COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Reference: Impact of illicit drug use on families

MONDAY, 28 MAY 2007

CANBERRA

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Monday, 28 May 2007

Members: Mrs Bronwyn Bishop *(Chair)*, Mrs Irwin *(Deputy Chair)*, Mr Cadman, Ms Kate Ellis, Mrs Elson, Mr Fawcett, Ms George, Mrs Markus, Mr Quick and Mr Ticehurst

Members in attendance: Mrs Bronwyn Bishop, Mr Cadman, Mr Fawcett, Mrs Irwin, Mrs Markus, Mr Quick and Mr Ticehurst

Terms of reference for the inquiry:

To inquire into and report on:

How the Australian Government can better address the impact of the importation, production, sale, use and prevention of illicit drugs on families. The Committee is particularly interested in:

1. the financial, social and personal cost to families who have a member(s) using illicit drugs, including the impact of drug induced psychoses or other mental disorders;
2. the impact of harm minimisation programs on families; and
3. ways to strengthen families who are coping with a member(s) using illicit drugs.

WITNESSES

BALDOCK, Ms Emma, Client Counsellor and Community Development Officer, Canberra Mothercraft Society 26

BAXTER, Ms Josephine Helen, Executive Officer, Drug Free Australia 1

CHRISTIAN, Mr Gary, Board Member, Drug Free Australia 1

HERRON, Dr John Joseph, Chairman, Australian National Council on Drugs 38

RUSS, Mrs Carol, Parent, Drug Free Australia 1

THOMPSON, Mr Craig, Chair, Drug Free Australia 1

VUMBACA, Mr Gino Anthony, Executive Officer, Australian National Council on Drugs 38

Committee met at 9.37 am

BAXTER, Ms Josephine Helen, Executive Officer, Drug Free Australia

CHRISTIAN, Mr Gary, Board Member, Drug Free Australia

RUSS, Mrs Carol, Parent, Drug Free Australia

THOMPSON, Mr Craig, Chair, Drug Free Australia

Witnesses were sworn or affirmed—

CHAIR (Mrs Bronwyn Bishop)—The committee welcomes Drug Free Australia to give evidence. Drug Free Australia highlights that Australia has among the highest levels of cannabis and methamphetamine use in the OECD. The committee will also hear from the Australian National Council on Drugs, which has found that over 40,000 children live in a household where one adult is taking cannabis daily and that over 14,000 children live in a household in which one adult is taking methamphetamines daily. Also appearing will be the Canberra Mothercraft Society. The society recently prepared a collection of stories from grandparents about parenting grandchildren as a result of the effects of drugs on their adult children. Good morning everyone, thank you for being with us. Do you have any comments to make on the capacity in which you appear?

Mrs Russ—I am a parent, registered nurse and small business owner and operator.

Mr Thompson—I am Chair of Drug Free Australia and an acting magistrate in New South Wales local court.

CHAIR—Who would like to make an opening statement?

Ms Baxter—Thank you, Mrs Bishop and members of the committee. Drug Free Australia and the families we represent really do thank you for the opportunity to update information provided in our written submission to the inquiry sent in March. I say ‘families’, because the impact of harm caused by illicit drugs is by no means isolated to the individual who is addicted. There are three main things that make the evidence we provide of utmost importance and relevance to this important inquiry. Firstly, we are a not-for-profit community-based peak body in drug prevention. Therefore, we are unencumbered because our scope is national and we have no religious or political affiliations. Our main contact is with people whose lives have been decimated by illicit drugs—that is, mostly with family members of one or more addicted loved ones. Today we bring you the voices of many Australians. This is a very responsible task and one which we do not take lightly.

In the interests of time we have structured our formal presentation to elaborate on three recommendations from our recent international conference in Adelaide. Mrs Russ, who is representative of just one of the families who is living the nightmare of illicit drug use, will give her personal account of the impact of the lack of readily available and effective treatment services. We hope you will see that treatment is not just a numbers game; it is also a question of quality. Drug Free Australia Chair, Mr Craig Thompson, will elaborate on drug policy and legal

measures to assist families. Mr Gary Christian will illustrate with examples current disturbing trends in alcohol and drug research in Australia—research that underpins policy-making decisions.

My role is now to present to you the first of the recommendations from our international conference, which attracted many diverse community members. It was actually a conference with a difference in that way. The recommendation is that we move from a policy limited to harm minimisation towards one that reflects a zero tolerance approach to illicit drugs. In section 1.2 of our March submission, we illustrated components of the Swedish drug policy, because that country has taken a restrictive policy approach that is working. As recently as 2006, the United Nations Office on Drugs and Crime reviewed the Swedish policy and came up with a favourable evaluation. The linchpin of this successful policy, which started 20 years ago with a vision for a drug free Sweden, is:

We do not accept the integration of (narcotic drugs) in society and our aim is a society in which abuse remains a socially unacceptable form of behaviour, a society in which drug abuse remains a marginal phenomenon. A drug free society is a vision expressing optimism, and a positive view of humanity. The onslaught of drugs can be restrained, a drug abuser can be rehabilitated.

I have in my lifetime had the advantage of working and living in many different parts of Australia. Now when I travel back to these places, the most recent being Darwin, I see great change. I see a veneer of progress, or what we call progress, but when I talk to people there is no longer the optimism of the past. I meet with school students who feel angry, confused and overwhelmed because they know that most of the kids in their classes have had the chance to try drugs. There are health services that are not coping. There are people who need to feel there is hope. I see an unprecedented number of families suffering for so long in silence because they think they are the only ones facing the stigma of drug abuse, until something finally gives and they lose a son or a daughter.

We need urgent change and it needs to be a macro vision with detailed follow-through. It needs to be embraced with a whole of community approach—I would say a bipartisan approach that transcends electoral time frames. Then, and only then, will we start to clean up the mess or at least contain it. Our families and our young people want stronger prevention measures. I could provide further advice to the committee based on recent feedback from middle schools around Australia; I have brought some of that here. You already have our initial recommendations in section 1.3.5 of the March submission.

I will finish with an email sent to me by a mother in Victoria who wishes to remain anonymous. She shared with me in desperation an email from her daughter, who became addicted to heroin at 17 and now has hepatitis C. They are living with that. She has given me permission to quote from it as long as it remains anonymous:

Hi mum,

I was just thinking of you, and because this is free and you read your mail all the time i thought i would write to you for a change.

Although i don't have much to say, thought i'de let you know i love you and appreciate everything you have done for me, throughout my life and especially the last 8 years or so. I know i've put you and dad through alot and you know i am trully sorry for any hurt i have coursed, for all the lies and deception, but now this is not only my promise to you but to myself and everyone else. I am stopping it all for good! I am going to get professional help this time and not try to do it on my own. I don't want this is my life anymore. I still don't know why i do it besides the fact that i like how it makes me feel. And that isn't good enough for me anymore, i deserve better. You raised me so well and always taught me right from wrong, and i chose wrong far too many times. My life changes now! I'm sick of feeling so out of control about my life, worrying that if I get a job that I like, i will screw it up because of drugs or my compulsion to lie.

… … …

I love you mum with all my heart, thank-you for not only being my mum and never giving up on me, but for being my best friend.

love you for-ever and a day ...

Ladies and gentlemen, I would like to close by tabling some information that you might find useful. There are copies of some of this. I have a recent review by the United Nations. It is actually also on the website, but we are happy to send you further copies if you would like. Also included are extracts from a book produced in Sweden called *Preventing, Detecting and Curbing Drug Abuse* and from *Liberalization of Drugs Policies* by Orvar Olsson. There is also an excellent website that has been set up in the United States called the antidrug, which has excellent support resources on it for parents. It is a very good attempt—one of the best I have seen—to keep up to date so that parents can see trends and be assisted during the process.

CHAIR—Are you giving us a copy of those documents?

Ms Baxter—Yes, I have given you extracts of these so that you know what they are.

CHAIR—If you gave us the whole document we could make it an exhibit. We can make the extracts, which everybody has a copy of, exhibits. But can the evaluation be given as a exhibit? That looks very good.

Ms Baxter—You can have that definitely, yes.

Mr CADMAN—I take it that the one from Sweden is your only copy?

Ms Baxter—No, I have many copies of that one. These are our only copies, but I can probably get some more.

Mr CADMAN—We should get those.

CHAIR—We will take note of those and see if we can get a copy of this document, the appraisal. We will accept as an exhibit *Sweden's successful drug policy: A review of the evidence,* an evaluation in September 2006 by the United Nations Office on Drugs and Crime. Thank you very much. Would anyone else like to make an opening statement?

Mrs IRWIN—*The Liberalization of drugs policies* was from 1996; have you got the latest one? This is 11 years old and I know they have made a number of changes over in Sweden.

Ms Baxter—I will see what I can do to find that. This was given to me by—

Mr Christian—There is one.

Mrs IRWIN—That is right up to date, is it?

Mr Christian—Right up to date.

Mr CADMAN—You may remember that in the hearing in Sydney you doubted the existence of this.

Mrs IRWIN—I have been going into it recently and I know there have been some drastic changes.

CHAIR—The one here is September 2006. We will get additional copies of that and we will accept that as an exhibit.

Mr Thompson—In relation to an opening statement, do you want to know what we might be talking about?

CHAIR—If you would like to make a short opening statement, yes.

Mr Thompson—In relation to my particular evidence, I will be looking at questioning the policy of harm minimisation and I will say that it is responsible for the tolerance to drug use today.

CHAIR—We would be happy to have you make that statement before we go to questioning. You will each have the opportunity to do that.

Mrs Russ—I am going to share with you a brief insight to the effects of illicit drug abuse upon my immediate family—namely, my husband Mike, eldest son Tim, son Mark, daughter Kate and me. Around December 1995, at the ages of 12 and 13 years respectively, an uncle introduced cannabis to my sons, unbeknown to their father and me. Cannabis and amphetamines were used regularly whilst in the company of the uncle during frequent visits and weekend trips away boating or surfing until approximately the end of 2003, when we were alerted to the events of the relationship. Throughout this period, an addiction to illicit drugs was formed by both sons.

For the intent of today's meeting I am going to focus on the events of Tim, and the role of illicit drugs in his life. During the period of 1996 to 1999, Tim was casually employed at a local Hungry Jacks outlet whilst engaged in secondary studies. His aptitude in computer information technology was soon recognised by his local high school, which proceeded to employ him as a network administrator whilst he continued his studies. He left school approximately midway through Year 12 to pursue employment in the IT industry until 2001, when he joined our small business for almost 12 months as a production assistant technician. By this time, Tim had become a regular user of marijuana—up to 2 grams a day—with intermittent uses of street

speed, amphetamines—1 gram a day—and up to nine tablets of ecstasy per day, plus magic mushrooms.

On his 20th birthday, 17 January 2002, he went cold turkey on all drugs. In a psychotic state, he left for Queensland with a girlfriend of only one month. After torching his car and inflicting injuries upon himself, he was detained under the Mental Health Act in New South Wales. His father flew to New South Wales and returned home with him. Shortly afterwards he was detained in South Australia under the Mental Health Act and then released into our care. In April 2002, he booked himself into the Kahlyn Private Hospital drug and alcohol unit for treatment of his dependency, followed by further time at the Fullarton Private Hospital, after suicidal thoughts and actions.

With psychiatric support and support from a counsellor at the Second Story Youth Health Centre, Adelaide, Tim was able to finally make another go of his life, yet we believe he was still, on occasion, dabbling in marijuana and other illicit drugs. He regularly attended a local gym and developed a passion for ninjitsu, achieving a black belt and then striving to achieve a dan. During this time he found work as an electronic assembler and production technician with a local company and by April 2006 he had been appointed their quality manager, IT manager and service manager. He had a promising future and was being groomed for higher purposes.

Tim stated to us that he was under immense pressure at work, had related stress and was considering leaving the company. The end of a business trip to Queensland for an overseas client marked the beginning of Tim’s downfall, with a heavy relapse back into the drug scene. Consequently, in early April 2006, Tim was offered to either resign from his job or he would be sacked and his name would be blackened in the IT industry. Tim pursued legal advice and action, which is currently unresolved. Determined to get on with his life, he began studies with Mission Australia, to achieve a certificate IV in small business management, taking on private IT work when available, and eventually engaging in IT for employers. Withdrawal from drugs brought the realisation, humiliation and frustration of losing a well paid and valued job earlier. Tim’s dignity and pride suffered. His confidence and self-esteem began to wane, he struggled to concentrate, had panic attacks and suffered chronic depression.

Tim joined Narcotics Anonymous, became involved with Warinilla, Southern ACIS, DRUG ARM Australasia, and enrolled for support with beyondblue. He was advised by a care provider to withdraw from his current IT employment and ninjitsu. With early inquiries in September 2006, and desperate to rid himself of drugs, Tim was assessed and approved for suitability to participate in a drug rehabilitation program at the Woolshed Drug Rehabilitation Community, Adelaide. Elated at such an opportunity he diligently marked off the list of preparatory requests made, he telephoned regularly as required on 22, 26 and 29 September, and 3, 6, 10, 13, 17 and 20 October for a period extending five weeks, hoping and waiting desperately for a placement, for an opportunity to learn how to live without drugs.

Throughout this time, Tim had returned to live with us. He had stated that it was a particularly difficult time as not only did he have to deal with the long-term effects of taking drugs and withdrawal, he had to deal with the loss of autonomy in living in his own place of residence. He felt unable to apply for employment outside of the family business, because of his commitment to securing a placement at the Woolshed. Rehabilitation could take as long as six months, with then ongoing support required. On Sunday, 22 October 2006, in a desperate bid to end his pain

and suffering, Tim committed suicide in our family home. I have been informed by the Woolshed that there is only accommodation for 24 participants, with up to as many as 34 waiting for a bed at one time for periods as long as 12 weeks. As of 24 May this year, 30 people were waiting. Tim could wait no longer.

How has Tim's death impacted on my family and society? Foremost, we have lost a dearly treasured son and brother. He was his sister's soul mate. Our society has lost a brilliant young man in the early prime of his time. As the design engineer for our small company, my husband recently gave up a very lucrative project that he had spent almost 12 months on—for one of Australia's railways—due to an inability to function at a normal level. My youngest son, desperate to deal with his pain at the loss of his brother, resorted back to drugs, leaving a path of financial and personal ruin. He is now having to face and deal with that. My daughter, who won a music scholarship in a renowned secondary school and had plans to become a lawyer, is now failing Year 11 and considering leaving school due to chronic depression and an inability to concentrate. As a registered nurse, I have not been able to return to the workforce due to my inability to function at my normal level.

To leave the painful memories, we are now in the process of selling the family home that we have only lived in since March 2006 and which was purchased to enable our daughter easy access to her new school. Since Tim's death we recognise that our lives will never be the same again and wonder if ever we will find the peace that we feel we now deserve. This is a quote from Tim's journal, written, I believe, after being approved a bed in the Woolshed:

> I guess this is a new chapter in my life. What will it hold? What do I want it to hold? I see bad everywhere. I am afraid. However, I am more afraid that it is going to never change. Hence the paradox.

Thank you for this opportunity to hopefully bring positive change to those in our communities desperate for such.

CHAIR—Thank you very much, Mrs Russ.

Mr Thompson—Thank you. My concern is what is causing our current drug problem, and we have an enormous one; I think that is well publicised. Years ago I met a drug expert who came to Australia, Dr Gabriel Nahas, a man well respected by the White House. He has, unfortunately, been discredited by some people here in Australia, but he is regarded internationally as a drug expert. His first comment was that we had a quite considerable drug problem and that was because of tolerance, as he saw it. I have attended four international conferences in the United States and the participants were unanimous in their belief that tolerance is a huge cause of the spread of drug use. That belief is accepted in Sweden, which introduced liberal policies. You can see from the book that back in the sixties the prescribing of amphetamines and other drugs failed, there was an enormous increase in use, and they quickly moved, after two years, towards an increasingly restrictive policy.

