behavioural outcomes and widespread ongoing support. This would include school implementation and teacher competence; student, parent and community participation and input into the process; teacher training and support, including pre-service training; filling the gaps, post-compulsory years of education - years 11 to 12 - parent education and awareness, and strong school policies.

Another recommendation that we have come closer towards finalising is mobilising the community in parent education. A recommendation could be framed to further enhance and promote the activities of local drug action groups, drug service teams, Safer WA, local service clubs, police, local community groups and school drug education program regional organising committees. Another suggested recommendation would be in relation to the media. We know this is a controversial subject, and we may have some difficulty formulating this; however, in order to increase the number of protective factors and decrease the number of risk factors, we feel that the media can play an important role. Some of the elements of that recommendation could include a code of conduct and accurate reporting of drug-related subjects. The next recommendation that we are tackling - and some of the hard work is behind us - are the issues of management, administration and coordination. We need a structured, coordinated activity, cross-agency collaboration and common goals. These are the themes that run through the summit this week. We are fortunate in having been addressed by three speakers today: Tim Stockwell, Sven Silburn and Richard Mitford. I thank those gentlemen for the time they devoted to us. We hope to call on other speakers to address us tomorrow.

BATTLEY, MS JAN,
Chair of Working Group 5

Ms BATTLEY: I am speaking on behalf of the group looking at treatment and reintegration. It is a struggle in the sense - as Fred said at the beginning - of using our ears and our mouths, and everybody in our group is doing that. We have diverse viewpoints to bring to the group and everyone is working really hard. We have started to get pretty much into some of our recommendations. We have some overlaps with other groups, and we will let them know about that, but I will not mention them here.

Yesterday I told you that we were looking at the prongs of examining first, existing services; second, the gaps, third, innovations and fourth, continuous improvement. We have continued along that road and I will make this statement on those points. In the issue of examining existing services, we are formulating a statement that says a lot of services are in place. However, the options do not suit everybody; not all services provide immediate access when this is appropriate; waiting lists are starting to be developed and there are not enough services specifically for youth, for Aboriginal people and in our regional and remote areas.

In the gaps area, some of the priorities - we have not got to the end of this - are that existing services need to expand to eliminate waiting lists and enable immediate responses to people in need. When I talk about gaps I am talking about resources. Another priority is increased support for people after rehabilitation. Our recommendation includes linkages and transition to housing, employment and education, which is part of the reintegration idea. A further priority is self-help support networks, and the consideration of halfway-house type accommodation as a follow-on from treatment. We are also discussing a new residential-respite detox centre for amphetamine users and young people. We need to address other issues, such as people with high support needs and long-term cannabis dependence. I know that is a mishmash, but we are still developing the idea of a new residential-respite detox centre that provides immediate access and a flexible program.

The last area we have got to is the provision of a statewide network of home detoxification services. We have started to discuss new initiatives and innovations but the group is not ready to talk on those yet.

McKENNA, MS PAM,
Chair of Working Group 6.

Ms McKENNA: Group 6 is dealing with broadening service provision. We had a number of issues that we decided we would delegate to other groups. I have been able to check with one group which is interested in taking them on board. We will be needing to speak to a group about under-resourcing in the care system and drug-free units in prison. There needs to be greater emphasis on recruiting into treatment, people who use drugs. We regard co-morbidity as a major issue under our banner. We have categorised the remainder of the issues under six headings. We may collapse the number further; we will see how we go.

Broadening treatment is our major heading. If we focus only on drug services, we will not make any difference. We are looking at the various groups, such as general practitioners, Centrelink and other government agencies targeting the difficult-to-access groups and the needs of rural, remote and indigenous people. Those two last points will be considered in all of our recommendations. With shared care our concern is about fragmentation. If we do not pursue a shared care model, we will continue to lose people through the gaps. We are talking about shared care models, case management, continuation of care and also the funding models that I talked about yesterday. Access is a continuing theme throughout the summit. Once again it involves the remote, rural and indigenous population and buck-passing. We can hear continuing themes. The media is not a continuing theme. With messages and marketing, people do not know what is there. They are receiving conflicting messages. The media could be an ally but I do not think we are working well with them at the moment. There are three points: access to information for people who are seeking it, messages and protocols and codes of practice with media.

