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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Reference: Impact of illicit drug use on families

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HOUSE OF REPRESENTATIVES

STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Wednesday, 23 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, Ms Kate Ellis, Mrs Kay Elson, Mr Fawcett and Mrs Irwin

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

Committee met at 10.17 am

BRESSINGTON, the Hon. Ann, Private capacity

HIDDEN, Mr Ryan, Spokesperson, Recovered Drug Users League

CHAIR (Mrs Bronwyn Bishop)—I declare open this public hearing of the House of Representatives Standing Committee on Family and Human Services for its inquiry into the impact of illicit drugs on families. Today the committee welcomes the Hon. Ann Bressington, an independent member of the South Australian Legislative Council. She was elected on March 2006 on a platform of drug policy and treatment reform. Joining her is Mr Ryan Hidden, a graduate of the drug treatment program that Ms Bressington founded and managed at DrugBeat of South Australia. We look forward to their comments about how we can better support people to become drugs-free and how we can prevent others from being drawn into addiction and causing immense damage to themselves, their families and loved ones.

The transcript of what is said today will be posted on the committee's website. If you would like further details about the inquiry or the transcript, please ask any of the committee staff at this hearing. This hearing is open to the public.

I call upon the secretary to administer the oath or affirmation as appropriate. Normally we do not have a need to swear other members of parliament, but we did inquire of you and you elected to take the affirmation, so that will happen.

I wonder if you would like to begin by making an opening statement

Ms Bressington—To the committee, first of all thank you for the opportunity to present here to you. I come from probably a number of perspectives on the evidence that I will be giving. First of all, my daughter died in 1998 of a heroin overdose at the age of 22, after using heroin for four years. I know the struggle of parents who are trying to deal with a child who is drug dependent. I also come from a treatment and rehabilitation perspective. I started an organisation literally from the ground up and it has become one of the most successful outcomes-based treatment services in the country. Our average success rate over the last five intakes has been 93 per cent of people remaining drug-free and who have also gone back to either work or study.

We have also dealt with parents of drug users. They have their own separate program, but we deliver family therapy as well for those parents to teach them the difference between trying to communicate and deal with a drug dependent person, as opposed to a person or a child who is not using drugs. A lot of parents do not understand that when you are talking to a person whose mind is altered, that the words they are saying are heard very differently to what their other children would perceive to be the meaning.

We have also dealt with children of drug users to deal with their abandonment, neglect and abuse issues as well. We have seen some 40 children come through the program who have gone from having behavioural problems at school to topping their class, becoming involved in team sport and becoming quite functional within the school. Three of our children have progressed to being students on the committees in the schools, as drug advocates for other children who they believe are living the life that they were leading, and helping them to get a handle on where they

should be going for assistance, and also teaching them coping strategies until their parents actually get into treatment.

I think the most disturbing thing for me in the 11 years that I have been involved in this is the way that the message of harm minimisation has been manipulated. I do not think that anybody could argue that to reduce the harm, reduce the supply and reduce the demand are not noble objectives for any drug policy. However, we have seen that reducing the harm does not actually mean that. On the ground at the grassroots level it actually means minimising the harm, which is making it appear to be less than it is. Mr John Herron made it very clear in the newspaper that the children of drug users have been the hidden harm for a very long time. There are many hidden harms to drug use, to the way that our drug policy is implemented and the conflict that exists between the harm minimisation approach and the tough on drugs strategy. I believe that there is a way to bring these together to meet in the middle; that it cannot be all harm minimisation or all abstinence. However, I do believe harm minimisation needs to be reeled in.

One of the problems I have with harm minimisation is when they talk the need to build resilience into the children of drug users. I have heard a number of theories cast around that these children can be taught to cope with the drug use of their parents, and I tell you here and now, they do not learn to cope with their parents' drug use. What happens is, we have children who are looking after their siblings. I have had an example of one five-year-old who had the responsibility of looking after her two-year-old sister and her one-week-old baby brother while the parents were off their face on methamphetamines. That little five-year-old did remarkably well, but she is now eight and she wears the scars of that emotionally, and also wears the scars of the fact that her little baby brother nearly died from starvation and it became all about her and her responsibility. We have got to remember that our children are not born grown-up and that our children will live what they learn.

Up until about the age of nine I think the research shows that kids are absolutely against tobacco, alcohol and drugs, but something seems to happen at the age of nine where they flip, and they are prepared to try cigarettes and they are prepared to be a little bit more adventurous. Eventually those children of drug users will become drug users themselves, and this is where that generational cycle of drug use is our major concern in society now.

As far as the children of drug users go, they need care, they need love, they need attention and where possible they need to be able to go into a rehabilitation centre with their family, with their parents, and they need to be able to recover as a whole family. The issues are not separated; they are all intertwined.

As far as drug users go, I have not met a drug user yet in 11 years who has not wanted to stop using. I know that there are plenty out there that do not want to stop using, and believe that it is the public responsibility for them to have their drugs provided, a safe place to use and all the rest of it, but I have found the harm minimisation lobby, and I call it a lobby, supports those drug users wholeheartedly. The drug users who want to stop have been left high and dry. They can take anything up to six to eight weeks to access treatment and in that six to eight weeks they fall through the cracks. We have a very small window of opportunity for drug users who get to the point where enough is enough. It is usually about a 24- to 48-hour window; if we do not catch them and we cannot provide a service to them within that period of time, their drug use will continue, on average, for about another two and a half to three years.

I am sure you have had this evidence of a study by Collins and Lapsley which showed it is costing us about $80,000 a year for every active drug user in our community. On average, to get a drug user well, it costs about $25,000; that is residential and non-residential. There is also plenty of evidence to show that for every dollar spent we will get a $7 return as soon as drug users enter into treatment, and that then stops the collateral damage that occurs.

I have also been representing to grandparents for grandchildren; this is another hidden harm of our drug use, where we have hundreds of grandparents in their seventies and sometimes older, now responsible for raising their grandchildren because the parents are not capable of doing so. While we continue to enable these parents and drug users to avoid their responsibility to the community, then our drug problem is not going to get any better.

I have introduced legislation into South Australia for mandatory treatment for people who have been brought to the attention of welfare for abuse and neglect of their children, that they must attend an abstinence-based program and they must be committed to that for about 15 months, because, in our experience, between 15 and 18 months is the ideal time for a person to recover well. Funnily enough, the civil libertarians got involved in that debate and believe that it is against a person's civil liberties to be forced into treatment to give up their drug use. However, I will persist with that one.

I guess the overall thing is that Australia and their attitude to drugs is a lot like Sweden and their attitude to drugs in the late 1960s and early 1970s; we are now doing in Australia what Sweden did 30 years ago. Sweden abandoned harm minimisation and adopted a restrictive demand reduction policy. In September of last year the United Nations Office on Drugs and Crime made a statement that Sweden is the country to which countries with a serious drug problem need to be looking, that drug control does work. In the year 2000 I spent two weeks in Sweden and one week in Amsterdam and their approach is not what some academics and professionals would have us believe it is. It is not harsh, it is not inhumane, it actually deals with the needs of drug users and their families very well. Their methadone program is very structured and produces good outcomes; far better outcomes than we produce here on methadone, I might add. They just do not seem to have the collateral damage that we have. The hepatitis C rates in Sweden in 2006 were 26 per million; in 2004 in Australia our hepatitis C rates were 66 per million.

We have to start looking at the mental health issues that come from drugs as well. Sweden does not have the mental health problems that we have, it does not have the crime rate that we have, it does not have the number of grandparents raising their grandchildren that we have. I think about 2 per cent of their youth have ever tried a drug like marijuana.

CHAIR—What percentage did you say?

Ms Bressington—Two per cent of their high school students have ever tried marijuana. We sit in Australia and believe and fool ourselves. I have heard the Hon. Christopher Pyne talking about how the tough on drugs strategy is working. I find it very hard to believe that we are making any dents in this at all. If we are seeing a reduction in teenage drug use, then it is probably because we have less teenagers rather than the fact that less teenagers are using drugs, because we are certainly not seeing that on the ground. We are seeing that the age of drug users is getting younger all the time. The average age now of kids starting to use marijuana is between

ten and 12, and to me that is just the most disturbing future or projection of the future that we can hold.

