

**NSW PARLIAMENTARY LIBRARY
RESEARCH SERVICE**

**The New South Wales Drug
Summit: Issues and Outcomes**

by

Marie Swain

Background Paper No 3/99

RELATED PUBLICATIONS

- The Medical Use of Cannabis: Recent Developments by Gareth Griffith and Marie Swain - Briefing Paper No 11/99.
- The Illicit Drug Problem: Drug Courts and Other Alternative Approaches by Marie Swain - Briefing Paper No 4/99.
- Cannabis: The Contemporary Debate by Gareth Griffith and Rebekah Jenkin - Background Paper 1994/1.

ISSN 1325-5142
ISBN 0 7313 1652 5

July 1999

© 1999

Except to the extent of the uses permitted under the *Copyright Act 1968*, no part of this document may be reproduced or transmitted in any form or by any means including information storage and retrieval systems, with the prior written consent from the Librarian, New South Wales Parliamentary Library, other than by Members of the New South Wales Parliament in the course of their official duties.

The New South Wales Drug Summit: Issues and Outcomes

by

Marie Swain

NSW PARLIAMENTARY LIBRARY RESEARCH SERVICE

Dr David Clune, Manager (02) 9230 2484

Dr Gareth Griffith, Senior Research Officer,
Politics and Government / Law (02) 9230 2356

Ms Rachel Simpson, Research Officer, Law (02) 9230 3085

Mr Stewart Smith, Research Officer, Environment (02) 9230 2798

Ms Marie Swain, Research Officer, Law/Social Issues (02) 9230 2003

Mr John Wilkinson, Research Officer, Economics (02) 9230 2006

Should Members or their staff require further information about this publication please contact the author.

Information about Research Publications can be found on the Internet at:

<http://www.parliament.nsw.gov.au/gi/library/publicn.html>

CONTENTS

1	INTRODUCTION	1
2	BACKGROUND	1
3	THE NEW SOUTH WALES DRUG SUMMIT	8
	Day One (17 May 1999)	9
	Day Two (18 May 1999)	20
	Day Four (20 May 1999)	33
	Day Five (21 May 1999)	38
4	OUTCOMES FROM THE DRUG SUMMIT	42
	Nature and extent of the problem	44
	Regarding extent of use	44
	Regarding harm	45
	Regarding reasons for use	45
	Principles	46
	Resolutions	48
5	RESPONSES TO THE DRUG SUMMIT	61
	Appendix 1 Premier's Seven Point Plan	
	Appendix 2 Participants at the Drug Summit	
	Appendix 3 Resolutions from the Final Communique	

1 INTRODUCTION

This Briefing Paper examines the recent New South Wales Drug Summit (referred to hereafter as ‘the Summit’) held at Parliament House between May 17 and 21 1999, and describes the events leading up to its establishment; the issues considered at the Summit; and possible ways forward.

2 BACKGROUND

Teenage injecting drug use: On 31 January 1999, a photograph of a teenage boy engaged in injecting drug use in a lane-way in Redfern, appeared on the front page of a Sydney newspaper. This acted as the catalyst leading to the establishment of the Summit.¹ In the articles which accompanied this photograph the age of the boy was given as 12 or 13 (he was subsequently identified and his age confirmed as being 16²), and it was asserted that the injecting equipment was obtained from a near-by needle exchange (a NSW Department of Health report into the incident later revealed that the boy did not obtain any injecting drug equipment from the near-by needle exchange outlet³).

The apparent contradiction of governments spending millions of dollars on the ‘war against drugs’, yet at the same time funding needle exchange programs where injecting equipment and advice are handed out, was alluded to in the article. The desirability of such a situation was made even more questionable if, as appeared the case in this instance, such equipment was provided to minors under these programs. The then Minister for Health, Hon A Refshauge MP, reacted by immediately closing down the needle exchange outlet, and ordering a review of the \$9 million statewide needle exchange program. The view was expressed in the Sunday newspaper article of 31 January that:

It is time to treat drugs as a national emergency, to abandon political point scoring and develop a concerted response. Premier Bob Carr and Opposition Leader Kerry Chikarovski should now call a special all-party summit. It should include our best experts and Federal Ministers.

The following week the Premier, Hon B Carr MP, announced such a summit would take place if his government was re-elected. It would be held over five days in the first Parliamentary sitting period after the 27 March election.⁴ Mr Carr was reported as saying:

¹ ‘A picture which shames us all’, *Sun Herald*, 31 January 1999. Following the conclusion of the Summit the Premier was reported as saying that the photograph was the spark that led to the Summit. ‘Salvos hit at heroin galleries’, *Sun Herald*, 23 May 1999.

² ‘Needles dry up and users are sharing,’ *Sydney Morning Herald*, 2 February 1999.

³ ‘Syringe staff cleared over boy’, *The Australian*, 8 February 1999.

⁴ ‘Carr calls summit’, *Sun Herald*, 7 February 1999.

It will be a no-holds barred, non-party examination of the drug problem ... This is a community problem that touches all of us. It should be treated as a challenge above politics. We will push aside all other business. We have to look at fresh ideas.⁵

Following his re-election, the Premier elaborated on the envisaged format of the Summit to be held from May 17 to 21. It would include addresses to the Parliament, working groups, panel discussions and field trips to inspect the Drug Court at Parramatta, a methadone clinic, treatment facilities and needle exchange outlets. Approximately 60 drug experts, community leaders, families and interest groups would be invited to participate. A plan to tackle the drugs policy would then be issued by the government about one month after the completion of the Summit. The Leader of the Opposition, Mrs K Chikarovski MP, was reported as saying that the Opposition was determined to work with the government to come up with solutions.⁶

NSW Coalition approach to drugs: During the State election campaign, the Opposition Health spokeswoman, Mrs J Skinner MP, announced that under a NSW Coalition government, three drug rehabilitation jails would be trialled in Sydney, the Hunter region and country NSW in spare prisons or 'secure hospital settings'. Convicted non-violent prisoners would volunteer for the scheme and courts could use the Custodial Drug Treatment Programs as a sentencing option. Methadone would not be used in the pilot programs. Later in the campaign the Opposition Leader announced that if elected, a Coalition government would spend \$34 million a year on drug treatment programs, which would provide an extra 4,000 residential rehabilitation beds or 27,000 outpatient treatments such as those operated by the Salvation Army. Prisons would be made drug free by requiring inmates to undergo daily drug tests and prison officers would be screened in an attempt to stop drug smuggling.⁷ In relation to the third element of the Coalition's anti-drug strategy, education, drug education in schools would be increased and principals would be given increased powers to expel students for serious drug offences. Changes were also flagged to the methadone and needle exchange programs. Earlier in the campaign the Coalition had announced a \$105 million Drug Enforcement Agency of 300 specialist police officers.⁸

Injecting room initiatives: On 25 February a youth welfare group, Open Family, announced its intention to open rooms in its Cabramatta and Footscray offices for young heroin users to inject drugs. Open Family's plan was partially supported by Footscray's local council, but met widespread condemnation from other drug welfare groups and the

⁵ 'Carr calls summit', *Sun Herald*, 7 February 1999.

⁶ 'Carr promises action rather than words over scourge', *Sydney Morning Herald*, 9 April 1999.

⁷ 'Libs, ALP lay down the law', *The Australian*, 23 March 1999.

⁸ 'Libs pledge 4000 places for addicts', *Sydney Morning Herald*, 23 March 1999.

local community.⁹ In Sydney the Carr government condemned the plan as ‘irresponsible, dangerous and illegal’.¹⁰

On 4 May a group of clergy, social workers and health professionals opened an injecting facility, the Tolerance or T-Room, in the Wayside Chapel in Kings Cross. The room was to be open on a limited number of days and for a limited number of hours. It was to be staffed by volunteers with health experience. Injecting drug users would be required to comply with a number of conditions such as ensuring the areas used are cleaned following injecting activity. The establishment was visited on several occasions by police, and on the last occasion various charges were laid against those using the facility. One man was arrested and charged with possession of heroin, and two others were issued with notices to face court at a later date, charged with self-administering a drug.¹¹ The T-Room was closed down on 12 May in the lead up to the Summit.

One of the organisers, the Reverend Ray Richmond said this course of action was taken in ‘deference to calm and rational debate at the Summit’ but warned that the length of the moratorium would depend on the outcome of recommendations to emerge from the Summit. He was reported as saying: ‘Our next action will be on the basis of an assessment of the final communique at the end of the Summit ... if it is weak or equivocal or taking too long a time, we will look at the options, and these include lifting the moratorium and continuing the injection room trial either here or in another place’.¹² Following the resolution of the Summit that medically supervised injecting rooms be trialled, those responsible for the T-Room announced on 21 May that it would remain closed as it was no longer needed.

Approaches to the illicit drug problem in other jurisdictions: The illicit drug problem was also the focus of the 5 March meeting of available State and Territory leaders arranged by the Victorian Premier, Mr J Kennett, ahead of the 9 April Premiers’ conference, where the Prime Minister, Mr J Howard, had foreshadowed the topic would be on the agenda. The meeting of the Premiers of Victoria, Queensland, South Australia, and West Australia and the Chief Minister of the ACT, endorsed a comprehensive drug strategy that includes a heroin trial in the ACT and Victoria. It also backed harsher penalties for drug traffickers and further research into safe injecting facilities.¹³

Treatment centres: The \$4 million 20 bed Fairfield detoxification unit, Corella Lodge, and a 30 bed detoxification unit at Mulawa Women’s Prison, were opened by the Premier on 8 March 1999. However, as at 15 May Corella Lodge was still recruiting specialist staff

⁹ ‘Kennett open to drug clinics’, *The Australian*, 26 February 1999.

¹⁰ ‘Kennett supports shooting galleries’, *Sydney Morning Herald*, 26 February 1999.

¹¹ ‘Summit push to decriminalise injecting heroin’, *Sydney Morning Herald*, 13 May 1999.

¹² ‘Injection reforms on table, says A-G’, *Sydney Morning Herald*, 14 May 1999.

¹³ ‘PM asked to reconsider heroin trials’, *Sydney Morning Herald*, 6 March 1999.

to run the unit, with the result that while it was providing outpatient detoxification services to about 60 clients, as well as counselling, in-patient services were not expected to be offered until July.¹⁴

Premiers' Conference: On 9 April at the Premiers' Conference, held in Canberra, the Prime Minister committed a further \$220 million to the Federal government's fight against drug abuse. The allocation to NSW amounts to an extra \$17 million a year for four years. The States agreed to alter police powers so that they could divert apprehended drug users to treatment centres rather than courts. Diversion, which its advocates say could save \$100 million a year in prison costs alone, is aimed at steering young offenders away from the prison system where they were more likely to become hardened criminals than to be cured of their addiction.¹⁵ Mr Carr presented a seven point plan for tackling the drug problem to the Conference. The main points from this document are presented below, and the full text can be found at **Appendix 1**.

Long Term Solutions - A Seven Point Plan for Action Against Drugs: The New South Wales Government considers there are seven key action areas with potential for long term innovative solutions in the battle against illicit drugs. There is no easy fix - solving the drug problems requires forward thinking, and ongoing commitment and hard work by all Governments and the community. The 7 key strategic action areas for attacking the drug problem are:

1 Preventing Drug Abuse: Enhanced Prevention and Early Intervention:

Targeted early childhood interventions in vulnerable and disadvantaged families and communities can make all the difference in equipping young people to resist drug abuse. This should begin before birth and be a top priority until the child is 3 years old. Establishment of a new *National First Three Years Foundation* and expansion of the *NSW Families First* program across NSW would target these vulnerable children. Key support must also continue at critical developmental and transitional stages in the lives of children and young people.

2 Fast-tracking of New Treatments: A National Scheme

The investigation, approval, and availability of new treatments like naltrexone, buprenorphine, LAAM, and others must be expedited to bring help as quickly as possible to those who want to leave their addiction behind. Much more work needs to be done to find ways of helping people,

¹⁴ 'Detox unit opened during poll campaign is still closed', *Sydney Morning Herald*, 15 May 1999.

¹⁵ 'Howard gives States another \$220 million for drugs fight', *Daily Telegraph*, 10 April 1999.

over time, to get off drug substitution programs such as methadone, and into healthy drug free lifestyles.

3 Better Service Delivery and Outcomes: A National Training Program

A new national training program is needed to properly equip health and welfare professionals with necessary expertise in providing treatment to drug and alcohol dependent patients. There is a need for more people with specialty in this area, for incentives for workers to become involved, and for minimum national standards.

4 Better Case Management of Drug Users

It is not enough simply to have access to the latest treatments. Drug users receiving treatment need to be supported in all areas of their lives. That means health needs co-ordinated with education, vocational training, housing, childcare and other services, including law enforcement and correctional services. This applies especially to former prisoners seeking to adapt to a drug free lifestyle after release.

5 Breaking the Drugs and Crime Cycle

Too many young people are being caught up in the justice system through experimentation and involvement in drugs. Commonwealth funding is needed to allow the nationwide establishment of Drug Courts and other diversion schemes. These schemes need to link young people and their families with a comprehensive range of support services to assist in resolving drug problems. Youth unemployment is a critical causal factor in drug abuse that needs to be addressed at a national level.

6 Community Drug Action Teams

It is important to get organised at a state and national level. But what is also needed is people on the ground making sure that plans translate to action in local communities. Community Drug Action Teams will bring together local councils, local community groups, local business, local police, and State Government agencies to identify local drug problems, work out community based solutions and help deliver these solutions.

7 Defending our Frontiers: A National Strategy - (Disrupting And Reducing Supply)

100% of Australia's heroin and cocaine is imported across our borders. Cocaine looms as the next great threat. We have got to work together to keep drugs out, and we need committed Commonwealth resources. NSW

is better equipped than ever before to blitz drug dealing and drug crime within its own borders, but without enough Commonwealth resources committed to stopping drug imports at the borders, providing sophisticated intelligence, high levels of co-operation tackling whole drug trafficking networks from source to distribution, then NSW and other States are destined to fight a losing battle.

General Principles: The seven key action areas are consistent with the agreed National Drug Strategic Framework. The New South Wales Government considers that the seven innovative action proposals will be far more productive if there can be national agreement on approaches in these areas; if there is greater national consistency in what are the agreed best outcomes of anti-drug initiatives; and provided there is greater Commonwealth funding, co-ordinated with the needs and programs within States and Territories.

National Approaches: All Australian Governments - Commonwealth, State, Territory and Local Governments - should be encouraged to increase the levels of co-operative and co-ordinated development, and implementation of initiatives and services in the fight against drugs.

National Consistency: So far as is practicable there should be consistency in policy across Governments and services based on agreed and desirable outcomes. Commonwealth, State, and local policies should be consistent with the National Drug Strategy agreed upon by Police and Health Ministers. There also needs to be more alignment between National, State and Local processes.

Improved Commonwealth Funding: The recent increases in Commonwealth funding under the National Illicit Drug Strategy are commendable, but further enhancements are needed in the areas of prevention, treatment, diversion, law enforcement and research if the States and Territories are to be able to make any headway in tackling the increase in drug misuse, drug overdoses, the availability of drugs, and the threats posed by new drugs. Commonwealth funding needs to be provided in accordance with State and Territory priorities, with funding allocation and management of services to remain the province of the States and Territories. It is particularly important that the States and Territories identify an agreed and consistent set of funding priorities, so far as practicable depending on the specific needs of each jurisdiction.

Establishment of the Summit: On 11 May 1999 the Premier moved the following resolution in the Legislative Assembly: ¹⁶

¹⁶ NSWPD, Legislative Assembly, 11 May 1999, p19.

(1) That this House, recognising the problem of the use of drugs in the community and its impact on society, agrees to hold a Drug Summit at Parliament House, involving members of both Houses of Parliament and invited community representatives, in order to:

- create a better understanding by members of Parliament and the community of the causes, nature, and extent of the illicit drug problem, particularly in New South Wales;
- better inform members of Parliament through a forum bringing together a range of drug experts and community representatives who reflect the spectrum of views on drugs;
- hear and consider the views of young people;
- examine existing approaches to the illicit drug problem and consider new ideas and new options in a bipartisan forum;
- consider evidence regarding those strategies that work and those that do not, and in particular, to consider: the effectiveness of existing New South Wales laws, policies, programs and services; and the effectiveness of current resource allocations in the drugs area;
- identify ways to improve existing strategies and services that work and identify gaps and needs in programs and services;
- build political and community consensus about future directions in drug policy; and
- recommend a future course of action for the Government to consider.

(2) That the services of the Parliament of New South Wales be provided for the hosting of the Drug Summit from Monday 17 May 1999 to Friday 21 May 1999, with Plenary Sessions in the Legislative Council Chamber and Working Groups convening in the various meeting rooms.

(3) That the Summit be chaired by the Right Honourable Ian Sinclair and the Honourable Joan Kirner, A.M.

(4) That members of both Houses attend as Parliamentary Delegates and fully participate in all proceedings in accordance with the proposed Summit rules to be agreed on by the Summit

(5) That non-Parliamentary Delegates and Associated Delegates, as

invited by the Premier, be admitted to participate in Plenary Sessions and Working Group meetings in accordance with the rules to be agreed on by the Summit.

- (6) That this House request the Summit to provide a communique outlining an agreed framework and directions for the Government to consider.

This motion was agreed to, and a similar resolution adopted by the Legislative Council on 12 May 1999.

3 THE NEW SOUTH WALES DRUG SUMMIT

The Summit commenced on 17 May 1999, chaired by former Federal National Party Leader Ian Sinclair and former Victorian Labor Premier Joan Kirner. It was attended by 135 NSW Parliamentary delegates; 2 Federal Parliamentary delegates; 80 non-Parliamentary delegates; and 45 associate delegates. Delegates had voting rights, associate delegates did not. The major parties had allowed their members a conscience vote instead of voting along party lines. However, the resolutions are not binding on the Government. The Summit was addressed by a number of speakers ranging from experts in the fields of criminology and public health to those with personal experience of illicit drug use.

Some comments were made in the press on notable absences from the Summit such as the NSW Director of Public Prosecutions, Mr Nicholas Cowdrey QC; the commander of Police Internal Affairs, Mal Brammer, a highly respected former Kings Cross patrol commander; Dr David Dixon, Associate Professor of Law at the University of NSW and one of Sydney's leading criminologists in the area of illicit drugs; Dr Nick Crofts, head of epidemiology at the Macfarlane Burnett Centre for Medical Research and a world authority on blood-borne viruses; and a representative from the National Centre in HIV Epidemiology and Clinical Research, which runs the largest surveillance of injecting drug users in the country.¹⁷ However, according to the Government physical and time constraints meant a limited speaker list was necessary, but it maintained a balance of all interested parties had been achieved. The list of participants is attached at **Appendix 2**.

Working groups:

The participants were allocated to one of eleven working groups as follows:

Group 1: Preventing Drug Abuse chaired by Hon F Lo Po MP, Minister for Community Services;

Group 2: Young People and Drug Abuse chaired by Hon C Tebbutt MLC, Minister for Juvenile Justice and Minister Assisting the Premier on Youth;

¹⁷ 'Experts shut out of summit', *Sydney Morning Herald*, 7 May 1999.

Group 3: Health Maintenance and Treatment Services chaired by Hon C Knowles MP, Minister for Health;

Group 4: Case Management, Co-ordinated Care, Service Standards chaired by Hon Dr A Refshauge MP, Minister for Urban Affairs and Planning; Minister for Aboriginal Affairs; and Minister for Housing;

Group 5: Training Requirements and Building Skills chaired by Hon K Yeadon MP, Minister for Information Technology, Energy, Forestry and Western Sydney;

Group 6: Breaking the Drugs and Crime Cycle chaired by Hon J Shaw QC MLC, Attorney-General;

Group 7: Drugs in Correctional Centres and Corrections Health chaired by Hon B Debus MP, Minister for the Environment; Minister for Emergency Services; Minister for Corrective Services; and Minister Assisting the Premier on Arts;

Group 8: Drugs and Community Action chaired by Hon J Della Bosca MLC, Special Minister for State; and Assistant Treasurer;

Group 9: Drugs and Law Enforcement chaired by Hon P Whelan MP, Minister for Police;

Group 10: Drugs in Schools and in the Community chaired by Hon J Aquilina MP, Minister for Education and Training;

Group 11: Drugs in Rural and Regional NSW chaired by Hon H Woods MP, Minister for Local Government, Regional Development and Rural Affairs;

Each working group met confidentially, with resolutions agreed to at these workshops being presented to the Summit at week's end, and passed only if supported by a two-thirds majority of those voting. Some sections of the Summit were open to the public.¹⁸

Agenda:

[A] On the first day of the Summit, **Monday 17 May 1999**, the participants were given an overview of the nature and scale of the problem and its causes, and the cost of drug use and its effects. The Summit began with opening statements by the Premier, the Leader of the Opposition and the Leader of the National Party. Following these opening remarks, a number of key note addresses were given. The significant points made by each speaker are listed below. The full text of all Summit proceedings can be found on the Internet at <http://203.147.254.2/NSWDS/NSWDrugSummit.nsf/Content/Transcripts/>.