That policy appears to have provided enormous benefit for that country. Even during times of lowering of the economy, when unemployment became rife and one could have expected increased drug use and of course fewer treatment facilities because of the unavailability of finances, drug use continued to drop. Again, that is outlined at page 35 of the book. They clearly say it had everything to do with their drug policy, which was promoted quite highly throughout

the Swedish society, and a national anti-drug advocate and coordinator was appointed by the national drug policy coordinator's office to do that. So parents and all members of society were inundated with that policy. The Prime Minister's policy of zero tolerance is almost identical, in my view, to that policy stated in the Swedish program, but he has been criticised for saying it. Prohibition is not a policy of tolerance. It is clear that harm minimisation is.

I have here today two documents. One outlines the Harm Reduction Coalition, which began in America many years ago. It has its roots in the culture in America. It was introduced in particular by an organisation called NORML, which preached the safe and responsible use of illicit drugs and in particular cannabis. It was a huge lobby. Dr Norman Zinberg is a national director, a former Harvard University psychiatrist and a user of cannabis. He has written a book called *Drug, Set and Setting*, which the reform movement regard as a brilliant piece of work for the promotion of that particular policy. The policy was introduced, as we know, in 1985. To be quite frank, from where I stand I see that drug use has just increased and increased. Our policy has not been prohibition; it has been harm minimisation in every sense of the word, including the decriminalisation of drugs in South Australia, in Canberra, and now, I believe, in Western Australia.

I listened very carefully to Dr Eva Brannemark, who is the chief detective superintendent of police in Stockholm. I asked her how important policing of streets in relation to drugs was. She said it was very important to their program because that is where drugs are spread. Decriminalisation to infringement notice status clearly hampers them because they cannot apprehend people who are found in possession of drugs. They could be sellers, but the law says they are to be regarded as users only if they have minor quantities—up to100 grams, I believe, in South Australia. So it is very open for people to sell drugs on the street. If apprehended, provided it is under the decriminalised amount, they only need pay for the infringement notice, and that is the end of it. They are never punished for repeat offences, and they can go on selling their drugs. The cost of an infringement notice compared to what they might make in a day's outing would be absolutely nothing to them. I accept that policing of the streets is a very necessary component of any program that is going to help eradicate drug use in this country.

I was president of PRYDE, Parents Reaching Youth Through Drug Education, for many years. I had contact with many parents. In court and in mental hospitals I saw the effects of drugs, and in particular cannabis, on individuals. I have been conducting inquiries in mental hospitals since my retirement in 2001, and I have noted an enormous increase in the number of hearings that we have been undergoing—it has almost tripled since 1996. Doctors are very quick to tell me they believe it has everything to do with drug-induced psychosis. Cannabis plays a major part; amphetamines are stepping in. I do not say amphetamine use is exactly catching up at this particular point in time, but it is certainly causing a lot of heartache. It seems to cause brain damage very quickly, according to the doctors.

The question is how we help parents. I have had contact me over the years many parents with children who were using, mainly cannabis, and whose behaviour had become absolutely intolerable in the home—there was assaulting and destructive behaviour that you simply could not believe. In a number of cases I helped them to get their children into treatment, but they simply would not stay. It occurred to me with my knowledge in mental health that perhaps many of those young people had become psychotic from use of drugs. That was stated to me by a psychiatrist many years ago in Liverpool, who expressed a concern that something like 80 per

cent of young people going into the hospital at that stage were suffering from cannabis induced schizophrenia. Her concern was how many were in society in that condition. She had tried to get her information through to authorities, but she said she ran into a brick wall.

I would have to agree. There are no statistics kept, and I believe there should be. I get varying opinions. I have had the same statistic quoted to me by a doctor at Shell Harbour. A medical superintendent suggested between 40 and 60 per cent. When I was at Sutherland—I left there in 1990—a social worker estimated about 50 per cent. I get varying opinions, but they are all that drug-induced psychosis is high. Of course, amphetamines are now coming in on the scene as well.

CHAIR—The Australian Institute of Health and Welfare keep statistics on admissions and separations for hospitals. Do they include that information in their statistics?

Mr Thompson—I do not believe so. Certainly the statistics I have seen refer to the number of adjournments and the number of people against whom orders are made, community treatment orders and other matters relating to the orders made at inquiries. I do not believe that there are any statistics kept as to people who are suffering from a drug-induced psychosis. It is not abnormal when a patient comes in suggesting to be suffering from a drug-induced psychosis for doctors to ask me to adjourn the matter for a couple of weeks. They say that if it is only a drug-induced psychosis it normally lasts from days to weeks. If it goes longer they say it could be an underlying psychosis that is being exacerbated by illicit drug use. My question back to them is, 'How can you be sure that it's an underlying psychosis when there are no characteristics of the drug?' The response has been, 'There's increasing literature to suggest that cannabis may cause longer term psychosis.' It is something that really needs consideration, in my view.

My recommendation when I spoke at a conference in Adelaide in 2005 was that we really need treatment for people who are addicted. Addiction is not catered to in mental hospitals. The doctors are interested in giving them anti-psychotics to bring their illnesses under control. They leave the hospital and return almost immediately to their drug use because they have an addiction, and they are back in. It is a revolving door syndrome. I have had patients coming back 20 or 30 times because they have simply continued to use drugs. Cannabis is now recognised as a very addictive drug, as are amphetamines, and something needs to be done about it, in my view.

CHAIR—You are saying there is no treatment for addiction under these court orders. Do they come under the drug courts?

Mr Thompson—The inquiries are under the Mental Health Act. They are people who are brought in on schedules who are mentally ill.

CHAIR—When someone is scheduled, they come under your jurisdiction?

Mr Thompson—That is correct. The police can apprehend people who are committing a crime or who are attempting to hurt themselves whom they believe to be mentally ill. They can bring them to a mental hospital and of course they are assessed by two doctors, one a psychiatrist. Then I come along and I conduct an inquiry, for which the patient must be presented as soon as practicable, and I determine whether further treatment is necessary.

CHAIR—One of the things that I have found out about those sorts of orders is that they are limited to the jurisdiction in which they are made. So if someone leaves the state nobody has any jurisdiction.

Mr Thompson—Yes, a difficulty, I agree. There seems to be nothing to stop them from leaving the state. It is not as if they were put on a bond by a court restricting their comings and goings, so to speak.

Mr QUICK—Your second recommendation is:

Introduce a restrictive drug policy with nationally unified laws.

In light of Mr Thompson's evidence, what do you see as a series of nationally unified laws?

Mr Christian—Cannabis decriminalisation is not even across the states.

Mr QUICK—No, but you want to introduce a 'restrictive drug policy with nationally unified laws'.

Mr Christian—Yes.

Mr QUICK—What does that mean?

Mr Christian—A 'restrictive drug policy' is what Sweden does; they do not call it zero tolerance. They do not put people in jail; they put them in rehab. We would advocate the same. I think the talk about states is that our states do not have unity. That is a problem with states I suppose; they all think differently.

Mr QUICK—Unity in sentencing, unity in rehabilitation?

Mr Christian—Yes.

Mr QUICK—I have been to the Woolshed. If we had a hundred Woolsheds around Australia I think we would cut off the number of people. You have two problems: one is those who are in the pipeline who are currently taking drugs, and then the siblings who can see perhaps the advantage of or like mixing with that sort of culture. If you are going to have nationally consistent laws, they are not just about zero tolerance; they are also about dealing with those who are afflicted by drugs, surely?

Mr Christian—Yes, for sure.

Mrs Russ—Yes.

Mr QUICK—Sweden is a great example, but it is one country. Here we have six states and two territories.

Mr Christian—Yes.

Mr QUICK—A huge area. Just ensuring that the drugs do not come in is costing us hundreds of millions of dollars a year in surveillance and the like, not only in Australia but in South-East Asia and goodness knows where else. How realistic is this? Is there a time frame; do you see it as a five-year or a 10-year program?

Mr Christian—There are certain things that can be done at a federal level and which have already been done—making sure that there is increased funding for drug rehab, for instance—which override whether there are shortfalls at a state level. I think we would look to a lead from federal government.

Mr QUICK—It is interesting that your third recommendation is:

Give priority and funding to implement the 'Road to Recovery' report's recommendations

I was on that. It took us two terms, two parliaments, three years. We thought we came up with the solution.

Mr Christian—You are feeling frustrated?

Mr QUICK—Yes. It took the government three years to come up with a response to that report, and the response, to say the least, was absolutely hopeless. Because I was involved in that report, this pamphlet was put out in my electorate. 'Harry Quick and Labor, soft on drugs. Harry Quick just doesn't have what it takes to protect our community and our families from drugs. Who has a strong and responsible policy to keep drugs out of our community?' We are politicising a report and recommendations because we did not necessarily agree and there was not consensus on some of those recommendations in *Road to recovery*. I think that is cheap politicisation and bears no relationship to what I believe, but I am being labelled as 'soft on drugs' in my electorate.

Mr Christian—I do not think you will find that coming from our organisation.

CHAIR—That has got to be authorised; by whom is it authorised?

Mr QUICK—It is; by the Liberal Party in Tasmania.

CHAIR—That is politics, Harry. You cannot say these people are doing it. Coming back to the question, I would have thought the things you were saying is that you would want marijuana to be illegal across all the states.

Ms Baxter—Yes.

CHAIR—One of the problems that you see is that, because it is legal in South Australia, South Australia becomes a honey pot and a source of exports, particularly into the Northern Territory—into Aboriginal settlements—where it has become a major problem. Dare I say the railway probably helps it.

Mr Thompson—When we originally signed the 1961 United Nations Single Convention on Narcotic Drugs, all states ratified the convention. It was a convention that unified a number of

conventions that had been held. It was mainly directed at trafficking, which had become an increasingly big problem over the early years of last century; it concerned the supply of drugs, cocaine and opium to China, and things of that nature. The United Nations Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988 certainly strengthened the law by demanding that cultivation and possession of cannabis for personal consumption must be made a criminal offence by the parties. They accepted exceptions that if people could be induced into treatment, they could be offered leniency by the court in terms of no conviction, and things of that nature.

CHAIR—That is the 1988 convention on?

Mr Thompson—The United Nations Convention Against the Illicit Traffic in Narcotic Drugs and Psychotropic Substances.

CHAIR—Australia signed onto that?

Mr Thompson—Yes, and it was said to have a large input into that particular convention.

CHAIR—And a term of that convention is the cultivation and possession of cannabis must be illegal?

Mr Thompson—The cultivation and possession of cannabis for personal consumption must be illegal.

CHAIR—Did we ratify that?

Mr Thompson—Yes.

Mr CADMAN—We signed and ratified did we?

Mr Thompson—It had to be. It was said, certainly from what I read, that Australia had a large input into the enactment of that particular convention.

CHAIR—Is this the one that Mr Soros wants to overturn?

Mr Christian—Yes, 1961 particularly.

Mr Thompson—Mr Soros has been promoting the medical use of marijuana extensively. As I see it, it is a way around those conventions, because the exception to non use is medical and scientific use. I believe that those who are looking for reform—that is, perhaps legalisation—accept that it is very difficult to overcome the convention because something like 150 countries are signatories to the single convention. They are looking for the exception.

CHAIR—When you say single convention?

Mr Thompson—The Single Convention on Narcotic Drugs—the 1961 convention that I mentioned.

Mr QUICK—Carol, 'zero tolerance' and 'harm minimisation' are phrases that are bandied around. Your son was obviously very intelligent. If you were the person responsible for putting the education brochures out, how would you see the education aimed at primary school kids initially? We have had fridge magnets, pamphlets, we have had things to parents and the like, but nothing seems to work. Singapore and Indonesia have death penalties but we still have stupid Australians going over there. How would you see the education aimed at primary school kids initially?

Mrs Russ—Earlier than primary—junior primary, definitely.

Mr QUICK—What message would you give?

Mrs Russ—For a start, it is all about appreciating what you have been given as a human being—your health, your wellness level. I believe education could even start in kindergartens as such whereby when they share the bowl of fruit around, the children are aware, because of things taught at home, that they are eating well and they are doing the right thing, and the kindergarten is promoting it.

Even from a kindergarten level there can be pictures up of people smoking cigarettes and a line through it or something. I do not know exactly how to approach it, but I believe an approach should be taken from as early in childhood as possible, and right through schooling. Not just for the students, but for the families. How many families out there are naïve?

Let me give you a classic example. My husband went on a river trip recently with a group of friends who fly model aeroplanes. They take their boats out on the water, they put floats on them and for a weekend they fly their boats. A friend said to my husband, 'How are you dealing with the loss of Tim?' My husband shared how we were or how we were not surviving as such. Another gentleman stood up and said, 'Well, I believe it's the parents' fault.' My husband had made the comment that we need education, families need to understand, to be informed, they need to be able to make informed decisions themselves as to their children, as to whether they want to use drugs. When you go to a local GP he has to inform you of the effects of certain drugs or procedures so that you can make an informed decision. That is what it boils down to: information. This gentleman declared that it was the parents' fault and the parents should be the teachers. My husband bit his tongue, because it was early in the weekend and he was there to relax. I would have said to him, 'You are a parent, are you not?' and I know that he does have children. Then I would have said to him, 'How have you educated your children?' because he was saying, 'Why give this to the teachers? The teachers have enough to contend with and they do enough and all the rest of it. Why give it to the teachers?' I would have said, 'Well, as a parent, how have you educated your children against the usage of the drugs?' I can guarantee he would have just said, 'It's not good for you.' He does not have the knowledge and the understanding, like a lot of families.

Even as a registered nurse I was naive as to how drugs affected the body as such. Unless you get into looking at illicit drugs and have a knowledge base, it is airy-fairy. All you know is that you see road rage, you see anger. I have seen violence in my own home, and different people respond differently. With my son Tim there was no aggression; with my son Mark it was horrific to the point he ended up living on the streets because we could not have him under the roof with

us, which was just a terrible time for us. We had two going at the same time. It is all about education, and I believe it should be at a very tender age and in the community as such.

Mr QUICK—How do we convince governments at both the state and federal level that money should be there? When state elections come along it is all about law and order and 'We need another thousand police to put the lid on drugs.' Yet schools and rehabs et cetera are scratching around for the dollars to do that. We are not only dealing with intelligent parents who do know right and wrong; there are also a lot of dysfunctional families out there who do not have the ability, the resources or the support to ensure that when their kids are at risk they have a coping mechanism.

Mrs Russ—This is where I feel the schools and our communities play a vital role; it may be our sporting communities. How do we go about doing it? First of all I believe in zero tolerance to drugs. My son, Tim, is a clear example of someone using drugs occasionally and it still having an effect on his life. When he was in crisis, when his work pressures were too great, he resorted to a means that would ease his pain from the past. It was a habitual process, and I guess there are alcoholics who do the same thing. It is with any form of addiction, whether it is pokies—when people are looking for an out or a support structure somewhere, sadly, sometimes they turn to it. That was Tim's downfall. Had he been in rehabilitation or got into rehabilitation, I believe he would be working with us within our company today. He wanted to become an integrated member and we wanted him because he had brilliant skills. We could not take him in under the role that he wanted while he was still in limbo with his drug addiction. He needed to be able to learn how to live free without drugs. He needed to be able to have those support structures, those friendship groups, those like people, to be able to brainstorm with.