The target groups that I try to represent here today are drug users; the drug users who want to stop and who cannot access treatment. Ryan Hidden will tell you his story. The messages that drug users are given when they seek out treatment is to cut down, 'Only use weekends; there is no need to stop altogether; you can recreationally use these drugs.' These are counsellors: 'I used to, and I still recreationally use; I have managed to keep my drug use under wraps on weekends only for quite some time now.' The addict in a person will grab onto that and run with it, and Ryan will tell you himself that he heard those messages and it put him off getting involved in treatment for some months, to the point where he was suicidal and misdiagnosed with a mental illness. We have people with mental illnesses who are being diagnosed while they are under the influence of illicit drugs, and nobody seems to want to accept the fact that when a person's mind is altered, they will exhibit behaviours that mimic mental illness. To diagnose people with a mental illness and not expect them to stop their use first so that they can do an accurate diagnosis is just a miscarriage of medical treatment and I find it quite negligent.

We have actually had one client who was stuck in the mental health system for five years on heavy duty medication. He was diagnosed with schizophrenia, bipolar, manic depression and paranoia, and he was heavily medicated on top of the illicit drug that he was using, which was methamphetamine. At no stage was he required to stop using his methamphetamines. He ended up in jail for trying to run over two police officers in a psychotic episode. While he was in jail he managed to get clear of his illicit drugs. He came to DrugBeat. He is now two years clean and there is no sign at all of any of those mental illnesses. So, the psychiatric approach to this needs to be reviewed; the medical approach to this needs to be reviewed. Addiction is not a medical condition. Addiction is addiction; it means that you are chemically dependent on substances that change your brain chemistry and therefore change the way you think, change the way that you feel and change the way that you perceive, and you cannot fix that with medicine.

Frances Nelson QC is head of the Parole Board of South Australia. She is having to deal with the fact that we have a lot of people who are using drugs in South Australia and committing violent crime against others under the influence of illicit drugs, and are getting off with a judgement of mental impairment because they are supposedly mentally impaired because they are using drugs. We are working to change that law. In her view, only five per cent of the people who commit violent crime have actual mental impairment; the rest of it is caused through illicit drugs. She wants to see that law changed so that they do not get off with the consequences of their actions because they choose to use drugs. I am open for questions.

CHAIR—Thank you very, very much for that. Ryan, you might like to speak before we go to questions.

Mr Hidden—Most certainly. I had initially considered doing a big spiel about my history, but I figure most of that will come out in questions. I did want to touch on a few things, though. I am really passionate about harm minimisation. While I tell most people that I am a recovered drug user and I survived my addiction, to my friends and people who I trust, I tell them I survived harm minimisation, because it literally threatened to destroy my life and my family's life through the messages that it can implant into that structure and the way it threatened to tear us apart, literally. It was almost like that was its objective; it did not want me to escape my addiction, it

wanted me to stay stuck there. To give you a few examples: my school counsellor—and most of you would have read this in my submission—believed that drug use was normal teen behaviour. He said that it was fine as long as it did not become a serious issue for me to go down that path, never mind the fact that my behaviour was deteriorating constantly. My grades dropped and I eventually ended up getting expelled from that school. I went from being the teacher's pet, everyone loved me, to a kid who was abusive. What was the worst thing I did at that school? I drenched a teacher with a hose just because it was something to do; I was a really horrible person. That was over a period of 18 months, two years, since my drug use began. I got expelled from that school.

By this stage my parents were getting pretty freaked out by what was going on and they sent me off to other local programs which went down the same path. By this time I was an addict. They were telling me to cut down my usage: 'Just go back to where you can use, don't put yourself in risky situations when you do use; when you do use, make sure you clean your bong,' and 'You don't share your bong so you don't get any diseases.' I got that from five or six different sources. A psychiatrist, while not as bad, did not recognise that my use was contributing to my behaviour and did not pass that information on to my parents. All the time, my parents were falling into helplessness and hopelessness. Now they are recovered and are still in touch with DrugBeat.

I see parents who walk in that door and it tears my heart out, because I remember my parents, I remember all the things I did to them and I think about the relationship that I have now had to rebuild. I always thought growing up as a kid that the bonds you shared between your parents was eternal; that that was eternal love and you could not break that. When you are a drug user and you change your behaviour completely, you physically assault your father and you make your mother scared to be in the same room as you, that goes. Since recovering and during recovery, I have had to try and rebuild that love and rebuild that trust and it has been really hard. Every time I see a parent who comes in and they are not recognising that they need to hate the drugs and love their kids, and they are hating their kids, it tears my heart out. Sorry, I am getting emotional, I should stop.

I am passionate. We need to move away from harm minimisation. I appreciate the merit of some of their programs, you have to, but at present I see it as a mask covering a very ugly face. I take a different approach. I would much rather see a swing to the other side and put up with the problems over there than stay where we are, because we are already in a very perilous situation and I do not want to envisage where it goes from here. How much worse can it get? We have huge drug rates in this country, and especially in my home town of Gawler, Elizabeth and anywhere in the northern suburbs really. You cannot go out at night unless you are with a group of people. In Gawler close to four months ago one of my best mates got bashed, he got his jeans and his shoes taken. Most people know that was just for a laugh. Drug users like to bash people, they are angry inside and they want to project that anger. Things like that; it has become a really scary society to live in.

Mrs IRWIN—And the gangs.

Mr Hidden—Let us not even mention the gangs.

Mrs IRWIN—They have all been drug-related, have they? No alcohol has been—

Mr Hidden—They go hand in hand quite often. I personally take the same approach to alcohol, but that is because I now know I have got a central nervous system disorder and I cannot drink, because I have attempted it and it sets me off. Unfortunately I fall straight back to where I was emotionally, physically and mentally; I just cannot do it. I now take the same approach to alcohol. I do not include it under the list of all other drugs but I do appreciate that other people will not be of that same view. I have found that alcohol is just as bad as drugs and that it often exacerbates the effects of drug use. Someone who becomes violent on their drugs, when they combine that with alcohol, goes right off.

CHAIR—How did you start?

Mr Hidden—Through school. The thing I thought of when Ann was talking then was that drugs becoming cool does not come from below, it comes from the top. The older schoolkids in the yard, they are the ones who pass it down through the year levels. This is the shift when it happens; at nine, 10, 11 years old, you do not see drugs as cool, you do not see cigarettes as cool, you do not see alcohol as cool, but you get it passed down through the year levels from the up above. I started when I was late 13, I might have just been 14, I cannot remember the exact date. It was just at a school party that was no different to any other, except there was more liberal parents, parents that decided they would stay in the living room while the kids hung around the backyard. There were some older kids there and they shared the dope around.

CHAIR—What was it?

Mr Hidden—Just marijuana. I say just, but not just. From there is was every party that I could go to that I knew that would be there, I would go there. I am talking 13, 14 years old here. You do not get invited to many of those parties, or not at the school that I went to. It was only once every three or four months. As soon as I made the right contacts, it was a downward spiral straight away and within six months to a year I was a full-blown user, or full-blown addict, I should say.

CHAIR—What did you do then? Did you stay with that drug or did you add to it?

Mr Hidden—The adding did not come for a long time. My behaviour was bad enough on marijuana, but I drank as well, drank at parties and at home by myself as well. Adding the other drugs came after I had been kicked out of home when I ended up living with a meth addict whom I met through another friend who was going to my school at the time. She introduced me to meth. I did not take it on straight away, because I thought my life was bad living out of home and not seeing my parents and all of that type of stuff, feeling alone and isolated, but her life was crap. I tried to make a vow to myself that I would not go there, but it happened anyway. It went methamphetamine, ecstasy, I got into the rave scene. In this time I managed to convince my parents that I was off the drugs and I went to a live-in rehabilitation provider. I would not call it rehabilitation because there was really no attempt. It was an escape. It was based in the desert miles away from anywhere and I tried to sneak out on several occasions but no-one would give me a hitchhike. Everyone in the area knew where I was coming from. I stayed there for ten weeks at a cost of $2,500.

CHAIR—Who put you there? Your parents?

Mr Hidden—My parents. By this stage they had not lost their love, they were still trying really hard to get their son back and they were exploring every option that came in front of them, and this was something that popped up. I came to them one night really destitute and in a pretty bad way and said, 'I'm starting to realise that it's the drugs that's doing this to me and I want to stop,' That was always their condition, if I wanted to move home that I would have to stop the drugs. I went up to this program and stayed ten weeks. No emotional work was done, no biological information was passed on. I was just as clueless the day I left as the day I got there. I think it was less than 24 hours later, 18 hours, I was back using again.

Mrs IRWIN—What group was this that you went to? Was it funded? State or federal?

Mr Hidden—Yes, it was.

Ms Bressington—No, it was not.

Mr Hidden—Was it not? That was why it was so expensive. They were called Addiction Counselling Services. I am not sure if they are still around.