¹⁸ 'Workshop chair MPs in drug summit hot seats', *The Australian*, 5 May 1999.

Prior to the commencement of the Summit, the Premier had been at pains to stress that while he expected a better understanding of the illegal drug problem to emerge from the Summit, he did not expect instant solutions:

There's no magic cure. There's no instant solution. Action against drugs will only work if we've got every part of the community working together ... There is real substance in it (the Summit) and there are people who represent every major strand of thinking when it comes to drugs, but this is a very difficult community problem. My expectations are that people will emerge from the Summit better informed about the problem and there will be a community partnership.¹⁹

Commissioner Peter Ryan, New South Wales Police Service: Commissioner Ryan told the Summit that:

- despite the media focus on heroin, the reality is that the possession and use of cannabis accounts for the majority of drug offences recorded by police in New South Wales. In 1997/98, 11,159 offences for the possession and use of cannabis were recorded, which was 47% of all drug offences. In 1997/98, the police arrested 12,400 people for drug offences, laid 9,000 charges, issued 8,200 court attendance notices and 1,500 summonses.
- although needle and syringe exchanges have a positive role to play, in Commissioner Ryan's experience, these programs also bring with them certain problems. According to Commissioner Ryan police often experience huge social problems with these outlets, particularly methadone clinics, which have a 'honey pot' effect by attracting people to them to deal or to exchange drugs and this has a ripple effect. He said crime tends to increase, drug dealers prey on addicts, businesses close down and there is a degradation of the social fabric in the area which begins to fall into dereliction. These problems need to be addressed by better planning and co-ordination when methadone clinics are established, and tighter controls and monitoring of clinics, particularly private clinics, to ensure ethical behaviour and prevent opportunities for malpractice.
- while supply reduction strategies have a deterrent effect on drug traffickers because they increase the risk of detection, the reality is that drug seizures by law enforcement authorities have had little, if any, impact on the overall availability and price of drugs at street level.
- legislation relating to major drug importation and distribution needs to be very robust with ambiguities surrounding the possession of traffickable quantities removed, and asset confiscation powers need to be less rigid. In essence, police need more powers to seize the assets of drug dealers.

¹⁹

'Drug Summit is no quick fix', *The Australian*, 17 May 1999.

Professor Wayne Hall, Director of the National Drug and Alcohol Research Centre: Professor Hall presented Summit participants with an overview of patterns of drug use and major harms, and identified some of the options available to deal with the problem.

- overall prevalence of lifetime use (use at any time in life by Australian adults) in 1998 of alcohol, tobacco and illicit drugs, reflects the fact that illicit drugs are still illegal, with the lower rates of prevalence overall. But still ... we are talking about a little under half of all adults who have used an illicit drug at sometime in their lives, and about one in five have done so in the previous year.
- the illicit drug most widely used is cannabis or marijuana, which has been used by just under 40% of Australian adults in their lifetime, and a bit under 20% in the last year.
- the age group in which rates of use are highest is among 20 to 29 year old adults. Almost two-thirds of those of that age group have used marijuana at some point in their lives and well over one-third have used it in the past year.
- the health risks associated with cannabis use include those associated with respiratory disease, dependence and the effect on young people with schizophrenia. In relation to whether cannabis is a 'gateway' drug, Professor Hall said that while it was certainly true that most of those who use harder drugs, like heroin and cocaine, began with cannabis, it was equally true that 95% of those who use cannabis do not go on to use the harder drugs. It is the heavier users who are most likely to do so.
- included in the range of responses to cannabis is: developing credible education about the risks of the drug that is acceptable to both parents and young people; developing school policies that more appropriately balance the interests of users and non-users; and examining the extent to which community resources are put into handling through the criminal justice system young people who get caught up in using marijuana.
- the health risks associated with the so-called 'party drugs', amphetamines, hallucinogens, MDMA or ecstasy, and cocaine are less likely to be toxicity and fatal overdose, (there were four such deaths in 1997 in Australia) but rather the risks that arise from the majority of users who get involved in very heavy patterns of use, particularly by injection, in the case of amphetamines and cocaine. There are always the standard risks of infectious disease from injection, and there are some uncertainties about the effects on brain function of very heavy use of those drugs.
- again the main response to dealing with the use of these drugs is to try to provide credible health education on the risks associated with their use. The emphasis needs to be less on the rare and very serious outcomes, such as death, and more on their very common side effects and after-effects.

- in relation to heroin, the following trends have been observed over the past two to three years: the availability of very cheap and pure heroin has increased; there are indications of increased use by young people in terms of reduced age of first use; there has been more initiation of use by smoking which then leads to more people moving on to injecting use; more people have sought treatment; more overdose deaths are occurring amongst these younger users; and the other more worrisome trend in recent times, particularly in inner-city areas, has been the increased rates of cocaine use by heroin users, bringing increased risks of infectious disease and problems related to chronic heavy use, such as psychosis and violence.
- although heroin has the lowest rates of use of any of the illicit drugs, it has the highest mortality rates and causes the most severe problems for users and the rest of the community. The harms associated with heroin use include dependence. Although people do not begin to use heroin with the intention of becoming addicted and not everyone who uses heroin does become dependent, it is something people slip into. It is a very insidious and, often, slow process, but once people become dependent it is very difficult to break. The major public health impact from a community point of view is the increase in fatal overdoses, for which we have data among young adults aged 15 to 44 (there were 600 such deaths in the most recent period, 1997). There is a risk of infectious diseases, such as HIV, hepatitis C and hepatitis B, and an underappreciated risk is depression and suicide. The other consequence, from the law enforcement point of view, is the property crime and drug dealing that a substantial minority of dependent heroin users engage in to finance their use.
- education has a lesser role to play in the response to heroin use because the small number of people who do use it suggests that most people have been deterred from such action. There is a need to make available an increased range of treatment options.
- it is important to realise that most users who enter treatment, most of their families and the community, would prefer people to become and remain abstinent from these drugs. But this is not possible for a substantial proportion of people who enter treatment, therefore, we have to accept that short- to medium-term maintenance or stabilisation is a reasonable goal for treatment.
- although treatment outcomes tend to be better if treatment is offered when people request it, coercion into treatment has a role to play but this requires a commitment of real resources by government. All diversion options need to be examined including pre-arrest, cautioning and assessment and post-arrest treatment and drug courts.
- there is an ongoing need to have in place programs such as the needle and syringe exchange programs to contain the risks of infectious disease resulting from injecting drug use. Specific strategies for preventing overdose are also necessary, and proposals such as the trial of injecting rooms and heroin trials should be considered.

Dr Don Weatherburn, Director of the NSW Bureau of Crime Statistics and Research: Dr Weatherburn made the following points in his presentation to the Summit:

- according to Dr Weatherburn, four important questions which Summit participants needed to address were: (i) Does drug law enforcement do anything to reduce the harm associated with illegal drugs? (ii) Does it do anything to exacerbate the harm associated with illegal drugs? (iii) Have we got the balance between treatment and drug law enforcement right ? and (iv) Is there anything more to drug policy than getting the right balance between treatment and drug law enforcement? Dr Weatherburn examined these questions in relation to heroin use.
- he began by making the point that there are two kinds of harm associated with any drug. There are harms which arise directly from the effect of the drug on the user or those affected by the user's behaviour - 'direct harms'. Direct harms associated with heroin include things like newborn drug toxicity, child neglect, road fatalities and low birth weight. Then there are harms which result not from the effect of the drug on the user but on the fact that heroin itself is a prohibited substance - 'induced harms'. Induced harms include higher property crime rates, police corruption and organised crime.
- to determine whether drug law enforcement reduces the harm associated with heroin, it is necessary to distinguish between direct and induced harms. In relation to direct harms, if a drug causes any direct harm at all, the more of it people consume the more direct harm it causes. Drug law enforcement seeks to reduce the direct harm caused by heroin by making life difficult for users.
- according to a recent survey conducted by the Bureau of Crime Statistics and Research of 500 heroin users at needle exchange centres and on the streets in south-western Sydney: 73% had been arrested for drug-related crime; nearly 70% had been stopped by police without being arrested typically within the last month; 44% had already been imprisoned for drug-related crime; and another 25% had court cases currently pending for a drug offence. This is a reflection of the non-financial burden the criminal justice system imposes on heroin users. The monetary costs on heroin users are greater. For a dependent user, it means having to find more than \$55,000 a year to finance his or her habit. There is no doubt that the economic and non-economic burden on heroin users is substantial, but does any of it reduce the direct harm caused by the drug ?
- the effect of prohibition on the willingness of young people to try heroin is not known. Commonsense suggests that drug law enforcement exerts some deterrent effect on heroin users simply because only 2% of the population uses heroin. However, other factors such as the fear of disease, the fear of injecting or the fear of overdose may also discourage people from using heroin.
- drug law enforcement efforts appear to encourage heroin users to give up. When heroin users were asked why they sought treatment, about 65% stated that reducing

involvement in crime is important or very important; about 70% stated that avoiding more trouble with police and courts is either important or very important, and over 80% stated that spending less money on heroin is either important or very important. Those who have been stopped, arrested or imprisoned are more likely to want to enter treatment than those who have not.

- when heroin users enter methadone treatment, even if only on a temporary basis, the amount of money they spend on heroin falls dramatically, as do the health risks associated with using heroin, and the level of involvement in crime reduces. Before treatment about 60% of heroin users are involved in some form of property crime, and approximately 40% are selling drug to fund their own addiction. Within four weeks of entering the methadone treatment, the number of heroin users involved in property crime dropped to about 40%, and drug sales were down to about 20%. For those who stay in the program after four weeks, they were down to about 20% involvement in some form of property crime, and just over 10% involvement in drug sales.
- there is no doubt that drug law enforcement plays a role in limiting the amount of direct harm caused by heroin. At the same time, drug law enforcement greatly increases the amount of induced harm associated with heroin. This induced harm stems entirely from the costs, both monetary and non-monetary, associated with those who use heroin. As a result of drug law enforcement, heroin is literally worth more than its weight in gold. The cost of heroin greatly increases the amount of crime in the community, and it presents a standing inducement to police corruption. Heroin users typically resort to drug dealing, property crime and prostitution in that order in order to fund their addiction. As a result, more than 20% of offenders received into New South Wales prisons each year are regular users of heroin. While many heroin users are involved in criminal activity before they become addicted, the effect of drug law enforcement on heroin users greatly increases the amount of crime they commit. Heroin-dependent burglars, for example, commit burglary at a rate that is approximately 50% higher than, and make double the income of, burglars who do not use heroin.
- another induced harm arises when police destroy or confiscate injecting equipment when they make arrests. This leads to users adopting unsafe injection procedures such as sharing needles. This increases the risk of transmitting blood-borne viral diseases such as hepatitis C and HIV/AIDS, and the risk of fatal overdose. From a community point of view this presents an increased public health risk and places an added burden on the public health system.
- the paradox of prohibition: the very same drug law enforcement which deters some young people from using heroin, which encourages many young people out of the heroin market and which, in so doing, helps reduce the direct harm caused by heroin, at the same time greatly increases the induced harm that heroin brings. If we significantly lower the cost of heroin use, we can lower the amount of induced harm that heroin brings - but then we run the risk of increasing the direct harm

caused by heroin.

- according to Dr Weatherburn, the correct balance between treatment and drug law enforcement has not been struck, partly because we are so used to thinking that if crime is the problem, law enforcement must be the answer, and it never occurs to us that if drug crime is the problem, treatment may be the answer. According to Dr Weatherburn while we have made life hard for heroin users, we have not done nearly enough to provide them with treatment options. We have inadequate and poorly designed treatment. There are approximately 50,000 dependent heroin users in New South Wales at the moment. Not more than one in three or four of these people is in treatment. Research shows that 15% of heroin users would definitely start methadone treatment tomorrow if they could get a place on the public methadone program. The same applies to cannabis users. There is a huge problem with kids who commit crime so that they can buy cannabis, yet there is no comprehensive treatment program to deal with this problem. Treatment should not be seen as an alternative to drug law enforcement or as ‘going soft’ on crime, but as a way of making drug law enforcement more effective.
- treatment options offered need to be rigorously evaluated and rigorously administered. For example, take-away doses of methadone when dispensed correctly can help treat a heroin addict. However, dispensed carelessly or by corrupt doctors, they can help people avoid the need to seek treatment.
- police should refrain from confiscating or destroying injection equipment, but if this is legally impossible, serious consideration should be given to the establishment of safe injection rooms or removing the criminal sanctions for self-administration of heroin. Dr Weatherburn said that while some Summit participants, would view such actions as sending all the wrong signals, he pointed out that drug law enforcement also sends the wrong signals when, however inadvertently, it encourages heroin users to risk disease and death.
- Dr Weatherburn told the Summit that the solutions he had spoken about were short-term solutions and that there is much more to drug policy than drug law enforcement and treatment. In the long run, the best way to reduce the harm caused by drugs is to reduce the number of people who want to use them. He concluded by saying that drug abuse is not a plague sent to us from outer space. Its roots are to be found in poor parenting, poor school performance or peer influence, unemployment, parental abuse and legal drugs such as alcohol and tobacco. Summit participants needed to consider those sorts of issues as well as law enforcement and treatment.

Professor Margaret Hamilton: Professor Hamilton, the Director of the Victorian organisation, Turning Point, an alcohol and drug research and development centre which also provides clinical treatment, addressed the question of why people use illicit drugs:

- the first reason that people use these substances is that they are potent and desirable.

Throughout history human beings have discovered, identified and used psychoactive substances. We use them because they can change us: they change our mood, they change our thinking and they can change our behaviour. That is why we like them and that is also why we need and try to control them. They can enhance or even cause pleasure and they can certainly remove or relieve pain. They therefore have physiological and biochemical effects on our brain which relate to our desire for them. But these become associated with social and cultural meanings, both symbolic and convivial. Their use of them takes on secondary meanings and confers certain identities and status for some users.

- one of the main differences in our choice of substance (be it alcohol or heroin), the way we take it, and the possible consequences, rests in the different social, symbolic, historic and especially legal status of the substances.
- the second reason people use illicit drugs is that cultural and social traditions in part determine the patterns of their use. We live in an extraordinarily drug-tolerant community.
- while crude gateway theories that the use of one drug causes the use of another should be avoided, the associations between use of various substances cannot be ignored. For instance, those who are most likely to be heavy binge drinkers when teenagers are those who are already tobacco smokers and someone who smokes tobacco is much more ready to try marijuana than someone who does not.
- there is no single causative factor on which we can put our finger to describe who will use in harmful ways. We must ask, therefore: What is it that confers particular risks of harmful drug use involvement and what might confer particular resilience? According to Professor Hamilton, some of the factors are:
 - biology and our genetic inheritance may have some small or slight contribution to our predisposition to continue to use drugs once we are introduced to them. However, far more potent are social and environmental factors including our families of origin and our parenting. Higher risk is conferred on children from families with lone parents; where parenting is poor or inconsistent or with harsh discipline; where there are low nurture and care, little warmth, little affection; where there are low involvement with the children, poor supervision and inadequate boundary or limit setting. We know that where families have poor social or local attachment there is increased risk of their children using drugs harmfully.
 - family illness, especial psychiatric illness, increases the risk that children will be drug users. Substance use among the parents, of both licit and illicit drugs, also increases risk.
 - disruption and disharmony, aggression and violence, particularly abuse but also neglect, confer added risk. Social circumstances also heighten risk. They include long-term unemployment, poverty and socio-economic disadvantage, a lack of

opportunity, poor or crowded housing and crowded environments, and poor support services. Discrimination can contribute to enhanced risk. Drug use can be a response to all of these risks.

- there are education-linked factors such as school failure. Throwing children out of school makes them more likely to use drugs.
- there are also economic reasons for drug use. These substances behave like other commodities. When they are desired or demanded someone will always supply them at a price.
- there are things that we can do that might enhance primary prevention. These have recently been well documented in the national crime prevention strategy document called 'Pathways to Prevention'. They include a long list of resilience factors that may be present even for a child growing up in a household that is poor. Life transitions are critical, and we need to provide support for early childhood experience. Support to families then might be worth a lot more than facts and figures about heroin use 15 years later.

Professor Hamilton concluded by relaying some observations from her 30 years of working the drug and alcohol area. These included:

- drug education based solely on the provision of information - telling young people to just say no - in my experience and from research, is not helpful at all. Different information and delivery will be suitable at different ages and stages of drug use.
- programs in the formal education system have a place and the contribution is best provided by the pupil's usual teacher, not an outside group or expert.
- very few are treated only once; there is no 'right treatment' for everyone which is why it is important to have a menu or repertoire of options. At different times in a person's drug use different treatments will be necessary. Treatment is a cumulative process and any reduction in drug use should be seen as a successful step.
- predictors of success in treatment include things such as stable housing, social support from the family or others, membership or meaningful identities and a sense of belonging.
- treatment options need to be palatable to attract people to treatment. It also needs to be recognised that there is more to treatment than just overcoming the physical dependence. The provision of substitute pharmacotherapy allows cessation of craving and this is helpful in stabilising lifestyle, improving general health and allowing people an opportunity to get their life in order. Non-medical treatments have a place. Self-help and those who care for others must be recognised.
- appropriate options and treatments need to be available in each locality, rural and

metropolitan, recognising the particular needs of special groups such as indigenous Australians.

Professor Penington, former Chair of the Victorian Premier's Drug Advisory Council: Professor Penington provided an historical perspective on the development of Australian drug policies.

- bipartisan Federal Senate inquiries reported in 1971 and 1977 with very similar conclusions. The 1977 report recommended that personal use of marijuana should 'not be defined in law as a crime . . . the penalty be solely pecuniary . . . with no record of conviction . . . used in subsequent proceedings'. These recommendations were not implemented.
- several royal commissions were established between 1977 and 1980, and they either recommended no change or elaborate strategies for enhanced law enforcement thought likely to reduce importation. The Sackville report in 1979 in South Australia, however, questioned the whole basis of drug laws in Australia. It recommended that in respect of cannabis 'cultivation for personal use, use in private and small scale gratuitous distribution in private to adults would not be a criminal offence'. But public opinion remained on the side of law enforcement and no action was taken at the time.
- in 1984 the South Australian Parliament legislated to provide for persons charged with possession of a drug of dependence to be referred to an assessment panel with the option of treatment and rehabilitation as an alternative to prosecution. The Act provided for payment of a fine for expiation of a charge for use of cannabis.²⁰
- in 1992 the Australian Capital Territory became the second jurisdiction in Australia to decriminalise possession and use of small amounts of marijuana, or even cultivation of a small number of plants, with the police being given discretion as to circumstances in which an expiation fine should be imposed.
- the Northern Territory moved similarly in 1997.
- a change in direction in drug policy occurred in 1984 following a Federal election, during the campaign for which Prime Minister Bob Hawke cried on television when asked questions about his daughter's heroin dependency. A special Premiers' conference then established a new framework of policy aimed at reducing supply, demand and the harm done in the community to users and the community generally.

²⁰ Recently the Federal Government's Ministerial Council on Drug Strategy was advised that decriminalisation of marijuana for personal use in South Australia has not resulted in significant increases in the drug's use among young people. The Report, commissioned by the Council, says the South Australian government's system of issuing fines to people caught with small amounts of cannabis, rather than recording a criminal conviction is fair and cost-effective. 'Drug Summit is no quick fix, says Carr', *The Australian*, 17 May 1999.