When I was doing my nursing degree I was looking at alcoholism and the use of sleeping medications synergistically with alcohol—how people can best work through it. I found out, talking to Alcoholics Anonymous, that group support was essential for them to keep clean of alcohol. That was the fundamental that keep them strong and together. In promoting rehab here, I personally believe that it is a very important stage for those who want to be there. That is a very important statement in itself; they need to be ready. They need to know that this is where their life is going and they need support to get out of it. Otherwise, I believe it will not work. We need to be able to give them that option to get on with their lives. Our society has lost a valued member. I really, firmly believe that. I am not saying it because he is my son. I saw his skills and his abilities. I have copies here if the committee would like of his evaluation during his working career. There will be many people like him. At his funeral, I had a mother weep on my shoulders—someone I have not had dealings with for many years—whose son is in rehab. I was elated for her but I felt insanely jealous. It is all about education.

CHAIR—What you are saying is that you want a policy that is in two parts. Firstly, you want a prevention policy to stop people starting in the first place. Secondly, for those people who did, you want an effective rehabilitation policy to bring their lives back and make them useful people.

Mrs Russ—Yes.

CHAIR—I know Louise Markus is going to ask a question in a minute, but one of the things that we saw that was hugely effective in the early eighties was the Grim Reaper ads about AIDS.

They worked because they frightened people silly. I am coming to the conclusion that we need a full-on campaign like that. The evidence is that that campaign worked for AIDS for a long time. We have AIDS on the rise again because there is a new generation who did not see those ads.

Ms Baxter—There are a couple of things that I would just like to add in answer to Harry's question. Firstly, it was briefly highlighted in what I said before. Sweden certainly is one country, but it is broken into municipalities that are quite territorial; the south of Sweden is quite different from the north. With their vision for a drug-free Sweden in the eighties, they made a decision that regardless of what government was in power, they all embraced that same common vision. From that they said that the government budget would remain to keep the thing ongoing, like the campaigns that you are suggesting.

CHAIR—That is fine, but there is a problem. There is a solid body of people within our community, within our nation, who want drugs to be accepted as a part of life and that we have to learn to live with it. That is opposed to what I think, but it is a reality, and we will hear from them. We do hear from them. We had one who said he wants marijuana legalised, taxed and treated like tobacco. To me that is immoral as well as everything else.

Mr Thompson—Can I just make this comment? I wonder if he would say the same thing about tobacco.

CHAIR—He wants to treat it like tobacco.

Mr Thompson—Tobacco is a legal drug.

Mrs IRWIN—It is a killer as well.

Mr Thompson—The policy now is zero tolerance. The Quit For Life program is one cigarette can harm you. It is not promoting moderate or safe use.

CHAIR—We get a statistic that says 19,000 people last year died of tobacco related use, but they count everyone from nine to 99. I have never seen anyone commit a violent act under the influence of tobacco.

Mr Thompson—Yes, that is right.

CHAIR—Our methodology does not count deaths from drugs, except by overdose.

Mr CADMAN—Mr Thompson's point is a good one. You can go into a shooting gallery and be forced not to smoke while you are there.

CHAIR—That is right.

Mr Thompson—That promotion is media-wide; we see on the television the terrible harmful effects of tobacco.

CHAIR—That is what I want to see for drugs.

Mr Thompson—Yet you will get people saying that scare tactics do not work.

CHAIR—They do.

Mr Thompson—There has been quite a reduction in tobacco smoking as a result of the educational component being pushed, not only in schools, but through the media extensively. It is constantly before people, in addition to addressing sidestream smoke and the harm done to nonsmokers.

CHAIR—You would agree that we need a full-on campaign?

Mr Thompson—Yes.

Ms Baxter—Ongoing.

CHAIR—Louise, you have been waiting.

Mrs Russ—Can I say something. Throughout all of this I also have a brother with a mental illness induced through using cannabis. I have chased him for the last six years from one end of Australia to the other. In saying that, we live under an umbrella of shame with drugs. For years I would not tell my friends where my children were at when our family was in pain and agony. It is like mental health—I believe it is a similar umbrella of shame. You do not declare that your children have a schizophrenic uncle who is living with us, because it creates fear.

I think one thing we need to do as a nation is eliminate this shame, eliminate this fear. No-one chooses to become a drug addict. Believe me, you do not wake up in the morning and say, 'I want to become a drug addict.'

CHAIR—No, but you choose to take the drug.

Mrs Russ—Yes, and you may choose for numerous reasons. You may choose because it looks exciting, or peer pressure, or maybe this will get rid of my pain, or it will not affect me—again, naivety. There are always reasons for choice.

CHAIR—We heard evidence here last week from a young man from South Australia, Ryan, who told us he started because it was cool—cool kids did it. And society said, 'There is no shame, it's fine.' Society said, 'It's okay to take it; it's not going to hurt you.'

Mrs Russ—Until there is illness or there is crime and all the rest associated with it; yes. I believe those in society who approve of it either are users or there is some benefit in it.

CHAIR—Or there is money to be made out of it.

Mrs Russ—Exactly. You just need to look at the families and society suffering and say, 'What cost is it for Australia to do something about it?' Look at the costs upon Australia. For a start, these people cannot provide to society for our taxes or for goods and services because of their illnesses.

CHAIR—That is why the Australian Federal Police have developed their drug index which shows the amount of money they have saved us by keeping drugs off the street. They say over the last 10 years they have saved us, above and beyond the cost of their services, $5 billion. For every kilo of crystal meth they keep off the street, they are saving us $280,000; for every kilo of heroin they keep off the street, it is in the vicinity of a million dollars. They are performing a really measurable tremendous benefit. That was splendid evidence.

Mrs Russ—It is.

Mrs MARKUS—Carol, during the course of that time when your sons were using drugs, what information did you need and what attempts did you make to get help? I am trying to understand what did you need to happen that did not happen; whether you called the police or someone else. At the same time, what information did you need that you now have that, if you had already had it, may have made the outcome different today?

Mrs Russ—First of all, they were in early puberty. Being novice parents, we knew there were pimples and everything happening with hormones raging, so when we saw mood swings or an inability to concentrate in school and all the rest of it we questioned whether it was simply puberty blues or things associated with puberty. So from that point we were naive about the effects of drugs and what to be looking for. We started to research and communicating more with our children—well, let us say they started opening up to us more—and my son, Tim, had the audacity to download from the web how marijuana was a safe drug and things written by other people. He would throw this in our face and say, 'How can you argue'—thinking we are fuddy-duddies or we are just not with it or cool or whatever—'it is a bad drug!' We kept telling him, 'Tim, if you continue to use these drugs they will be to your demise.' We lacked the education—

Mrs MARKUS—But if you had the information saying, 'These are the facts, this is how many people have died, this is how many young people who now have bipolar or other disorders'?

Mrs Russ—Yes, we could have been armed with a comeback. I was studying for my nursing degree during that period as well. The body is a marvellous piece of equipment, but it is very fragile. I must confess I was devastated knowing that my children were dabbling in drugs. It was a bitter fight for us with them on a daily basis saying, 'Look, this is no good for you.' We had ACIS teams involved and local doctors involved. We worked with the schools which is where Tim ended up getting his job as well. They wanted to keep him focused. They saw he had incredible potential, but they also wanted to keep him focused on his studies. He left year 12 because of the drugs. Essentially he went off into IT, but he just could not concentrate at school.

We needed to have more knowledge and information as parents at the time. Resources were difficult. There were time periods if you wanted ACIS or someone from a mental health facility to give the support; you had to wait weeks before the next appointment. With Tim in his latter stages they were seeing him, I believe, every second or third day—as he said one day, 'Just to make sure I'm still here.' But he needed more than that. You asked what we needed. We need more funds.

CHAIR—Carol, do you think some families are at more risk than others?

Mrs Russ—I wondered about that; you do question yourself as a parent. No. There are people I am aware of from good wholesome families where parents have good positions in life, who offer to our community in positive ways—in organisations, in groups they are with—and their children have goals and ambition. All it takes is that one: they take one smoke and think, 'That was all right, that didn't harm me.' The next thing you know, peer pressure, they are at a party, they are given more. Some people can have a pre-existing addictive nature and possibly genetically, too, people are predisposed to drug abuse. My family has a history of alcoholism on my father's side; a grandfather and all five of my cousins have been alcoholics. We have a predisposition, I consider, to perhaps becoming addicted to substances, in which case perhaps we need to tread more carefully. My understanding is anyone can become addicted with continual use of anything. Perhaps some have the genetic make-up to become more of a chance for addiction.

CHAIR—That is when prevention becomes even more important. Alan is terribly keen to ask a question and then we will come back to Louise.

Mr CADMAN—Have you read the evidence we took from Dr Alex Wodak and others in Sydney regarding the Swedish results? Have any of you read that?

Mr Christian—I have had to be pull up Dr Wodak over misquoting the Swedish results. He has constantly done this and, despite me correcting him, he continues to trot out the same story which is wrong and falsified by their own information, even from the European Monitoring Centre for Drugs and Drug Addiction report.

Mr CADMAN—Would you clarify that, because I only have a vague recollection of what he said? He said something like, 'You need to take the Australian figures in context; actually we're getting great results and the Swedish are very authoritarian and we wouldn't want to have that.'

Mr Christian—Yes. The figure I am talking about is that he continually claimed a number of years ago that the Swedes had 250 heroin overdoses per year—

Mr CADMAN—That is right, people kill themselves in Sweden therefore they will not figure.

Mr Christian—as against the figures of 958 and 300 now. That was totally incorrect. Their actual heroin overdoses are between 80 and 100. It is just that they count all the other drug deaths, just as our Australian Bureau of Statistics do here. We do not do a great job of that, but we have cocaine deaths and all sorts of other deaths as do they in Sweden. The bulk of their deaths are not heroin overdoes. Dr Wodak continued to say this on *60 Minutes*, he puts it in the paper, but it is totally untrue and he has been corrected.

Mr CADMAN—Could you send us something written on that?

Mr Christian—I can.

Mr CADMAN—With the facts.

Mr Christian—I will even give you my corrections of Dr Wodak's actual emails too and his replies.

CHAIR—Also, Dr Wodak gave a report where I think a Swedish doctor had to correct his statistics on needles.

Mr Thompson—That doctor was at our conference.

Mr Christian—Yes, I have this in my presentation.

CHAIR—We will come to you in a minute because we are running behind time.

Mrs MARKUS—Can I come back, Carol, to the family. In terms of setting boundaries—and obviously it is unique when your child is using drugs—what about help with that, and also understanding who to let your children be with? I know it is easy now.

Mrs Russ—You trust an uncle, don't you?

Mrs MARKUS—Do you know what I am saying?

Mrs Russ—Yes.

Mrs MARKUS—Teaching parents to ask the questions that generally parents do not ask.

Mrs Russ—When we were aware even of parents of children involved in drugs we would not let our children go over to their places to stay overnight. If we knew of children who even took cigarettes or drugs, we encouraged our children not to play with them or phone them. We were always caring of our children and what actions they got up to and did not get up to. When we realised the relationship with the uncle, we severed all relationships with him. We feel like our trust has been crushed. You never consider a family member would do this sort of thing. I had left home because there was quite a distance in years between my brother and myself and I was not aware of his essential make-up. It was all foreign to me and quite distressing on finding out about it. At that time we had a problem.

You ask how far does it go? You would do anything for your children. But then you have a child come home at night totally stoned who almost sets the house on fire because he got the munchies, put something in the oven and turned it up high. We woke up in the morning and the kitchen was filled with smoke—the house could have burnt down whilst we slept. So we reached the situation where we said to our youngest son, Mark: 'We cannot live like this. You show aggression in the house. I feel intimidated all the time. We do not have to live under these conditions. We are prepared to help you to have rehabilitation and get over it and support you through your endeavours. But if you choose that is not what you want, there's the door, because we have a right to live feeling safe and comfortable.'

That was a terribly hard thing to say and he ended up choosing the door. Addiction is so hard and so strong that they will do anything. They give up their lives to carry on their addiction. When my youngest son hit a wall after his brother hung himself, he ended up going back into drugs heavily. Consequently he drove a motor vehicle without a licence, was speeding, drove

under the influence; he threw his life to the wall. He has these things now to deal with. He sold his personal possessions to support his habit. He was nearly thrown out of his unit and a best friend saved him and kept paying his rent. They have no rationality; they do not understand or the drugs take such a hold that they do not consider that they will end up living on the streets.

CHAIR—He could have killed someone else, too, driving his car.

Mrs Russ—Absolutely. We ended up detaining his vehicle in our back yard and then he started threatening us and we were worried our building would burn down, our work premises. It is a terrible thing to live through. We ended up having his vehicle towed unregistered to his property because we could no longer be responsible for him and his vehicle. It has been a journey through hell.

CHAIR—Maybe he should have had compulsory rehabilitation. Is that what you are saying?

Mrs Russ—Yes.

Mr Thompson—Can I just make a quick point. Part of my presentation was about the parents that I have contacted and the ones who contacted me. It was quite clear that a lot of them were terribly desperate to get their children into treatment. The doctors say at the mental hospitals that they have to be brought under control. Those children would go in and they would leave. There is nobody to control them. They do not want police intervention because they are afraid of criminal convictions for possession and things of that nature. I turn my mind to other ways in which you could assist parents to get their children into treatment where they can be controlled. In my view, a lot of these children are clearly suffering from a psychosis because of their use. If they went to a doctor and let a doctor examine them perhaps they could be admitted into a hospital to be treated there.

CHAIR—But they have to be made to stay there.

Mr Thompson—You can, you can.

CHAIR—There has to be an order.

Mrs MARKUS—There has to be legislative—

Mr Thompson—That is the other part of my recommendation. We would need to look at treatment services within mental hospitals not only for the psychosis but also for treatment of the addiction as well. The other thing I raised at the drug summit was the issue of a complaint that parents used to be able to make in the Children's Court. It was a civil process to have them brought before a court when they were uncontrollable and the court could put them under control and of course channel them into treatment. I used rehabilitation in court for many years and I thought quite successfully. It was placing people under control and putting them into treatment.

Mr QUICK—Can I ask Josephine a question. When we talk about Drug Free Australia are we talking about narcotic Drug Free Australia? Is that what your organisation is on about and if it is, perhaps that would be a better name with all due respect. In this Swedish National Institute of Public Health pamphlet that you have given us, it says:

Alcohol is easy to come by in Sweden, it is used by about 80 per cent of the population and abused by about 200,000 to 300,000 persons. Narcotic drugs are much harder to get hold of. They are 'used' perhaps by one per cent and abused intensively by perhaps 17,000 persons. Since the legal drug alcohol causes so many more problems and so much more harm than illegal drugs, narcotics, it ought to be obvious that narcotics should not be legalised; the suffering and expense inflicted on society by one legal drug is more than enough.

Is your organisation 'Narcotic Drug Free Australia' or Drug Free Australia?

Ms Baxter—Our mandate is to draw attention through public education and further community awareness about illicit drugs. We understand the impact of alcohol and certainly tobacco and often find that they are gateways to other things. For example, the rather unnatural smoking exercise can then perhaps lead to other smoking. You are right, Harry, about what we have tried to do is encapsulate that in our mission. It is also an excellent talking point, if we made ourselves 'Narcotic Drug Free Australia', then we would be thinking about the psycho-stimulants and other categories as well.

Mr QUICK—Yes, but as Carol mentioned, I am talking about educating people. If we talk about a drug-free Australia, there is the Collins and Lapsley reports, the billions of dollars on alcohol, road accidents, cigarettes, emphysema wards and the drain on public hospitals—

Ms Baxter—I can answer that by saying that in any of our community education, it is the first thing that we explain. It is a great starting point because it draws attention. People think, what does 'Drug Free Australia' mean and we are able to explain it.