Mrs IRWIN—Was it run by the churches?

Ms Bressington—No, it was run by Addiction Counselling Services. It was called Pitchy Ritchy rehab and it was a privately funded organisation that ran out of Kahlyn Private Hospital for quite some time, which is a private hospital in Adelaide. They were then given the opportunity to access facilities at Pitchy Ritchy, which is out in the country, and they ran that for about 12 months I think until they ran out of money. Obviously addicts and their families do not have a lot of money to be spending on rehabilitation. When they found that it was not quite as easy to have those families pay up all the time, it eventually ran out of money and closed.

Mrs ELSON—There was no carry-on services after you left; that was it?

Mr Hidden—That could be partly due to the fact that I relapsed 18 hours later, and I just was not interested.

CHAIR—Eighteen hours?

Mr Hidden—There was no changes. I did not change whatsoever. I went straight back to those friends. I came home with the same mentality that I left with. Nothing had changed in my mind about drugs.

CHAIR—Were you off those drugs for the whole ten weeks, then?

Mr Hidden—Like I said, I tried desperately to hitchhike and no one would give me a lift. I tried every day. There was a main road that was about a three kilometre hike to get there. I used to walk along that stretch of road all day every day and pretend I was going for a walk up a mountain just to see if I could get a lift into the nearest town. It did not happen. Yes, I was clean, I was clean for ten weeks, but being clean does not make you clean; it does not change anything in you. It is the information that is provided. In the first period it is actually stabilising you and

trying to get you in a place where you are receptive to information. There was none of that even. I was I call it drugged, I was on naltrexone, which is an antipsychotic medication.

Ms Bressington—Neulactil.

Mr Hidden—Yes, sorry, naltrexone is an implant. I was on Neulactil, an antipsychotic medication, which was pretty much one of their conditions to go and do the program, because it put clients in a medicated state and made them a heck of a lot easier to deal with.

CHAIR—To manage.

Mr Hidden—Yes, that is it. Rehabilitation is not an easy industry and it is not an easy service to provide. If you do not know what you are doing and you do not have the passion, the skills and almost the past experience in addiction yourself—it kind of seems to need to be that way—you cannot cope with addicts, you cannot relate, you do not know the process that they go through. It is a pretty standardised process I have come to notice watching past and present clients go through DrugBeat. They all seem to hit the same stumbling blocks around the same period. If you are not aware of those and aware of the underlying biological conditions as a service provider, you are doomed to failure. These guys had obviously realised that and thought it would be easier to chuck them on Neulactil and see if they could last out the ten weeks. If they did, wish them on their merry way.

Mrs IRWIN—Who introduced you to DrugBeat?

Mr Hidden—My parents. When I came back from this, like I said I relapsed, I hid it from my parents for about two months. I managed to go back to school and stayed there for a little while. I got expelled from school and my parents became aware of what was going on, and then that started that whole chaos again. They eventually kicked me out of home.

CHAIR—It was the second time you were kicked out?

Mr Hidden—Yes. I spent I think it was seven months in total, three months was in a caravan, four months in my car.

Mrs IRWIN—I think you put that in the letter that we have got.

Mr Hidden—Yes, but in this time my parents, while refusing to have contact with me—because, like I said, they were bloody afraid of me and I can honestly look back and understand why; sorry for swearing—they kept searching and crossing their fingers that they would come across something. At present there is nothing really to direct parents in the right direction to a program that works. I was going to raise this later, but if possible it would be brilliant if you could have a systematic evaluation of all service providers and base the evaluation on outcomes: whether families are rebuilt, whether the client achieves abstinence, whether the client is happy. You meet so many people who come out of service providers and they are still miserable underneath the surface. They chuck a smile on their face, but you just scratch them a little and they break down because nothing has been resolved. If you can somehow devise a system to evaluate service providers.

Mrs IRWIN—Just briefly, could you tell us the treatment that you have been on, or counselling, say from the first time you walked through the doors?

Mr Hidden—Like I said at the start, it is a stabilising procedure, so it is one-on-one counselling for a little while. Once they are sure that you are going to go down the right path and that you are going to be receptive—because if you chuck a bunch of addicts in a room together that are not really in the frame of mind where they want to recover, even if there is just one in the room, they will detract from everybody else, and you will end up with a culture of not listening to the workshop or whoever is running the workshop, you just end up with a crappy culture that does not lead anywhere. Is it six weeks?

Ms Bressington—It is a minimum six-week assessment period where we can determine—

Mrs IRWIN—They have to be drug-free during that six-week assessment?

Ms Bressington—No.

Mr Hidden—From there you go into the drug and alcohol stage. From then on it gets intensive: you have workshops at least once or twice a week, an individual counselling session, a support group meeting and the doors are practically open. A lot of people in that early period spend as much time there as they possibly can, because everything outside is all their old culture. It is really funny, the place where DrugBeat is currently based, you can smell pot everywhere you walk around out there, because it is grown in every second shed. Especially if you come from that area, and I had contacts in that area, you know who sells what and what houses are dealers' houses and all the stuff that goes on. Not detracting from DrugBeat, but it is to demonstrate everywhere outside, especially in that first period where you are not committed to the cause yet, you do not want to be out there. You do not see any of your old friends, you cut your ties with them, and you spend as much time there as possible. From then on it is central nervous system, all the information that you need to know to—

CHAIR—When you say that, so they explain to you what is happening to your central nervous system?

Mr Hidden—In simplified terms. It is all accurate, and I know that for a fact, because I was pretty suspicious at this stage and I went off and did my own research to make sure everything they were telling me—

CHAIR—This is like drugs going onto the synapse and stopping it, all that stuff?

Ms Bressington—We have a very simplified version. People do not actually need to know the in-depth science of this; they need to know a general overlay of the fact that they have changed their brain chemistry, they have literally changed the structure of the flow of electricity or energy through their brains so messages are skewed, messages do not hit the spot that they are meant to hit. It is a diagram that we do that breaks down the effects of -in, -ine and -one drugs, so any drugs that end -in, -ine and -one have a specific effect on the central nervous system and the neurotransmitters that they mimic. If a drug mimics a neurotransmitter then it is highly addictive and it is mind altering. We do a specific part of that on the cannabinoid system; what the function of the cannabinoid system is, how that is disrupted through flooding that system with

THC, basically abolishing the normal cannabinoids that are formed as part of that system itself and the damage that can be done to short-term/long-term memory, appetite, mood stabilisation, learning centre, ability to retain and process information. It is quite amazing to watch someone who is a heavy dope smoker and is smoking enough to get stoned—because people can smoke dope and build a tolerance and not get stoned anymore—could not read an instruction manual and put together one of the most simplest of constructions. They cannot process. We have actually done that in the program as a way of showing that there is a lapse between being able to read something, process it and put it into action. Whereas, nine months off that drug, they can read the diagram and they can put the structure together. Imagine our kids in school who are smoking dope on a daily or even a weekly basis, who are trying to take in maths, logarithms, English, et cetera and are getting misunderstood all over the place, there are information gaps; is it no wonder they drop out of school.

CHAIR—You can pick them a mile off.

Ms Bressington—Absolutely.

Mrs IRWIN—Especially cold turkey, no medication whatsoever.

Mr Hidden—Nothing. I am truly absolutely reformed. I do not drink and even drugs such as Panadol that I know will not have an effect on my central nervous system, I am really wary of these days. I am really careful about what enters my system because I know when I ingest something that will have a mind altering effect, the effects are protracted; it is not just for the period while that is in effect, it is like six weeks say for a Panadeine Forte or something. It is a really long time that that will send me into Dry Drunk for, which is another phenomenon.

CHAIR—What is that?

Ms Bressington—Dry Drug/Dry Drunk. Dry Drug/Dry Drunk is a syndrome that was recognised in 1980 and was referred to by Dr Forest Tennant, who is a drug rehab person in the United States. He called it post drug impairment syndrome. He focused it mainly on the behavioural aspects of people in recovery, that there were certain periods where their behaviour would, for no reason, appear to lapse back to addictive behaviour, even though they were not using.

The Salvation Army used to include Dry Drug/Dry Drunk information for their clients as a matter of course. All of the clients of Robbie House, which used to be a rehab centre in South Australia, were informed about Dry Drug/Dry Drunk. Somehow or other that information has been lost with harm minimisation. It is the key. I believe that when addicts know about Dry Drug/Dry Drunk, that it is a set syndrome, that it does return every three months to the day that they have stopped using their drug for the rest of their life, they have to then develop a management plan for that. Although the signs and symptoms decrease over a period of time, still that physical side of it or the psychological side of it will tweak them every three months forever, really. They need to learn a management plan for that, they need to identify and be well versed in the signs and symptoms of that and they need to actually know that they are high risk times for them, to not necessarily relapse, but to put themselves in risky situations that could precipitate that and keep it going longer.