-
- in 1995 the Victorian Premier established an Advisory Council because of concerns about widespread use of heroin in Melbourne. The Committee's task was to examine all aspects of illicit drugs. The council comprised eight people, who had extremely varied views at the outset. It consulted widely and received more than 300 public submissions, and held public meetings in the city and in country areas. From the outset a decision was made not to reach conclusions until all the evidence had been taken. Seven weeks after the establishment of the Council, thought was given to what the recommendations should be, and the entire exercise was completed in 10 weeks, with 70 recommendations, every single one of which was unanimous.
 - the recommendations covered a wide range of issues, including education for primary prevention, provision of improved counselling, treatment and rehabilitation services - particularly those designed for young people - and improved processes for handling drug-dependent people in police custody and prisons. Trials of new drugs to assist in the processes of withdrawal and rehabilitation from heroin dependency were recommended, and the proposed Australian Capital Territory heroin trial supported. The Council recommended the decriminalisation of possession and use of moderate quantities of marijuana or the growing of a small number of plants in order to take this trade out of the hands of criminal traffickers. Undermining traffickers was important to reduce the growing recruitment of school-aged children into heroin use. It was also to be linked with a strong health-based campaign against marijuana abuse, which is a very real problem but a problem which is not resolved by declaring it criminal.
 - the Government did not accept the recommendations in respect of decriminalisation of marijuana. However, almost all of the other recommendations were accepted and have been progressively implemented by the Victorian Government over the past three years.
 - attitudes of the police and of the community have shown a very significant shift in Victoria. Following a six-month trial initiated by Victorian police of a formal cautioning program for possession and the use of marijuana, this has now become statewide practice. A trial is under way for similar cautioning in respect of all other illicit drugs. Tasmania has adopted a similar program in respect of marijuana from July 1998.
 - in 1997 the Wood Royal Commission in New South Wales pointed to the inevitability of corruption associated with prohibition and explored the possible regulated provision of currently illicit drugs. Whilst police commissioners nationally have not embraced that position, their public statements in dealing with the problems of drugs over the last three years have shifted significantly. The capital city Lord Mayors of Australia have unanimously supported fresh approaches.
 - Professor Penington's assessment of the policies of the last year was that

prohibition is a simple, populist answer to a complex problem, which explains why it holds political attraction. According to Professor Penington, clothing it in a moral dimension places it beyond rational argument and analysis. However, in the situation in which Australia now finds itself, such a program cannot succeed and alternatives must be explored.

- Professor Penington said that diversion of State resources from education and health to build and fund more prisons is not an answer when 70% of the inmates of those prisons are there for drug-related crime. Better treatment options for those in prison are needed. He supported initiatives such as the NSW Drug Court, or the diversion programs in Victoria as diverting people from courts into treatment options is more cost-effective.
- He concluded by saying that the continuing rise in the death toll and in drug-related crime, means that something will have to be done differently from what we have done in the past. The time is fast approaching when the community will demand fresh approaches and now is the time to think these through ... such action will require civil and political courage to examine and re-think conventional approaches.

On the first day of the Summit there were also two short speeches made by people with personal experience of injecting drug use. *Mr Joe Latty*, a former heroin addict now a successful and drug-free businessman told the Summit: 'I've had people in my life I would have died for ... but if they had stood between me and my drugs I would have killed them ... I lived to use (drugs) and I used to live ... I wreaked havoc on anyone who came near me, mostly the people I loved most'.²¹

Ms Kristine French, a former heroin addict, now a drug and alcohol crisis centre manager, said:

... today I work at the Wollongong Crisis Centre where I am the manager. One of the things that really strikes me today that is a lot different to when I was seeking treatment is that whenever I sought help in the early 1970s and early 1980s I found that in general I could access a service within 24 hours. As other speakers have said, I did not need help when things were going well, I needed help when things were going bad. At the service I run - and I know at many of the other services that are represented here this afternoon - the waiting for detox is two months. More and more people try to access our service. I believe that this Summit is an opportunity to look at the many options, because there is no one option, as has been mentioned. Some people do not want to stop using and, therefore, need to be provided with a safe environment to do so. Those who do want to stop using need to have access to services to be able to do that as well, and that is not the case today.

²¹ 'Drug summit sinks into political row', *The Australian*, 18 May 1999.

[B] On the second day, **Tuesday 18 May 1999**, the Summit heard about current policies in the drug area and their effectiveness, and the merits of various existing strategies and potential improvements.

Professor Peter Reuter, Director, Social Policy Specialisation, University of Maryland: Professor Reuter presented an overview of drug policy and programs in other countries, focussing primarily on the United States.

- the United States has had a serious drug problem since at least 1967 with the beginning of the heroin epidemic. Current policies have been regarded as unsatisfactory by many people: first, they are intrusive; second, they are divisive, particularly by race and to some extent by age; and, third, they are expensive - approximately \$35 billion is spent each year on drug control. Despite this, it is very hard to provide an empirical base for making a substantial change in policy.
- in the United States two different debates occur regarding drug policy. First, there is the ongoing debate in Congress which is largely about the single issue of balancing Federal drug control expenditure between enforcement on the one hand, and treatment prevention on the other hand. Professor Reuter argues that is far too narrow a debate to help policy formation. Second, there is the legalisation debate, which has very little political currency and is quite marginal.
- United States policy is consistently punitive. The statutory punishments keep on rising. When any new drug appears, a more severe sentencing provision is introduced. In an era of guidelines and mandatory penalties, that has profound effects. The result of this increased punitiveness is that sellers and, to a lesser extent, users face quite a high probability of going to prison, and even though drug courts are increasingly popular they are not yet developed enough to make a substantial difference to the numbers incarcerated.
- a punitive approach is also adopted in more general social policies. When welfare reform was put in place in 1996 there were provisions specifically aimed at requiring abstinence on the part of recipients. To some extent this reflects the clear goal of American drug policy, which is not harm reduction directly but reduction of use.
- as for the shape of American drug use and related problems, each year a survey is conducted of the household population in the United States. Figures on changes in the prevalence rate, that is, the fraction of people who use in a high-risk age group, 18 to 25, indicate that there was an increase through the late 1970s, then either a decline for marijuana or a flattening out for cocaine, and then a substantial reduction to fairly stable rates since about 1990. This suggests that American drug use has been declining, or at most stable, for quite some time. Yet, in fact, what has happened is a redistribution of drug use in an important way ... a large share of all the cocaine and heroin in the US is consumed by people who are regularly in the criminal justice system.

- despite the stability in use, there has been a continuing, almost relentless increase in the number of people showing up in emergency rooms with problems related to cocaine or heroin use. But it is important to note that they are getting older. It is not evidence that there is a larger population. It is a population which is ageing and which is more vulnerable to the adverse effects of cocaine or heroin use. So although the indicators suggest a worsening of the situation, it is important to look at the composition of the population to understand those indicators.
- the consumption of drugs has gone down somewhat modestly over the past 10 years. There has been a decline here in the quantity of cocaine use and a fairly modest decline, if any, in the quantity of heroin used. Two comments about this. First, this is almost a universal phenomenon. That is, similar declines have been noted in western Europe, Canada and Australia. Second, it is striking that these declines have occurred in the face of massive increases in punishment. There is a theoretical framework that explains why punishment ought to raise prices, and the truth is we have certainly raised the punishment, yet prices have continued to fall. This is a matter of serious concern to those who would advocate toughness. Toughness also looks as though it has been unsuccessful in the United States because it has failed to change availability.
- the American experience indicates that: the epidemics, the periods in which there was a lot of recruitment of new users into frequent use, are long past. Nonetheless, the history continues for a very long period of time, and we are now living with problems of 25 to 30 years ago.
- there are fewer occasional users of drugs. That change is not a consequence of decreased availability or higher prices; it is very much as a result of a change in attitudes. Whether enforcement is responsible for that change in attitudes is something one can argue about. Professor Reuter takes the view that the evidence is mildly against that.
- there is lower violence in drug markets in the United States. The explanation for that may lie simply in the ageing of those people who are buying and selling cocaine and heroin. Violence is a young man's game; they are no longer young.
- finally, even as these indicators get better, there are more deaths and medical emergencies, and it is a reminder of how important it is to keep different measures separated out in terms of what drives them.

As for western European experiences, Professor Reuter described the variation between them:

- Sweden talks tough and its policies are very consistent with a paternalistic State that is highly consensual. On the other hand, it probably does have the most generous treatment system.

-
- at the other extreme is the Netherlands, which is consistent and explicit about applying principles of harm reduction to every aspect of its drug policies. According to Professor Reuter, Europe in general is moving the Dutch way.
 - the French had been very resistant to methadone and buprenorphine and any type of pharmacotherapy, but in about 1994 suddenly opened up a very large set of programs, public and private, to provide that.
 - the Germans have also followed the harm reduction camp, but the evidence suggests that the national policy choices do not reflect perceptions about what will work, but come out of that country's cultural and political traditions.
 - the Spanish decriminalised possession of small amounts of drugs 25 years ago. The rationale was more to do with preventing the police from intruding in the private life of citizens than a considered strategy of an overall drug policy.

Professor Reuter concluded his address with several observations:

- the United States has a uniquely severe drug problem. Its prevalence is high but if you look at the fraction of population that is dependent upon expensive drugs the United States stands at the head of any league. Not only does it have more who are dependent but their conditions are in some ways much worse. It has a very high level of HIV, and it has had extraordinary levels of violence.
- the explanations for this are as likely to lie in societal and social policy factors (for instance, the American emphasis upon individual identity, on expressing yourself and hedonism). The alienation of large sectors of the population, particularly urban minorities, has also played a role, particularly in the development of violent street drug markets. There are many factors which have nothing to do with drug policy itself, which play a role.
- in answer to the question: has the tough American approach in some way reduced the drug problem? Professor Reuter says that it is striking that enforcement has failed to make drugs harder to obtain or made them more expensive. The reductions in overall drug use are probably driven more just by the natural course of an epidemic coming to its end than they are by drug enforcement.
- because illicit drugs have been treated so much as a moral problem, there has been very little systematic research about what works, in particular about the effects of enforcement. That causes a real problem for reformists, certainly in the US, who want to push for less harsh policies but who do not have an empirical base on which to rest their case. By the same token, if you feel that the drug policy that is in place has a reasonable logical and factual basis, the mere observation that problems are getting worse is no basis for making changes. We do not know what are the effects of policies.

Professor Tim Stockwell, Director, National Centre for Research into the Prevention of Drug Abuse:

Professor Stockwell addressed the Summit primarily on the issue of prevention, which he defines very broadly. For him, the concept of prevention is not only about preventing people from using drugs initially but also about what can be done to limit the uptake of harmful drug use and what can be done for those who are already using drugs to limit the harmful consequences of their use.

- a comprehensive policy needs to ensure that the focus is not just on illegal drugs but also incorporates the harms associated with legal drugs. In this country alcohol-related deaths each year exceed by a factor of four the number of deaths associated with all illegal drugs, and tobacco deaths are much higher. The other reason for incorporating alcohol and legal drugs within the whole picture is the incidence of poly-drug use in heroin-related deaths.
- prevention efforts need to be broad and comprehensive, and more than narrow school-based programs or media programs.
- the person who is already involved in drug use should not be abandoned ... many of these people will come out all right at the end of the process. The long-term follow-up studies suggest that after seven years, approximately 50% of even a hard core group of people in contact with the treatment agencies will have moved away from drug use. There is an issue of keeping people alive long enough and minimising the harmful consequences of their actions to the rest of the community as well as to themselves until they manage to move through to the end of the process. There are many different drug users who experience a variety of consequences ... many hold down a job, are married, have a mortgage, have children and are productive contributors to society. We must not stereotype drug users as being those people who have fallen through the cracks of society and who engage in or make contact with treatment agencies.
- only a small minority of people who are engaged in drug use will actually make contact with specialist drug agencies. We need to look at primary care workers and what they can do but we should also be aware that many people simply choose not to be in contact with those agencies. Therefore, we must be modest in our expectations of what treatment can achieve, however important it is to provide the best range of accessible services.
- if the Summit is considering school-based programs, major attention should be focused on legal drugs. Alcohol, particularly hazardous alcohol use, and tobacco use - for whatever reasons - are major gateways for subsequent illicit drug use. There is also a concern about the capacity of these programs to do harm. There is

evidence that some programs can increase curiosity about some drug use practices - for example, sniffing aerosols. Just describing the dangers of those practices appears to put into the minds of many young people the suggestion of the possibility of using them more than it deters others from not engaging in that activity ... I urge this Summit through Commonwealth or State funds to support efforts to develop better and more effective models to provide school-based education programs.

- on the law enforcement issue, limited resources should be focused on drugs that are associated with the most harm in society ... among all drug offences, between 70% and 80% in this State are minor offences for the possession of cannabis. These take up a considerable amount of police time and court time and divert resources away from where they are perhaps most needed. I recommend that this Summit look carefully at the experience of the Australian Capital Territory and South Australia where an infringement penalty applies to such activities. Note that the evidence in those States suggests that levels of cannabis use are not higher than in States that have total prohibition of cannabis. Note that studies have found little evidence of deterrence from enforcing the cannabis laws. Persons have shown little inclination to stop using cannabis after they have been convicted of such offences. In addition, there are arguments for separating out drug markets and reducing opportunities for corruption.
- we need to use our best efforts to run evidence-based harm reduction strategies in combination with abstinence-orientated treatments. In particular, such programs need to be co-ordinated with law enforcement actions to make sure that the two do not trip each other up and create problems for the other's sphere.

Professor Vimpani, University of Newcastle, and Area Director, Hunter Child Adolescent and Family Health Service:

Professor Vimpani addressed the Summit on the issue of primary prevention and early intervention. He began by presenting some definitions. 'Primary prevention' describes those activities that build the capacities of individuals, families and communities to not use drugs, whereas 'early intervention' describes those strategies that are offered only when risk-taking behaviour or early drug use has commenced, and aim to reduce risk or increase protective factors.

He pointed to a number of the myths relating to criminal behaviour and illicit substance abuse:

- whilst there is no single cause of substance abuse some individual, family and community factors increase its probability. These factors include conduct disorder in children, poor parental supervision of young people and exposure to criminogenic communities or peer groups.
- whilst it is important to start early, all is not lost if a teenager embarks on experimentation with illicit drugs. Things can be done that minimise the risks of

progression to regular or damaging use.

- there is no single path to substance abuse, but some circumstances and backgrounds are predisposing factors. These include poor attachment in early life, by which we mean a lack of responsive, nurturing care giving by a child's primary caregivers.
- macrosystem issues have major influences on the emergence of substance abuse. Widening socio-economic inequality has almost universally adverse effects on health outcomes, especially in children and young people. So too does the despair arising from the mismatch between young people's hopes and aspirations for the future and their beliefs about what will actually happen,
- mind-altering substances have been with us for millennia and the inventiveness of human beings will probably ensure that they stay with us in increasingly exotic varieties for as long as we inhabit the planet.

On principles for intervention, especially for primary prevention strategies, Professor Vimpani said:

- a developmental approach to prevention is needed. Interventions that aim to reduce risk factors and increase protective factors that have been shown to have a relationship to later adjustment are important. Intervening at transition points is important.
- early outcomes influence later outcomes, and successful earlier transitions improve chances of later transitions also being successful. Cumulative risk is important so multi-component interventions are needed. Prevention has diverse benefits, and benefits are much wider as a result of these interventions in the reduction in substance abuse. And prevention is a cost-effective investment.
- extended home visiting is a model of an effective primary prevention program that incorporates these principles. Home visiting is a central component of established programs such as HomeStart and Family Support and many newer programs such as Families First and Good Beginnings. Home visiting is predicated on the importance of a developmental approach and intervening at a key transition point - the last few months of pregnancy for a first-time mother. Home visiting is a strategy that provides opportunities to respond to multiple family needs. It reduces the rate of substance abuse, both alcohol and smoking, in pregnancy and improves diet. In doing this, it reduces the risk of neurodevelopmental impairment in the unborn child, itself a risk factor for later conduct disorder and substance abuse. After birth it provides emotional and practical support for mothers and encourages improved care giving and more sensitive responsiveness to infant needs. It offers benefits in multiple domains. It improves maternal life chances by increasing job skills, employment, pregnancy spacing, and reducing maternal depression and welfare dependency.

-
- it improves multiple outcomes for children - improved mental development scores, lower rates of child abuse and injury, lower rates in the use of cigarettes and alcohol in children up to the age of 15 years and lower rates of criminal behaviour. It also changed the way mothers disciplined their children. Although they actually punished their children more, the punishment by intervention group mothers was less reactive and unpredictable. It is a cost-effective intervention even when future benefits are discounted..
 - in many ways home visiting provides a range of opportunities that are known to be associated with the emergence of resilience, even this far into an individual's life course. As well as improving many young mothers' sense of self-efficacy, visiting nurses often provide the older extra familial friend that the resilience literature has shown to be so important.
 - the major drawback of such strategies is that, although there are some immediate benefits, many of the beneficial effects lie 10 to 20 years in the future. Governments need courage and our support to take the risks needed to make such long-term investments and we need to know whether the benefits observed elsewhere can be realised in New South Wales, and to do this funding for rigorous and longitudinal research is required.

Major Watters, Salvation Army Officer and Chairman of the Australian National Council on Drugs: Major Watters presented a paper to the Summit entitled 'Treatment - the way forward'. He observed that:

- there was a fundamental issue of difference amongst Summit participants as to the best way forward. On the one hand, there are those who believe in treatment leading to a drug-free status and, on the other, those who call for drug law reform and acceptance of the inevitability or even the normality of illicit drug use.
- what exactly are we seeking to treat and what are the dimensions of the problem? Obviously a prime goal of the drug policy and treatment should be to reduce drug-related deaths. It is important to remember ... that the big killers are tobacco and alcohol. I am sure I speak for the treatment community when I say that we are frustrated that we are least successful in the treatment of the biggest killer. Too often I have seen people overcome addiction to alcohol and other drugs but then die of smoking-related causes. For that reason alone - and there are many others - we should resist the pressure to decriminalise marijuana.
- there has been a dramatic change in admissions to treatment services from the middle-aged alcoholic to the younger poly-drug user. Heroin is but one of the drugs identified by the clients as their choice. Whilst heroin has gained a high and somewhat sensationalist profile and is undoubtedly a serious and increasing problem, let us be careful of the 'doom and gloom, everything has failed' picture that is too easily and too often presented by the media. Given that approximately 98% of the population is not using heroin, it cannot be said that existing strategies

have failed.

- the challenge, therefore, is for treatment to not simply deal with any particular substance, but with addiction per se. The actual substance abuse is largely symptomatic of what lies beneath. Focussing on a particular substance, providing it or the means to use it, substituting one substance for another, will not bring healing and wholeness or the quality of life that we saw demonstrated to us yesterday by those two very inspiring speakers who are in recovery. Whilst I recognise the legitimate and necessary place of methadone and other pharmacotherapies, because if they are accompanied by appropriate counselling and support services they remain as valuable harm reduction strategies, I do not see them as treatment.
- the Salvation Army's abstinence-based treatment services do not promote abstinence for purely moral reasons. We do in fact provide outpatient services, treatment programs and counselling that recognise that some people are simply abusing alcohol rather than being alcoholic. But the truly addicted person cannot safely use the substance of his or her addiction in a controlled way.
- the treatment of addictions should not be limited to a biomedical model. It is not only a medical problem; it is a health problem, in the holistic sense. Of course, there are certainly medical elements to the condition and required in the treatment, but the paradigm of treatment must be broad enough to recognise and encompass the gamut of factors involved: psychosocial, legal, economic and societal. I believe there is a significant spiritual dimension to addiction.
- the good news is that treatment works. It is both effective and cost-effective. As the Rand Corporation research shows, \$1 spent on treatment returns \$7 to the community. These figures from the United States of America refer to the effectiveness of treatment one year after use.
- Major Watters referred to the recent visit to Australia by Mr Keith Halliwell, the United Kingdom's drug policy co-ordinator, and outlined that country's position on illicit drugs. According to Major Watters, the United Kingdom, with a population of more than 50 million, has approximately half the number of overdose deaths that Australia has. This has been attributed by Mr Halliwell to the United Kingdom's comprehensive policy of preventive education, for both school and the community; community policing and diversionary policies; treatment services in prisons; and increased resourcing of treatment facilities in the community. The goals are directed towards a drug-free outcome for the people who come to notice. Mr Halliwell remarked that the United Kingdom policy is similar to the Commonwealth national illicit drug strategy and to Premier Carr's seven-point plan presented at the Council of Australian Governments conference.

Dr Ingrid van Beek, Director of the Kirketon Road Centre: Dr van Beek also addressed the Summit on the area of treatment and rehabilitation.