CHAIR—Gary Christian has not given his opening statement yet, so we will hear that.

Mr Christian—I am speaking as the board member responsible for coordinating Fellows of Drug Free Australia. This is an academic and practitioner group that covers addiction medicine, epidemiology, psychology, ethics and pharmacology. Australia has been in the grip of an illicit drug epidemic with the worst illicit drug use in the developed world for the last decade. Heroin mortality was amongst the highest in the developed world before the heroin drought hit, and the consequent elevated loss and grief to Australian families is a result. Our grave concern here at DFA is that this epidemic might be partly attributable to evidence based Australian research studies being bent to ideological ends. In other words, the conclusions are not following from the data. There are glaringly faulty methodologies which are being used to cover up the failure of harm minimisation or drug law reform initiatives. Both of these things will give a false reading of success and mislead the public.

An example is the Kings Cross injecting room evaluation paper for 2003, which I have given you a copy of. You may be aware of Drug Free Australia's exposure of the false conclusions, silences and the failure of the evaluators to make the required comparisons in the Sydney injecting room evaluation. When corrected and completed it shows the abject failure of this project to meet almost every harm minimisation expectation. This is not the only study that has been so subverted. National Drug Strategy monograph 52 entitled *NEPOD 2001* compared the effectiveness of methadone, buprenorphine, LAAM and most importantly oral naltrexone. Naltrexone was at that time a growing threat to the hegemony of maintenance programs. The naltrexone trials done by NEPOD had devastating results. Against 57 other Medline naltrexone trials that had been done over the previous 25 years, there had been an average of 34 per cent

retention rates at six months in those studies, but NEPOD was able to get a pitiful four per cent retention rate after six months. Regarding drug-free outcomes at six months, 37 Medline studies averaged 52 per cent outcomes—over half were drug free, but NEPOD received an even more pitiful 5.6 per cent. This study operationally appears to have done everything possible to get these appalling results. It further excluded Jon Currie's Sydney NEPOD funded naltrexone trial which had 63 per cent drug-free outcomes at six months, due to his insistence on a more rigorous abstinence testing procedure than NEPOD wanted. They only did urine tests. At closure, NEPOD investigators then informed the public through a heavily funded media campaign that oral naltrexone was largely a failed pharmacotherapy. A great way to put your opposition out of business. Thank God that implants have come along since, but that is the damage done from a very poor study.

I have given you five examples in the paper I provided to you. I will also cite another one: the World Health Organisation needle exchange review by Wodak and Cooney. In 2004 they reviewed the effectiveness of needle exchanges in reducing HIV. They found that six of the 11 relevant studies that they could find amongst the journals were positive, suggesting success for needle exchange. Then in 2005 a Swedish doctor, Dr Kerstin Kall, revealed that one of the six positive studies that Wodak used was marked inclusive by its own author. In other words, it was not positive at all. A second study was invalid because it did not even fit the criteria that was being studied in the first place. A third one was inconclusive on other very demonstrable grounds.

In other words, that left only three out of the 11 that were positive for needle exchange programs. Two of those three that remained are dubious ecological studies, and you can read about the work that has been done on that by Dr Joe Santamaria, a fellow of Drug Free Australia. This evidence led the prestigious US Institute of Medicine to declare the success of needle exchanges inconclusive in 2006. I think we should take their advice. In light of these studies, which snatched harm minimisation success from the jaws of failure, Drug Free Australia submits that Australian governments must seek truly independent evaluations on drug policy and interventions. The propagation of failed interventions upon the misdirection that they were successful when they were not will only bring mounting grief and loss to users and families. That is as much as I have to say.

Mr CADMAN—In your earlier comments you made some comment about misdirected or extraordinary research programs. I do not know whether that relates to your comments.

Mr Christian—Yes.

Mr CADMAN—I do not know how my colleagues feel, but I know some of us feel that there are not enough resources being directed towards prevention and intervention.

Mr Christian—True, I would agree with that.

Mr CADMAN—Too much is going to research which does not appear to be, to my knowledge, producing particularly relevant results.

Mr Christian—Yes, there is a mountain of research bolstering harm minimisation, but when it comes to abstinence-based prevention, we need a lot of research as to what is best practice. If

you look for it, it is a molehill as against a mountain. That is how it has been funded in Australia. I think we pay the price for that.

CHAIR—I have observed, in taking evidence, and I have termed that there is an industry out there, for which I have been criticised by Dr Wodak—fairly vehemently, I might add. He seems to be waging a little campaign of his own against me, however we will wear that. There does seem to me to be an industry of people out there who are dedicated to keeping the status quo or seeking legalisation. It is interesting that, in the figures that we count on drugs, methadone for instance is never counted. Yet Dr Reece gave us evidence—

Mr Christian—109 deaths.

CHAIR—that people on methadone not only die from overdoses of methadone, but they lose 46 years of their life.

Mr Christian—Yes.

CHAIR—When we count smoking deaths, we count them from nine to 99 and we link it up with lung failure or something. They might have lived to 99 but they are still counted as a smoking death, whereas these people who are losing 46 years of life expectancy and look dreadful—their mouths rot, their teeth fall out, their bones start to disintegrate, they age, they look vile—are not counted.

Mr Christian—Correct.

CHAIR—They are not counted as being a drug-related death and we have 38,000 of them now on methadone. We have a group of people who are making a lot of money out of methadone who do not want to see naltrexone used because that is competition. How do we get research to show these figures up to develop a methodology? Is your organisation capable of doing that sort of work?

Mr Christian—I think Stuart Reece has already made that kind of call, that we need a centre for addiction research in this country. His concern is that psychologists are the ones who are doing these research papers for us. I have pointed out that they are not always honest in their conclusions. We desperately need a decent addiction medicine research centre.

CHAIR—Later we will have a look at a DVD of which we all have a copy. The DVD shows one of the people who is a member of the industry giving a lecture overseas which he did not know was being taped. He is describing particular ways of how they manipulate the media; how when something comes out that is not in accordance with what they think is their hegemony over this area, their orthodoxy, they go out and spin the story and get their people to write negative stories.

Mr Christian—A great case in point is the injecting room evaluation. When it came out, if people had have taken the time to read that document they would have seen very poor results. The media got hold of this and told us about six lives saved, a totally false figure; they told us the public amenity had actually been improved and that there had been no honey-pot effect.

Everything they said was wrong, nothing was true, but the media had hold of it and that is how Australians hear about the injecting room—a great project. That is the problem.

Mrs IRWIN—It is keeping people alive.

Mr Christian—It is keeping people alive but, by the same token, our cost-effectiveness measurements show that it is saving at best about a third of a life statistically per year, for $2.5 million. That $2.5 million will buy you more than 100 drug rehab places.

Mr CADMAN—What about Carol's story?

CHAIR—That is very important.

Mr Christian—You have to weigh that.

CHAIR—If that money had been directed your boy may be still alive.

Mrs Russ—I believe he would still be alive. He was determined to do the right thing with his life. He was a very reflective young man and I have journal entries where he wanted to give up drugs. The first time he crashed and burned when he was brought back from Sydney, he wrote 40 or 50 reasons why he should give up drugs. It is heart wrenching to read them. I can give them to you.

CHAIR—Would you like to make that an exhibit?

Mrs Russ—Yes.

Mrs IRWIN—Were there any other programs that your son tried? Was he on methadone or did he try naltrexone?

Mrs Russ—No, thank God he did not do needles. He took orally and snorted amphetamines I believe. He used a bong for marijuana and ecstasy orally. I do not know how people consume magic mushrooms, I guess they just eat them or smoke them. I have no idea.

Mrs IRWIN—The only sort of program that you were trying to get him into was the one at the Woolshed Drug Rehabilitation Community in Adelaide?

Mrs Russ—Yes.

Mrs IRWIN—I must admit we need more funding for that. I have been to the Woolshed and it is very impressive.

Mrs Russ—Yes, they desperately need funding, I have spoken to them. He ended up at the Second Story Youth Health Centre in Adelaide after he crashed and burned the first time. They were extremely supportive of Tim. He had a counsellor there who always looked at Tim as his success story because Tim was so determined to turn his life around. He does not know to this day that we have lost Tim. I think one of the important factors is to have an interest. When Tim was advised to give up his work in IT, his IT boss at that time was his ninjitsu instructor, so they

had a very close relationship. The laws of ninjitsu are that you are not allowed to do drugs, but he saw where Tim was at, took him under his wing and offered him work in his company. Because Tim was coming off substances, he said to Tim, 'The conditions are that you must come to every training session and you must be a part of this.' He was a good young man who was determined to help Tim get back on his track. I think they are all good young men; it is just that drugs totally destroy humans. We were very upset when we were told that one of his support teams had suggested Tim give up both the ninjitsu and working for his boss. Because Tim was coming off drugs, he found it very hard to concentrate, his self-esteem was low. The realisation of losing such a fabulous job—he was on $50,000 a year plus benefits at the age of 24—was looming and he was without tertiary qualifications. He did not even complete year 12. He loved what he did. When he was advised to give up both, I think that was because he had put a lot of pressure on himself and he could not concentrate. He felt like he was not doing the right thing for his boss and felt that maybe—

CHAIR—But then he was concentrating on the drugs and did not have a diversion for his mind.]

Mrs Russ—On the withdrawal he did not have the sports that he loved. He wrote in his journal that the most important things to him in his life were, first of all, his family, then his job, then his ninjitsu and then his friends. He went down the list of hierarchy. He lost it all. He got right to the top—he had lost his job and he had lost his dignity, he felt annihilated essentially. Sadly, the way he was fired was disgusting. There was no support for Tim. Now they realise what they did was wrong. At the funeral they said, 'Yes we have other members in our employ that we realise have drug issues and we are consequently handling them in a different manner.' I am grateful for that, but geez I wish they had done it with my son. If people are down and out, as a business we support our employees, we try to help them.

CHAIR—Carol, there is a problem I met in Western Australia: two young women who were nurses and were on heroin. One of them said to me that she realised she had to get off heroin. I said, 'But you could have killed somebody as a nurse.' I said, 'Furthermore, you don't know that you didn't.'

Mrs Russ—Yes, they lose all control.

CHAIR—Therefore you cannot have people in certain jobs—you cannot have a nurse taking drugs.

Mrs Russ—No. This comes back to the point of how can you look at harm minimisation as valued? How can someone be operable if they are using a mind altering substance? They cannot be working at their best.

CHAIR—Young Ryan sat in that very chair last week and said that harm minimisation nearly killed him. He said he was told by a counsellor and by a psychiatrist, 'Just cut down your drug use. You can still use it on the weekends.' He said that nearly destroyed him; it nearly killed him

Mrs Russ—That is where Tim was at.

CHAIR—That is just wicked advice to be given, wicked.

Mrs Russ—It is. It does not work.

Ms Baxter—It is resonating through with the—

CHAIR—It is part of that industry approach, is it not?

Ms Baxter—Yes.

CHAIR—What we are doing is challenging the orthodoxy and as a result I am getting attacked.

Ms Baxter—We are too, but something has to change because it is very rampant out there. What concerns me are the middle-school students we talked to who just say 'I can count on one hand the number of kids in the class who wouldn't have at least tried something.'

CHAIR—We have got two more witnesses to go, so we are going to have to wind this one up. I know we are all grateful you have come. I will shamelessly say I am particularly grateful you have come. I think you have given a great insight. Can I say to you Carol, I just feel for you so much.

Mrs Russ—Thank you. I would not want any family, any community to go through what we still are going through. Whilst we are grieving the loss of a son, I had a son hell-bent—he is coming clean now, he is working for us—on destroying himself. He had no regard for others on the road, et cetera. He was walking in front of traffic, I believe, that is what his girlfriend told me. We have to do something.

CHAIR—Yes, we do. Thank you for coming.

[11.04 am]

BALDOCK, Ms Emma, Client Counsellor and Community Development Officer, Canberra Mothercraft Society

Witness was sworn—

CHAIR—Thank you for coming and joining us today. We have seen the book that you put out and indeed that is one of the reasons why we wanted to hear from you. Would you like to make an opening statement?

Ms Baldock—I have also brought a report on some research that we did called *Grandparents parenting grandchildren* because of alcohol and other drugs. I would also like to table that. Our work has actually finished with this group because we are no longer funded. We had a small amount of money from the National Illicit Drug Strategy that came through ACT Health to undertake research into the needs of grandparents who are parenting because of alcohol and other drugs. Out of that research we held a forum which became a national forum at the National Museum of Australia for policymakers, service providers and grandparents, and that is in that report.

The other continuing ongoing project is the Grand Jugglers, which is a family resilience-building program, a circus program for children who are being parented by their grandparents. It is an opportunity for the grandparents to meet and the children to gain communication skills through circus, improve their self-esteem and also to spend time with other grandchildren who are being parented by grandparents so that they do not feel so isolated, which they do. The other thing that came out of that money was *The Grandparents' Story*, which I suppose has been a very powerful way of telling how it really is for people who are parenting because of alcohol and other drugs. I would draw your attention to the lived experience of these people.

The main points that we would like to raise are on page 4 of our report; there are some key recommendations—

CHAIR—We will accept that as an exhibit.

Ms Baldock—We would like to emphasise that when considering the key issues faced by grandparents raising grandchildren there are significant areas: information, financial hardship, legal issues and the health of people. We know that, if you parent over the age of 55, you will have significant health issues as an outcome of this, and that costs our whole society. Another key issue is the significant contribution that grandparents make to the social capital of our society through taking on their grandchildren; it is a difficult task. The final key issue is the need for further research. The Australian Institute of Family Studies are publishing an article about our research in the next issue, issue 76. Families Australia has started collecting a lot of data about the impact of illicit drugs on families and specifically grandparents, and grandparents more generally and the role of grandparents.

CHAIR—Who is publishing that?

Ms Baldock—The Australian Institute of Family Studies are publishing a research article that I have written. That will be out in the next issue, the next quarter. From listening to the people who preceded me, one of the issues is the need for an inter-sectoral collaboration. When people come to drug services they need to be seen as part of a family and not just a person seeking treatment. When you turn up at a drug rehab or methadone service, you are seen as the person who is treated, the addict. That is fair enough, but on the other hand behind that person are a whole lot of suffering people. We need to find out if they have children. We must collect a really good minimum data set on the rest of the people attached to the person using drugs to find out how many people are being impacted. Since July 2003 in Canberra, we have met around 100 families with grandchildren who are parenting. I would say the majority of those grandparents are parenting either because of mental health or drug and alcohol abuse, and so often drug and alcohol use go hand-in-hand with mental health.

CHAIR—Our inquiry is on illicit drugs. Did you give us the figure that 30,000 grandparents are in this position? Did that come from you?

Ms Baldock—The Bureau of Statistics says that in 2003 there were 22,500 grandparent families with 31,100 children aged nought to 17 in the care of their grandparents.

Mr QUICK—The expectation would be that the problem is growing rather than lessening—would that be right?

Ms Baldock—Yes, and that is supported by UK and US data. The UK Home Office wrote a very powerful report which is referenced in the back of our report that you have just tabled called *Hidden harm*, about the impact of drugs on families.

CHAIR—I think the Australian National Council on Drugs has put out a report in which their estimate is that 30 per cent to 70 per cent of the children living in households where the parents are the drug addicts are sexually abused.

Ms Baldock—Yes.

CHAIR—They call that hidden harm because they can be no more specific.

Ms Baldock—And they are neglected. In my role as the counsellor at the QEII Family Centre, which is run by the Canberra Mothercraft Society, we have of a lot of families who use drugs. Many of them are on harm minimisation programs and many are on methadone. I suppose that is better than being on the streets and getting heroin because at least there is some attention to the children, but in the end we say to them, ‘In the end, a good parent’s an attentive parent and a stoned parent is not attentive.’