The first episode of Dry Drug/Dry Drunk hits them when they are clear of drugs for three months. It is a very distressing thing for them to go through. It lasts for around six to ten days. It is not withdrawal; it is a physical, a psychological and an emotional hole that they will fall in. Anyone who has been giving evidence to this inquiry would surely acknowledge that drug abuse or drug addiction is a high relapse disorder. That is the time; most will say that around three months is a high risk period. This is why. Clients or recovering addicts who do not understand about Dry Drug/Dry Drunk will fall in that hole and it seems like an eternity to them. They lose all perception of time, they forget all about the progress that they have made and they turn quite black. This is normally the time where in AA or NA or other programs like that, they will be recommended to go to a doctor and to go onto antidepressants. If they do that and they still do not use, they will be in a constant state of Dry Drug/Dry Drunk for the rest of their life, and they get used to being just miserable. That is why recovery has such a dirty name, and that is why it is not all that popular with addicts, because most of the addicts out there do not get this information, do not have the biological recovery that is required and they will live with that central nervous system disorder niggling them all the time, and it becomes quite distressing.

CHAIR—It is sort of a permanent damage that has been done?

Ms Bressington—It is not permanent; it is actually fixable. We did some research at DrugBeat about what they call biochemical repair for addiction.

CHAIR—That is scientific research is it?

Ms Bressington—It is run through four rehabs in the United States that I have been in contact with for quite a long period of time. They have identified that if addicts take a certain group of vitamins—vitamin C and vitamin B—and five amino acids that you can buy in a compound called GenF20, then the biological repair will begin. It is not a short process; it is a long process. Usually by about 12 to 15 months clients are actually okay without having to take a supplement because that repair has actually happened. There is a lot more to recovery than just throwing a cup of methadone down somebody's throat and hoping to God it is going to work, and hoping to God that they only use once a week when their pay cheque comes in rather than every day.

Mrs IRWIN—You do not believe in methadone programs whatsoever?

Ms Bressington—I did not say that. I do believe in the methadone program. I absolutely believe it has its place, but it is not the be all and end all. If we are going to continue to have methadone in this country we need to go to Sweden to see how they run their methadone program to actually get outcomes. I know of people who have been parked on methadone for 25 years and they cannot come off it now.

CHAIR—That is right, and then they die.

Ms Bressington—Yes. They would never physically manage. I think we have had a coronial inquiry in South Australia into a young man who died from an overdose of methadone that was not prescribed for him. One of the key players in South Australia for the methadone program said, 'Well, you know, people die,' and 'Yeah, there's a lot on the street in the black market.' Well, hello!

CHAIR—It does not even get counted in the figures.

Ms Bressington—Why are we not doing something about curbing the amount of methadone that is ending up on the black market? Ross Goodridge, a barrister at law, wrote a paper in about 2000 called *The Methadone Conspiracy: Can Addicts Sue*, and his conclusion is absolutely they can sue. State and federal governments should be very much aware that this is not that far away, that they are misinformed about the side effects of methadone. It is not informed consent; they cannot possibly give informed consent if they are drug addicted to go onto the methadone program, and they are not informed of the side effects. This is a time bomb waiting to go off.

Mrs IRWIN—It is like smoking too really, is it not? Alcohol is the same thing.

Ms Bressington—It is any addiction. Let us not get into alcohol, tobacco, illicit drugs, whatever.

Mrs IRWIN—The package.

Ms Bressington—Drugs are drugs, they are all dangerous, but we need to separate alcohol and tobacco and we need to have a totally different approach to what we doing. They are legal. If we really wanted to do something about alcohol and tobacco, by God we could. To meld together those and alcohol—I can tell you our children are getting a very mixed message that illicit drugs are less harmful than alcohol and tobacco. They will argue their way through that.

Mr FAWCETT—Hear, hear!

CHAIR—Did you believe that, Ryan?

Mr Hidden—Like I said, it was a culture that drugs were cool. It is mainly because of that discourse that happens between firstly alcohol and cigarettes when they all get mashed together; there is a lot of discourse out there. You walk down the street and see a shop selling bongs, and all that type of stuff. You just cannot entertain the thought in the present environment that drugs are really all that bad. The scare tactics that they use, they do not really—

Mrs IRWIN—Do you feel that your problem might have started from alcohol and then escalated?

Mr Hidden—No, I started with marijuana first.

Mrs IRWIN—Before alcohol?

Mr Hidden—Yes, then moved on to alcohol.

Ms Bressington—Very few of them actually start on alcohol. Ninety-three per cent of our clients started smoking cigarettes first and then they went on to marijuana. Alcohol was then combined with marijuana and it was followed by amphetamines. This is going back; this is not this ice epidemic that we are all talking about. This ice epidemic has been around for five years. We sent warnings to the state government that a wave was coming, because this is a recorded pattern. We will have a five-year heroin wave and then it will start to subside, and then we will

have a five-year methamphetamine wave, and then it will start to subside, and then the heroin will come in again. Guess what? It is nearly all the same people using the same drugs. We have not reduced the number of heroin overdoses because people stopped using heroin. People switched from heroin to methamphetamine when there was a heroin shortage. Why? Because that is what addicts do. The ones who could not get on the methadone program 'switch the bitch'—that is what they do. That is what addicts do.

Unless we are actually prepared to deal with the fact that addicts have different wants to the rest of the community, that they think very differently to the rest of the community, that we are not doing them any favours whatsoever by keeping them addicted or enabling or rescuing them, then their lives are miserable. We say to addicts, 'We've got to keep you alive,' and I have had many of them respond, 'There's worse things than death, believe me.' Their life is not enjoyable. The party is over a very short period of time after they start using. I can remember my daughter telling me when she first started using heroin, 'Look, you know, it's all right. I'm not going to end up like that junky on the street corner. I've seen that happen to all my friends, I know what not to do.' Six months later she is ringing up with the intention of injecting herself with an overdose of heroin because it is all too hard. 'I can't do this anymore.' That is how short the decline was.

Do not think that junkies have a great time out there. Do not think that methamphetamine addicts when they are not stoned and out of their mind are enjoying their life and partying. They are not free and easy people. They are miserable. They scream out for help and they cannot get it. When they go to doctors, they are told just to cut down. Addicts cannot control their use. Controlled drinking was dispelled in the United States and Great Britain. We are still doing it here. We have people in constant Dry Drug/Dry Drunk, in that horrible, horrible place, because we have professionals and academics who refuse to accept that addiction exists. Addiction is addiction is addiction. If you do not fix it, people remain trapped in that for a very, very long time. We are not doing them any favours. As I was saying, the methadone program in Sweden has a beginning, a middle and an end, and it is very successful. For those sort of treatment programs to work and for them to be implemented, we have to spend some money and we have to change the direction that we do that in. We do not need more money into the drug industry.

CHAIR—You need it better spent.

Ms Bressington—We do not need more funding. We need to target it better. There is heaps of money. There is enough money that is already being invested to do what we need to do. We have academics who are just spoilt brats who have not learned to live within their means. DrugBeat is functioned on $250,000 of state money and $150,000 of federal money, which was only in the last 18 months. We have run a 24/7 program treating 140 addicts a year and over 200 parents a year on that budget, and we have done it well. Anybody who is asking for more money, I would suggest that you ask them—

Mrs IRWIN—You say you have got 140 clients per year?

Ms Bressington—Yes.

Mrs IRWIN—Is this at Shay Louise House?

Ms Bressington—Yes, it is.

Mrs IRWIN—It was DrugBeat, and that is where you went. Were you a resident there?

Ms Bressington—It is not residential.

Mrs IRWIN—It is not residential?

Ms Bressington—No, and it works quite well, because our addicts actually recover while they are walking amongst it. They do not have to be in that sort of environment.

Mrs IRWIN—How many have successfully completed the program?

Ms Bressington—Ninety-three per cent.

Mrs IRWIN—Have you got evidence on that?

Ms Bressington—Yes.

Mrs IRWIN—Can you take that on notice and give us the evidence?

Ms Bressington—Sure.

Mrs IRWIN—You say that 93 per cent are still drug-free today?

Ms Bressington—Yes. We have had an evaluation done by University of South Australia to reinforce that. I do not know whether you guys are au fait with the politics behind all this.