-
- she said that from a public health perspective there are two key components to providing effective treatment and rehabilitation. First, the access to the health system is very important. It is necessary for the health system to have contact with as large a proportion of the injecting drug using population as possible at any one time - at all stages of their injecting drug use, preferably even before they commence but during and also when they are ready for treatment. Second, treatment and rehabilitation services should be attractive, appropriate and acceptable to the injecting drug using population and also to the community that must host the programs. So consultation and involvement of the affected community, and the consumers (namely, the drug using population) are important for the treatment and rehabilitation programs to be successful.
 - Dr van Beek also commented on the scarcity of treatment places and made the point that while she supported the recent Drug Court initiative, it could be argued that a stage has been reached where people have better access to treatment and rehabilitation programs if they have committed a crime and not before that time.
 - treatment and rehabilitation initiatives need to be considered in the light that drug dependence is a chronic relapsing condition. Drug users are individuals. They have different needs at different times. We need to consider which treatments are most effective and then tailor those to an individual at a particular time. It is an hierarchical approach: you try one thing and if it does not work you try another.
 - the methadone program is the cornerstone of not only drug and alcohol treatment but also HIV prevention. However, there is a need for diversity in treatments including naltrexone, buprenorphine, cheaper LAAM, residential programs and therapeutic communities and inpatient-outpatient medicated and non-medicated detoxification. Support should also be given for Narcotics Anonymous.
 - we must also look towards new approaches and not be scared. Fear, of course, underlies a lot of approaches to drug use. Given that this is all associated with great morbidity and mortality it is understandable that the parents of young people are fearful and anxious about what we do and the messages we send out. However, other countries have tried other approaches. Dr van Beek recommended that consideration be given to such things on a trial basis and, pending the results of those trials, introduce them into the communities in a limited way. We need to be careful with new initiatives and not make the mistake of applying a test that is completely unrealistic and unachievable.
 - there is a need for further integration at a micro level between treatment and rehabilitation programs. Many people fall through the middle, after detoxification, before rehabilitation. We need integration between the government and non-government services and between services and the local communities. At a more macro level we need a whole-of-government approach.
 - we have major training needs, particularly medical training. There is no medical

training in addictions medicine. Those who work in this area are there by accident and have usually come from related areas.

Professor Mark Findlay, Faculty of Law, University of Sydney: Professor Findlay looked at the problem of drug control from a criminal justice perspective.

- according to Professor Findlay, criminal justice responses to the illicit drug problem have been the least successful of any social control strategies, by any measure. Moreover, they are relatively expensive, inherently discriminatory, and often tend to lull the community into a false sense of security. In certain situations criminal justice intervention will exacerbate the problem it is directed towards controlling. However, because of the connection between drugs and crime, it is unlikely, indeed inappropriate, that criminal justice strategies will disappear from the drug control agenda. Public opinion remains confident in a criminal justice response to drugs, irrespective of unfavourable success measures or warnings from royal commissions. The community's desire to punish those who profit from the drug trade and to deter those who might experiment is perennial and politically persuasive. To satisfy this, resort will be had to the criminal justice process. And so long as law enforcement alternatives are equated with getting tough on crime, it will attract a disproportionately favourable budgetary allocation.

In his paper, Professor Findlay focussed on three themes which, in his view, will enhance the viability and appropriateness of the criminal justice model and a variety of control problems. The themes were: (i) the promotion of what criminal justice does well; (ii) the reduction of what criminal justice does poorly; and (iii) an integrated management approach to drug control, in which criminal justice has a central place.

- given that criminal justice absorbs almost four times the budget for drug control than that directed to treatment, health and welfare, it is certainly time to ask the value-for-money question and to exact some simple measures of value or potential success from our criminal justice strategies.
- examining the area of what criminal justice does well, Professor Findlay said that: while the police are well positioned to exercise discretion to produce rational and clever control outcomes when it comes to the control of street offences in particular, they are reluctant to employ discretion in important drug-control situations. This is particularly so when the discretion is visible and beyond one-to-one encounters. For as long as cannabis remains a proscribed drug - and it is only a matter of time before the views of millions of Australians will see this position changed - the police will be the front-line control agency for youthful users in particular. The police in New South Wales, as in Victoria, can build on their successful application of juvenile cautioning in general and direct the discretion in a uniform fashion to first offenders on marijuana charges. This would produce a far more efficient outcome and would be better down the line.

-
- police have recently revealed an effective control capacity in the licensing area. Campaigns for responsible sale and consumption of alcohol, and the regulation of pawn-shop transactions, identify areas in which police are effective. In jurisdictions like Japan, Scotland and Germany - each with favourable crime control methodologies when compared with Australia - prosecutors exercise well-developed diversionary practices. Scottish prosecutors can impose fines on an admission of guilt. German prosecutors manage a detailed diversionary and conference-based program. The Japanese prosecutor can impose conditional bonds. There is no professional or procedural reason why our Director of Public Prosecutions might not be empowered to develop his diversionary potential in similar fashion.
 - the use of courts as treatment referral agencies is a costly application of limited resources. Despite initiatives such as the Drug Court, it could be argued that the decision-making paraphernalia of our courts should be rationalised to deal with drug-related crime which is the common consequence of drug use, such as assault, property crime and trafficking. If only those matters progressed to a court over which judicial officers could impose a legal logic and activate sentence penalties, then judicial wisdom would find its most suitable direction in drug control. Particularly for the lower courts, this may require a diversification of sentencing options. Consideration should be given to the re-introduction of suspended sentences and greater funding of the probation service for supervision.
 - beyond isolation and containment, correctional institutions are not known as successful drug control environments. Their deterrent impact is problematic and while drugs remain available in the State's prisons, their detoxification and abstinence potential is compromised. Perhaps the best thing that prisons could provide for drug control outcomes would be a residential setting for medium- to long-term treatment and life-skills enhancement.
 - as for what the criminal justice system does poorly, Professor Findlay said: that specialisation in drug enforcement leads inextricably to corruption. Police admit they can do little to prevent drug use. Currently, when it comes to offences of self-administration, for instance, police practice is largely to turn a blind eye. The challenge to the legislators is to bridge the gap between intuitive and appropriate police practice and symbolic sanctions by removing as many of the offence categories relating to self-administration as currently stand in the statute book. Users and police agree that this would produce positive health outcomes while risking neither any significant increase in usage nor decrease in real deterrents.
 - in relation to property crime the consequences of the drug problem are significant for police, which may mean they have to re-invent their involvement. There is a real need for liaison between police and the insurance industry so police can be relieved of their clerical responsibilities in providing reports that form the substance of later insurance claims. There is a real need to resource police in their forensic and investigation activities so that they can satisfy a real community desire that break

and enters should be properly investigated and cleared up.

- in relation to the integration of control strategies, Professor Findlay pointed out that criminal justice is not managed in an integrated fashion, as evidenced by the allocation of resources to the primary justice institutions. Most money goes to policing, followed by corrections. What crucially links these components - the prosecutors and the courts - lag far behind in the resourcing stakes. Sector management is not in evidence in criminal justice in this State. According to Professor Findlay, we cannot continue to increase police numbers and cut funding to the courts, the prosecutors and legal aid. It makes bad management sense.
- integration in the area of criminal justice should occur on two levels. The most obvious is the interconnection of the aims, objectives and outcomes of the principal institutions of justice. This could be advanced around the agreement on common themes for control. One might be a preference for diversion - that is, diversion prior to appearance in court, otherwise it is not cost-effective. Another might involve a formal case-management commitment in which each institution with an interest or investment in the outcome of the offender will be recognised and reconciled.
- at its most complex, integration is the challenge for criminal justice, treatment and education. It must encapsulate the most local of encounters - where a police officer diverts a user to treatment facilities - up to the organisational sharing of resources through a performance-based funding model. It may be necessary for government to create a commission or secretariat to co-ordinate resourcing institutional need and service availability in the drug control agenda.
- in the struggle to create a new approach to drug control, criminal justice can take a lead in reconciling its mutual interests with education and treatment.

Mr Craig Thompson, Magistrate and member of the Australian National Council on Drugs: Mr Thompson related to Summit participants his approach and experience in dealing with offenders who are drug addicts.

- according to Mr Thompson, the focus of our attention should be on early intervention to stop young people getting involved in the first place. He referred to the dilemma faced by parents whose children have a drug problem and the difficulty in getting young people into treatment programs.
- Mr Thompson supports the Drug Court initiative and would like to see it extended to deal with juveniles. He told the Summit that he was a firm believer in coercive rehabilitation, and that he adopted the Drug Court approach in his dealing with offenders who are drug addicts. Before sentencing such an offender, he would direct that person into treatment and make it fairly clear what can be expected if treatment is not undertaken. Offenders come back before him and they are required to bring back reports from the centres informing him as to their progress. Mr Thompson also obtains updated pre-sentence reports. In Mr Thompson's opinion

this approach has been very successful.

- Mr Thompson expressed certain reservations about diversionary programs. His main concern was as he believed in coercive rehabilitation, he felt that if gaol was removed as a possible penalty from the judiciary, it would be taking away a lever currently available to get people into rehabilitation. In Mr Thompson's opinion people would not stay in rehabilitation if what they are going to face for not doing so is a fine.
- Mr Thompson maintained that offenders were not jailed for their drug use, but rather for the substantive offences for which they are appearing before the court, where cannabis use or possession is an additional concurrent charge.
- he told the Summit that certain ways of dealing with offenders are already available to magistrates to enable them to deal with drug users in a lenient manner. For example, community aid panels whereby a person comes before the court and is required to go through a form of community service as penalty. When they return to the court, it is customary to dismiss the matter under the provisions of section 556A so that there is no record of a conviction.
- Mr Thompson pointed to the discrepancy in the treatment of young people appearing before the Children's Courts. Children under 16 years of age cannot be convicted of most offences, including possession and use of drugs. However, if the offenders are between 16 and 18 years of age they may be convicted. If they are, the conviction is wiped from their record after three years whereas for adults it is after 10 years.
- he stated his belief that we should look at intervening, both with the law and with education, in programs designed to stop young people getting involved in drugs in the first place, and that rehabilitation should be examined to further reduce drug use.

On the third day of the Summit, **Wednesday 19 May 1999**, participants were provided with first hand knowledge of the problems, difficulties, resources and client profiles at frontline services. Delegates took part in visits to drug rehabilitation facilities and hospital detoxification units in key areas such as Kings Cross and Cabramatta in the morning, and in the afternoon presentations were made by people close to the drug problem such as doctors, nurses, ambulance officers, counsellors, family members and young people.

[C] On the fourth day, **Thursday 20 May 1999**, participants heard about the roles of local communities and groups in preventing the drug problem, and the support that can be provided to these communities.

Dr Col Gellatly Director-General, Premier's Department: Dr Gellatly presented the Summit with an overview of some programs that the public sector has been involved in, to do with strengthening communities and generating community action.

- he said that illicit drug use, which undermines community capacity and wellbeing, was not just a health or law-enforcement issue but a whole-of-community issue and it cannot be addressed by government acting alone.
- the major initiative last year was a forum held at Dubbo which brought together the Premier, Ministers, department heads, local staff, Aboriginal community representatives, 12 local council mayors and community organisations. As a result of that, 12 western communities have started on joint actions and key themes on such issues as local co-ordination and service delivery.
- this took place under the umbrella of a regional co-ordination program, which has been a change in the way governments have operated. Previously each agency had its own region. The Premier's Department has a person in the region helping to co-ordinate and facilitate the agencies working together. This involves working not only with the local agencies but local government, the Commonwealth Government, and community and business organisations.
- some of the specific projects that have been undertaken as part of this initiative include Kings Cross, Cabramatta, Redfern, Waterloo, Canterbury-Bankstown, Kempsey and Moree, with a different approach for each town being adopted as necessary. One size does not fit all. The Cabramatta project has been strongly associated with local government, which has its own 'place manager' for Cabramatta, as part of the Fairfield council. That has been a success in alleviating some of the impacts of the drug problem. It will not solve the drug problem but it has helped to alleviate it.

Dr Gellatly then elaborated on what were considered 'success' factors:

- the community has to take ownership of not only the issues but the solutions. Unless the community is involved and fully committed to it, it does not work.
- similarly with local government, in some western areas of New South Wales the major driver has been the mayors. In some cases they have shown a strong commitment and because of the network and infrastructure that local government has, it is crucial that it is involved in any community action projects.
- it is important to build on the strengths, not on the problems in the area. Total harmony is not possible as different parts of the community will very likely have different views. But it is essential to try to find common ground.
- sustainability needs to be achieved and not just a one-off - something that happens for a period 12 months. It must have some elements that keep it going for a number of years. It must not be only a vision; it must be more about achievable goals and concrete tasks.
- Dr Gellatly concluded by making a number of points. It is not a simple or single

action; it is a holistic effort towards the renewal of communities which involves all stakeholders, local organisations, religious groups, local government and all other levels of government. With particular emphasis on those areas, towns and communities that are most disadvantaged. One of the challenges is to harness not only public sector resources but also corporate sector resources. This applies to the whole community action and effort. In most of the towns involved to date the Chambers of Commerce have been very supportive and involved in these initiatives. Across the board the big corporate organisations do not put enough resources into some of these community action projects. Finally, efforts have to be aligned to meeting the needs of young people and families in particular places. Different issues have to be handled differently.

Mr John Mant Consultant, Phillips Fox: Mr Mant addressed the Summit on how government can better relate to communities, business, families and individuals. The challenge, according to Mr Mant, is to improve government and to make it more relevant.

- Mr Mant focused on the development of Western Sydney, stating that what has been created in some parts of Sydney really does not reflect well on government, as these places are ‘non-places’ - a series of bits that do not add up to a whole, which makes it difficult to have real communities operating there. In this setting, Mr Mant said he could understand why young people might be attracted to a drug culture. These places are the products of what are called ‘silo’ governments, not ‘outcome’ governments. Each organisation is a separate specialty or guild offering its own input - police, teachers, social workers, nurses, home care, town planners, public housing operators and engineers. Everyone is involved but no-one is allowed to be responsible for the result. According to Mr Mant, silo governments breed co-ordination and advisory committees. Advisory committees are useful because they capture people inside the tent, however, co-ordinating committees are not really designed to achieve a real outcome. Generally, you attend a co-ordinating committee meeting to protect the department’s patch.
- Mr Mant posed a number of questions in relation to these different forms of government: How can a silo person relate to a community ? ‘Sorry, I am the pavement person. I will ask the cleaning person to come to the next meeting.’ How does a silo government relate to a family ? ‘Sorry, I will get his teacher, nurse, home help or probation officer to come to the next meeting.’ How does a committee relate to a community or a family ? How can a committee form meaningful, ongoing working partnerships ?
- the ‘place management’ concept is useful when overall responsibility for implementing a plan is needed, particularly where actions cut across a number of agencies and involve things for which no-one in particular is responsible. The State’s ‘place manager’ is located in the Premier’s Department because in this sort of structured government only the Premier’s Department can be responsible for the outcome. Only there can it all come together.

- Fairfield Council, recognising that something needed to be done to tackle the problems of Fairfield, adopted a 'place management' approach. The council changed the way it was organised and it has changed the way it works. Instead of the 'input silos' - the traditional engineers, planners, health and building surveyors, librarians and community workers - there is in Fairfield now a corporate division that is about governance, as well as an outcomes division which is about effectiveness and which has outcome officers who are responsible for systems such as the catchment, places, cases and projects. The traditional guilds have been turned into more business-like operations under the services division, and the regulatory function has been set up as a separate operation because the council's view is that it could not have a place outcomes officer also running the regulatory system. There had to be an arm's-length separation.
- the four divisions reflect four separate functions of government - effectiveness, efficiency, governance and transparency. This is a much better way of designing a government than is the ever-increasing number of divisions and sections that are based on the ever-increasing number of specialist qualifications. Of course, the key to the change is the outcomes division. Outcomes officers are now free from being responsible for only a single answer and are able to tackle whatever the problem is. Outcome officers can appreciate the real nature of the problem. The council does not have to define the problem in a way that justifies the continued existence of some particular specialty or guild. Outcomes officers are able to do whatever it takes to solve the problem and to make a difference. Because of the way that division is structured, if the council changes its priorities, the next day a council officer can be appointed to take responsibility for achieving that new outcome.
- it should not have to get as bad as Cabramatta did before someone is given responsibility for an outcome or for a place. At Fairfield, this approach has been recognised. Because of the new way of working, every area now has a place manager. Some areas will need more intensive management but every area is important. Each area now has an officer who is concerned about how the areas do or do not fit together and who is able to enter into partnerships with the local community and with families. The same applies to the system outcomes, such as having a future for our kids or the local catchment and accessibility. Governments should be able to assume some responsibility for every place. Governments should be able to work with communities and business to manage places as unique areas. Places should not be just the product of ill-fitting pieces from a dozen different jigsaws. Governments should also be able to respond in a flexible manner to each family and individual who needs assistance. Governments should be able to tailor comprehensive help and support, not just offer the particular input that they happen to supply.
- if governments are to play their part in working with communities, businesses and families to solve complex problems, they must be able to take responsibility for outcomes, such as places, systems or catchments, and cases. What is needed is a rearranging of the organisations of government so that individuals and small teams

are allowed to take responsibility for places, systems and cases. It works: Kings Cross and Cabramatta have proved that individuals and government can make a difference, if they are given an outcome to be responsible for. It has worked in the Department of Housing, where the management of estates has been delegated to small multidiscipline teams.

Mr Mike Montgomery, Mayor of Moree: Mr Montgomery described to Summit participants Moree's experience of implementing 'place management'.

- according to Mr Montgomery most communities want to know that they have a future, and that people in government will listen to them and act upon what they have had to say. They do not expect a white knight to ride into their communities or into their section of the community and deliver everything that is available in other places around the State, but they do want to know that politicians, councillors, bureaucrats or members of government departments will actually sit down and hear what people are saying to them.
- in an attempt at change, the Moree council has gone out to sections of our community and asked: What is your community? We have asked people where their community of interest is, and we have asked them what they want. Generally, people do not want an awful lot. Certainly, they do not want their houses broken into, but they do want job opportunities for themselves and their children, and they want people to work together.
- in the place management program at Moree, we have government departments, the local council and the ATSIC regional council jointly funding the place manager's position. Each group contributes \$10,000 and has input into what it believes the place manager can do for each of them. This involves the place manager and the council asking the community what the place manager means to them and what the place manager can deliver for them. This program has been running since October and, at this stage, the big message is: Come out and talk to us and find out what we have to say. We have done that, and at a council level we have broken up our teams so that each community of interest has an individual officer within the council structure who, together with the place manager, will address the issues of concern that those people have..
- regional officers must co-ordinate with input from the local community so that they know what the community wants. Information comes from the local level up to the regional level, and the regional managers can, within their own structures, allow the community to get what they want. That process seems to be working. We will continue to flog those people who do not understand that the community requires the services it wants, not what regional officers believe it needs.
- if communities at a base level are going to help themselves, they need to have the appropriate skills. At the moment they do not have those skills. They need to have

specific skills, whether they be in drug and alcohol counselling, and they need those skills to be readily available, not five or six hours' drive away. They also need the ability to have skills transferred to them by having the right people working with them in the community. It is sometimes difficult to get committed people who have the skills to not only deliver a service to the community but to also transfer their skills to the community. They have to go and work in the areas. That is not only the case in Moree or in the western areas of the State, it is everywhere. We are locked into the metropolitan mind-set.

- local leadership must be fostered at the community level, which means assisting the movers and shakers within a local community area and giving power back to those people and individual groups. If we want the community to be involved and to have ownership, we have to give them the ability to make decisions. That means giving up a bit of the power base that we so often hold dear. Again, that means listening to what the community wants and trying to deliver on some of their requirements.
- resources are needed where the rural and regional people reside. Again, we need people with the skills to deliver what the community wants and the transferring of skills to the local people. Small community groups need someone on the ground to help them get their 10-year plans in place, because their planning structures will fall down unless they are done properly, and they need access to support once the ball gets rolling.
- the challenge is to ensure that results are not just achieved in the short term, but that the action continues. The crime rate in Moree at the moment has gone way down. In fact, it would be among the lowest in country New South Wales, and we want to keep it that way. We will not be able to keep it that way unless we continue to work on providing the skills and the people on deck to work with the community. Corrective Services officers are working hard in the community and the police have increased powers. But that does not address the bottom line: the problems of unemployment and racism that have been in our communities for decades because of our large Aboriginal populations. Although we are reaping the rewards of action, we need to continue that action to overcome those problems.

[D] On the final day of the Summit, **Friday 21 May 1999**, proposals for new initiatives and strategies in generic areas were considered.

Professor Ian Webster President, Alcohol and Other Drugs Council of Australia: Professor Webster presented an overview of the week-long Summit and highlighted the main points addressed in the Final Communique. Some of the points made by Professor Webster were:

- in 1985 Prime Minister Robert Hawke convened a Summit of all Premiers, the first time that a Summit had ever been called in Australia about a social problem. That led to the national campaign against drug abuse. On 9 April this year another Prime Minister, John Howard, called the Premiers together, and together they issued a communique on a new approach to the national illicit drug strategy. It focused on

diversion from the criminal justice system to treatment and rehabilitation, to education, and to the direct involvement of the community sector. This week in New South Wales - arguably the State with the biggest and most difficult drug problem - we have had this remarkable Summit, and the recurring theme has been to find that common ground.