CHAIR—A lot of these attitudes with leaving children behind are really kind of left over from the stolen generation concept, aren’t they, where people are frightened to death of giving those children a break?

Ms Baldock—Yes. Back to the grandparents specifically, one of the powerful stories that were told at the forum was from Tony Lauer, the former New South Wales Police Commissioner, and his wife, who have raised their four grandchildren for one of their daughters. This is just an

example of the financial issues faced, and there are many grandparents who are not perhaps even as well off as the Lauers—they had to sell their house at the coast. It was not a luxury. They had saved hard for that, or it might have been inherited through the family, as with one of the families we know. They had to sell that in order to extend their house in the city to bring up the grandchildren. That is a very common story. The other common story is them having to mortgage their homes, which they have paid for, when they were about to tour the country in their four-wheel drive and caravan, or maybe they were just planning retirement. They are having to sell off property or take out a mortgage on the home that they have paid off after many years of working in order to take out legal proceedings to gain custody of their grandchildren. Grandchildren come in very many ways. Sometimes grandparents get a call from child protection services asking them to take their grandchildren and sometimes they take their grandchildren—as comes out in our stories—out of very unsavoury, unsafe situations.

CHAIR—When you get a situation like that, where the children are taken by the grandparents because they can see what is happening to their children—and we have some stories that have come in from grandparents which are just horrendous—what happens in terms of the parents trying to get them back? Do you they get legal aid? Does the department help them against the grandparents?

Ms Baldock—They do. One of the stories in this book was: ‘I was not eligible for Legal Aid. I was on a disability pension. I had $2,000 in the bank and lived alone in a home I owned. I appealed their decision and got legal aid. That started my three-year battle through the court.’

CHAIR—A lot of grandparents cannot get legal aid.

Ms Baldock—That is right, because they have assets.

CHAIR—They have drug-ridden children who are the parents of the grandchildren, and the children can get legal aid and the department will support them with a policy that is supposed to be in the interests of the child. That seems to me—and we found that in our other inquiry—

Ms Baldock—It is often not child focused.

CHAIR—It is not child focused at all.

Mr QUICK—Has there been any change in the attitude of DoCS around Australia and the education system with a realisation that grandparents do have a duty of care, for want of a better phrase, in removing some of these children? Has there been a bit of a mind shift or is it still, ‘We have to go through the bureaucratic red tape in schools and also in DoCS because we don’t want to leave ourselves liable and set a precedent’?

Ms Baldock—And Medicare. There are all sorts of issues. You might take the grandchildren just because you fear for their safety. Indeed, one grandmother had taken the children and the police came to see why she had taken the children. They knew her son, they knew of him, but legally she had in effect kidnapped them, and the son tried to charge her with that. That was part of her three-year battle. Often these parents are known to the authorities. Reports have been made but perhaps not been able to be substantiated. Many of the families that we see through our residential family program, through the substance use in parents program at the hospital, through

child protection, DoCS or through the office for child and family support here. Has there been a change? There have been some small changes. The Canberra Mothercraft Society set out to raise visibility. When we asked in 2003, 'Who are you, where are you and what do you need generally as grandparents parenting?' we discovered that the majority were parenting because of drug issues, which usually goes hand-in-hand with alcohol and frequently with mental health issues.

CHAIR—Let us be specific on that. Do the majority of grandparents find themselves in this position due to the fact that their children are solely taking alcohol or are taking illegal drugs and also using a legal drug?

Ms Baldock—I would say they are using alcohol and other drugs, but I have not got the numbers; I have not got the research. It was not our charter.

CHAIR—There is a tendency to merge them all together because the people who want to legalise this stuff say: 'Illegal drugs are only as bad as alcohol and tobacco, and we control those by regulation; therefore, we can do this by regulation. So it is okay to have drugs.' That is their methodology. Every time we mix them up, we are reinforcing their plan. It is important that we know, for the grandparents with whom you are dealing, that this is as a result of illicit drugs plus or minus anything else.

Ms Baldock—Yes, it is as a result of illicit drugs.

CHAIR—Thank you.

Mr QUICK—There is an organisational structure that you put in place to have the national forum and that sort of thing, but am I right in saying that most of those 22½ thousand grandparents see themselves as individuals dealing individually with the bureaucracy rather than the bureaucracy realising that they have this serious problem, and these people are carrying the can—for want of a better phrase—on behalf of DoCS in lots of cases?

Ms Baldock—Yes.

Mr QUICK—But DoCS has not realised it so there are not brochures going out saying, 'As one of 22½ thousand people, we would like to inform you of some of these things that might make things easier.' It is up to your organisation. Is that right?

Ms Baldock—I have to be clear that our organisation only deals with people in the ACT. That is a national figure from the Australian Bureau of Statistics. What we really need is national figures from the ABS—and I do not know how you would get them—that show what percentage of people are dealing with drugs, what percentage are dealing with drugs and alcohol et cetera.

CHAIR—It does not matter if they add in any other substance. If they are using illicit drugs, we have got a problem.

Ms Baldock—Yes. They are using illicit drugs, and the grandparents are parenting the grandchildren because of that. And it is a hidden issue. People feel enormous shame.

Mr QUICK—That is right.

Ms Baldock—The grandparents feel blamed; they feel that they stuffed up with their own children. They say: 'Did we go wrong with our own children? Are we okay to parent our own grandchildren?' It has a huge psychosocial impact on the families.

CHAIR—The families themselves, the grandparents, understand that using illicit drugs is wrong; they understand that.

Ms Baldock—Yes, they understand that.

CHAIR—And yet they get all these mixed messages.

Ms Baldock—In fact, this book came out of one part of the funding. One part of the brokerage funding we had was to run a program like the Stepping Stones program run here by the drug and alcohol unit in ACT Health to help families deal with a family member who is using illicit drugs. These grandparents said: 'No; we're over it. We are not interested. We do not want to put any more energy into this drug-using person. We've now got our grandchildren.'

CHAIR—They need a break.

Ms Baldock—This is why we would like these stories to be heard by the powers that be—because they are over dealing with the drug using. The issue is that when that person is still around the family and using drugs, their behaviour is not nice. We know that grandparents have lost all their possessions, et cetera, and there is continual grief. When the children's parent has died there is grief, but when the parent is still around, trying to make contact and behaving inappropriately and often in very hostile and dangerous ways towards the grandparent and the children, there is ongoing grief on a day-to-day basis. Some grandparents are able to hang in with their own child and parent their grandchild in the stories here and some just go: 'We don't want to have anything to do with that person. We will just focus on the grandchildren.'

Mr QUICK—How much money did you get from whoever?

Ms Baldock—We got $60,000 from the National Illicit Drug Strategy to put together this book and the report, which is a report on the forum, and we got another $36,000 in brokerage funding. So altogether we got $96,000. We employed a part-time project officer supervised by me to do this work. The Canberra Mothercraft Society is one of Canberra's older community organisations. We just had our 80th birthday last year. For our small society, this is ongoing work.

Mr QUICK—You are not getting any ongoing funding?

Ms Baldock—It is a privilege to come and talk to you, but I am not paid to do this in this time; this is out of the grace of our organisation.

Mr QUICK—So you raise the expectation, provide this wonderful booklet—

CHAIR—And we top up the funding.

Ms Baldock—We thought very carefully about this in terms of raising the expectations. We were very clear that we were there to raise the visibility, and what came out of that was a gift. If you do raise expectations, I believe personally and professionally, you have an ethical responsibility to keep going. The Canberra Mothercraft Society has run a grandparents' education and support group since 2003 in partnership with Marymead and Relationships Australia. It is for any grandparent parenting grandchildren. That continues, but there is no funding.

Mr QUICK—How do grandparents who suddenly today have to start picking up the pieces get into the network? Is there a website? I come from Tasmania, and I know the problem we have down there. There is a whole host of the grandparents who are parenting; they are probably part of this 22½ thousand. You are lucky here in Canberra; it is a little enclave, and you have done wonderfully well. I commend you.

Ms Baldock—Thank you.

Mr QUICK—How do we have a national approach? There are a whole lot of grandparents out there thinking: 'Where the heck do I go to? I am on my own. This is all too hard.'

Ms Baldock—And maybe, 'I don't want to identify myself in some way because of many things, like all the legal implications.'

Mr QUICK—That is right. You are in your late 60s and you are going to the supermarket with a couple of little kids on a regular basis, and people think, 'What the heck's going on here?'

Ms Baldock—And you lose your own friends; you lose your own social networks. We found impacts on the grandparents like age-related health issues and impacts on their family relationships. Perhaps their friends do not want them to bring around the grotty kids.

CHAIR—They do not!

Ms Baldock—We had one set of grandparents who had four grandchildren and their daughter died when the four children were under four. Two of the children were the same age, but they were technically not twins. They described their grandchildren as feral. These children had been put through windows to rob houses when they were between the ages of two and four. Their daughter, who died of a heroin overdose, had a double uterus—she had two complete sets of reproductive organs—and the two children grew around the same time, but they were not technically twins. They had different fathers.

CHAIR—And different eggs?

Ms Baldock—Different eggs and different sperm.

Mr QUICK—I am just trying to understand how you could raise those children in a normal family with normal parents.

Ms Baldock—They do an extraordinary job. Back to your question, one of our recommendations is to have, alongside the research and some minimum data set, information

that is consistent. The Mirabel Foundation in Victoria has put out a lovely book called *When the Children Arrive*. We developed an information kit. But information comes and goes very quickly. You need to have the funds to update it, and we have never had the funds to update it. We have an excellent national parenting site which started in the last couple of years. There could be information on that for grandparents who are parenting. Of course, that assumes that you have internet access. Your health practitioner should have internet access, and the library has internet.

CHAIR—Going back to these families, presumably the mothers were drug addicts through the pregnancy and through the birth, and then they were allowed to take the children home. There was no equivalent of DoCS supervision of these families? I would have thought any child born to a drug-addicted parent was at risk.

Ms Baldock—They are, and there is recognition. Locally, the Canberra Hospital has a substance use in pregnancy support service.

Mr QUICK—Like the one in Western Australia that we saw, which is doing wonderfully well.

Ms Baldock—That assumes that they turn up for prenatal care, which they notoriously do not, or they turn up once and then they do not turn up again. The children will be born addicted in varying stages. We have the Blue Star Clinic at the Canberra Hospital run by Professor Graham Reynolds.

CHAIR—There has got to be permanent damage from that; there has to be.

Ms Baldock—Yes, there is.

CHAIR—On a brain that is evolving like that, to be born with that substance in their body, there just has to be.

Ms Baldock—I think there has been some Danish studies—I cannot be quoted on this—around the impact of using drugs and the longer term effects on the children that say that they may then go on to seek drug use themselves because their brains have been bathed in narcotics.

Mr QUICK—Where to from here for your organisation?

Ms Baldock—It does not have to be our organisation that does it, but there needs to be a coordinated inter-sectoral approach. We need some research and we need minimum data sets on the number of children that are impacted by illicit drugs. I do not know that we need to reinvent the wheel; the *Hidden harm* report from the UK is brilliant. It would serve to do a little bit more research for Australian standards. I think we would have to look to the Bureau of Statistics as to how you would collect that data.

Mr QUICK—If we had the department here and you were listening in, they would say, ‘Well, Mr Quick, we’ve poured hundreds of millions of dollars into the drug policy strategy. We’ve set up all these wonderful organisations. We’re about to hear from another one after you.’ Yet, when it comes to the grassroots, Carol’s son hung himself because he could not get into rehab when he wanted to. You have highlighted a whole lot of problems with grandparents, and you say we

should have this coordinated intersectoral approach. What is happening to the DoCS in every state and territory? What is happening to juvenile justice? What is happening to our health program, our housing program?

Ms Baldock—Do they talk to each other?

Mr QUICK—That is right. COAG meets, and there is a big deal that all the premiers and the ministers come, yet we have countless examples of people falling through the hole.

Ms Baldock—We do. Some do not want to be identified. For those who do not want to be identified, if the information was on the national parenting site, at least they would have access to it, and, when they are ready, they may seek support. The education system needs to be able to identify these children through the schools and provide specialist counselling and support for the children and, in turn, specialist counselling and support for the grandparents. We have a little bit of money with Relationships Australia that they can access for counselling. If I could be so bold as to suggest it, perhaps on some level it even requires tax law reform, because if you sell off a property then you have to pay $35,000 capital gains tax on that. Some people would say, ‘They had the property in the beginning,’ but that is hard fought for if you have been a public servant all your life perhaps and you have put away a little bit or you have had your super. The other thing that is costing us as a society is the health of those grandparents.

CHAIR—I do not think the way to cure that problem is through the tax system.

Ms Baldock—No.

CHAIR—I think we have to do it with other support.

Ms Baldock—Yes.

CHAIR—I think to corrupt the taxes for that way is not a good way to go.

Ms Baldock—Perhaps a recognition that these people are contributing.

CHAIR—Make services available to assist them and recognise them.

Mr CADMAN—One of the organisations that constantly has been pushing itself forward as a spokesman is the Family and Friends for Drug Law Reform. What is your link with them?

Ms Baldock—For our key informant interviews and questionnaires we sent out information. The purpose of this report was to find out who the people were and to raise the awareness of them. We sent information out to any organisation that had anything to do with drugs and drug treatment services. They came and knocked on our door and said, ‘Well, one thing you could do is you could have a forum,’ but we included everybody in that forum. The information went out very widely. We do not have a particular agenda. Our bottom line agenda is that we want support for the grandparents, but really underneath that is the children.

Mr CADMAN—You are a separate and distinct organisation with different goals?

Ms Baldock—Completely. We are an NGO. Our mission statement is towards healthy families.

CHAIR—One of the things we might be able to do, for instance, involves foster money. The state governments have refused to pay the foster money they pay to foster parents to grandparents. Federally we could look at an equivalent payment for grandparents who take on that role, which would be a better way than going via tax arrangements.

Mr QUICK—Also my understanding of the Medicare offices, when we had our adoption inquiry—

CHAIR—Yes, that is right, that they recognise the child.

Mr QUICK—The sensitivity of dealing with, 'They are not on your Medicare card; why are you bringing them in here?'

Ms Baldock—Care but no responsibility.

CHAIR—That is right. We have already taken action to enable the grandparents to get the family tax benefit payments.

Ms Baldock—Yes, that has been powerful.

CHAIR—That has been huge.

Ms Baldock—Centrelink has been more responsive to them. There are some good things that have come out since we started to raise the visibility.

CHAIR—I think foster parents also get the family tax benefits, do they not?

Ms Baldock—Yes. Some of these grandparents are not eligible for payments because they are asset rich and income poor.

CHAIR—That is right. I think those sensitivity things are important.

Ms Baldock—I mentioned the tax issue because they are penalised if they are the people who have the most assets. They may be retired public servants with superannuation, but they have put away for 50 or 60 years.

CHAIR—That would show up in Canberra particularly. It is not necessarily going to show up anywhere else.

Ms Baldock—That is right, but it is an issue for them. They have to build another three or four bedrooms to raise and educate four grandchildren. Children are expensive.

CHAIR—Then they may have been prepared to pitch in and assist with the education. Plenty of grandparents do.

Ms Baldock—They already were sometimes; that is true.

CHAIR—I do not think that is necessarily—

Ms Baldock—It is a recognition of the legal complexities and all their complexities of their lives, and the health.

CHAIR—Yes.

Mr QUICK—I am a non-Canberran, even though I have been here for 15 years. Whereabouts are you sited?