Mrs IRWIN—Just one other question regarding Shay Louise House, and I think you were going on about some counsellors before, they were just saying cut down on your drugs or just try to have it of a weekend.

Mr Hidden—Yes.

Mrs IRWIN—How many staff would Shay Louise House have and what are their qualifications?

Ms Bressington—We have five staff that have client contact. Two of them have a Diploma of Professional Counselling and have done quite a bit of drug and alcohol training, only because we have to, because quite frankly, the harm minimisation training is useless if you are running an abstinence-based program. We have three recovered drug users who are currently going through their diploma course, and who are supervised, basically support workers; and myself. I still do groups with DrugBeat. Plus we have three or four administration staff who will share with client contact, but not in any depth.

Mrs IRWIN—You must get donations. I think you were saying you get $250,000 annually from the state and $150,000 annually from the federal government. You have to pay five staff and to run Shay Louise House; do you get donations?

Mr Hidden—I did not pay a cent.

Ms Bressington—Over a five-year period, our donations have been the equivalent of between $10,000 and $12,000. We ran as an organisation that was volunteer for six years, without any payment, and we learnt to live within our means; that is what I am saying. These people who are saying, 'We need more money, more money, more money,' just need to learn to manage it and to spend it in the client-focused areas. Every cent that we get goes towards providing a service to our clients. We have just had an occupational health and safety audit in which they said, 'Very sorry to say that there's nothing that we can help you with, this is perfect.' We have met our service excellence framework. We are now accredited. We have the evaluation from the University of South Australia, yet we still have people within the drug and alcohol sector in South Australia who insist on calling DrugBeat a backyard operation. It is prejudice. We have never had one person referred to our service from Drug and Alcohol Services South Australia or from any other NGO who could not manage their addiction. Our clients come to us through word of mouth only. How sad is that?

CHAIR—Would you like to tell us about the politics of it?

Ms Bressington—The politics of this is, quite frankly, that abstinence is the goal of harm minimisation. If it was the goal of harm minimisation, would not that be your first port of call? Would you not try abstinence first, and if it did not work, be able to refer people onto a maintenance program or whatever to help stabilise them for a little while and then give abstinence a go second? No; we do not do that. As soon as a person presents with a drug and alcohol problem we put them on a maintenance program. If they are on dope, we put them on Neulactil and other antipsychotic drugs that, according to—

Mrs IRWIN—This is all groups that you just put on these drugs?

Ms Bressington—Yes.

Mrs IRWIN—I find that very hard to believe. My electorate has got Cabramatta in New South Wales, and I know that I have a great team of street workers in Cabramatta and they always give someone a choice. You reckon they do not get them a choice?

Ms Bressington—Good on Cabramatta. Come to Adelaide. It is not working like that here in Adelaide. We have a culture within the politics of the drug problem. We have empires that have been built and we have ideologies that have to be proven. Look around and tell me, as it is currently being implemented, what outcomes we have achieved with harm minimisation. Our hepatitis C rates have increased, the number of people accessing needle and syringe programs have increased, drug use has increased, mental illness has increased and crime has increased. Where are the benefits?

Ms KATE ELLIS—Ann, can I just clarify one thing that I was getting a little bit confused about when you were talking, and can I also say how much I appreciate you sharing your own

story, Ryan. It seems to me that we were talking about something that I would say was bad advice from a school counsellor as harm minimisation or misdiagnosis as harm minimisation. Both you and Ryan have been saying, about the initial evaluation, that what DrugBeat does is not appropriate for everyone, if people are not ready.

Ms Bressington—That is not true.

Ms KATE ELLIS—Just say they want to give up the drug.

Ms Bressington—That is just not true. This 'when they're ready'; an addict very rarely knows when they are ready. We have had coerced clients in the DrugBeat program through court, coerced through families and they have achieved very good outcomes from being coerced. When did we start to believe that addicts are capable? This is forgetting the fact that addicts do not think well, and they do not.

Ms KATE ELLIS—No, I am just basing this on what was actually said, when it was said that in the initial evaluation some people were deemed not appropriate because it was said that they were not in the frame of mind that they wanted to recover.

Mr Hidden—Yes, I said that, and what I was trying to get at is, in that six weeks they get you into a position where you blame the drugs for the problems in your life.

Ms Bressington—Rather than blame your parents.

Mr Hidden—Because up until then you have blamed everything outside of yourself. You do not want to blame yourself, you do not want to blame your drugs, because your drugs make you feel good.

Ms Bressington—If that does not happen in that six-week period, they still stay with the program, they are still engaged.

Ms KATE ELLIS—I think we get into these arguments about abstinence or harm minimisation as one or the other—and I know in the letter you have included here from the state government says they fund this and fund a lot of programs—do you acknowledge that different people are going to respond to different treatments?

Ms Bressington—Absolutely.

Ms KATE ELLIS—And that, whilst we should absolutely encourage what you are doing, and it sounds like you are doing a great job, there is a role for a variety of different—

Ms Bressington—There is a role for a variety of approaches that have outcomes outlined. When I say harm minimisation approaches, I will be very clear, they are approaches that do not have any benchmarks, they do not have any outcomes. There is nothing to be achieved, to be shown on paper, that they are actually achieving anything at all. I said when I first came in here that it cannot be either harm minimisation or abstinence, that somehow we have to move to meet in the middle and work together. To do that is going to take a clear definition of what is harm minimisation. What is it? No-one seems to know. We hear minimise the harm, minimise the

supply and minimise the demand. Let us look up the word 'minimise' in the dictionary and see what it exactly means; it means to create a perception of less. We certainly have. It has been very successful in creating the perception of less harm from illicit drugs, has it not?

CHAIR—Do you find people, not all, because it seems to me that harm minimisation can be interpreted to mean what you want it to mean—.

Ms Bressington—Absolutely.

CHAIR—Have you come across people in what I have called the drug industry, or rather the harm minimisation industry—people who are making their reputations off people like you, Ryan—who want to regulate drugs and make them legal, so they can have it?

Ms Bressington—Absolutely.

CHAIR—Can you tell me any of those people?

Ms Bressington—Dr Alex Wodak is one, Dr David Caldicott is another, who is still talking about pill testing at raves when that particular practice was abandoned in the Netherlands about four years ago, because, guess what, in the Netherlands it even sent the wrong message to their youth. Dr Caldicott himself has admitted that one of the costs of having harm minimisation in this country is that we will have more people using drugs, but best to have them using drugs and keeping them alive than having them die in the gutter. Now, I do not quite get the logic. I have got that on transcript.

Mrs IRWIN—I would prefer to see someone kept alive than dying in the gutter, and I would like to see them help someone to take them on their road.

Ms Bressington—Who wouldn't; but would you not rather stop people using drugs, prevent people using drugs in the first place and not have to pick up that mess?

Mrs IRWIN—We have got to have programs in place to keep these people alive, to send them on their road to recovery.

Ms Bressington—I have told that you addicts have told me, 'There's worse things than death.' That is from the addicts. I am not saying that I want to see addicts die; I am saying that we have got to change our focus to as much prevention and education as possible. We have to change the message in our drug education as well, that you cannot use these drugs recreationally and not be affected by it: safe use, party drugs.

CHAIR—That is the message that goes out at the moment?

Ms Bressington—Absolutely it is.

CHAIR—That you can use them recreationally or for party purposes and be unaffected, and you cannot.

Ms Bressington—That is right. I was involved in the primary school in our area that started drug education, getting all the kids together and talking to kids, parents and teachers about drugs. I was horrified when they were comparing taking illicit drugs to taking vitamins, or taking illicit drugs to taking medication for illness. I was horrified when the person who delivered this education to these children and parents flashed up on a projector on the wall a picture that said 'Columbian street party', with five big black men with huge white straws up their nose and a pedestrian crossing, obviously supposed to be cocaine, and the thing underneath there was 'A Columbian street party'. Half the kids in the room did not get it. Parents and teachers got it, and there was a giggle. Then the kids had to ask, 'What are you laughing at.' Guess what? The harms of these drugs was minimised immediately. This was the message to those kids who are eight, nine, 10 years old. How irresponsible is that?

CHAIR—How do you deal with a statement like this:

> War against drugs supporters have failed to demonstrate that cannabis distributed by criminals and corrupt police, as happens inevitably under strict cannabis prohibition, is less damaging overall than regulated provision of cannabis, taxed and regulated provision of cannabis.

Is that responsible?

Ms Bressington—It sounds like Dr Wodak to me.

CHAIR—It is.

Ms Bressington—I will read you a statement now.