- the commission given by the Premier was to build on the seven-point plan that he had taken in April to the Heads of Government meeting. That seven-point plan spoke about enhanced prevention and detection; a national first three years foundation and families first; fast-tracking new treatments, a national training program; better case management, breaking the drug crime cycle; drug courts, which are an aspect of diversion; community action teams; and defending national frontiers.
- everything that we have said at this Summit has been consistent with that preliminary plan, and it must be built upon. But let me intrude one note of caution about fast-tracking treatments. The management of dependants requires the same tests of ethics and of science as the introduction of treatment for any other major condition - even more so when there are families and individuals so desperate for help.
- with goodwill and with resources, we can expect improvements: new approaches to early intervention and treatment, families at risk from drugs, in-school education, and the nature of schools and the way they relate to communities, in new specific services, especially in high-risk communities, in diversion programs, in the range of treatment and rehabilitation programs available, and in the nature of medical treatment.
- the Summit has been a process of reconciling different viewpoints. It has been very important for the public to be able to see politicians openly and in public re-examining the current orthodoxy about drugs; prepared to acknowledge that a problem exists, to explore the full nature of that problem, and to acknowledge that our approach needs strengthening in some areas and a new direction in others; and, above all, prepared to agree that there are some priority core areas that we need to address. This approach to the problem of illicit drug use has been the finest achievement of the Summit.
- participants learned over the five day Summit that the drug problem involves drugs of dependence, affecting particular people, in particular social and geographical environments. The people and the reasons they use pose fundamental questions to us, but the answers are so elusive. There are communities and individuals with higher risks, but what happens in the individual case is rarely known to us. The Summit has acknowledged that many groups are involved: community organisations, parent groups, health and welfare and legal professionals, police, teachers and different communities, each with its different viewpoint, each with its

different advice, each with its different level of contribution.

- we have learned also that illicit drugs are readily available. Drug markets are operating in many of our suburbs. Drug dealing is increasing in others and in the rural areas. Drug-related crime is increasing - 60 % to 70 % of prisoners have been convicted of a drug-related offence. Overdose deaths are increasing. Hepatitis C is out of control, HIV is becoming stable, but that is a brittle stability. Poly-drug use is common. That pattern of use is changing. Marijuana use is rising, cocaine use is rising. Amphetamines and psychostimulants are widely used. Injecting drug use is commencing at earlier ages in young people. Mentally ill people have high rates of drug use, including a range of illicit drugs, and among people with drug problems there are high rates of mental disturbance. These combined problems are poorly dealt with and need very new approaches. We have learned of the effects - in death, illness, disease, injury, crime, violence, economic costs, workplace issues and the effect on families and relationships.
- but drugs are not the problem alone. Professor Vimpani told us of the antecedents of youthful drug use and of other problems. There are environments that promote drug use and misuse. There are individuals with higher risks of drug problems. There are young people at risk, those with inadequate child and youthful development, exploited young people, those harmed or abused through their childhood, those in families that have lacked affection, support and parenting skills. Peer pressure and the ambience of the youth culture influence young people, and those with personality disorders and mental health problems are at high risk.
- Professor Hamilton spoke to us about protective factors and about the fact that some groups of young people are resilient. This is the way we think about the problem of youth suicide and this thinking about positive aspects of the development of young people needs to be applied more appropriately and more often to substance abuse, and we have done that in the working groups. The Summit has heard of the areas where drug use is concentrated, and the members and delegates have gone out and visited some of those places. These are areas where unemployment and disadvantage is high, where social and community support is lacking, where family formation is difficult and where young people have few opportunities. We see this in some of our rural communities, in the inner city, and in the south-west and west of Sydney, and delegates, members of Parliament, have said they have those hot spots in their electorates. Therefore, we have made recommendations to deal with early intervention - very early intervention in some cases - and for locally organised and relevant strategies involving local agencies working together. Evidence was presented that illicit drugs are more available.
- set against the illicit drug problem is a set of policies and services. In those services we have met dedicated people who work at the front line. The efforts that they undertake have been made known to us. We have visited some of them and we have heard from them. We have examined the effectiveness of some of those programs and services. None are perfect, none have the answer. Some stand up pretty well to

scrutiny but some need a major rethink. Throughout this Summit people have spoken about the need to evaluate and to examine effectiveness, and they have asked that the processes we get involved in are transparent and accountable.

- to make policy fit and appropriate for the whole of the State we need more robust claims than those that come from personal anecdote. We need systematic information of what is being done, what is working and what is not working.
- Professor Reuter explained to us how it is often the history and culture of a country, of a nation, which influences its drug policy more than the research which, if used, could better inform that policy. His arguments were very persuasive that punishment and retribution as the main, principal, national drug policy creates massive economic, social and human cost in a country such as the United States. I believe that we have all accepted that dealing with this problem goes well beyond drug policy. It has to do with social and economic policy and, as we have often heard from many of our groups, a whole-of-government approach. Our recommendations reflect that.
- the stories which have been recounted to us by some remarkable people give the lie to the prejudice so often harboured about people who have problems with drugs. Thanks to Joe Latty, Kristine French and Annie Madden.
- aspects of regulation and control have been questioned. The law enforcement effort is a tremendous cost, both economically and socially. Commissioner Ryan said that the illicit drug-use cost was of the order of \$1.6 million in 1992. Professor Penington said that Access Economics had estimated the drug trade as being \$7 billion. Both Commissioner Ryan and Professor Penington pointed to the high costs of imprisonment. We have been informed about the law enforcement strategies, about surveillance, about interdiction, about the need for high level intelligence to track and intervene in drug trafficking and laundered money transactions. We have learned also that, at a local level, there is a State and regional approach to strategic policing based on some fundamental ideas about prevention by police, preventive policing and the idea of community policing. The police said to us that they want to work co-operatively with other agencies. The Summit has recommended local and regional arrangements to support such co-operation.
- diversion is now a major focus. Everyone at the Summit has accepted that as a key way to go forward. It is better that people not enter the criminal justice system or be held in it if they can overcome the drug problem that causes their anti-social behaviour in the first place. Two years ago it was almost unenvisaged that we would be discussing diversion now in Australia. It was at most discussed by a select few people. Now there are drug courts in New South Wales, there are other approaches in other States, there is a national agreement arising out of the Council of Australian Governments to go down this path. And a powerful case has been put that a similar scheme needs to be put in place for children and for young people. Our

recommendations reflect this alternative in the criminal justice and correction systems.

- Professor Webster described both areas of common ground, and those where there was some disagreement. He said that participants agreed on a huge range of issues. These included: the need for bipartisanship and openness; that a range of treatments was required, which should include education, employment and welfare policies as well as those which are more associated with treatment; that the delivery of methadone programs needed rethinking; that the police need greater investigative powers and the introduction of new initiatives such as diversion from the criminal justice system to treatment and rehabilitation and a pilot children's drug court.
- areas where differences were evident included the position on 'zero tolerance' from those supporting extreme zero tolerance at one end, to those advocating total legalisation at the other. Those positions have not been accepted. There were recommendations to lessen the sanctions against minor drug offences involving cannabis and to provide for cautions and diversion to education, treatment or rehabilitation. There was strong debate about these recommendations, but at the end of the day the support was there.
- difference of opinion was expressed in relation to the amendment of sanctions against minor drug use by young people in the *Young Offenders Act* so that they can be kept out of the justice system. Many people felt that such an approach gave the wrong messages. But the Summit has recommended in this direction. There was discussion and a proposal debated on the changes in the law that would be required to allow self-administration of prohibited substances. The provision of injecting rooms was seen as a question of safety by their advocates. This, too, was criticised by many people who felt strongly about it, as sending the wrong message about illicit drugs to others. The Summit ended up recommending that non-government organisations be permitted to trial injecting rooms after there had been wide community and public consultation locally and that this should not be part of a one-off process, but part of a constructive, comprehensive, local strategy.
- a trial to evaluate medically supervised administration of heroin was advocated, but again this was seen by many people as giving the wrong message. This proposal was not supported by the majority of Summit delegates.

Following the conclusion of the Summit, the 71 State Labor MPs attended a Caucus meeting where they were requested to explain to their electorates the Summit outcomes and processes and to gauge community attitudes.²²

4 OUTCOMES FROM THE DRUG SUMMIT

²² 'Carr tells: my drug switch', *Sydney Morning Herald*, 22 May 1999.

The Working Group Revised Provisional Resolutions were put to the vote by Summit delegates on the afternoon of Thursday 20 May. Opening this final debate and voting session, Justice James Wood addressed delegates and described for them the pattern of drug addiction he observes in his role as a Supreme Court judge. It is a cycle of poverty, crime and imprisonment which often results in young, first-time offenders becoming recidivist, institutionalised adults. In Justice Wood's words:

This person in custody, who seriously tried to get off in the past, tried to do so but was unable to get into rehabilitation or detox, now has a record for a major criminal offence and now has little hope of gaining employment because of it. In the immediate future he will stay four or five years in jail with ready access to drugs and while there, will form associations with other drug users and criminals and will leave that institution better trained for the means of committing property crime and economic crime. The long-term future ? Return to jail. Or death from overdose, HIV/AIDS or hep C ²³

He told the Summit that this was a recurrent pattern except in rare cases where the person was:

fortunate enough to find someone who would shepherd and support him or her through rehabilitation. This is not a [single] case ... this is virtually every case played out with monotonous regularity every day of the week, before the children's court, the Criminal Court, the District or Supreme Courts. The offender cannot be dismissed simply on the basis of their personal choice to play with drugs. There is an element of that involved but it is only part of an inadequate system that costs us so dearly in terms of the loss of friends and family, property loss and escalating insurance premiums, escalating health and law enforcement budgets, and where I came in, the risk of police corruption, and the enslavement of young people through prostitution to feed a drug habit.

Justice Wood urged voting delegates to listen to those who worked on the front line - the parents, the counsellors, the doctors, court and law enforcement officers who dealt with the drug problem every day.

... We can continue on that path of destruction ... or we can seriously consider the options that are available to us today ... the danger we face is a search for a single, simplistic solution ... whether by unremitting and unthinking law enforcement or a magic bullet of a substitute or antidote for opiate addiction. For law enforcement, no matter how determined or how well resourced, can never prevent the supply, let alone demand for these substances. There is no means for inoculating people against the life circumstances and social events that lead to their cycle of substance abuse and criminality and we should not pretend there is. Because to do so is a

²³

'A time to show courage: Justice Wood', *Sydney Morning Herald*, 21 May 1999.

disservice to the community. The truth is, we can only go forward with any sense of pride and achievement for the summit if we have a comprehensive plan ...

Justice Wood said that this plan should contain several elements including:

- maintaining the law enforcement attack on drug importers, manufacturers and suppliers, targeting their assets and pursuing the chain of money laundering
- funding for rehabilitation facilities relevant to community needs and accessible to all, but particularly young people
- guaranteeing constructive diversion programs for young drug offenders and first offenders charged with minor offences away from jails
- trialling of facilities such as licensed injecting rooms as an adjunct to health services
- comprehensive rehabilitation and detoxification services

The majority of Working Group recommendations were passed with a large degree of unanimity, even the proposal relating to a trial of medically supervised injecting rooms was supported by Labor MPs, most of the 80 non-parliamentary delegates, and a small number of Coalition MPs exercising a conscience vote. The vote on the most radical proposal put to the Summit, namely consideration of an ACT style heroin trial received 78 votes against, and 67 for, with Labor left-wing MPs including senior ministers supporting it.²⁴ A Final Communique prepared by the Special Resolutions Group was put to the Summit for debate on Friday 21 May 1999. Extracts from the Final Communique adopted by the Summit appear below. The full text can be found on the Internet at: <http://203.147.254.2/NSWDS/NSWDrugSummit.nsf/Content/Outcomes>

Nature and extent of the problem:

The Summit is advised:

The complexity of the drug problem has divided the community. There is a need to find common ground and new approaches. There is no single problem of drug use and no single solution. The causes of drug use and constructive responses vary according to the particular drug, locality and nature of user.

Successful responses are likely to be multi-faceted, recognising the roles of demand reduction, supply reduction and treatment. This will require extra resources, and, in some cases, the reconfiguration or reallocation of existing resources.

²⁴ 'Carr tells: my drug switch', *Sydney Morning Herald*, 22 May 1999.

Regarding extent of use: It is estimated that, among Australian adults:

- over 45% have used an illicit drug at some time in their lives, and about one in five have used one in the past year,
- close to 40% have used cannabis at some time in their lives, and close to 20% have used it in the past year,
- close to 10% have used hallucinogens and amphetamines at some time in their lives, close to 5% have used ecstasy or cocaine, and approximately 2% have used heroin, and
- rates of use, generally, are highest among 20 to 29 year olds.

There are approximately 50,000 dependent heroin users in NSW. These people will typically spend more than \$55,000 per year supporting their habit. Many resort to crime to meet this expense.

About 12% of NSW inmates are imprisoned for drug offences. About 70% of inmates in NSW prisons were under the influence of alcohol or other drugs at the time of their most serious offence.

In 1997/98, there were 11,159 offences in NSW of possession or use of cannabis, representing 47% of all drug offences recorded.

NSW Police estimates suggest that Commonwealth and State law enforcement agencies are intercepting perhaps only 10% of imported illicit drugs, 80% of which enter the country through Sydney or NSW by sea or air cargo or by parcel post.

Regarding harm: In 1992, alcohol use caused 3,660 deaths and 731,169 hospital bed days; smoking caused 18,920 deaths and 812,866 hospital bed days; illicit drugs caused 488 deaths and 40,522 hospital bed days.

In 1992 there were 327 opiate overdose deaths in Australia among 15-44 year olds, whereas that number had climbed steadily to 600 by 1997. In NSW alone, 292 people between the ages of 15-44 died as a result of opioid overdoses in 1997.

In 1996, there were 739 illicit drug deaths in Australia, of which 182 were due to causes other than opioid overdose.

Injecting drug use accounts for between 1 and 5% of HIV cases. Hepatitis C infection is highly prevalent among injecting drug users, with prevalence rates estimated to be between 50% and 70%. Family disruption, poor living conditions, poverty and a loss of personal potential are among the common consequences of illicit drug use.

The total social and economic cost to Australia in 1992 of drug use (including prevention and treatment, loss of productivity in the workplace, property crime, accidents and law

enforcement activity) was \$18.8 billion, including tobacco \$12.7 billion, alcohol \$4.5 billion, and illicit drugs \$1.7 billion.

Access Economics has estimated the scale of the Australian illicit drug trade, as opposed to the cost of drug use to society, at \$7 billion per annum.

Between 1993 and 1997 the percentage of cannabis dependent patients suffering from drug induced psychosis rose from 15% to 26%.

Regarding reasons for use: There are clear risk factors that show correlations with a person's likelihood to misuse drugs. These same risk factors also show correlations with a person's likelihood of juvenile delinquency, criminal involvement, youth suicide and mental illness. Risk factors include poor parenting or abuse, a family's lack of social or local attachment, family illness especially psychiatric illness, and substance abuse by parents. They also include social factors such as long-term unemployment, poverty, poor or crowded housing, poor support services and peer pressure.

This is not to say that all people who experience these factors will misuse drugs, nor that all people whose lives are free from these factors will be drug free.

In the same way, there are protective or "resilience" factors. It is important to build protective factors into young people's lives, so that they are less likely to develop life problems, including drug use. This is particularly so at transitional phases, such as pregnancy, birth, entry to preschool, school and high school, and school leaving.

People who use tobacco or alcohol are more likely than members of the population at large to try cannabis. People who use cannabis are more likely than members of the population at large to try other illicit drugs.

Principles: The underlying principles of the NSW Drug Summit were expressed to be that it:²⁵

- 1 Recognises the shared desire of all people in this State that we should live in a society free from drug problems.
- 2 Recognises that the causes of illicit drug use are complex, result in significant harms to individuals, families and communities, and there is no single or simple solution.
- 3 Recognises that drug abuse and dependency may indicate social and economic problems, poverty and unemployment, mental health problems, family stress and breakdown, social peer pressure, cultural dislocation, and a lack of hope.

²⁵ This information taken from the Drug Summit website maintained by the Cabinet Office <http://203.147.254.2/NSWDS/NSWDrugSummit.nsf/ArticleLookup/A052199N7Principles>

-
- 4 Affirms that the drug problem must be owned and solved by all levels of government and all sectors of the community, individual and corporate. To achieve a substantial reduction in the use of illicit drugs will require an integrated approach sensitive to local and regional requirements. It will also require a change in our values and priorities; communities need to make a commitment to valuing and supporting all young people.
 - 5 Recognises that rural and regional communities face unique challenges in dealing with the drug problem.
 - 6 Recognises that the drug problem presents particular challenges for indigenous communities, and acknowledges both that mainstream services need to be culturally appropriate and that Aboriginal specific services are needed.
 - 7 Recognises that other cultural groups face particular challenges in relation to the drug problem, and acknowledges both that mainstream services need to be culturally appropriate and that specific services are needed for a diversity of cultural groups.
 - 8 Reaffirms the principles of compassion for users and protection for all sections of the community from the adverse effects of drugs.
 - 9 Recognises the importance of intervening at the earliest possible time to assist those who may become involved in, or are at risk of, drug misuse.
 - 10 Believes that the solutions that will be of most benefit to the community are those that can successfully divert drug users away from the criminal justice system and into treatment.
 - 11 Calls for a commitment to policy making based on evidence and demonstrated best practice, and for rigorous longitudinal evaluation of policies and programs.
 - 12 Recognises that effective responses to the drug problem require bipartisan co-operation, and commends to others the example set in this regard by the NSW Drug Summit.
 - 13 Recognises that, in the Australian context, effective responses to the drug problem require co-operation and shared funding between the Commonwealth, the States and Territories, and local government.
 - 14 Calls for drug programs, services and expenditure, in both government and non-government sectors, to be regularly audited and evaluated to ensure the most effective use of resources.
 - 15 Recognises the urgency for additional Commonwealth and State funding for drug

prevention, education and rehabilitation services, both existing and new, and that funding for these, based on the many presentations and submissions of non-government providers at this Summit, be significantly increased.

- 16 Recognises the need for particular attention to be given to the quality and accessibility of drug treatment and rehabilitation programs in regional and remote communities.
- 17 Calls upon the State and Commonwealth governments to identify as clearly as possible funding allocated to drugs education, drugs prevention, drug law enforcement, and drug treatment and rehabilitation providers.
- 18 Recognises that the drug problem presents particular challenges for the prison population during incarceration and post release.
- 19 Affirms that rigorous scientific research is the basis for meaningful advances in demand and harm reduction and new treatment progress.
- 20 Recognises that extensive public education programs using TV, radio and print should be generated to inform the public of the problems caused by the usage of hard drugs.

Resolutions: The Final Communique contained 172 recommendations, the overwhelming majority of which were carried without dissent, although there were a number of significant and contentious proposals included. The main thrust of the recommendations, however, is on a renewed financial and policy commitment to education, expanded rehabilitation and detoxification facilities, and police targeting of traffickers and suppliers. Some of the more noteworthy recommendations have been listed below. The full set of resolutions as contained in the Final Communique can be found at **Appendix 3**.

Preventing Drug Abuse:

The Summit recommends that:

- 1.1 There be an expansion of evidence-based prevention and early intervention services which strengthen all families with children, as a means of preventing drug abuse by children and young people now and in the future. These services should:
 - (b) include universal home visitation to all first time parents,
 - (c) continue support with targeted interventions at critical developmental and transitional stages in the lives of children and young people so that the risk of drug abuse at any critical point is substantially reduced. The critical stages after early childhood are: school entry, transition to high school, and school leaving. Other life crises for families, like unemployment and divorce, will require appropriate

intervention,

- 1.5 Arrangements be made for the systematic and comprehensive sharing of data and research across Australia and overseas on prevention and early intervention. These arrangements should include:
- 1.6 Further research be conducted to identify ways of developing the social capital of communities, including the development of longitudinal studies on the social capital of communities that can be reported annually to inform policy and practice.
- 1.7 Additional resources be provided to ensure adequate emergency and short-to-medium term accommodation for families and young people is equitably distributed across NSW.
- 1.8 A code of conduct be developed with the media to guide the reporting of issues about drug use and addiction, such as currently exists with the reporting of suicide.
- 1.10 There be an expansion of appropriate models of community drug action teams similar to those in the United Kingdom, Western Australia and Aboriginal controlled health services, to link primary carers and service providers in supporting young people at risk.
- 1.12 The policy framework should recognise the importance of common effort around agreed goals. It should provide leadership in promoting the values, attitudes, life skills and attributes which will prevent drug abuse. Those values will include a strong sense of community and care and respect for self and others.

Young People And Drug Abuse

The Summit recommends that:

- 2.1 It should be recognised that the reasons that young people use drugs are complex and varied, including the alienation of some young people from society and their belief that society does not value them. An effective response to illicit drug use by young people has to be a holistic approach as complex and varied as the needs it addresses. It must seek to prevent, minimise and manage harm caused by drug use and must be provided to and involve young people in the context of their family, peer group, school and community, and not in isolation from these factors.
- 2.5 There should be established a pilot program for a Children's Drug Court as part of the Children's Court system, to be adequately resourced for the treatment and rehabilitation of young people with alcohol and other drug problems.
- 2.6 There should be resources to provide additional alcohol and other drug detoxification, treatment and rehabilitation services for young people, both community based and residential. These services must also be available to

incarcerated drug offenders and continue after they leave the detention centre. They should be appropriately linked to mental health services.