Ms Baldock—Curtin, and you are very welcome to come and have a look at our centre. There is no residential families centre in Tasmania. I was at a meeting two weeks ago in New Zealand of all the residential centres, and there is a representative now of the Tasmanian health department who comes to the association of parenting centres meeting. There is no residential centre in the Northern Territory or Tasmania, but there are in every other state. Many of the centres talk about the same thing: we are all seeing families with drug use, and many of those families have grandparents. Part of the challenge in Australia of course is that we are a federation and there are all the states and territories.

CHAIR—Where you have the grandparents who are taking it over, I take it that when a woman of childbearing age is a total drug addict then contraception and all those sorts of things go off the horizon, do they not?

Ms Baldock—Yes.

CHAIR—Inhibitions as to sexual behaviour would disappear as well?

Ms Baldock—Often, or you might be using your sexuality to procure the money for your drug habit; that is common.

CHAIR—Equally there would not be any precautions against falling pregnant taken at all.

Ms Baldock—No. It is exploitation. You may be very exploited.

CHAIR—Yes.

Ms Baldock—You may be very young.

CHAIR—We really do need to pay attention to the welfare of the child born into such circumstances. We have an obligation to do that, have we not?

Ms Baldock—We do, because the statistics would show that that child has a very high risk of entering that whole lifestyle themselves.

CHAIR—Harry and I took evidence in Western Australia that, in a Perth hospital, out of 5,000 births in a year, 350 of them were to drug-addicted mothers; 107, if my memory serves me right, were heroin addicts, and they fed the mother methadone through the entire pregnancy. The children were born addicted to methadone.

Ms Baldock—Then they go on morphine.

CHAIR—Your heart just turned over. All but 25 of those children were sent home with their mothers with no supervision.

Ms Baldock—Yes, and sometimes loose supervision by child protection.

CHAIR—There was not any.

Ms Baldock—Or wait until something happens.

CHAIR—Wait until something happened. Another 30 of them were redeemed, taken away from the parents. What sort of policy is that?

Ms Baldock—It is the right to have a child, is it not? With that right comes responsibilities, and the child has rights.

CHAIR—The child has a right to expect safety. We as a civilised society have an obligation to do things in the interest of the child. That sure is not.

Ms Baldock—We know child protection is having a real struggle.

Mr QUICK—Could you read from page 24 of the report about three-quarters of the way down, that case study about the grandmother aged 62?

Ms Baldock—This was the grandmother from New South Wales, aged 62, who said:

I have to work fulltime to pay off a $100,000 tax bill incurred by the tax office charging 12.7 per cent interest on unpaid tax—the money was used to pay $59,000 legal fees.

Mr QUICK—They are the untold stories.

Ms Baldock—Another grandmother had to take her children from I think it was Bathurst to Newcastle for access to the children's parent or parents, and there were several different fathers. There was supposed to be supervised access, but DoCS could not provide supervision, so she was taking these children into a hostile environment where she was not safe and the children were not safe. She had six grandchildren under 12 that she was raising for her daughter and various of her daughter's partners who had produced these children. Child protection needs a lot more; it is not working in child protection.

Mr QUICK—I thank you for raising the issue—

Ms Baldock—Thank you.

Mr QUICK—and for the wonderful work your organisation does—if you can pass it down the pipeline to all the state agencies. I would like to get a whole lot more of these so I can send them out to people in my own electorate, because I know firsthand that there are lots of grandparents who are totally frustrated. Do you have more than just this—even that I could buy?

Ms Baldock—We will not sell them, but if we can get them couriered it would save us the cost of the postage.

Mr QUICK—No, I can come and pick them up.

Ms Baldock—Somebody can pick them up?

Mr QUICK—Yes.

Ms Baldock—How many would you like?

Mr QUICK—I would like 50.

Ms Baldock—All right. I have just sent 150 of these to Centrelink in Tasmania.

Mr QUICK—Thank you very much.

Ms Baldock—It is getting out there. Thank you for the opportunity.

CHAIR—Thank you very much for coming. Thank you for that initiative with regard to Tasmania. In our adoption inquiry, we shared a lot of issues where we know that there is a need for a lot more to be done in the interests of children.

Ms Baldock—I will just write our address down and somebody can come and pick them up. I will have them ready today. It is 129 Carruthers Street, Curtin.

CHAIR—I know that you came at reasonably short notice, but I do notice that you are very familiar with all of the material. I think we could have called you on five minutes notice and you would have told us everything. You are obviously very, very committed to it.

Ms Baldock—Thank you. I had no access to my computer drive this morning, and then before I left I had a power failure, so I had nothing to bring to hand out; I am sorry.

CHAIR—That is all right.

Ms Baldock—I would have been more organised.

CHAIR—That is all right. Thank you very much.

[11:41 am]

HERRON, Dr John Joseph, Chairman, Australian National Council on Drugs

VUMBACA, Mr Gino Anthony, Executive Officer, Australian National Council on Drugs

Witnesses were sworn—

CHAIR—Welcome to you both. Would you like to make an opening statement?

Dr Herron—Thank you for the opportunity of appearing before the committee. The Australian National Council on Drugs was established nine years ago by the Prime Minister. It is the principal advisory group to government, and I have been chairman for a year. My predecessor was Major Brian Watters, who has been elected to the International Narcotics Control Board and is now deputy president of that body. For the purposes of our meeting this morning I would ask Gino Vumbaca to do a PowerPoint presentation to explain the position of the Australian National Council on Drugs. Copies of these slides should be before you.

CHAIR—Just before you start, there is a lot of discussion out in the community about the name of the organisation. Would you be happy if the name were changed to the Australian National Council against Drugs?

Dr Herron—My answer to that is: what is in a name?

CHAIR—A lot.

Dr Herron—Radio Rentals sells furniture. I do not get tied up with terminology. That was the name, as I understand it, that was agreed to when it was established, and it has persisted until now.

CHAIR—Would you mind a change? Would it matter?

Dr Herron—If that is what government decides, so be it.

CHAIR—Okay.

Dr Herron—I will ask Gino to do the presentation to fill you in.

A PowerPoint presentation was then given—

Mr Vumbaca—As John has said, the council is appointed as a principal advisory body to government and is appointed by the Prime Minister every three years. This is the current membership for the 2007 to 2010 term. Dr Herron is the chairman and Commissioner Michael Joseph Keelty is deputy chairman. There is an executive appointed. We have 19 members, so we need an executive to carry forth a lot of the business decisions on a regular basis. As you can see, there is representation from service providers, law enforcement, people working in research and

academic institutions, government and Indigenous organisations, and the school principals association is also represented in an ex-officio capacity. With Professor Ian Hickie and David Crosbie, CEO of the Mental Health Council of Australia, coming on board, there has been recognition of what we call dual diagnosis of comorbidity in people with co-occurring mental health and drug use problems. That is the structure.

As I said, it is appointed by the Prime Minister and reports directly to the Prime Minister on a regular basis. John has meetings with the Prime Minister to discuss a number of drug policy and program issues. He also gives reports to the Ministerial Council on Drug Strategy through the intergovernmental committee, which is the senior health and police bureaucrats from state, federal and territory governments.

CHAIR—Can I stop you right there. Dr Wodak says that the governing body for setting health policy is the ministerial council. Do you agree with that?

Mr Vumbaca—The National Drug Strategy has to be signed off by the Ministerial Council on Drug Strategy, so yes.

CHAIR—That is more important than this body?

Mr Vumbaca—The ANCD is an advisory body. It provides advice to government.

CHAIR—You are less important than the ministerial council?

Mr Vumbaca—That is a judgement. In my opinion, no.

Mr CADMAN—The National Drug Strategy would guide everything that you decide?

Mr Vumbaca—Yes.

Mr CADMAN—You work within that framework?

Mr Vumbaca—Yes.

Mr CADMAN—The chair’s point may well be right.

CHAIR—It is very important to get this right because the Prime Minister, the Treasurer and the Deputy Prime Minister all say that the official policy of the Australian government is zero tolerance, tough on drugs. They say that is the policy, and yet other people in the industry say, ‘No, it’s the National Drug Strategy; we make the rules.’ I think Dr Margaret Hamilton herself says that the Prime Minister’s remarks are very unhelpful.

Mr Vumbaca—I have a slide here which talks about the National Drug Strategy. It talks about the framework under which it has been constructed and agreed to by all states, territories and the federal government.

CHAIR—Who do we believe: the Prime Minister or the National Drug Strategy? Who is right?

Mr Vumbaca—They are both right.

CHAIR—They are in competition with each other.

Mr Vumbaca—No, not necessarily. I would disagree with that. I will skip through because I think it is probably easier to look at it. There is a pictorial representation of what constitutes Australia's National Drug Strategy. It is made up of supply reduction, demand reduction and harm reduction; they are the three pillars of Australia's Drug Strategy. Zero tolerance refers very much to a supply reduction in particular; the states and territories agree, and they have fairly strong and powerful legislation enacted.

CHAIR—It applies to the lot. Dr Hamilton says it only applies to education, but it applies to the government's policy as stated by the Prime Minister, and I can pick up a speech and read it out to you.

Mr Vumbaca—Sure.

CHAIR—It applies to all of that.

Mr Vumbaca—That is the characterisation that the Prime Minister gives—zero tolerance—to the National Drug Strategy, but that is the framework of the National Drug Strategy.

CHAIR—Yes, and it applies to all of that.

Mr Vumbaca—Sorry, I am at a loss to know what the point is.

CHAIR—Anyway, go on.

Mr Vumbaca—The ANCD also releases a number of reports and you have the most recent one, which has been tabled today, *Drug use in the family: impacts and implications for children*.

CHAIR—Can I ask about that too?

Mr Vumbaca—Yes.

CHAIR—If you picked that up off the shelf, you would think drugs were used in every family. You would think it was a normal occurrence. Look at it: nice happy family picture, drug use in the family. You would think it goes on all the time. The only thing good about it is that it is black.

Mr Vumbaca—We did not get it market tested, but there has been no issue raised yet about the cover of the ANCD report of which I am aware. No-one has raised it with me and we have not received any correspondence or emails. We have received a lot of positive feedback about the report but not about the cover.

CHAIR—I am quite interested in things that are in the report—very interested. But that is the first time I have seen that. I know what effort we put into our covers.

Mr Vumbaca—The ANCD commissions a lot of work. It has about a quarter of a million dollars each year quarantined as part of its budget to commission research projects and undertake other work. Some of the things that we currently have in train include the family project that has been released. You would be aware that there is also a second families project being conducted at the moment which looks at the impact on families of children who are using drugs. They are older children, obviously, but that has an impact on the family functioning and what that is going to be. We also give out development grants for people based in NGOs in rural and regional areas. There are the national drug and alcohol awards, compulsory treatment, homelessness and the future of NGOs. There is a range of commissioned work being undertaken for the ANCD.

Mrs IRWIN—Can you tell us a little bit about the compulsory treatment project?

Mr Vumbaca—That is just coming to conclusion now and will be finalised in the next few months. That is to assess under what conditions, if any, compulsory treatment is appropriate. That is what the researcher’s brief has been.

Mr CADMAN—Does that look at the diversion program as well?

Mr Vumbaca—Yes. There is an argument of semantics that is dealt with within the report about diversion still being a voluntary option.

Mr CADMAN—Oh, yeah? I think there is a fair bit of coercion in that myself.

Mr Vumbaca—Yes, that is true as well. With compulsory treatment they are also talking about where there is a compulsion of someone in some countries, and some legislation says that the person has no ability to make rational decisions and their own health or others may be in danger.

Mr CADMAN—Like somebody in jail. Do you look at anybody in jail? You should. They have got no choices. They should have no choices.

Mr Vumbaca—About treatment?

Mr CADMAN—Yes. If they are in jail they should not be using drugs.

Mr Vumbaca—There is a compulsory treatment program being run in New South Wales prisons.

Mr CADMAN—So, everybody using drugs in New South Wales must go through compulsory treatment programs?

Mr Vumbaca—No, for offenders who are brought in—

Mr CADMAN—A voluntary compulsory treatment program?

Mr Vumbaca—No. Offenders who are brought in with drug related charges and who enter the prison system can be sent into the compulsory treatment program.

Mr CADMAN—If I shoot up a bank and I am on drugs, I would not necessarily—

Mr Vumbaca—I do not know enough of the rules. Serious violence disqualifies people from being able to access drug treatment under a diversion program. That is the legislation in most states and territories. There are caveats there about who can—

Mr CADMAN—Sorry, I should not question you when you are not yet even public with it yet.

Mr QUICK—I think the last person who was talking about grandparents said we need a coordinated intersectorial approach. How do these grants and projects meld in with, for example, as Alan said, what is happening in prisons, what is happening with DOCS or what is happening with the juvenile justice system? How does it fit in? Because you are the Australian National Council on Drugs, do you have an overarching view of what is happening in the states and territories to ensure that people are not going to fall through the hole—that there is a coordinated approach to this? The punters are saying: 'As taxpayers, we are giving the government imprimatur to spend hundreds of millions of dollars.' I guess these grants and projects are going to well-deserving organisations, but how do you make sure that the gaps in the net are very, very small?

Dr Herron—I should mention that this commissioned research is only a quarter of a million dollars. The answer to your question lies in the second—

Mr Vumbaca—The overhead slide shows the initiatives. These are commissioned research projects. These are some of the things you are talking about. This is some but not all of them. This is not a fully inclusive list, but these are some of the initiatives that have been committed to with new funding by the federal government in the last 10 years.

Mr QUICK—Who has the overall responsibility to ensure that $1½ billion, which is a hell of a lot of money, is working? How does the Customs Service fit into retractable needle and syringe technology and school drug strategy, education and peer things?

Dr Herron—Through the federal government.

Mr QUICK—Is it the health department or is it a ministerial council?

Dr Herron—If you go back to the second slide, officially the ANCD reports through the health department to the Prime Minister, but also through the Ministerial Council on Drug Strategy, which is all the state and federal ministers, Customs, attorneys-general and Health. It coordinates through that policy as well. As you would appreciate, a lot of state government expenditure occurs as well.

Mr Vumbaca—That is the difficulty. At a federal level, the ANCD can provide advice—you saw that the membership includes Mick Keelty and the like—but states and territories have their own budgets as well to contribute to drug and alcohol, families, Indigenous issues, and law enforcement as well.

CHAIR—You have to say Mick Keelty is doing an outstanding job in developing this harm index whereby they show, as I said earlier today, that in the last 10 years they have saved Australia above and beyond the cost of them being run $5 billion by keeping drugs off the streets and, therefore, keeping people out of hospitals, out of road accidents and all that sort of thing.

Mr Vumbaca—There is no argument whatsoever here.

CHAIR—They put a price on every kilo of the different drugs—and they are transparent; they are accountable. I think that is the point Harry is making. Of all these things here, how do we know if any of them are any good?

Mr Vumbaca—There is an evaluation that takes place on these initiatives.

CHAIR—By whom?

Mr Vumbaca—The federal government commissions a National Drug Strategy evaluation.

CHAIR—Who does that?

Mr Vumbaca—The Department of Health and Ageing coordinates it.

CHAIR—No, I want names, people—who are they?

Mr Vumbaca—The Drug Strategy Branch. It changes.

Dr Herron—It is the Drug Strategy Branch that is responsible for evaluation.

Mr Vumbaca—Yes.

CHAIR—We have had the department in here, and they have a few problems.

Mr QUICK—Sweden is being touted as the country that seems to be doing it better.

Mrs IRWIN—By some, Harry.

Mr QUICK—Well, by some. They have the Swedish National Institute of Public Health. We have all these—

Mr Vumbaca—Well we have national research centres in Australia. We have three that focus on drug use.

CHAIR—Even more importantly than that, Dr Herron, when you were a senator and went to Sweden, you published a book when you came back.