Mrs IRWIN—Seeing as we are all knocking Dr Wodak, I might actually put on the record that I frankly admire him. I have visited his clinic and he saves so many wonderful lives. There are so many people who are drug-free today who are not on the methadone program.

Ms Bressington—Good on you. I just wanted to read a paragraph.

Mrs IRWIN—I just want to go back to a bill about school drug testing that you just recently introduced into the South Australian parliament, I think you were saying it was defeated.

Ms Bressington—No, it is not defeated, it is in committee stage.

Mrs IRWIN—Can you just tell us a bit about that school drug testing?

CHAIR—Then you can come back and read out what you want.

Ms Bressington—Thank you very much. The school drug testing bill is about drug testing children in year 8 to year 12, twice a year for the detection of illicit drugs in their system. It will be a non-invasive process. The outcome of testing positive to illicit drugs will be that the schools will have a referral system that they can recommend for the parents and for the children to attend to get a handle on how serious the drug problem is and if counselling is needed. An outside source of counselling could then be accessed by the parents and the students. It is absolutely confidential. There would be no one who would know the results of those tests, except for

perhaps the school counsellor and the parents. The reason I decided for all kids across the board to be tested was because I did not want the finger pointing starting at school, for example, if Ryan was called up to the office for a drug test, then everybody just may think Ryan uses drugs, and start the whispering. This was about a blanket cover for kids who are using and kids who are not.

CHAIR—Random?

Ms Bressington—Random but compulsory.

Mrs IRWIN—Compulsory? Compulsory, like the parents would have to agree?

Ms Bressington—There have been amendments for that.

Mrs IRWIN—If the child refused?

Ms Bressington—If the child refused then it is up to the parents to take responsibility for that and ask them why they do not want to be drug tested. My background for that was that I went to two colleges in Melbourne, Melbourne Grammar and Geelong Grammar, that have been doing drug testing in the school since 1999. I know that they are two elite schools; however, their drug testing policy has worked very well: it has helped to build a good relationship between parents and teachers and also between students and teachers. I spoke to kids in those colleges who said that the drug testing regime actually gave them a reason to say no to drugs when they were out on the weekend, because 'I might be drug tested through the week and I can't afford to get kicked out of school.'

CHAIR—It gives them an excuse to say no?

Ms Bressington—I do not see drug testing as the panacea for this. They also have a system called restorative justice that they have in place as well. The school drug testing bill was the beginning of trying to get some reform into our public school system where kids and parents can actually start to take responsibility for the choices they make. The main objection to this has been that the state is taking over the role of the parents, that parents have to assume responsibility.

Drug users are not all that honest. Teenage drug users are even less than honest, because if they wanted their parents to know they were taking drugs they would just come straight out and tell them; you would not have to wait for the behaviour to surface to have to scratch your head and go, 'Well, something is not quite right here.' Parents are very afraid of approaching their kids if they suspect that they are using drugs because they might get it wrong. If they do get it wrong, what is that going to mean for the relationship between my son or my daughter and myself. This was a way of the schools being proactive in helping parents to detect whether kids were using drugs or not, to set up a reasonable intervention program or strategy if you like, and actually assist parents to take responsibility when they know what they are dealing with.

Mrs IRWIN—Is it a blood test?

Ms Bressington—No, it is not. It is a saliva test.

Mrs IRWIN—Every month, every year, once a year?

Ms Bressington—Twice a year. There are two methods we could use for the drug testing. The first is a skin test where a swab is rubbed on the skin. This particular method is actually used by the Australian Federal Police, Customs, BHP Billiton and other mining groups that have drug testing in place. The skin swab is slotted into an electronic machine that gives a reading within three minutes of what drugs are in their system and at what levels. The cost of that test is $50 per test. I found out about that after I went with the mouth swab that we are using for roadside drug testing.

Mrs IRWIN—With Grammar, is that compulsory at their school, for every student?

Ms Bressington—In one school the parents will sign a form saying that they will agree to have their children drug tested. If the parents do not agree, then basically the school said, 'Well, sorry, guys, that is a determination of entry.' At the other school, however, it started out as random and parents could offer their permission. Over the period since 1999 it has taken a while for people to get used to change, but what they were telling me now was that 98 per cent of parents give their permission for their children to be drug tested. Regarding the reduction in drug use in those schools, one school says it has experienced a reduction of 80 per cent, the other school said it has experienced a reduction of around 87 per cent. They have a separate class set aside for these kids, so they are not suspended.

Mrs IRWIN—They have a special class set aside for these kids?

Ms Bressington—They do, which is a drug program.

Mrs IRWIN—The other students would know they have had a drug problem, that is why they are in there.

Ms Bressington—That is why they have said—

Mrs IRWIN—You were telling me before that it was going to be confidential and no-one would know that they were.

Ms Bressington—Hang on; I said that is what the schools do. I never said that that was the intention. I cannot tell the education department to set up schools. I said they would access counselling outside of the school so it would remain confidential. There are two approaches. I am telling you what the two colleges in Melbourne told me about their results and how they handle it. What I was proposing in South Australia with my bill was nothing like that.

Ms KATE ELLIS—Can I ask a quick question, and I apologise that I have to run away a little bit early. This might be nice because I think it is something on which you will agree with Dr Caldicott. It comes back to the point that you made about needing more advertising. I know that he has spoken about this, but I think there is a feeling in the community, which I must say I have picked up on, about particularly the so-called party drugs—and I know you hate the term. There is a sense that people have a much greater awareness about heroin or about methamphetamine, but that with ecstasy and cocaine, you can have a great life, do this at parties on the weekend and go back to your successful careers. I am just wondering what is the

evidence, what are you seeing on the ground about those particular drug users, and what message—

Ms Bressington—What particular drug users?

Ms KATE ELLIS—The ecstasy and cocaine, or do you think they inevitably cross over?

Ms Bressington—Of course they do. I have not met one drug user yet who just uses one drug.

CHAIR—That is what that barrister died of in Adelaide.

Ms Bressington—Yes. There is this belief or myth or whatever you want to call it out there, that dope smokers are dope smokers and ecstasy ravers are ecstasy ravers and methamphetamine addicts are methamphetamine addicts. I have not seen evidence of that. In my experience the majority, 99.9 per cent, are poly drug users and when there is a shortage of one drug, they will top up with another. This is my concern about that way that we now run methadone and naltrexone. If naltrexone just targets the site of the receptor that is affected by heroin, people will still smoke dope, they will still take their methamphetamine and who knows what extended damage that is doing them. The same with methadone. Addicts like to get stoned.

Ms KATE ELLIS—What do you think are the key messages in the advertising that you believe we are lacking?

Ms Bressington—I think that the advertising that the federal government ran, and they run it intermittently, was very effective: the kids arguing with their parents; the 'let's talk to your kids about drugs'; seeing a 12-year-old in a body bag. That is the reality, ugly as it is. We might not like to acknowledge that that stuff happens, but it does, and we have got to get out of this mind frame it is not at the extreme end of this.

CHAIR—What about a campaign a bit like the Grim Reaper that was for AIDS? It worked.

Ms Bressington—There is evidence that that is working in the United States for crystal meth. I believe crystal meth in its form now and level of use now requires an aggressive approach as far as education goes, because it is not just the speed of the past. I believe our kids need to know about the DNA damage that it does and the genetic damage that it is doing. Imagine young girls who love to look at *Dolly* magazine seeing a picture of someone who has been using methamphetamine for 18 months, and it is a dregged out person who looks twice their age. Those are the sort of messages that will appeal to young girls.

CHAIR—Paris Hilton, before and after.

Ms Bressington—Exactly. They say the aggressiveness that they are doing in America with the methamphetamine is producing results. I say if it is America, Great Britain or Sweden, if they are getting results with a certain approach, why are we not prepared to embrace it here?

CHAIR—Is that because we have got people whose careers are built into what is happening?

Ms Bressington—Empires.

Mrs ELSON—The first five years I was elected, I had parents come in and tell me about their children's drug problems. I used to sit there as a parent and prejudge the parents. I said 'Well, I wonder what sort of lifestyle those children were living in?' That happened to me. I am telling all the members of this panel that you really have to walk in those shoes ever to understand what is not out there for your children.

Ms Bressington—Absolutely.

Mrs ELSON—I hope I do not get too emotional here.

Ms Bressington—We can cry together.

Mrs ELSON—Yes. I have been fighting this fight for six years, and I have been on this panel for a while. I have not heard a thing that sparked my emotions since I have been on here, but today you did.

Ms Bressington—Thank you.