- 2.11 There is a need for a continuum of government and non-government services for drug abuse including prevention, early intervention, detoxification, rehabilitation and follow up. These services should:
- (a) be accessible and timely,
 - (b) recognise the importance of assisting drug users and also their families,
 - (c) be youth acceptable, and
 - (d) look at the whole person's needs not just their drug addiction, including mental health, employment and accommodation.

Health Maintenance And Treatment Services

The Summit recommends that:

Service delivery

- 3.1 Service delivery for the treatment of substance misuse should operate within an integrated framework supported by a comprehensive range of services. These services should be available and readily accessible within all metropolitan, regional and rural geographic areas and indigenous communities.
- 3.2 These services would include assessment and referral, alternative pharmacotherapies, methadone and abstinence based residential and outpatient services, and alternative interventions which support the harm minimisation principle.
- 3.3 These services will reflect the quality needed to attract and where possible retain clients in treatment so that they receive the best treatment that can be offered supported by current research.
- 3.4 These services will be offered along a continuum which may include current interventions and the willingness to examine other options which are not part of current service delivery including within the correctional services system.
- 3.5 This will require:
- (i) ensuring the full range of treatment options is available to high need groups including prisoners, and
 - (j) increasing the number of detoxification places (including in prisons) and commensurately the number of rehabilitation places.

Role in health services

- 3.6 Drug dependency and misuse be recognised as major health issues. As such, the Summit encourages all health care providers to recognise that the provision of services to drug and alcohol dependent individuals is a core responsibility and should be integrated into their daily practice or business. A greater involvement of mainstream health providers, including Area Health Services and their hospitals and community services, general practitioners and pharmacists, will improve capacity to provide brief and early interventions and treatment and to thereby reduce drug use and harms associated with it.
- 3.7 To facilitate this:
- (e) medical practice in the drug dependency field should be recognised as a legitimate medical specialty with a training program, continuing medical education requirement and remuneration consistent with that status,
 - (f) general practitioners and pharmacists should be encouraged to assist with the methadone program, and

Quality

- 3.9 In recognition of widespread concerns over regulation, quality and accountability of clinics delivering methadone treatment, rapid detoxification and other drug and alcohol treatments:
- (a) regulatory standards be developed to oversee the operations of such clinics,
 - (b) these clinics be licensed, and
 - (c) the conditions of license include participation in a prescribed quality assurance program, adequate physical facilities, levels of appropriately trained staff, documentation of compliance with regulatory standards and jurisdictional guidelines, and documentation, monitoring and reporting of outcomes.

Health maintenance

- 3.10 Recognising that drug use is a chronic and relapsing condition, it be acknowledged that:
- (a) Drug users have a range of health needs in addition to treatment for addiction. These needs include access to comprehensive medical care, and psychological and social support.
 - (b) An individual's goals of treatment will vary at different stages of his or her drug use. Therefore a diversity of objectives, based on harm minimisation principles, and

ranging from safer drug use to achieving abstinence, is required.

3.11 To achieve this, there is a need for:

- (b) expansion of the needle and syringe programs, preferably incorporated with a broader range of health maintenance facilities,
- (d) open dissemination of information regarding resuscitation of overdose victims and increased availability of the reversal agent Naloxone in areas where drug users congregate

Community education

3.12 There is a need for greater public awareness about the nature of illicit drug use and its treatment. To achieve this the Government should support a community education campaign highlighting that:

- (a) drug addiction involves both medical and social issues, and that medical treatment must be linked with other forms of support if the successful, long term, rehabilitation of a drug addicted person is to occur,
- (b) addiction is a chronic, relapsing condition,
- (c) there is no single one-size-fits-all cure,
- (d) drug misuse occurs with varying levels of severity,
- (e) while abstinence is the desired endpoint, many users may require several attempts at cessation,
- (f) minimising harm to the community and the drug user during this process is a central part of drug treatment, and
- (g) a comprehensive range of treatment and health maintenance services is available.

Resourcing and accountability

3.13 Based on current unmet service demand and comparisons of funding levels with other States, there is a need to substantially increase current expenditure.

3.14 There is a need for greater transparency and accountability with regard to the size, funding and management of the illicit drug problem in NSW. To achieve this requires:

Medically supervised injecting rooms

- 3.15 The Government should not veto proposals from non-government organisations for a tightly controlled trial of medically supervised injecting rooms in defined areas where there is a high prevalence of street dealing in illicit drugs, where those proposals incorporate options for primary health care, counselling and referral for treatment, providing there is support for this at the community and local government level. Any such proposal should be contained in a local Community Drug Action Plan developed by local agencies, non government organisations, volunteers and community organisations. These should be submitted to full public and community consultation processes (such as those used in urban planning law) and preferably a local poll. They must be part of a comprehensive strategy for local law enforcement, health, community and preventative education initiatives.
- 3.16 Appropriate protocols for the exercise of police discretion be established within the Police Service to allow for the proper and effective operation of self administration facilities.

Breaking The Drugs And Crime Cycle

The Summit recommends that:

General principles

- 6.1 The Cabinet Office conduct a study into the need for whole of government co-ordination of drug services in order to achieve an integrated approach to combat the drug problem.
- 6.2 The development of drug law enforcement policies should:
- target solutions to specific problems,
 - reflect a commitment to evaluation of and full cost accounting of all programs, and
 - include an appropriate resource allocation 'mix' across a range of strategies.

Diversion

- 6.3 Existing research be reviewed to determine best practices in diversion, including the best point of intervention (for example, pre-arrest, post-arrest, pre-sentencing, first offence) to divert users into a treatment or diversion program. This review should include all existing mechanisms, including the use of Griffith bonds.
- 6.4 Existing police discretionary powers to caution minor drug offenders be identified, clarified and formalised, and public support demonstrated for the exercise of police discretion. There is a need to explore how police prosecutors, the Director of Public Prosecutions and the courts can exercise appropriate discretion to divert offenders from prosecution and custodial sentences.
- 6.5 The *Young Offenders Act 1997* should be amended to cover minor drug offences,

to allow warnings, cautions and conferencing.

- 6.7 In relation to minor drug offences involving cannabis (committed by juveniles or adults):
- (a) The police power to caution offenders be formalised and protocols developed to govern prosecutorial discretion. The protocols should be developed having regard to the following matters:
- the offender was found in possession of, or using not more than, a small quantity of cannabis, or in possession of items of equipment for cannabis administration,
 - the cannabis was held for personal use,
 - the offender admits to having committed the offence,
 - the offender consents to being cautioned, and
 - on receiving a caution, the offender is referred to an education or drug referral service.
- (b) There be a commitment to diversion of offenders to education and/or treatment before charge.
- (c) The Court's power to refer offenders to education and/or treatment be encouraged. The development of this policy should have due regard to the Victorian experience. The effectiveness of the use of police and prosecutorial discretion would be reviewed after two years based on criteria settled in advance.
- 6.9 There should be no gaol penalty for possession of cannabis, cultivation of a small number of cannabis plants or the possession of implements used to administer the drug. Custodial penalties should be removed for the following offences:
- (a) possession and use of not more than small quantities of cannabis,
- (b) possession and cultivation of not more than small quantities of cannabis plant,
- (c) possession of items of equipment for use in the administration of cannabis, and
- (d) sale, supply and display of water pipes.
- 6.10 An adult conferencing program be established in relation to drug-related and non-violent offences and evaluated after two years. This program should have the following features:
- (a) there should be discretion as to whether conferencing is appropriate,
- (b) the offender must admit the offence and consent to their participation in the program,

-
- (c) the victim should have a full right to participate in conferences and development of the ‘outcome plan’, and
 - (d) the victim should have the right to veto the ‘outcome plan’.
- 6.11 The current Drug Court trial be expanded to be available at other venues in NSW and the Children's Court be given comparable diversionary powers to the Drug Court.

Self administration and use of equipment

- 6.12 Section 11 of the *Drug Misuse and Trafficking Act 1985*, dealing with use or possession of equipment for use in the administration of a prohibited drug, should be repealed.
- 6.13 Section 12 of the *Drug Misuse and Trafficking Act 1985*, dealing with self administration of a prohibited drug, should be repealed.

Drugs In Correctional Centres

The Summit recommends that:

- 7.1 Subject to continuing evaluation and analysis of needs, the Drug Court should be expanded and include juvenile offenders.
- 7.2 The Department of Corrective Services investigate the circumstances under which a greater proportion of drug affected offenders may be referred to the probation and parole service for evaluation for suitability for home detention, in the context of enhanced case managed treatment and support and supervision by government and non-government agencies.
- 7.6 The range, effectiveness and cultural sensitivity of alcohol and other drug services and programs for juvenile detainees, including the provision of designated detoxification beds at larger juvenile remand centres, should be reviewed and evaluated by a panel including representatives of the Department of Juvenile Justice and the Department of Health. The recommendations of the report on the detection and management of illicit drugs in juvenile detention centres (the DAMOID Report) are noted.
- 7.9 The Department of Corrective Services should implement a pilot scheme to establish drug free zones as a program option within the correctional system. Such a program should operate on a principle that inmates enter into a contract to avoid drug-using behaviour and to participate in programs that will assist their eventual integration into the community.
- 7.10 Because the risk of recidivism and relapse is much higher among released

drug-affected offenders who have not entered community programs, greater emphasis should be placed upon measures for closer co-operation between government and non-government agencies to ensure continuity of care, treatment and rehabilitation both before and after the release of inmates from prison.

- 7.12 An advisory body to the Premier and Ministers be established, comprising high level independent experts to review policy and to advise on strategic direction and other drug related initiatives. The Chair should be a non-political, distinguished and highly respected legal or medical figure, appointed by the Premier after consultation with the Leader of the Opposition. The advisory body should include young people and/or a young offender.

Drugs And Community Action

The Summit recommends that:

Community education and information

- 8.2 There be a concerted campaign, based on best practice models to inform the community, especially local governments, parents, young and older people, and community organisations, about illicit drugs.
- 8.4 Support be given to the proposal in the Premier's 7 Point Plan for additional Community Drug Action Teams..

Community support and action

- 8.5 The importance of community support for a wide range of responses to the causes, incidence and harms of illicit drug use be recognised, and that communities be encouraged to make concerted efforts to raise awareness and take constructive action.
- 8.6 The need for a multi-faceted, collaborative and integrated approach to the causes, incidence and impacts of illicit drugs be endorsed. This should involve:
- (a) Each region or area providing a core or basic level of Drug and Alcohol services. Such programs can be provided through the public health system, community and welfare agencies, government and non-government agencies. They should be consistent with best practice standards, be properly supervised and include:

- assessment, counselling and referral,
 - case management,
 - detoxification - residential and non-residential,
 - residential rehabilitation programs (therapeutic communities),
 - methadone and opioid substitution programs (LAAM, buprenorphine),
 - early and brief intervention,
 - training and education,
 - prevention and community development programs, and
 - programs to address special needs groups like Aboriginal people, people from non-English speaking backgrounds, women and youth, for example specific detoxification for Aboriginal or Indo-Chinese youth.
- (b) More access points at a local level to maximise paths to advice and other services.
- (c) Central contact points to broker placement in rehabilitation facilities.
- (d) Additional treatment and post-detoxification places, especially for adolescents.
- (e) Greater use of peers as a positive means of reducing harmful behaviours.
- 8.7 Local Community Drug Action Plans be developed with local agencies, non-government agencies, volunteers, residents and community organisations, using the combined resources of Local and State Government. These should be submitted to full public and community consultation and negotiation processes (such as those used in urban planning law). These negotiated plans may include all lawful options as part of a comprehensive strategy for local law enforcement, health, community and preventative education initiatives. The Government should consider any legislative amendments needed to facilitate such plans.

Drugs And Law Enforcement

The Summit recommends that:

Community expectations regarding drugs and law enforcement

- 9.1 There be a review of current policies and development of new policies to address the issue of community fear associated with reporting drug crime, including such factors as fear of retaliation and not wanting to be identified.
- 9.2 The community be informed of law enforcement issues associated with perceived delays in acting on complaints about drug crime and specific acts of drug-related criminal behaviour.
- 9.3 Community knowledge and debate be promoted about police powers concerning drug use and drug-related crime.

- 9.4 Law enforcement approaches to address drug use and drug-related crime in other communities internationally be identified, monitored and reviewed, and the efficacy of adopting similar law enforcement approaches in New South Wales be assessed.
- 9.5 The object of drug legislation and policing should be the reduction of the aggregate social harm caused by drug use.
- 9.6 Consideration be given to the feasibility of having legislated principles to guide police in the exercise of their discretion in relation to illicit drug enforcement.

Harm prevention, crime prevention and illicit drugs

- 9.7 Action be taken to ensure better co-operation between law enforcement bodies and agencies in the health and social services sectors, with particular regard to:
- (a) developing a whole of government approach that incorporates community participation,
 - (b) confirming the role of the police and courts in addressing the social and criminal effects of drug use,
 - (c) providing education, health and social support services aimed at preventing people from commencing drug use,
 - (d) providing adequate drug treatment services to assist drug users to overcome their addiction,
 - (e) clarifying the responsibilities of different agencies in the delivery of these programs and services, and
 - (f) providing information as to the availability of drug treatment and rehabilitation services to police, the medical profession, and the courts (e.g., through the Computerised Operational Policing System, the Judicial Information Reporting System, mechanisms within the Division of General Practitioners, internet sites, and so forth).
- 9.8 It be recognised that there is inadequate research in crime prevention and mitigation, and that collaborative research should be undertaken into:
- (a) economic models of the drug industry investigating such aspects as the price sensitivity of demand of drugs,
 - (b) cost-effectiveness of incarceration and incarceration alternatives,
 - (c) background of incarcerated prisoners as part of a prospective look at outcomes to see where interventions would be most cost-effective,

-
- (d) delivery of methadone or similar substitutes, and
 - (e) cost effectiveness of different law enforcement, prevention and treatment strategies to reduce drug-related harm.
- 9.11 The NSW Police Service develop an explicit set of performance indicators for drug law enforcement and annually report on performance against these indicators.

Law enforcement strategies

- 9.12 The provisions of the *Bail Act 1978* be reconsidered, with particular reference to the types of conditions that may be attached to the granting of bail (including, for example, coercive rehabilitation) in order to provide opportunities for diversion into treatment programs and to remove recidivist offenders from the community.

Legislation relating to drugs and law enforcement

- 9.15 The law relating to electronic surveillance, listening devices, search warrants and controlled operations be urgently enhanced to assist police in quickly targeting drug traffickers.
- 9.17 That there be a trial and evaluation of a children's drug court.
- 9.18 A broad range of diversion programs for drug users be developed, supported and evaluated. This should include consideration of the efficacy of using Griffith bonds and suspended sentences in conjunction with appropriate treatment programmes where deemed necessary as a diversionary treatment option for drug users and drug related crimes.
- 9.22 Legislation dealing with the confiscation of the proceeds of crime be reviewed to maximise the impact on drug derived assets.
- 9.23 Money laundering provisions be tightened through representations to the Commonwealth and through State measures which attack assets in the names of persons other than the beneficial owner.
- 9.24 A review be undertaken of all the legislation relating to police powers in drug law enforcement to remove any ambiguities which may impede effective police action.

Drug Education In Schools And The Community

The Summit recommends that:

Curriculum

- 10.2 All Government, Catholic and Independent schools should continue to expand and enhance the drug education programs in Personal Development, Health and Physical Education in kindergarten through to year 10, and years 11 and 12, with particular attention to the following considerations:
- (b) the specific provision of drug education must begin in the early years of primary schooling.
- 10.5 For the reasons given in 10.4 there should be:
- (a) development of whole school programs from kindergarten through to year 12 to build confidence, resourcefulness and inner strength in all young people; to assist them to form strong and enduring relationships during and beyond their years at school; to foster their skills, talents and interests, and give them pride in their capabilities and achievements; and to build a foundation for a life-long perception of self-worth,
 - (b) further development of peer support programs, nurturing programs and referral services, so that young people might at all times 'connect' to their peers, to adults whose support they value, and to assistance as and when required,
 - (c) continued targeting of resources to address under-performance in literacy, numeracy and personal development, in both primary and secondary schools,
 - (d) establishment of educational institutions and campuses at senior secondary level to provide a learning environment appropriate to young adults and the full range of curriculum in both general and vocational education,
 - (e) greater provision and recognition of vocational education and training in the Higher School Certificate by all Government, Catholic and Independent secondary schools, so that students completing Year 12 might also complete part or all of a traineeship within the Higher School Certificate while also being able to enter university, and
 - (f) removal of restrictive practices which inhibit growth in the number of apprenticeships and traineeships.
- 10.7 All Government, Catholic and Independent schools recognise and act upon their potential for the provision of information and education programs on drugs and drug advice to parents and to the general community.
- 10.8 All parents (as well as their children) be provided with accurate, credible and relevant information on the identification and effect of all drugs currently available within the community.
- 10.9 Information programs be conducted for parents, setting out details of the schools drug education program and advising parents on their own roles in supporting their

children.

Drugs In Rural And Regional NSW

The Summit recommends that:

General

- 11.1 A review group be formed to meet six-monthly and monitor progress of the NSW Drug Summit outcomes, with a specific brief to overview adequacy and equity in country areas.
- 11.2 The existing Ministerial Advisory Committee on Tobacco, Alcohol and Other Drugs (or any future similar advisory body) include regional, rural and remote representation of at least two positions and further that the Committee develop regional, rural and remote specific strategies to implement policy.

Local community strategies

- 11.10 Drug Action Teams, comprising key agency regional managers and service providers, be extended across regional NSW and operate through the Regional Co-ordination Management Groups established as part of the Premier's Department Regional Co-ordination Program.

Equity and Resources

- 11.11 (a) Expenditure benchmarks for drug and alcohol services be set for Area Health Services after budget shortfalls and inequities have been addressed.
- (b) Additional funding be allocated to allow Area Health Services to meet benchmarks.
- (c) In setting benchmarks, local community groups and health professionals be consulted and consideration be given to all available data, including research by the Network of Alcohol and Drug Agencies (NADA).
- (d) Drug and alcohol services funding be clearly identified and performance evaluated.

Law Enforcement

- 11.25 Police resources are not re-allocated from rural and regional NSW to high demand metropolitan areas.
- 11.28 Diversion programs and a flexible drug court approach be introduced to regional NSW.

- 11.31 In order to keep family and social networks intact, strategies be developed to ensure that rural and regional families have reasonable access to family members in prisons. Such strategies should include consideration of transport issues and prison locations.

5 RESPONSES TO THE DRUG SUMMIT

Reactions to the resolutions adopted at the Summit were mixed, despite the level of unanimity which appeared to exist. Many media commentators expressed surprise that the majority of recommendations, including some quite radical proposals, were passed with such overwhelming support.²⁶ Sentiments expressed by various stakeholders following the conclusion of the week-long Summit indicated, however, that reactions were mixed. Some of those who saw the recommendations as positive included: the New South Wales Council of Social Services (NCOSS); the New South Wales Law Society; and the Australian Medical Society (AMA).

The Director of NCOSS, Mr Gary Moore, wrote:

The Drug Summit has produced sensible and progressive reforms which augur well for the individuals and communities affected by drug use. NCOSS is delighted that the Premier took the courageous step of supporting the trial of safe injecting rooms. There is no question that this will save lives. However, we will be looking to the upcoming State Budget for a credible increase in drug treatment funding to address the enormous shortfall in services available to drug users. NCOSS has been consistently arguing for additional resources for unmet need, and it is positive to finally see public recognition that existing services just don't have sufficient funding to respond to the many people seeking help. A \$15 million top up of the current \$70 million per year spent on non-government drug and alcohol treatment services would be a good start.

The emphasis on prevention strategies is welcome but needs to move beyond rhetoric to resources on the ground. *Families First* is one element, but we desperately need a network of adequately funded family support services employing specialist, trained staff, to tackle families with high levels of complex needs. A further \$5 million in the 22 June State budget would assist. And the Government should consult widely about plans for a Foundation to improve children's well-being in the first three years of life.

Changes to cannabis laws, and the decriminalisation of self-administration and possession of injecting equipment, will assist in keeping young people from inappropriate contact with the criminal justice system. The direction of some matters to the highly regarded Youth Conferencing Scheme is also welcome. Once again, new funds must accompany this proposal.

²⁶ 'The drug trade off', *Sydney Morning Herald*, 22 May 1999.