Dr Herron—It was a report—an individual report.

CHAIR—I think we need it.

Dr Herron—One of the problems in relation to Sweden—I have been there a couple of times and I hope to go there again—just as we have in Australia, is the number of treatment facilities that are available. There is enormous burnout in people working in this area, which you will appreciate. Every country in Europe that I visited was in the same position: the burnout of people working in the field and the inadequate number of treatment facilities. One of the things in Sweden, for example—and I cannot speak about now, because it is six years since I was there—was that the number of people that were actually going through treatment facilities was only a very small percentage of the number that required treatment, just as in Australia only 50 per cent of people who require treatment actually try to access treatment. It is a real barrier. To come back to Mr Quick's question, the budget, of course, determines the allocation of funds in relation to this field and then it is coordinated through the Ministerial Council on Drug Strategy, with the states in agreement.

CHAIR—You have got some states who legalise drugs and some who do not. It is a bit of a mishmash.

Mr Vumbaca—The Australian National Council on Drugs also auspices a national drug and alcohol magazine which presents current research in plain language.

Dr Herron—They are all available on the web, by the way. All of this material is on the web.

Mr Vumbaca—Yes, and there is a separate web site where you can search by topics as well as get all the PDFs of past issues. This is Australia's National Drug Strategy, in which harm minimisation is the framework. Now there is some confusion about harm minimisation versus harm reduction. Granted, the terminology could be clearer on that.

Mr CADMAN—You gave our last report a pretty good bucketing, mate.

Mr Vumbaca—Who did?

Mr CADMAN—Your council.

Mr Vumbaca—Which report was that, sorry?

Mr CADMAN—*Road to recovery*.

Mr Vumbaca—No, my understanding was, and I have not got the response from the ANCD in front of me—

CHAIR—We have. It is a disgrace.

Mr Vumbaca—I thought it supported just about every recommendation in there bar a couple. That was my understanding.

CHAIR—It did not do any such thing. It did not even deal with them individually.

Mr Vumbaca—Not individually, there were 107 recommendations.

CHAIR—It was an absolute disgrace.

Mr Vumbaca—I disagree with that. I do not think it was. I should clarify, I disagree with the description of the ANCD response as being a disgrace. I do not think that is a fair comment.

CHAIR—No, it is the written response that we got from the government.

Mr Vumbaca—From the government? That is not from the ANCD; that is the government's response.

Dr Herron—We are purely an advisory body. If the government does not want to take any notice of us, that is up to them.

Mr Vumbaca—There are other times when the ANCD has provided advice and the government has made a decision to the contrary.

Mr CADMAN—Do you think the structure is wrong? It seems to me that one part you miss out on is the ministerial council. Should you not be an observer or a part participant at that as the national advisory body?

Dr Herron—I appear before that ministerial council at their meetings and give a report.

Mr Vumbaca—But that is a fair point.

Dr Herron—It is a fair point. It would be useful if that was so.

Mr QUICK—They could just completely disregard your—

Dr Herron—Exactly.

Mr CADMAN—I understand the joint roles of the various levels and spheres of government in that body but it would seem to me that there are distinct federal roles that probably take a wider view than the various states may take. Rather than being hampered by the consensus of that group, is there any way in which you could as a council give advice to the federal government on distinctly federal matters where that council should have in practice no say. Then you could deal with the things where the council and the states in particular have a delivery program in policing or in recovery.

Mr Vumbaca—That occurs now.

Dr Herron—I think it is fair to say, given that structure, that everybody works cooperatively: the intergovernmental committee; the bureaucracy; the ministerial council. There is very little disagreement in terms of the objectives. They signed off on Australia's National Drug Strategy, for example. There is very little disagreement in regards to objectives and coordination of groups. There may be differences, of course, in the collection of data and the availability of treatment facilities in the different states and so on.

Mr CADMAN—Do you have the freedom outside that strategy to make statements of your own?

Dr Herron—Yes.

Mr CADMAN—Could you be seen to be in conflict with that strategy?

Mr Vumbaca—I should explain that the ANCD was actually established as an advisory group which is auspiced by the Salvation Army. It has gone out for tender every three years. I am employed by the Salvation Army currently as are the other members of the secretariat. The ANCD is really like an NGO that operates outside of government. It makes comments and sometimes the chairman in the past has made statements to the contrary.

CHAIR—Hang on; so you are not employed by government?

Mr Vumbaca—No. The ANCD was historically auspiced through the Department of Health and Aging. There was a decision made by the council members, after a year of operation, to outsource the secretariat functions.

Dr Herron—It was tendered for.

CHAIR—Who made that decision?

Mr Vumbaca—The Prime Minister's office as I understand it. It was before my time. Obviously, I applied for the position when it became available. It was advertised as an outsourced position.

CHAIR—Sorry I am not aware of this but when did you become the CEO?

Mr Vumbaca—In late 1999.

Mr QUICK—It is a Salvation Army NGO?

Dr Herron—They tendered for the financial operation. They handle the accounting of the ANCD.

Mr CADMAN—They receive grants to run it?

Dr Herron—They tendered for it, yes.

Mr QUICK—Is the selection of the members on the panel done by the Salvation Army?

Dr Herron—No, the Prime Minister.

Mr Vumbaca—The Salvation Army has no role other than the accounts.

Dr Herron—The executive is appointed by the Prime Minister.

Mr Vumbaca—The ANCD itself is not a legal entity, which is part of the problem we ran into, which is why it needs an auspicing body.

Mr QUICK—I do not believe this, it is not a legal entity.

Mr Vumbaca—No it is not.

CHAIR—Theoretically a tender could be won by the Australian Council for Drug Reform who are pro-legalisation of drugs. Theoretically, they could have won a tender to run this council.

Mr Vumbaca—It does not matter who wins the tender because they have no influence.

CHAIR—No, hang on.

Mr Vumbaca—They could theoretically yes, but it is irrelevant.

Dr Herron—It is determined by government.

CHAIR—Tenders as you know, John, are won on value for money.

Dr Herron—Yes, I do not disagree.

Mr QUICK—If it is not a legal entity, how can it receive Commonwealth government funding?

Mr Vumbaca—That is what I am saying. The financial arrangements are the money is received by the Salvation Army or the auspicing group.

CHAIR—How much money does the council—

Mr Vumbaca—Annually around $1.6 million.

CHAIR—Who distributes the $1.6 million?

Mr Vumbaca—That is determined by the ANCD executive.

Mrs IRWIN—Chosen by the Prime Minister?

Dr Herron—Yes. The $1.6 million goes to National Indigenous Drug and Alcohol Committee, which has a membership of 14.

Mr Vumbaca—The national magazine of substance—

Dr Herron—And we have an office of four.

CHAIR—Could you take on notice and give us a breakdown of how the money is spent?

Mr Vumbaca—It is in the annual report which is available on the web.

CHAIR—I have not got the annual report here with me.

Mr Vumbaca—Nor have I. I was not aware that the way that the ANCD runs was going to be part of today's discussion.

CHAIR—Yes.

Dr Herron—The government gets very good value for money. I do not have any staff, as you know I am unpaid. But there is less organisational structure than for any of the members or senators have who run this show. They are all devoted people who work very hard.

Mr CADMAN—Do you make decisions on funding or recommendations of funding to various bodies?

Mr Vumbaca—Not decisions. We provide advice.

Mr CADMAN—Say the annual budget is $60 million a year or a lot more than that, but you decide which organisations shall have it. Do you decide the break up between research and—

Dr Herron—No.

Mr Vumbaca—The ANCD provides advice to government regarding what they think the priorities should be and puts a budget submission in each year. Obviously the one for this year was very heavily focused towards treatment, the need for further treatment and investment in treatment. We saw, thankfully a great investment—

Mr CADMAN—Do you put that into the government or does it have to be siphoned through the department of health?

Mr Vumbaca—The government determines how that money is then provided. The treatment money goes through the department of health.

Mr CADMAN—I take it your submission goes to the Prime Minister?

Dr Herron—Yes, I meet with the Prime Minister. For example, in the last submission, I said to him that I thought there was a dearth of treatment facilities. There needs to be funding going into treatment facilities and upgrading the skills and training of people working in those facilities. There is a problem with burnout as I mentioned to the committee. Now after that it is in the Prime Minister's hands.

Mr Vumbaca—We await budget night like everybody else.

Dr Herron—We do not talk about how much money should go into separate things. It is an advisory body.

Mr CADMAN—Okay.

CHAIR—He is very strong on zero tolerance. He wants prevention policies; he wants zero tolerance to be the guideline. As I said, he is very strong.

Dr Herron—They have been effective.

CHAIR—They have. In policing, they have been extremely effective.

Mr Vumbaca—The most up-to-date figures available in Australia of combined state, territory and federal government expenditure on drug and alcohol issues show almost 80 per cent goes to prevention, education and supply reduction.

Mr CADMAN—It is a pity that could not be further broken down.

CHAIR—Yes we need to know where that money goes.

Dr Herron—We can break it down. We can give you an overview.

Mr Vumbaca—This gives you an idea, 42 per cent goes to law enforcement.

Mr CADMAN—Is this all governments?

Dr Herron—Yes, all governments.

Mr Vumbaca—Fourteen per cent goes to interdiction which is Customs, border protection and the like; so that is 56 per cent. Twenty-three per cent goes to prevention; a whole range of school based and other education activities. Only 17 per cent goes to treatment and only three per cent goes to harm reduction and there are other bits and pieces which the researchers had trouble classifying into one of these particular groups.

CHAIR—What is the size of that budget? How much money?

Mr Vumbaca—The annual budget was I think about two to three billion.

CHAIR—There is a big gap there, two to three?

Mr Vumbaca—It is available and I can provide that on notice. I do not have the figure in front of me. I do have it though. This is from research which is available online as well. It is not done by the ANCD but by the University of New South Wales. That gives you an idea.

CHAIR—How much is spent on methadone and how much is spent on syringes?

Mr Vumbaca—Syringe programs would come into the three per cent, needle and syringe programs are part of harm reduction.

CHAIR—No, I want numbers.

Mr Vumbaca—That is run a lot by state and territory governments. It is not information we have access to.

CHAIR—How much does the Commonwealth spend on methadone and syringes, and how do we do it? We have certain people, doctors who prescribe methadone, so they are making money out of it. And I am told by my friends in the pharmacy area that the people who dispense methadone are not registered in the same way as ordinary pharmacists—and they believe they should be.

Mr Vumbaca—That would vary from state to state.

CHAIR—Could you take that up and have a look at that for me?

Mr Vumbaca—The department of health would be able to provide you with costs and figures. They are the ones doing it. I am just trying to put a line there between what the ANCD does and has access to, and what the department of health as a federal government department has access to.

CHAIR—So you are really captured by the department of health, in a way?

Mr CADMAN—To some degree.

Dr Herron—In the sense that, as I say, everybody works cooperatively. I meet with them and they attend our council meetings.

Mr Vumbaca—The ANCD have just commissioned a report similar to the impact on families one but on pharmacotherapy programs in Australia, to look at how much money is going into it and what models are available, because they vary from state to state.

Mrs IRWIN—If they are working or they are not working?

Mr Vumbaca—I am well aware of the registration issue, but that may well come up as one of the issues.

Dr Herron—One of the problems that we have in Australia generically is the lack of statistics and the availability of statistics. You will see that research is from 2002-03.

CHAIR—It is ancient.

Dr Herron—That is the latest available. As best we can gauge, that is a fair and accurate representation of where it is at the moment, but we do not know. You will find in this field that, because of the variability in relation to the states—each state has different programs going—it is very difficult to get the statistics together.

Mrs IRWIN—It is very frustrating as well.

Dr Herron—Very frustrating, yes.

CHAIR—That is why I am very impressed with what Mick Keelty has done, because—

Dr Herron—So am I; he takes a keen interest in our committee as deputy chairman.

CHAIR—he has said what happens to the money. He has given us transparency. But the rest is all a great mystery.

Dr Herron—The health department does have that—what is available. It is not our responsibility, in the sense that we have only four people there in our secretariat, apart from Gino. But those figures are available, as best as possible.

Mr Vumbaca—I am not sure what you mean by ‘mystery’. There are reports available on where the money is spent, on which particular initiatives, and who gets the money.

CHAIR—Yes, but we visited that rehabilitation place in Queensland, Mirakai—a fantastic facility, getting great outcomes, and yet they beg and scrounge for a measly $200,000, with no guarantee of getting recurrent expenditure. Yet people who just write reports reinforcing their own reputations are getting all the money.

Mr Vumbaca—I am not aware of Mirakai’s actual funding sources, but the federal government, through the NGO Treatment Grants Program, which has been almost doubled in size with the recent budget, is putting in place—

CHAIR—Thank goodness. That was a very good initiative.

Mr Vumbaca—It was. NGOs are the particular focus, and there has been a big commitment given, and that has been driven by the ANCD members as well, over many years, about driving to get NGOs access to decent funding to provide treatment. Mirakai will benefit from that. There has to be a tendering process.

CHAIR—The problem is you are only an NGO, really.

Mr Vumbaca—Yes, that is right.

CHAIR—You would be seen by the bureaucracy as being an NGO looking after NGOs. Your clout would not be all that great.

Mr Vumbaca—I would disagree with that.

Dr Herron—We find it is pretty good, to be honest with you.

Mrs IRWIN—You do have the ear of the Prime Minister! That is important.

CHAIR—But I am talking about the bureaucratic level.

Dr Herron—At the bureaucratic level it is quite good as well, because the chairman of the intergovernmental committee sits on our ANCD council, ex officio. It is Keith Evans at the moment. It rotates every six months.

Mr Vumbaca—Every two years.

Dr Herron—Sorry, yes. We liaise with him regularly and find him cooperative, and we appear before that committee as well.

CHAIR—You appear before what committee?

Dr Herron—Before the intergovernmental committee.

CHAIR—You appear before it?

Dr Herron—Yes.

CHAIR—You do not advise it?

Dr Herron—It depends on the terminology. We give them advice, yes.

Mr Vumbaca—Mr Cadman raised the issue about the chairman sitting at the MCDS meeting. We do not get a seat at—

CHAIR—That is what I am saying: that is where the clout comes. I think you ought to have a voice there.

Dr Herron—Thank you.

Mr CADMAN—The IGC can be accountable, but the ministerial council to me is where the buck stops, and your role at that meeting, I think, would be very important.

Mr Vumbaca—I would not undervalue the importance of John being able to pick up the phone and meet with the Prime Minister.

CHAIR—That is hugely important.

Mr Vumbaca—Exactly.

Mr CADMAN—We are not seeking to take that away!

Mrs IRWIN—That might be one of the recommendations!

Dr Herron—I have to say that, having looked at other entities in the world, I think Australia has the best structure of the whole lot, with that facility. I met my English counterpart in February and discussed it with him. He has a committee of 34, I think it is.

CHAIR—That is not a committee; that is a convention.

Dr Herron—Absolutely. His biggest problem is getting the bureaucracies to talk to each other, let alone work together, whereas we do not have that in Australia. I really am extraordinarily impressed, having been there over the years.

CHAIR—They do not have any states, John.

Dr Herron—That is right, but it is interesting that the sort of territorial imperative, if you like, exists there to a greater degree than it does here. It is quite a pleasure to attend these committees, the intergovernmental committee and the ministerial council, where we can put forward our objectives and get, to the best of their ability, their cooperation.

CHAIR—How do you then explain the fact, if it is all so terrific, that South Australia has legal cannabis?

Dr Herron—I think they have got to wake up.

CHAIR—It is a honey pot.

Dr Herron—When I was in England, the front page of the *Sunday Telegraph* had on it 'We were wrong,' and it said that they had been advocating cannabis—and that is on the record.