Mrs ELSON—Because you could say exactly what was happening on the coalface and what is against getting help for our children. I have to say, Ryan, you portrayed it perfectly. I am understanding what your parents went through. I think you have something that works. I know there is system out there that stops our children from accessing the help. I have been everywhere, I even committed my child to a mental health system to try to get help. The do-gooders out there got him out when he was just about ready to accept that he needed to have some help. Then they said to me, 'You can't force him to have help.' He did not have a mind of his own to know what he wanted. He was close to it when, against the doctor's wishes from the public hospital that knew they could help him, he agreed that he wanted help, they set up a panel at the hospital of people from outside the hospital that came in and got him out of hospital without that help. I will keep trying. I am just saying, you have probably talked the most sense I have heard from people actually on the ground, knowing exactly what out children are going through and what they need they do not know.

Ms Bressington—That is right.

Mrs ELSON—As this young man said, they do not know. Unless you give them a try at showing them what is available out there to them, without someone telling them their rights beforehand, that they do not have to do this and they do not have to accept that help, how are we ever going to change the system? We need people like yourselves and like Ryan, who can get up there and say it exactly as it is. I want to congratulate you for the evidence you have given us today.

Ms Bressington—Thank you. I would like to get back and read out that paragraph from this book that I was going to read. I do not know if you have all heard of it but the book is called *The Drug Precipice*; it is actually out of print now. It was co-authored by Justice Athol Moffitt QC. Athol Moffitt got involved in this drug thing a long time ago when he was required to head the Royal Commission into Allegations of Organised Crime in Clubs in 1975. He found that it just basically led on into the drug industry. He made some pretty powerful predictions of things that we were not seeing as evident back then but we are now. He called it *The Drug Precipice*

because he believed, when this was written in 1992 I think, that we were on the edge, and if we did not pull ourselves up that we would not be able to pull ourselves back from this.

This is just a little about the subversive nature of what we are dealing with here. This is an organisation with which your Dr Wodak is tightly involved, and has been for a very long time, called NORML, and also the Australian drug policy foundation. They are all connected to the drug legalisation movement; they may portray differently, but they are. This is from Mr Stroup at a conference in the White House in 1992:

> Despite the obvious indication that the drug reform movement has been temporarily sidetracked, two facts guarantee that our movement will remain healthy and assure that we will eventually regroup and move forward with a vibrant program. An estimated 55 million Americans have used marijuana, and the average age of regular users in this country continues to rise. Simply stated, those of us who smoke marijuana will not sit by indefinitely and allow ourselves to be criminalised. When we eventually enjoy the support of a clear majority of American voters…

Now, let us just get the implication of that: they are waiting for the number of people who smoke marijuana to grow to outvote the number of non-drug users.

> When we eventually enjoy the support of a clean majority of the American voters, we will out vote our opponents. The ultimate victory is certain. The timing of the victory depends upon our organisation and political skills.

There is also a statement in this book, and it is a quote from a person who talks about the infiltration of the media in Australia and in America, that they have planted subversives who will filter the information that the general public will get about drugs and the harms of drugs. The intention of this is to change public perception about drugs over a period of time.

I do not know about you guys, but in South Australia we hear about drug-related crime in Victoria. We hear about it in Queensland. We rarely hear about South Australian issues in South Australia. We do not hear about the babies who are being thrown up against a wall because mum and dad are stressed out on crystal meth. We do not hear about the babies that are left on our hospital doorsteps because parent are incapable, whether it be from drugs or not, of caring for their children. We do not hear about the drug-related crime. I know of five people who have been stabbed by different people in methamphetamine psychosis and it never appeared on the news. We never heard about it. Why not? Why are we not being well informed about what is going on outside of our front door? Because our information is being filtered.

I do not want to rave on too much, but five years ago I took over the care of a little boy who was born addicted to drugs. His mother was a chronic drug addict and prostitute, the whole deal. She came to me knowing she was unable to care for this child. I do not know why, I do now, but at the time I offered to take care of this child as she did not feel comfortable having an abortion. I told her what her choices were: stop using, look after the baby yourself; continue to use and deal with a drug-addicted baby; have an abortion; or I will take care of this child. He is now five years old and the first nine months of his life were absolute hell, absolute hell. We do not hear about how many babies are born addicted in this country. Now he was not just a heroin baby; he was a methamphetamine baby, a methadone baby, a dope baby, a pill baby. God knows how he turned out normal. The first nine months of his life, he suffered; not just withdrawals, the Dry Drug/Dry Drunk as well. He is five now and twice a year now he still wakes up with his sweaty little hands and feet and he does not feel well: his appetite changes, his behaviour changes and

do you know what? He has learned to manage that. He says to me, 'This is not one of my good days.' At five!

There is evidence from the United States that we really need to get access and circulate here that these children are genetically changed, that their DNA now is different. They will not have the opportunity of their parents to muck around with these drugs for a little while before they become addicted; they are born addicted. They live with that central nervous system disorder. If he has one cone when he is 12, 13 or 14, he is gone. If he has one drink, he is gone. If he has one shot of heroine, he is gone. What are we creating? What future are we creating with what we are doing? How do we pull this back? It is by getting that side and that side to sit down and accept that there are things from abstinence-based treatment programs that people within harm minimisation do not understand. There are things within harm minimisation that people from abstinence-based programs do not understand. We need to have a coming together of the minds before this is all way too late. The best way to get that coming together of the minds is the Swedish drug policy. It is a little bit of both. It is not a hard line program; it has harm reduction, demand reduction aspects to it. It is a melding. What we are warring about how, they have had in place for 30 years and right now they are getting the benefits from it. They are the only country in the world that is not dead stuck on harm minimise that is achieving those outcomes. Very soon we are going to hear Dr Caldicott and his crew go 'We must look to the Netherlands for our drug policy' because we have even outstripped the Netherlands. We have doubled the Netherlands' drug use in this country. Who would have ever thought? Do not be fooled by the Netherlands having half the drug use that we have because it has an almost legalised, decriminalised system. It is because in this country we have gone to sleep at the wheel. We have taken our eye off the ball and we have allowed this problem to disintegrate to a point where our children's lives and our grandchildren's lives are affected and it is not going to get better if we do not change what we do.

Mr FAWCETT—You mentioned the idea of bringing the two sides of the debate together to move forward. You also identified that there are empires in the current system and certainly within the industry as the chair refers to it and academia around it. It appears the overwhelming body of evidence and opinion leans towards harm minimisation. If we were actually to move together obviously there needs to be a process where we have some equality in terms of the leadership who are having that input.

Ms Bressington—Absolutely.

Mr FAWCETT—Are there sufficient people who share your approach, whether they be faith-based or organisations like yourselves, academics or whatever?

Ms Bressington—We are not faith-based.

Mr FAWCETT—No, I said either faith-based or organisations like yours or academics. Are there enough of those people who share your view that we could actually name a number of people, with credibility in terms of outcomes, who can sit at a table with the current empire and actually thrash out this new middle ground to move ahead?

Ms Bressington—I would like to think that it would be a long process. We have been trying this with the ANCD for many years and it just does not happen. The people who are not harm

minimisation advocates on the ANCD, if you put any evidence forward of what you have observed or whatever, just because you have not published a paper, it is 'he said, she said'. I believe that what we need to do is send people to Sweden to see that it is not an inhumane, restrictive, through them in jail and throw away the key type of approach. They could see that the way we run our methadone program here could improve and that there is a flow-on through methadone program through to abstinence and it is a whole referral system that we do not have.

Mr FAWCETT—I said that. Where I am going is that if a recommendation from this committee goes to the federal government, and particularly if we can get the states on board, and say, 'Yes, we need to go and look at Sweden,' the people we send to Sweden need to have that balance of the current empire—

Ms Bressington—Absolutely.

Mr FAWCETT—and those who want the alternative approach which, from what you are saying, appears to have better outcomes. We would need to actually have names of people that we could say, 'Empire, you propose your half dozen; we will appoint another half dozen to go,' so there is a balance of people who have some credibility to bring back a report for the federal and state governments. That is the sort of thing that I think a supplementary submission from you saying, 'If I had an opportunity to be involved and I had to appoint six people, these are the six I would nominate.' That would be useful.

Ms Bressington—That should actually be Drug Free Australia. DFA have a list of fellows who are academics, doctors, forensic psychiatrists and whatever else. I am quite sure that Drug Free Australia, when Joe Baxter comes to gives evidence, would be able to provide you with more than half a dozen names to put up for that proposal.