The Drug Summit process has proved that it is possible to get genuine progress on a critical social issue among people passionately holding strong and opposing views. It is now up to the Carr Government over the next six weeks to demonstrate how well it can plan to put the Summit's recommendations into practice.

A number of areas in which the Summit made positive recommendations, were identified in an earlier joint protocol between the NSW Law Society and the State AMA, which adopted the principle that the results of drug abuse are mainly health and social rather than criminal issues. Among the issues contained in that document were: the scrapping of criminal penalties for possession and cultivation of small quantities of cannabis; a review of the performance of needle-exchange programs; the conducting of clinical trials in which cannabis is made available to people with terminal illnesses; an examination of overseas research on safe injecting rooms; the doubling of government funding for drug treatment and detoxification from \$70 million a year; and giving prisoners the same treatment and rehabilitation options as other addicts.²⁷

Reverend Ray Richmond, who was responsible for the opening of the T-room in the Wayside Chapel indicated his support; and Mr Paul Nicholau, chairman of the Ethnic Communities Council, said he welcomed the forthcoming consultation with ethnic communities.²⁸

Police: The President of the Police Association, Mr Mark Burgess, indicated that his 13,000 strong union was cautiously open to reform of the State's drug laws. He said that like the general community, the police force had come to an understanding that:

drugs were no longer just a law and order issue but a significant health issue too. The NSW Drug Summit had shown that there was now a need for co-operation, not just competition and that debate on reform, backed by community support, would not be rejected. But ... change needed to be based around diversionary issues, keeping kids outside the criminal justice system and ensuring rehabilitation. Most police have an open mind themselves. In areas like Byron Bay, Lismore they have an open mind because areas like that have significant drug problems.²⁹

Teachers: In keeping with the Summit's recommendations, a new Personal Development, Health and Physical Education course is to be introduced into schools aimed at kindergarten to Year 6 students providing an early introduction to drug education and the dangers of illicit drugs. But given the sensitivity of drug issues, schools would be expected to consult parents about how much, and at what age, primary pupils should learn about illicit drugs.

²⁷ 'Doctors, lawyers unite on drug use', *Daily Telegraph*, 15 May 1999.

²⁸ 'Success hailed on all sides', *Sydney Morning Herald*, 22 May 1999.

²⁹ 'Police back drugs reform', *Sydney Morning Herald*, 28 May 1999.

The President of the NSW Federation of Parents and Citizens, Ms Beverly Baker, said parents might well be concerned about students getting such information.³⁰

For the more conservative participants, including the Salvation Army's Major Brian Watters, Mrs Angela Wood, whose daughter had died from an ecstasy overdose, and Mr Normie Rowe, who had family experience of heroin addiction, the only approach that drug policy should adopt is to halt supply and imports of drugs, to maintain visible, high-profile policing and to enhance drug treatment and rehabilitation facilities. Major Watters said:

It seems to me that there is a fundamental issue of difference as to the best way forward. On the one hand, there are those who believe in treatment leading to a drug-free status and, on the other hand, those who call for drug law reform and acceptance of the inevitability or even the normality of illicit drug use ... I believe heroin injection rooms are a negative response to the problem.³¹

An informal alliance of conservative church leaders, parents, councils and academics, including Major Brian Watters, Sydney barrister Ross Goodridge, and anti-cannabis campaigner Dr John Anderson, have launched an 11th hour campaign against any relaxation of drug laws consisting of lectures, public statements and rallies in a bid to shift public opinion as the NSW government prepares its formal response to the Drug Summit recommendations. The groups, all opposed to so-called harm minimisation strategies are fighting the agenda of reform, which includes a police caution system for personal use of cannabis, and the trial of medically supervised injecting rooms.³²

Coalition parliamentarians: Following the conclusion of the Summit, the Prime Minister, commented that the Summit had been pressured into recommending changes as a result of the recent trial of the Wayside Chapel's injecting room and he expressed concern that NSW would become a magnet for drug addicts if the proposals to relax the drug laws radically were adopted. The leaders of the NSW State Coalition Opposition maintained their opposition to injecting rooms and relaxing cannabis laws. Mrs Chikarovski also criticised the government for failing to support an amendment to treble funding for rehabilitation and treatment. She also backed the recent warning by Mr Howard, that NSW could become the drug capital of the southern hemisphere.³³

Councils: Almost 50 councils will form an Australian wing of European Cities Against Drugs, the powerful anti-drug Coalition that fears Sydney is poised to become 'the next Amsterdam'. The move is designed to block any moves by the Carr government to allow heroin shooting galleries as recommended by last month's drug summit. The chairman of

³⁰ 'Dangers of drugs to be stressed in schools', *Sydney Morning Herald*, 31 May 1999.

³¹ 'The drug trade off', *Sydney Morning Herald*, 22 May 1999.

³² 'Backlash to drug reform ... takin' it to the streets', *Sydney Morning Herald*, 17 June 1999.

³³ 'Chikarovski steps up the pressure on drug laws' *Sydney Morning Herald* 21 June 1999

Australian Cities Against Drugs (ACAD), Mr Ross Goodridge, said many NSW mayors shared the fears of their European counterparts. Mr Goodridge said 46 councils had already agreed to join the Australian wing, and that more were expected ahead of its formal launch in August. He said councils feared the State government would try to force communities to allow injecting rooms in their area. Anti-drug campaigner, Mr Tony Wood, whose daughter Anna died in 1995 at the age of 15 after taking ecstasy, strongly supported the Europeans' warning. Mr Wood who is working with Mr Goodridge on the formation of ACAD said the drug summit proposals were 'a form of surrender'.³⁴

Responses to injecting rooms: In relation to recommendations that medically supervised injecting rooms be trialled in communities where there was local support, the following points of view have been made:

Although a survey of Kings Cross residents, commissioned by NSW Health, shows a majority support the trial of heroin injecting rooms in their local area (in the past two years support for such a trial has increased to 76%) many local government areas are not willing to endorse such a trial. The Mayor of Fairfield, Councillor Chris Bowen, has ruled out such a trial for Cabramatta and indicated that no development application for an injecting room would be approved by his council, although no poll has been conducted of that community's residents to gauge their opinion on such a step.³⁵

A number of other mayors throughout NSW have voiced reservations about allowing injecting rooms into their areas. The Mayor of Dubbo and State MP, Councillor Tony McGrane, said any application to get a room in his area had a '100-1 against' chance of succeeding. The Mayor of Lismore, Councillor Ros Irwin, said any application to have an injecting room in Nimbin, another drug hotspot, would face strong opposition from sections of the community and councillors. However, the President of the Local Government Association, Councillor Peter Woods, accused those opposing the injecting rooms of hysteria. He said: 'it may be that the initial trialling of injecting rooms would include only 2 or 3 rooms, and no-one is pushing for them to be introduced in every community across the State. There should be a trial of safe injecting rooms in the areas where local government and their communities support the trial.'

The Mayor of Bathurst, Councillor Ian Macintosh, said his council would probably look at what nearby centres such as Lithgow, and Orange were doing if faced with a development application for an injection room. The Lord Mayor of Newcastle, Councillor Greg Heys said, with 35 young people dead from overdoses in his city last year, there might be community support for an injecting room. South Sydney's Mayor, Councillor Vic Smith, said he would welcome an injecting room into his area, and Cambelltown's Mayor,

³⁴ 'Councils unite in drug pact' *Daily Telegraph* 16 Jun 1999

³⁵ 'Kings Cross for heroin rooms', *The Australian*, 25 May 1999.

Councillor Paul Sinclair, said councils should think responsibly on the issue.³⁶

And a Supreme Court judge, Justice Robert Hulme, wrote in a letter to Mr Carr and the Opposition Leader, Mrs Chikarovski, that injecting rooms would attract drug addicted criminals and pose problems for the police and judiciary. He said it was 'inevitable' that drug dealers would establish themselves near injecting rooms, leading to logistical problems if police had to 'tolerate' these suppliers.³⁷

Responses to methadone clinics: Pre-empting the governments approach to methadone clinics and its review of the methadone administration system, a number of local councils have taken action to close such facilities in the wake of the Summit. On 27 May 1999, the Wyong Council bought out a lease on the oldest and largest private methadone clinic on the Central Coast, and said that any applications for a new facility, even in the specially zoned Wyong Hospital, would be rejected. It argued that resident complaints, combined with claims of rising crime rates in the area and the fact that private clinics are 'profit driven' should preclude methadone clinics in the area.³⁸

A day after this disclosure, the Salvation Army announced that it will take action in the Land and Environment Court after its plan to build a \$5 million, 40 bed drug rehabilitation centre was rejected by Newcastle Council. An alliance of 30 regional and city councils condemned news of the decision, carried 6-5 at a meeting this week despite support from council planners and the Labor Lord Mayor, Councillor Greg Heys. However, the head of the newly established conservative organisation, Australian Cities Against Drugs, Tamworth Deputy Mayor, Councillor Warren Woodley, called on the Salvation Army to move the project to another town in NSW.³⁹

Over the past few weeks a community backlash against drug treatment clinics has resulted in three Sydney clinics, in Merrylands, Fairfield and St Marys, either being closed or fighting for survival in court to overturn zoning or lease changes, and in Summer Hill, Ashfield Council is attempting to restrict a local clinic's hours and close it at weekends.⁴⁰

Cannabis potency: In response to an issue raised at the Summit that the potency of cannabis in Australia had increased by as much as 30 times, the Attorney-General called for submissions from experts on cannabis strength. Clearly relaxation of drug laws regarding personal use of marijuana would be less likely to occur if the drug were found to

³⁶ 'Mayors wary to commit over injecting rooms', *Sydney Morning Herald*, 25 May 1999.

³⁷ 'Injecting rooms big crime risk - judge', *Sydney Morning Herald*, 28 Jun 1999.

³⁸ 'Council pays out \$70,000 to close methadone clinic', *Sydney Morning Herald*, 28 May 1999.

³⁹ 'Salvation Army goes to court over drug clinic rejection', *Sydney Morning Herald*, 29 May 1999.

⁴⁰ 'Clinics make millions on methadone', *Sydney Morning Herald*, 9 June 1999.

have become more potent and perhaps more injurious to health. A report by the National Drug and Alcohol Research Centre was provided to the Attorney-General has debunked these claims. It says that Australian police forces do not test cannabis samples for potency but such tests in the United States have found only minor changes ... the most recent data collected in the US has revealed that, at most, cannabis seizures tested for potency have shown small increases in THC content from 2% to 3.4% in the two decades since 1980. The report concludes that while there is no evidence of 10 to 30 fold increases in cannabis strength, there is indirect evidence of a marginal increase. It states that: 'What may have changed in recent times is that more potent forms of cannabis such as 'heads' and 'hash' have become more widely available and more widely used among cannabis users.' and that data showing Australians have begun to try cannabis at an earlier age is a far greater problem than increased potency.⁴¹

Government response: The Premier, candidly described how the material put before Summit participants, particularly Justice Wood's graphic account of the cycle of drug dependence, jail, poverty and crime and the visit to a detoxification and rehabilitation centre, caused him to revise certain views. The 'weight of the scientific presentation' to the Summit, Mr Carr said, could not be overlooked in its potency to persuade him and other MPs that the arguments for alternative policies were worthy of at least serious consideration by his government.⁴² While none of the recommendations are binding on the government, it is faced with the challenge of deciding which, if any, recommendations it will implement and how this will be achieved. The Premier has said that a detailed action plan setting out the government's intentions will be released in response.

In answering a question put to him in Parliament on how the government would respond to the Summit resolutions, the Premier said, amongst other things, that:

Contained in the final communique are 172 resolutions. As Members are aware by far the majority of these resolutions enjoyed bipartisan support. Today I repeat the undertaking I gave at the end of the Summit: the government will examine all resolutions. To each proposal we will apply this test: whether it makes the drug problem better or worse in New South Wales, better or worse for the families of this State ... a process is in place for examining the Summit resolutions. I will chair a special drugs committee of Cabinet, whose members will be the Minister for Police, the Minister for Health, the Attorney-General, the Minister for Corrective Services, and the Special Minister of State. All matters raised at the Summit will be carefully considered over the coming weeks, including the issue of resources ... I can report to the House today that work has already begun on one important resolution. Members may recall that the Drug Summit Communique called for all drug programs, services and expenditure - in both government and non-government sectors - to be

⁴¹ 'Myth of potent cannabis exposed', *Sydney Morning Herald*, 19 Jun 1999.

⁴² 'Carr tells: my drug switch', *Sydney Morning Herald*, 22 May 1999.

regularly audited and evaluated. As the first step to this process Price Waterhouse Coopers has been commissioned to review and assess expenditure on drug and alcohol programs across the New South Wales government.

A strong theme to have emerged from the Summit is the value of channelling drug users into treatment and education programs. The expansion of diversion programs was also a key proposal at the special Council of Australian Governments meeting on drugs on 9 April ... This morning I was briefed by two senior government officials from Victoria ... Victoria diverts drug offenders at every point in the system, from moment of arrest through to assistance for inmates post-release. Of particular interest is Victoria's cannabis cautioning system implemented statewide by the Kennett government last year. Under this system first or second-time cannabis offenders are given a formal caution by police. The offender is given a phone number to call for further advice and information, and a warning from police that charges will follow if he is caught again ... This system applies only to individuals with small amounts for personal use. In a six month pilot scheme conducted in the outer suburbs of Melbourne, 97 people were cautioned. 80% of those cautioned were carrying less than 5 grams of cannabis. The recidivism rate was 5%. I was advised this morning that police involved in the pilot ... were unanimous in their support for the cannabis cautioning scheme.

On each of the resolutions put forward by the Summit we will seek further information. We will look carefully at the experience of other jurisdictions, as we are doing in this case. At the beginning of the Drug Summit the catchcry was courage. I still believe that courage is vital in this difficult area of drug policy. As we now work our way through the resolutions, equally important is another catchcry - caution. We will continue to adopt a cautious approach as we deliberate over the next few weeks.⁴³

On 22 June 1999 Mr Carr was asked for an update on the government's response to the Drug Summit. His reply was as follows:

... I can report today that a huge amount of work has already been done. Senior staff from the Police Service, the Attorney-General's Department, the Health Department and the Department of Education and Training have been seconded to the Cabinet Office to work solely on drug policy. The senior officers group is meeting regularly to analyse the final communique. Meetings are being held with chief executive officers to ensure input from the highest levels, and the Cabinet committee on drugs is shaping the final response.

⁴³Hon B Carr MP, *NSWPD* Legislative Assembly, 27 May 1999, pp599-600.

Meanwhile, consultation is continuing with experts and members of the community ... to each of the 172 resolutions the government is applying this important test: Are we confident that this will improve the current situation? The reason for applying that test is that we certainly will not risk making matters worse. The government's detailed response to the summit will be released in due course. However, I should like to make a number of key points today. First, I should like to refer to resources. Incorporated in the budget to be brought down today is the capacity to fund additional drug treatment services and programs. The money is there ... Second we continue to reject any proposal that could encourage a shift towards a drug-tolerant society. The government will do nothing to condone drug use.

... The government will release a full and detailed response to the resolutions from the Summit towards the end of July ... These are complex policy issues and that is why the government will take time to consult, to develop proposals and to finance them. As I stated in the seven point plan I took to the Council of Australian Governments meeting on drugs last April, an effective drug policy needs to focus on long-term solutions ... the government is constructing a coherent framework that will guide drug policy for a number of years. Clearly more work is required on some of the resolutions. I am not prepared to finalise the government's response until I am convinced sufficient work has been undertaken.⁴⁴

The Premier made it clear that there would be no funding squeeze for new drug services, and that the budget had the capacity to fund all recommended new drug treatment services and programs. The Treasurer, Mr Egan, said the Drug Summit recommendations would be funded either from this year's surplus (\$214 million) or the Treasurer's advance of \$160 million. He said: 'This Budget contains a further \$21.3 million over the next four years for new drug treatment services and harm minimisation measures announced before the election ... and includes provision for: \$2.4 million to expand the Community Drug Action team program, to improve co-ordination between agencies; \$9.7 million statewide for new drug and alcohol treatment services; \$1.8 million to expand GP-supported treatment programs; and \$2.8 million for an expanded home detoxification program. The largest proportion of expenditure has been targetted in the years 2001-2003.'⁴⁵

⁴⁴ Hon B Carr, *NSWPD*, Legislative Assembly, 22 June 1999, pp1053-1054.

⁴⁵ 'Cash ready for policy response', *Sydney Morning Herald*, 23 June 1999.

APPENDIX 1

*Long Term Solutions: A Seven Point
Plan for Action Against Drugs*

**Paper presented by Premier Carr
at the Premiers' Conference**

9 April 1999

LONG TERM SOLUTIONS - A SEVEN POINT PLAN FOR ACTION AGAINST DRUGS

The New South Wales Government considers there are seven key action areas with potential for long term innovative solutions in the battle against illicit drugs. There is no easy fix - solving the drug problems requires forward thinking, and ongoing commitment and hard work by all Governments and the community.

The 7 key strategic action areas for attacking the drug problem are:

Preventing Drug Abuse: Enhanced Prevention and Early Intervention

Targeted early childhood interventions in vulnerable and disadvantaged families and communities can make all the difference in equipping young people to resist drug abuse. This should begin before birth and be a top priority until the child is 3 years old.

Establishment of a new "National First Three Years Foundation" and expansion of the NSW Families First program across NSW would target these vulnerable children.

Key support must also continue at critical developmental and transitional stages in the lives of children and young people.

Fast-tracking of New Treatments: A National Scheme

The investigation, approval, and availability of new treatments like naltrexone, buprenorphine, LAAM, and others must be expedited to bring help as quickly as possible to those who want to leave their addiction behind. Much more work needs to be done to find ways of helping people, over time, to get off drug substitution programs such as methadone, and into healthy drug free lifestyles.

Better Service Delivery and Outcomes: A National Training Program

A new national training program is needed to properly equip health and welfare professionals with necessary expertise in providing treatment to drug and alcohol dependent patients. There is a need for more people with specialty in this area, for incentives for workers to become involved, and for minimum national standards.

Better Case Management of Drug Users

It is not enough simply to have access to the latest treatments. Drug users receiving treatment need to be supported in all areas of their lives. That means health needs coordinated with education, vocational training, housing, childcare and other services, including law enforcement and correctional services. This applies especially to former prisoners seeking to adapt to a drug free lifestyle after release.

Breaking the Drugs and Crime Cycle

Too many young people are being caught up in the justice system through experimentation and involvement in drugs. Commonwealth funding is needed to allow the nationwide establishment

of Drug Courts and other diversion schemes. These schemes need to link young people and their families with a comprehensive range of support services to assist in resolving drug problems. Youth unemployment is a critical causal factor in drug abuse that needs to be addressed at a national level.

Community Drug Action Teams

It is important to get organised at a state and national level. But what is also needed is people on the ground making sure that plans translate to action in local communities. Community Drug Action Teams will bring together local councils, local community groups, local business, local police, and State Government agencies to identify local drug problems, work out community based solutions and help deliver these solutions.

Defending our Frontiers: A National Strategy - (Disrupting And Reducing Supply)

100 percent of Australia's heroin and cocaine is imported across our borders. Cocaine looms as the next great threat. We have got to work together to keep drugs out, and we need committed Commonwealth resources.

NSW is better equipped than ever before to blitz drug dealing and drug crime within its own borders, but without enough Commonwealth resources committed to stopping drug imports at the borders, providing sophisticated intelligence, high levels of cooperation tackling whole drug trafficking networks from source to distribution, then NSW and other States are destined to fight a losing battle.

GENERAL PRINCIPLES

The seven key action areas are consistent with the agreed National Drug Strategic Framework. The New South Wales Government considers that the seven innovative action proposals will be far more productive if there can be national agreement on approaches in these areas; if there is greater national consistency in what are the agreed best outcomes of anti drug initiatives; and provided there is greater Commonwealth funding, coordinated with the needs and programs within States and Territories.

National Approaches:

All Australian Governments - Commonwealth, State, Territory and Local Governments - should be encouraged to increase the levels of co-operative and co-ordinated development, and implementation of initiatives and services in the fight against drugs.

National Consistency:

So far as is practicable there should be consistency in policy across Governments and services based on agreed and desirable outcomes. Commonwealth, State, and local policies should be consistent with the agreed National Drug Strategy agreed upon by Police and Health Ministers. There also needs to be more alignment between National, State and Local processes.

Improved Commonwealth Funding:

The recent increases in Commonwealth funding under the National Illicit drug Strategy are commendable, but further enhancements are needed in the areas of prevention, treatment, diversion, law enforcement and research if the States and territories are to be able to make any headway in tackling the increase in drug misuse, drug overdoses, the availability of drugs, and the threats posed by new drugs.