CHAIR—Who said that?

Mr Vumbaca—The *Independent*, it was.

Dr Herron—The *Independent*, sorry. The *Independent* in England were promoting—

CHAIR—The what?

Dr Herron—The *Independent* newspaper, in their Sunday edition, had on the front page 'We were wrong'.

CHAIR—How many lives got destroyed while they were—

Dr Herron—They apologised for their advocacy of the use of cannabis. We produced a report actually, which we released last year, on the dangerous aspects of cannabis overall, and of course it did not receive a great deal of publicity.

CHAIR—No, because the industry kills it.

Dr Herron—Well, it did not receive much publicity. But it is on the web and is available. I went through that era—I never inhaled—when cannabis was thought to be harmless and useful and all the rest of it. It was the general consensus in the hippie era that that was so. Now, it has taken years—a bit like cigarette-smoking; it took 50 years for cigarette-smoking.

CHAIR—But it is not like cigarette smoking, John.

Dr Herron—No, I am saying the deleterious effects of cigarette-smoking took 50 years to be enacted in legislation.

CHAIR—Yes, but do not compare the two, because I have never seen anyone commit an act of violence under the influence of tobacco.

Mrs IRWIN—They have under alcohol.

CHAIR—I said ‘tobacco’.

Mr CADMAN—I understood you were saying, John, that during the hippie era that is how it was understood.

Dr Herron—Yes, that is right. That is what I am saying.

Mr CADMAN—He is not saying that now.

CHAIR—I disagree. Tom Lehrer was out there promoting LSD at the same time.

Dr Herron—Yes, that is right. A lot of these things—

CHAIR—I did not take it, because it was illegal.

Dr Herron—Yes, but it took a long time for these things to come through into consciousness and then for legislation to be enacted. I remember the tobacco story because, as you would well remember, in the Senate, Sir Richard Dole produced that report in 1954, 53 years ago.

CHAIR—Yes, but, John, even blind Freddy should be able to see or understand that taking anything into your body that destroys your brain is bad.

Dr Herron—I agree.

CHAIR—Yet we have a whole bunch of people whose ideology says, ‘No, drugs are here to stay; we should learn to live with them.’ I find that absolutely offensive. And we hear the stories like the one we just heard about a family destroyed by cannabis.

Dr Herron—Yes, that is in our report.

CHAIR—We have pages and pages of human stories, because somebody has an ideology that says we have all to accept drugs. Well, no, we do not.

Mr Vumbaca—There are some people who say that, but there is some confusion—

CHAIR—They are dominant.

Mr Vumbaca—The reason we put this slide together was to show that the majority of focus is on prevention, supply reduction and the like.

CHAIR—What percentage of that 79 per cent goes into policing?

Mr Vumbaca—Fifty-six per cent of it goes into policing.

CHAIR—Exactly.

Mr Vumbaca—What I am trying to say is that, despite our best efforts with that, and Mick Keelty and law enforcement reducing supply—

CHAIR—Doing a fantastic job.

Mr Vumbaca—there are people who still will use drugs and then require treatment and assistance.

CHAIR—We had read out today that it was the Swedish vision to have a drug-free Sweden, and part of that vision was that the number of people using illicit drugs would be minimal, marginal. The OECD figures indicate that we are one of the largest takers of illicit drugs. We heard from Mick Keelty that a pill that sells here in Australia for $30, $40 and $50 a tablet sells in Europe for $8, and that the pushers of it could land it here and sell it for $12 and still be making big profits.

Mr Vumbaca—Yes.

CHAIR—However, we have conditioned people with words like 'recreational drugs' and 'party drugs'—implying it is all fun. Things are put out that say what it will make you feel like. The market will pay $30, $40 and $50 a tablet because we have conditioned them to think it is okay.

Mr Vumbaca—I would draw your attention to the reduction in illicit drug use in Australia since 1998, measured by the national household survey. I think that sometimes there is a focus on old data or perceptions, rather than the reality.

CHAIR—That information was given to us three weeks ago; there is nothing old about it.

Dr Herron—I think we are talking at cross-purposes. This manufacturing slide shows what we are up against, all of us collectively. The clandestine laboratory; this is for the amphetamines.

CHAIR—Yes, and it is worse in Queensland.

Dr Herron—That is correct. The next one shows the manufacturing facility. This is what you are up against throughout South-East Asia. That is just one of probably thousands in South-East Asia that are producing those materials that Mick Keelty was talking about. We had a report from the Federal Police that there is something like two million containers coming into Australia every year and the associated opportunity of detecting that. There are so many millions of postal articles coming into the place with small quantities. This is apart from the number of people that

come in with concealed drugs in their possession. That is happening virtually every day and you have a flood. This is distributed through organised crime throughout Australia. That is what you are facing on the one hand, and on the other hand, despite all the funds that are spent, the interdiction, the policing and all the rest of it, you are up against ruthless people who do not care about the consequences. We suffer those consequences because people are stupid enough to take drugs.

CHAIR—John, we have an obligation to have a major advertising campaign, a bit like the Grim Reaper, to tell people what it does to you. Pictures that show what drugs do to you: the rotting teeth, the ageing face, the haggard look, the bone disintegration.

Mr Vumbaca—Australia has a national campaign.

CHAIR—No, I said like the Grim Reaper.

Dr Herron—No, there is. There is an ice one, drugs in general.

CHAIR—No, a campaign with the intensity of the Grim Reaper, which really did push AIDS right down. It worked. The one that is working for smoking is that one of that face—the Australian Institute of Health and Welfare gave us that information. If people on the ABC, the official government owned radio station, talk about recreational drugs and party drugs, it is telling the world that it is okay.

Dr Herron—I have just communicated with the Australian Press Council pointing this out and getting agreement from them. I found, interestingly enough, when we released this families report a week ago, that the support from media was quite outstanding and supportive. It was quite extraordinary. I think there has been a change overall from the last time that I was involved in this area in relation to the media. People are now supportive: the talk-back programs and television programs are all supportive. I think there has been a shift in society towards zero tolerance, which I applaud. It has taken a long time, but I think it is occurring. Perhaps we might finish with those other slides.

Mr Vumbaca—The only point I want to keep making is that people keep falling through. Ideally you do not want people to use drugs at all. The reality is that some people will, and you have to provide treatment and other services for them.

CHAIR—We were talking about that with the last witness, and I do not know whether you heard the mother's testimony, Carol Russ. She lost a child she dearly loved and who was a valuable person. What we obviously need is an anti-addiction policy, which is part of the road to recovery and then a good treatment policy to reclaim those lives. We had another young man sit here last week who said the reason he started taking drugs was because cool kids did it. It was cool. He then got addicted and he said his life was nearly destroyed by the harm minimisers, including a psychiatrist and a counsellor, who told him it is okay, just lessen it, just take it at weekends. Now that is happening.

Mr Vumbaca—I would be surprised.

CHAIR—That is happening. I have got plenty of examples of that.

Dr Herron—No, it has occurred.

CHAIR—Harm minimisation has come to mean different things to different people.

Dr Herron—That is correct.

CHAIR—It is a bit like the term 'multiculturalism' I suppose. It is ruining people's lives.

Mr Vumbaca—There you see prevention, then treatment and then harm reduction for those that are still experiencing problems. I suppose what you said, in slightly different terminology, is exactly the same as that.

Dr Herron—Peer group pressure is the hardest thing to counteract. We know with our own kids, that has been the greatest influence on them.

CHAIR—Here is a picture of a mouth that has been affected by drugs. Here is the face of someone who is 44 years old on drugs.

Mr Vumbaca—What I think personally, or what John or anybody else thinks, may or may not work with a campaign. If you are targeting young people you have to have a message and information that actually—

CHAIR—I do not expect us to be the instant advertising experts. All I am saying is we need the campaign. Would you agree with that?

Dr Herron—We would endorse that, yes. As I understand it, the ANCD has advocated support for grandparents in the past.

Mr Vumbaca—There has been a fair bit of movement in the last couple of years with FaCS, or FaCSIA I should say now, about support for grandparents, and it may be worth investigating that further. Because, as I said, in the last 12 to 18 months there has been some significant movement in that area. One of the programs recommended for funding, devised by the ANCD, was grandparents raising grandchildren in Tasmania, which received a grant and still does from FaCSIA. That was a pilot program about seeing how best to support grandparents. They have been quite active in some of the issues that grandparents are facing when raising their grandchildren as a result of the drug use of their own children.

CHAIR—I think we need to go back a step further too, and start looking at the interests of the children who are born to drug addicted parents.

Dr Herron—Part of that will be in our second report, as I understand it.

Mr Vumbaca—Yes, some of that.

Dr Herron—Also, I must put on the record that Professor Margaret Hamilton, who is appointed to the executive, is one of the most outstanding members of our committee. She works the hardest in my belief.

CHAIR—I have to disagree. She is the one who disparages what the minister says.

Dr Herron—She has not done that in my presence, Madam Chair.

Mrs IRWIN—She is a very, very dedicated woman.

Dr Herron—She has been dedicated and an outstanding worker and I have found her to do more work than any other member of the committee and I would like to have that on record.

Mr Vumbaca—I can second that.

CHAIR—Thank you. I am happy to have that on the record, but I have to say in reading her book, *Drug Use in Australia*, her comments about the Prime Minister and the government's policy are totally unacceptable to me. I would like that on the record too.

Dr Herron—Well, people's views change.

Mrs IRWIN—Just out of curiosity; you have got members of the ANCD that have got differing views on drug policy. How do you resolve this in providing advice to the Prime Minister?

Dr Herron— It is quite interesting really. We have never had a vote.

Mrs IRWIN—Not even a show of hands?

Dr Herron—Not even a show of hands, no. As I say, I have inherited this and I feel honoured to chair that committee. They are the most outstanding group of dedicated people that I have ever met. There is no argument. There is often debate, but there are no personality conflicts of any kind. Decisions of the executive may be debated by the full council, but by and large it is a cooperative group that works collectively in the interests of the Australian people, and I think that is wonderful. I did not strike that, if I may say so, in politics, where you have an adversarial situation, and that is understandable too because that is democracy. But in this committee it works cooperatively and constructively.

Mrs IRWIN—It is funny that you say that, because I know that Brian Watters—I met him when I was overseas as I visited a number of countries that he was visiting at the same time—virtually said the same as you when he was in that position.

Dr Herron—Did he?

Mrs IRWIN—He did change his views. Not a lot, but slightly on some issues.

Dr Herron—We have not colluded, but I admire him and the committee greatly, because it has evolved. Its membership changes every three years, but essentially Professor Hamilton has continued. She has been there from the beginning and Professor Robert Ali. They are the only two that did not.

CHAIR—How do you resolve her comments that harm minimisation avoids the minefield of moralistic arguments about whether drug use is inherently good or bad and, from the perspective of harm minimisation, drug use per se is neither good nor bad. How do you resolve that?

Dr Herron—I think you can resolve that because I ran into this situation where different things mean different things to different people. On the one hand we have the harm minimisation and the harm reduction and then we have tough on drugs. We have got a terminology that means different things to different people. That is how I resolve that.

CHAIR—That is exactly what I said before, but it is not acceptable to give mixed messages. I like your comment; you said you were in favour of zero tolerance.

Dr Herron—Zero tolerance, everybody is the same.

CHAIR—No, everybody is not.

Dr Herron—There are those we have to collect. It is like people falling through the cracks, we have to help those people who are addicted.

CHAIR—Margaret Hamilton does not.

Dr Herron—With respect, to my understanding she does.

CHAIR—Perhaps I will read out the quote where she says she does not.

Dr Herron—When was that written?

CHAIR—You mean she has changed her mind totally? She has gone cold turkey?

Dr Herron—I have no idea, you would need to ask her that. But people change their views.

CHAIR—Like Brian Watters, on some things.

Dr Herron—Madam Chairman, I remember when you were in favour of the tobacco industry.

CHAIR—This has been reprinted in 2004.

Dr Herron—People's views change. I have found her the most cooperative and constructive worker on my council.

CHAIR—We wish you well in your zero tolerance crusade.

Dr Herron—It is probably an unwinnable battle in the long-term.

CHAIR—Only if you lose faith, John.

Dr Herron—We should aim at it, there is no question about that.

CHAIR—Have a vision.

Dr Herron—We did not mention the biggest problem overall in Australia is alcohol. It is the huge problem, and it is a mixture of alcohol, cannabis, illicit drugs.

CHAIR—We are looking at illegal drugs here and there is plenty of people looking at the other.

Dr Herron—But we cannot sweep it under the carpet.

Mrs IRWIN—It does sometimes go hand in hand. Our most important thing is to keep our young ones alive on their road to recovery.

Dr Herron—Absolutely.

CHAIR—First of all, thank you for coming. Gino, I am just amazed at the structure, thank you for giving us that information. I think we will probably want to talk to you some more.

Dr Herron—I would be very happy.

CHAIR—If you do not mind being there for us to talk with, because I think your role is very important and we would like you to have a voice on the ministerial council. I am amazed that you do not.

Dr Herron—I would accept this on a voluntary basis, because I think it is worthwhile. As you know, I have been involved in this area since birth. I was brought up in a hotel from the age of two to 16. I have been involved in alcohol and drugs as a medical officer and as an assistant government medical officer with the police in Queensland.

CHAIR—They were not pushing pills in the pub in those days, were they?

Dr Herron—No, but I was assistant government medical officer with the police examining drunken drivers so perhaps I have an interest. I have written reports in this field as well.

CHAIR—And in Victoria, of course, they test for drugs.

Mr Vumbaca—I think you will find most jurisdictions do now.

Dr Herron—They are starting to now in Queensland.

Mrs IRWIN—They are starting in New South Wales to my knowledge.

CHAIR—What about South Australia?

Mr Vumbaca—Maybe not; I do not know. I did hear a report that most jurisdictions now had a drug-driving testing regime in. Some are smaller than others.

CHAIR—When I have been doing my test in New South Wales, nobody tests for drugs.

Mr Vumbaca—If they have not started—

Mrs IRWIN—It has just recently been introduced.

Mr Vumbaca—I have seen photos of the vans they are going to use and everything.

CHAIR—They are not happening yet.

Mr Vumbaca—I could not say.

CHAIR—It is very important.

Dr Herron—Yes. I recall perhaps five years ago talking to the inspector-in-charge of traffic in Queensland where, at that stage, drug driving was becoming dominant in relation to drink driving.

CHAIR—Yes, that is right.

Dr Herron—Interestingly enough, as you know, I was ambassador to Ireland and the Holy See and I used to meet with the police commissioner there, because of my interest, on a regular basis. They have no random breath testing in Ireland and they have a high mortality rate on the narrow roads overcrowded with vehicles.

CHAIR—Maybe it is something to do with the culture.

Dr Herron—We should be proud of Australia and what we are doing in this regard. We are in many respects leading the world in a lot of these activities.

CHAIR—Going back, there was a report in the paper the other day from the Alfred in Melbourne which showed the amount of drugs in trauma patients that come into the hospital. Forty-six per cent of them had cannabis in their bloodstream. It is pretty scary stuff.

Mr Vumbaca—I think there is a cultural shift needed about people under the influence of drug driving that we have not seen in the same way we have seen with alcohol.

CHAIR—It is like the kid that said when he was taking illicit drugs and somebody said, ‘If you must have something why don’t you smoke a cigarette,’ and he said, ‘No, that might kill me.’ But there we go. We do need some education.

Dr Herron—Thank you very much for the opportunity of appearing before the committee.

CHAIR—Thank you very much.

Resolved (on motion by **Mrs Irwin**):

That this committee authorises publication of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 12.35 pm