No amount of policy change will change things on the ground. We need a change of attitude and destigmatisation. We are looking at cultural change, which might sound like an odd heading. We need to start with strategic direction and policy. We need to filter that through professional education, capacity building and funding models. Co-morbidity has its own heading because we regard it as such an important issue, although it could well fit under another heading. It is the hard end of the spectrum, it requires accountability and partnership, and we will ban buck-passing with mental health and alcohol and other drug sectors working together, access to psychiatric assessment, skilling up of existing workers and awareness of alcohol and other drug services in the mental health area.

MEOTTI, MR JASON,
Chair of Working Group 7.

Mr MEOTTI: We too have a very coherent working group. Considering the nature of the subject matter which can be so divisive in the community, we have a group that has the focus at hand. We are moving in a forward direction, which is tremendous. As I mentioned yesterday, we have basically broken up what we wish to look at in performing recommendations on the basis of five areas. They are legal legislative changes, policing resources, corrective system issues, diversionary options and juvenile justice issues. We had two speakers, Mr Peterson from Sweden and Professor

Sven Silburn, both of whom have been useful for the recommendations that we have put together so far and will make.

This afternoon's panel that discussed indigenous issues was useful and we have incorporated some of those ideas into the matters that we will discuss. We will deal first with the issues in which we reached a consensus and we will deal later with the issues that concern legal legislative changes - that should be fun and games.

The group's recommendations dealt with juvenile justice and diversionary and corrective systems. I will inform delegates of the draft recommendations. We recommend that parents or carers should have the right of audience in the Children's Court and that parents and carers should have formal rights to have an influence on the outcomes of the decisions made in the Children's Court. The rationale behind this recommendation is that the parents and carers do not have a formal opportunity to influence formal coercion into treatment. Children have the right to access legal support, whereas parents and carers do not have the same rights. Clearly, referral options should have adequate resources. A draft recommendation is currently before us that the range of diversionary options should be reviewed and significantly broadened, especially for areas outside the metropolitan region and for indigenous communities. Treatment and therapeutic services must be provided with adequate resources including physical resources and staff expertise to meet these additional demands. Although a number of options are available, they are limited, especially outside the metropolitan area and for Aboriginal people. In addition, clinical support services must be developed to ensure effective interventions are readily accessible within a reasonable time and at reasonable geographical locations.

A draft recommendation is before us that drug treatment programs must be determined on entry to the prison system by using quality assessment and matching interventions to individual needs. These programs should be monitored comprehensively and continually. We hope to provide prisoners with quality access to prison treatment and harm reduction strategies and those programs must be consistent with community standards and expectations. The needs of prisoners may vary at different stages; for example, some prisoners may require withdrawal management, others may be at risk of using drugs, for example, pharmacotherapies, during imprisonment. Programs must be provided to prepare prisoners for release, which are linked to community services, to reduce the risk of overdose.

Some other issues that were raised by the group are still to be addressed. Under the legislative framework there appears to be a gap in the mental health laws in that they do not include drug-related psychoses, for example, amphetamine abuse, and they should be included for further discussion.

MARSH, MS ALI,
Chair of Working Group 8.

Ms MARSH: Our group is examining ways to reduce harm caused by drug use to the community and to individuals. In its discussions, our group has focused on the family community. We consider that the family plays an important part in harm reduction. This morning, Tim Stockwell and Sandra Collard spoke to our group and provided us with useful and informative information for our purposes to consider harm reduction strategies.