Mrs ELSON—Going back on that Sweden one, I can recall being on the committee many years ago to do with drugs and we had a lady doctor came out from Sweden. She was telling us—and I do not know whether this caused the reduction in Sweden of drug use—that going back ten years ago they took a drastic step. They thought to cut down their crime that they would supply the drugs so then people do not have to commit the crime. They then got so many young people using drugs that crime was running rampant because the government could not keep up the supply. Then they decided to do something totally radical in one section of Sweden, and my memory does not recall exactly where. They decided to put the message out that drugs are harmful and they have got some consequences so that young people got the message. They did not. They purchased an island or took over an island called Visby Island in Sweden. If you were at a disturbance and they took a blood test from you and found out you had drugs in you, for six months you were put over on that island. They had two workers for every one person who was sent there. You had to be self-sufficient and learn to get back to nature: make your own clothes, milk your own cows, that sort of system.

Ms Bressington—Okay.

Mrs ELSON—It sent a message to the young ones that there was a consequence of taking drugs. I am just wondering whether that was the start of young people not wanting to look sideways at it because there was a consequence? I think Australia fails in not telling young ones that there is a consequence, that drug taking is fun. We give it a recreational aspect and say at the

end that it does have a consequence. I wonder whether Sweden's figures fell down because of the fact that a strong message was sent.

Ms Bressington—I have been in contact quite regularly with Torgeny Peterson, who is the treatment director over there, and also Dr Christina Oguz, who was responsible for implementing the methadone program in its current form in Sweden.

Mrs ELSON—How does it differ?

Ms Bressington—I will tell you that in a minute, I will just answer this question, sorry. One of the significant differences regarding drug education is that Swedish kids in their high schools are educated on George Soros and what is his global legalisation agenda. Those kids cannot be sold the myth of the legalisation, safe use or recreational use agenda because they know that there is one man who looks to make an absolute fortune out of this and have absolute power out of this. It is done in a very reasonable way. It is not painting him to be a big, black ogre, but it is also telling the truth to the school children that there is a legalisation agenda out there working outside of this country. The grandparents actually insisted that that information be put into the education system in Sweden.

There is also the message that there is no level of safe use. Also, if you deal to children in Sweden, it is life imprisonment: no ifs, buts, maybes, no civil liberties of kids' rights to use. If you deal to a minor, you go to jail for life and you are off the streets. Do you know how many people in 17 years have been charged with dealing drugs to minors in Sweden? One. Why? Because they know it will happen. Not like our laws here: 30 grams for personal use and a tree out your backyard where you can get 150,000 cones off it if you want to, and so much personal use of methamphetamine. There are no mixed messages there. I think it is recreating a culture.

Also, there is not a chemist shop on ever street corner in Sweden. It is not an over-the-counter medication culture either. If you need medication, you go to a doctor and you access the pharmacist at the doctor. There are literally no chemist shops that sell drugs over the counter there. We have a culture that is absolutely focused on prescription medications, headache pills and it leads on. Our kids are medicated on cough medicine when they are three months old and we have just learned the harms of that. A lot of those cough medicines have -in, -ine and -one in them.

CHAIR—Phenergan.

Mrs IRWIN—You have been to Sweden, have you?

Ms Bressington—I have, and I have been to Amsterdam

Mrs IRWIN—Other countries as well where they have got programs?

Ms Bressington—No, I have been to Sweden and Amsterdam only. This year I am going to the United States and to Great Britain on other study tours as well. I will be interested in their approach to school drug testing in both those countries. It is all a learning process. The difference between their methadone program and ours is that in Sweden, to determine the dose of methadone for an individual, they go through a lot of physiological testing: metabolic testing,

blood testing, blood plasma testing. A person's dose is determined exactly for that person. They do not get told what their dose is, so they do not go out to their buddies and go, 'I'm on 30 mil, how many are you on?' 'Oh, 60'. 'Oh look, if you tell them this, you can get your dose put up.' That does not happen in Sweden because nobody knows what their dose is until it is time for them to come off. They are put into a facility for a month to stabilise on methadone because the needle fixation side of injecting drug use is very real; it is an addiction aside from the drug itself.

CHAIR—The injecting?

Ms Bressington—Yes, they get a buzz out of injecting it, jacking it back, seeing the blood in the thing. It is all part of the ceremony of what do they call it?

Mr Hidden—Shooting up. No?

Ms Bressington—Anyway, they are stabilised in a unit for a month so they separate from the drug culture. That needle fixation thing is given time to subside and they are stabilised on methadone. While they are on methadone they are engaged in a program: a family program, counselling, determining what level of education they require to go back to to get a job. They either go back to education or they go back to work and they actually have their life pulled together while they are on the methadone program. The longest that they can stay on the methadone program without moving through is two-and-a-half years. Then they are reduced. Once they are reduced, they do six months in rehabilitation at Visby Island which then teaches them further skills. They came come back to the job or to the education standard that they left before they went to rehabilitation. This is a whole of a community understanding about addiction and how to break the cycle and it is cooperative. Their methadone for the hard core drug addicts who have been drug addicts since the 1960s, who are long-term maintenance, involves a behaviour contract. There are expectations that they will produce clean urines if they are on the methadone program and they will attend some sort of social interaction thing. They are not required to get a job. They are maintained on methadone but it is done very, very differently to what we have done here ,and they are socially monitored.

CHAIR—We have done something awful here. We have created a whole lot of people who make money out of it.

Ms Bressington—God yes!

CHAIR—How you start turning that around is horrendous. We are nearly out of time. Ryan, can I ask you one last question?

Mr Hidden—Sure.

CHAIR—Do you have brothers or sisters?

Mr Hidden—No, I do not.

CHAIR—You are an only child?

Mr Hidden—I am.

CHAIR—That hurt your parents a hell of a lot, did it not?

Mr Hidden—It did, yes. It still does. My parents have gone through and done their own counselling and they have healed or resolved most of the issues attached to it. When I am doing a presentation to a school or to a conference or whatever, I sit down with them and I find it really helpful to go through it with them again because it just refreshes me and it gets me emotionally involved with that which shines through when I do my presentations. It still hurts them to remember how I was and how it not only destroyed me and them, it almost tore them apart as well. Everyone in society was telling them it was their fault and they looked towards themselves, 'Well you did that', 'But you did that' and 'Remember on his sixth birthday when his cake flopped,' and all that type of stuff.

Mrs ELSON—Gunnysacking.

Mr Hidden—Yes.

CHAIR—You did not really have any issues when you began. Was it curiosity more than anything else or was it peer pressure?

Mr Hidden—I would not say I do not have any issues. I am yet to meet anyone who goes through and has a perfect childhood.

CHAIR—Everybody does, that is what I mean. What was the thing that made you join?

Mr Hidden—Drove me to my drug use?

CHAIR—Made you join in it.

Mr Hidden—Made me join in it? It was cool. There is a society perception and the youth culture out there that says—

CHAIR—It was perceived to be okay?

Mr Hidden—It is not just okay, it is the cool thing to do. This was my way of reaching the cool kids, of getting up to that level, of getting the girlfriend that I want. The cool kids take drugs. From there, you get into the drug culture which is totally different.

CHAIR—There is no way we can turn that around unless we have a huge campaign, is there?

Ms Bressington—Absolutely and run those ads. If we have ads for the harms of tobacco and for the harms of alcohol, why have we not got ads for the harms of illicit drugs?

CHAIR—That is the big question. Why have we not?

Ms Bressington—I do not know. The Prime Minister knows damn well that the ad campaign that he ran was successful, that it did produce outcomes, that it did wake kids up. Why is it not running every night of the week?

Mrs IRWIN—I think also, Ryan, by talking to young ones as you are and sharing your story.

Mr Hidden—Yes.

Mrs IRWIN—Trying to say, 'Look, don't go down my path. This is how it affected me and I fought this and I won.' I think going into schools—

Mr Hidden—Trying to cancel out what they have already heard.

CHAIR—I am going to read a statement into the parliament next Monday from a young man in my electorate. You have probably heard of Annabelle Katte, who died at a rave party?

Mr Hidden—Yes, she took PBA.

CHAIR—He told the story in his speech how all their family had been organ donors. The only part of her body that could be donated was the corneas of her eyes because it has no blood supply. Every other organ in her body was destroyed by the drug. His message is that you will make the choice but if you want to be addicted or dead, take drugs. It was very moving and he told it to other students. Annabelle was much loved. She will be missed. She will be grieved. She had so much going for her and yet she is gone.

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

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at public hearing this day.

CHAIR—I now declare this meeting closed. Thank you for attendance today and thank you also for Hansard. Thank you enormously to both of you.

Ms Bressington—Thank you.

Committee adjourned at 11.59 am