Today we identified our group's priority areas. We wrote on a white board the issues that are listed on the issues paper and then other members of the group added issues that they would like to be addressed. We had a system by which we ticked our five priority issues and thereby chose five issues to consider. So far, two of the issues that we decided to consider cross over with other

groups. The first issue we decided to consider was the need to address community attitudes and to educate the community. I note that group four has also mentioned that issue. The second issue is the media guidelines for the reporting of drug issues. Again, groups four and six have mentioned that, therefore, we must discuss that issue with them at the next meeting.

The third issue is the provision for Narcan to be administered by peers and family members of drug users. We are hoping to get Simon Lenton to address our group on that issue tomorrow. Our fourth issue is harm reduction in the workplace. The fifth is peer education for users.

The way we are dealing with those issues is that a couple of people for each issue have gone away to try to come up with a draft recommendation tonight, which we will toss around tomorrow. I guess the people who have chosen the issues that are linked with other groups should not spend too much time on them, just in case.

A couple of issues that we talked about regarding the priorities that we have identified were the need to include culturally sensitive aspects and also to make sure that services are available for rural and remote areas. We are keeping those two issues high on our agenda.

We were particularly divided on a sixth issue; that is, supervised injecting facilities. That issue was discussed, and the group was divided on whether a recommendation should be developed on that topic. We tossed around the issue, and in the light of community interest in this topic - it was in the matters for consideration - we agreed to report the discussion back to the plenary and perhaps seek advice from the Chairs, or from some other forum, later on.

The CHAIR (Hon Fred Chaney): To pick up Ali's last point, there will be a meeting of the Chairs this evening, as there was last night, along with the facilitators. That is the sort of issue we can discuss at that time.

FROYLAND, MS IRENE,
Chair of Working Group 9.

Ms FROYLAND: I represent the 11 hardworking members of group 9. I remind delegates that our topic - we have to keep re-reading it ourselves to make sure we are on track - is about linking drug strategies into overall social policies, particularly social policies aimed at addressing underlying causes of major social problems. We consider that this is a very overarching topic. Whereas other groups have said, "They're dealing with the media; we don't need to", sometimes we have to make an overarching comment, even if other groups are dealing with the specifics of things. We have looked at our booklet, where it refers to social policy as being concerned with the welfare of the community, and, at its heart, the relations between the components of the community. Therefore, we are taking our topic very seriously. The challenge for us is to come up with recommendations that are general enough to cover and include all of these important issues, but specific enough to be the basis of movement ahead in this area. Therefore, we are working to find that sort of balance.

We too have a group that is working extremely well together, and we are all quite amazed by that - not by the fact that we are working well together, but that on such a difficult topic we can achieve consensus. I congratulate the members of my group.

We were overwhelmed by the task early this morning, and we decided to use the old whiteboard approach. We have a number of focus topics. However, unlike the other groups, instead of working on one topic, word crafting it, getting it right and moving on, we are trying to get some sort of - I have been told not to use the word "holistic" - overview perspective of our topics.

I will give a little flavour of the things at which we are looking, rather than list them in any way. We are looking at some sort of affirmation of a current approach - whether we affirm it or make

suggestions for policy changes. One of our topics is whether or not this summit will affirm the government approach and policy and build on it. We are looking at the difference between acute treatment and tertiary prevention frameworks, and the interrelationship between them. I am just dipping into our topics, because we are not really ready to report on them in any detail.

We are looking also, although not in a specific way, at the dilemma between punishment and prevention, because sometimes one of those gets in the way of the other. We are looking also at the fostering of social capital. These sound airy-fairy, but I promise you that by tomorrow night they will be halfway down to earth, and by lunchtime on Thursday they will be well and truly down to earth.

We had a number of Aboriginal people here today. They challenged us with a number of things, one of which was to look at the status of cannabis. We wonder whether we need to look at that in any detail, or whether group 7 is planning to do that. I will leave that question with delegates. I think we are on track. Tomorrow we will have to work very hard, but we will be ready.

Summit concluded at 5.45 pm