Commonwealth funding needs to be provided in accordance with State and Territory priorities, with funding allocation and management of services to remain the province of the States and Territories. It is particularly important that the States and Territories identify an agreed and consistent set of funding priorities, so far as practicable depending on the specific needs of each jurisdiction.

PREVENTING DRUG ABUSE: ENHANCED PREVENTION AND EARLY INTERVENTION

Objective:

Expand integrated family, community, child and youth support services to prevent drug use in vulnerable and disadvantaged families, with children, to strengthen those families, and to improve the life outcomes of those children and young people.

Expand intervention services which should be provided before birth and be a top priority until the child is 3 years. Support needs to continue with targeted interventions at critical developmental and transitional stages in the lives of children and young people so that the risk of drug taking behaviour at any critical point is substantially reduced.

Develop and promote of more effective education strategies across the country which lead to a reduction in drug use behaviour, especially by school aged children, and provide help as soon as a young person takes drugs.

Rationale:

Targeted early childhood interventions in vulnerable and disadvantaged families can make all the difference in equipping young people to resist drug use, as they grow older. Evidence has shown that young children in vulnerable families are at greater risk of developing drug addiction than members of the population as a whole.

Research shows that the first three years of a child's life are critical for developing their capacity to deal with the vicissitudes of life and to be a successful member of society.

Research also shows that the great majority of physical brain development occurs by the age of three. The negative impact of stress and trauma on brain function and the influence of early environment on brain development are long lasting - and its impact is felt across a number of domains including drug abuse, crime, mental illness and emotional difficulties.

Although there still needs to be a better understanding of why kids take drugs, evidence shows that certain risk factors, such as poverty, substance abuse within the family or poor parenting

skills, can be an indicator of future drug use and other forms of social dislocation.

Government interventions at critical transitional points when young people may be engaging in risky behaviour is therefore an important way of dealing with potential/actual drug abuse, and interventions to help homeless, unemployed, truanting or depressed young people may provide beneficial drug prevention outcomes.

Investments by Government, communities and business in prevention and early intervention programs can produce significant long term reductions in drug taking by young people, a whole range of positive social benefits, and significant long term financial savings for the whole community, by reducing future involvement in drugs and crime and increasing the social contribution made by these young people.

And evidence from the United States indicates that long term financial savings to combined Government jurisdictions - local, State, Federal - has in some programs, exceed short term cost of intervention programs by a factor of four.

NSW - What is being done:

Families First - This \$19M initiative is now being trialed within 3 areas of NSW: The Mid-North Coast, The Far North Coast and South West Sydney. Families First targets families with children under 8 years of age providing parents with regular support and help in the home from a visiting nurse after a child's birth and then regular visits from a trained volunteer. The Families First program provides a useful precedent model and NSW offer assistance and information on the program to other States in developing similar models.

It involves four types of services all based on parental choice and local neighbourhoods :

Early Childhood Health Visitors, Volunteer Home Visitors, Early Intervention Teams, and Local Development Programs which bring parents in local communities together.

The Family Volunteer Home visits component involves trained local experienced parents visiting families in their homes and helping to provide advice or assistance, such as advice on where to get help about medical or drug issues. The Early Intervention Teams come in where the families is having real difficulties, for example in dealing with drug problems and provides immediate assistance.

NSW also has a number of telephone counselling services to help people with drug related problems, including the Alcohol and Drug Information Service, Family Drug Support run by the Trimmingham Foundation, and Centacare which offers advice to parents about a broad range of issues.

Commonwealth - What is being done:

The Commonwealth has:

- ▶ funded the piloting of a home visitation scheme, Good Beginnings
- ▶ allocated \$17.5 million under the National Illicit Drug Strategy to establish a National School Drug Education Strategy

- ▶ released a report (in March) on Pathways to Prevention : Early Intervention and Developmental Approaches to Crime Prevention identifying risk and protective factors associated with anti social and criminal behaviour.

The Commonwealth should include the States in the development and delivery of these types of programs to ensure consistency with State based approaches.

What needs to be done:

Much greater Commonwealth funding for programs which strengthen vulnerable families with children as a means of preventing drug use by children and young people now and in the future is urgently required.

The Commonwealth should provide funding for State based programs like the **NSW Families First program** so that it can deliver much greater assistance to those in need, **particularly in rural and regional areas.** NSW is already investing \$48 million over the next four years to expand Families First statewide, and asks the Commonwealth for \$17.5 million over that period. That would pay for the entire cost of volunteer home visitation by Families First statewide, to be progressively introduced over that period.

A National First Three Years Foundation should be established. Governments and the community need to invest in long term solutions - and the best investment is made at the outset of a young child's life. The proposed Foundation would assist families with information about the first three years, and advise Governments and the community on ways to support the first three years, and on the impact of Government policies. \$10 million over three years is required, and it is recommended that the Commonwealth, States, Local Government, and the corporate and community sector jointly fund this initiative.

A National Children and Youth Help Line identified and funded as a national initiative, is required, funded by Commonwealth, State and Territory governments, so that young people anywhere in Australia, on a 24 hour basis, can get urgent telephone counselling about their problems, including drug problems. The existing Kids Help Line service operating out of Queensland can only answer 50% of the 25,000 calls. The total cost could be divided between all jurisdictions at about \$3 million annually, and could be funded for a three year period and then evaluated.

There needs to be better **sharing of data and research** across the country on prevention and early intervention services and programs. A national agreement and protocol for sharing existing data and research on early intervention services and programs should be drawn up, jointly, by the key Ministerial Councils (Ministerial Council on Drug Strategy, the Australian Health Ministers Conference, the Community Services Ministers Conference, and the Ministerial Council on Employment Education Training and Youth Affairs).

Information and Education About Drugs:

There needs to be a better articulation of the "harm minimisation" policy in drug strategies, to ensure a clearer understanding that it involves minimising harm to both the individual **and the community.**

An agreed national framework for community and school anti - drug information and education on drugs so that clearer and more effective messages about the harm of drugs are sent with consistent messages at national, state and local levels.

All Australian Governments should review current school based intervention programs and the efficacy/outcomes of current drug education programs.

FAST-TRACKING OF NEW TREATMENTS: A NATIONAL SCHEME

Objective:

To provide more treatment services and a more flexible treatment system that better enables drug abusers to leave their addiction behind by :

- ▶ expanding the range of drug substitution treatments available in health services, private practice and prisons;
- ▶ fast tracking the evaluation and introduction of new treatments such as buprenorphine, naltrexone and LAAM, and encouraging the Commonwealth to expedite the necessary approval processes;
- ▶ improve current drug substitution programs such as methadone treatment programs in all jurisdictions to encourage people to get off these programs and into healthy drug free lifestyles
- ▶ trialing of new treatment approaches and new treatment regimes. Emphasis on both innovative pharmacotherapy treatments and innovative behavioural treatments.

Rationale:

Demand on treatment agencies has increased well beyond capacity as the availability and demand for heroin, and now cocaine, has increased.

Drug overdose deaths continue to increase annually, and significantly.

Studies have shown that \$1 in treatment provides a return of up to \$7 to the community, mainly in reductions in crime.

Methadone maintenance has been the corner stone of treatment in the management of opioid dependency and studies show clearly that it substantially reduces the involvement of users in crime - moreover the better the quality of methadone management, the greater the levels of crime reduction.

But increasing numbers of new innovative approaches are becoming available to increase and improve the outcomes of drug treatment.

NSW - What is being done:

13,000 methadone places are provided in NSW - and this is increasing by 8% p.a.- but significant demand is unmet and resources are stretched - often methadone is dispensed without optimum support and counselling services. NSW is also the only jurisdiction which provides a methadone treatment program for prisoners.

35% of methadone treatments are provided through the public hospitals/clinics and 65% through the private sector (GP's, private clinics and pharmacies). 17- 18 % of pharmacies provide methadone - a rate similar to Victoria and Queensland.

Greater participation by pharmacies and GP's in dealing with "stabilised" patients, would enable the public sector to deal with some of the unmet demand from new and difficult clients.

Methadone services have been reviewed and action is being taken to refine and improve delivery programs. Naltrexone (Rapid Opiate Detoxification) and buprenorphine trials have been funded and are underway. An additional \$16.4m will be spent over the next 4 years to expand treatment services.

Commonwealth-What is being done:

The Commonwealth Government provides funding for the cost of the methadone drug in NSW - but not for the cost of delivery and associated services - except insofar as costs are borne by the Medicare system where GPs are dispensing the methadone. Drug users are required to pay a small fee when accessing their methadone through the private sector - but not in the public hospital system.

However it is understood the Commonwealth is trialing a "Medicare cap" in relation to methadone patients receiving treatment from GPs, which would mean that GPs would get one lump sum each year for methadone treatments. It is understood Victoria is opposed to this approach, as it may have adverse treatment implications.

The Commonwealth has allocated \$50 million over four years directly to non government organisations (NGO) to establish and operate new programs and enhance existing programs. Most of these programs are based on the non-use of pharmacotherapies. \$4 million over 3 years nationally has been allocated to review, monitor and evaluate treatments.

A national project examining the health outcomes of a range of treatment modalities has commenced. \$1.3 million provided under NIDS to evaluate the effectiveness of treatment for opioid dependency. NDARC is doing this. NSW trials will be included.

What needs to be done:

A new joint \$100 million Commonwealth/State National Drug Treatments and Research Program, including pharmacological and behavioural treatment, should be established. The program requires:

Funding

New and significant Commonwealth funding is required to meet growing unmet demand for treatment places in the public health system and the private sector. NSW demand for methadone places is increasing by about 8 percent p.a. and increasing demand for alternative treatments, such as naltrexone and buprenorphine, are expected in the future.

A *Commonwealth commitment to fund* not only new abstinence based strategies (which is all that the National Illicit Drug Strategy funds) but also the new treatment strategies and appropriate support services linked to methadone management and management of methadone withdrawal.

Commonwealth agreement that funding for drug treatment programs in State jurisdictions should be on a co-operative basis based on **jointly agreed overall program** approaches, and on the basis of a clearly identified State/Territory needs assessment, so that funding is more effectively targeted and achieves better outcomes;

Fast Tracking

A commitment by all jurisdictions to fast track trials of innovative treatments

Faster Commonwealth Therapeutics Goods administration approvals for new treatments: Reckitt and Coleman have submitted an application for registration of buprenorphine, - approval should be fast tracked so consideration regarding listing on the Pharmaceutical Benefits Scheme can then be considered.

Faster Commonwealth listing of approved new treatments on the Pharmaceutical Benefits Scheme. For example, Orphan Australia, the Australian Distributor of Naltrexone, has indicated its intention to apply on 1 June 1999 for listing of that drug under the PBS, but that outcome will not occur until 1 February 2000 under current procedures. Orphan Australia have suggested this time frame could be reduced.

Some of the drugs now being trialed and submitted for approval have been canvassed as possible treatment options for more than 15 years - there should be an avoidance of any further delays so that flexible and more appropriate treatments for different classes of drug abusers can be provided as soon as possible.

Private Sector Involvement

Agreed approaches on private sector involvement in trials, evaluations, integrated service delivery, and accountabilities.

Encouragement of pharmacies and GPs to participate in all drug treatment programs at a national level backed up by appropriate support and a capacity to refer difficult clients back to the public sector. This is particularly important in rural and regional areas.

Treatment Delivery, Research and Trials

A cooperative National Research program on treatments and rehabilitation outcomes.

Promotion of trials in prisons of new and innovative treatment programs, and exchange of evaluation data between jurisdictions. In all jurisdictions very significant numbers of prisoners have been jailed for drug offences and there are significant opportunities during incarceration to promote a range drug treatment programs and reduce drug taking. These programs and trials also need to be linked with post release treatment services and probation and parole service outcomes.

Commonwealth funding for evaluation trials : naltrexone, buprenorphine, and other treatments, including trials in correctional institutions, linked to medical/counselling programs is essential.

Targeted population based treatment programs for young people, Aboriginal people, women, residents of rural and remote communities, and people from a Non English Speaking Background, which link the drug substitution programs and or behavioural programs with integrated multidisciplinary service provision programs.

The value of methadone as a stabilisation strategy is recognised but further development of programs to develop effective means of assisting people to get off methadone by additional support and counselling is required, and supplementation of current methadone services with counselling and multidisciplinary case management teams needs to be assisted through appropriate funding.

Growing polydrug use and the growing availability of cocaine as a cause of increased mortality and overdose, demands urgent and innovative treatment responses and funding for research.

Cannabis treatment programs, particularly for young people, need to be developed and funded as a matter of urgency, bearing in mind recent surveys indicating an increasing use of cannabis by young people.

Wherever practicable, providing services at needle and syringe exchanges which link the drug user to information, counselling, treatment and other rehabilitative services, including housing support services. Recent surveys have indicated up to 25% of opiate users may be homeless.

BETTER SERVICE DELIVERY AND OUTCOMES: A NATIONAL TRAINING PROGRAM

Objectives:

To provide better care and management of drug abusers across all service providers through development of a National Drug and Alcohol Training Program for all professionals working in the field.

Rationale:

Many clients are not receiving best practice care and management. Current service providers are not always sufficiently skilled in drug and alcohol management.

New South Wales is facing a critical shortage in medical and nursing drug and alcohol specialists; new services opening are unable to attract suitably qualified staff due to insufficient numbers.

Treatment and service providers need to be brought up to speed with the increasing range of treatment approaches available for drug users, and how they should best be delivered, including delivery in context of other support services.

NSW - What is being done:

Post-graduate courses in drug and alcohol counselling are available, along with TAFE courses including a Diploma or Certificate IV course in Community Services (Alcohol and other Drug Work) and specialist modules in diploma courses in Community Welfare and Youth Work, among others.

Some Area Health Service D& A Directors (e.g. Central Coast and South East Sydney) are running special drug and alcohol training for GPs within their areas.

Commonwealth - What is being done:

\$3 million has been allocated under NIDS to better train and equip front-line workers (including GPs, hospital staff and police officers).

The Commonwealth commissioned the National Centre for Education and Training on Addiction (NCETA) to undertake a scoping exercise to determine the focus and extent of training programs already being conducted for front line professionals and to identify the gaps in current activities across Australia. Following this scoping exercise, a list of recommendations and funding priorities for professional education and training has been compiled, but the recommendations have yet to be implemented. Specialist drug and alcohol areas to be targeted include dual diagnosis and working with youth.

What needs to be done:

The Commonwealth and States should develop a National Training Program for professionals working with drug clients and drug offenders. This should be jointly developed by Ministerial Council on Education, Employment, Training and Youth Affairs, and the Ministerial Council on the Drug Strategy. It should encompass and provide a national framework of training programs to :

- ▶ increase the level of specialisation in the drug and alcohol field and to improve the skills levels of health related staff in the drug and alcohol field.
- ▶ increase the level of drug and alcohol training provided for a range of disciplines in universities and colleges.
- ▶ significantly expand the number and range of practitioners in a variety of fields able to address drug and alcohol problems.
- ▶ Provide incentive for doctors and nurses to specialise in drug and alcohol.
- ▶ Provide broad based training in drug and alcohol for workers outside the health field including workers in the welfare, housing, education, (eg. School counsellors, law enforcement, corrections services, and in community organisations.
- ▶ Provide training for doctors, nurses and other professionals who may be dispensing new drug treatments such as Naltrexone, Buprenorphine or LAAM.
- ▶ Provide training in case management for professionals working in all areas in the drug and alcohol field.

BETTER CASE MANAGEMENT OF DRUG USERS

Objective:

To provide better and coordinated case management and broadening of services to help people

using drugs or at risk into healthy drug free lifestyles.

Rationale:

Drug users receiving treatment need to be supported in all areas of their lives. That means assistance with education and vocational training, housing, childcare and other services. This applies especially to former prisoners seeking to adapt to a drug free lifestyle after release.

The linkage between drug abuse and homelessness, for example, appears significant. One recent report has suggested that one third of homeless people in Sydney are dependent on or abuse drugs and one fifth are dependent on or abuse opiates.

The Commonwealth/State Coordinated Care Trials for the Frail Aged provides a good example of coordinated case management and cooperative pooling of funds to focus on the needs of a particular population group. The 11 trials around Australia pool funds from Medicare, MBS, PBS, HACC, hospitals and private insurance to provide delivery.

One key overseas model is the Netherlands "Social addiction care program". The program assists drug users to achieve a drug free lifestyle by addressing the social, economic and health problems they may be facing.

Key features of that program:

- ▶ a comprehensive assessment of each client entering treatment
- ▶ assessment of needs re housing, child care, employment, life skills training, and education and health based treatment
- ▶ provision of dedicated places in public housing employment, skills training, life skills and education programs for treatment clients
- ▶ a compliance contract between the client and the agency providers. Ongoing treatment is dependent upon the client undertaking the employment, education and training opportunities provided.

These types of programs would be of particular benefit to drug offenders in prison, representing 75% of NSW inmates, and drug offenders leaving prison and re-entering society, and those on community corrections programs, probation or parole.

NSW - What is being done:

Trialing Drug Courts. The NSW Drug Court is providing case management of drug offenders coming through the program and integrated service delivery. This is coordinated primarily by the Probation and Parole Service representative on the Drug Court team, with the drug offender being linked to programs operated by the Departments of Health, Housing, and Employment and Training, the Commonwealth Rehabilitation Service and NGOs.

Innovative and integrated state responses to localities with particular socio - economic problems, problems of drug abuse and high youth unemployment have been trialed through the "place management" approaches at Cabramatta, Redfern/Waterloo, Kings Cross, and Canterbury/Bankstown.

What needs to be done:

Innovative and Integrated Service delivery should be promoted, funded and enhanced in all jurisdictions as a means of dealing with the complex problems of people using drugs or at risk of drug use in all jurisdictions.

Better evaluation : All service delivery, whether by Governments or NGOs, should be more rigorously assessed against agreed outcomes than has been the case to date.

A National Case Management Program should be established by the Commonwealth to fund and promote :

- ▶ Cross sectoral team based approaches to case management
- ▶ Enhanced national approaches to innovative and integrated service delivery
- ▶ Co-ordinated care/case management trials and evaluations
- ▶ Customised and locally driven interventions across age, gender and locational dimensions
- ▶ Specific case management programs for drug offenders/misusers in prison, leaving prison, on probation/parole or on community corrections programs.

New integrated service delivery approaches for managing drug dependent mothers and fathers, and their children should be developed and funded co-operatively by the Commonwealth and the States, based on evidence of successful approaches in Australia and overseas, particularly as substance abuse is recognised as one of the two most important issues in child protection.

BREAKING THE DRUGS AND CRIME CYCLE

Objectives:

To help young people and young adults experimenting with drugs avoid being caught up in the justice system by linking them to other support services, assisting them into healthy drug free lifestyles, and assisting them with employment and training opportunities.

To reduce the level of drug related crime now and in the future, and to reduce the demand for drugs by these young people.

Rationale:

Too many young people and young adults are caught up in the justice system through early involvement in crime and drug use. There is an urgent need to address the underlying factors related to this outcome.

Youth unemployment is one of the most important causes, and must be recognised as a key factor in drug abuse - employment is therefore of critical importance in the treatment and prevention path. Other factors include: poor school performance, truancy, low levels of vocational skills, low self esteem, poor family relationships, mental health problems, boredom, and social dislocation.

The National Drug Strategy 1998/99 - 2002/3 also notes that low income and homelessness are

risk factors for harmful drug use. Similarly, the National Drug Strategy's "patterns of Drug Use in Australia 1985 - 95" noted that heroin users are predominantly male, unemployed and in their 20's. Unemployed and young are also characteristics found in amphetamine and cocaine users. Prima facie, there may be a decrease in drug use with a nationwide campaign targeting youth unemployment, particularly targeting areas with a known hard drug problem.

Interventions also need to be tailored to individuals as well as to specific populations, and to be closely linked to mental health strategies and suicide prevention. For example, US studies have shown that treatment is highly cost effective in tackling drug problems for heavy drug users, who consume a major share of the drug supply. Providing treatment for heavy drug users may have potential to significantly lower demand.

The Drug Court model is one example of a tailored intervention targeted at the more serious drug user. There is ample evidence from the United States of the efficacy of drug Courts in reducing drug related crime, rehabilitating drug misusers, and avoid costly incarcerations. (US studies have suggested Drug Courts can provide substantial savings in the criminal justice system - for every \$1 spent on the Miami Drug Court, it is estimated \$7 is saved.)

As a result, the US Federal Department of Justice contributed \$31.3 million to drug courts in state and local jurisdictions in the 1997 financial year, and has appropriated \$30 million for the 1998 financial year.

NSW - What is being done:

Unlike many other proposals regarding illicit drugs in this country, Drug Courts represent a genuine innovation which is neither speculative nor untested. The results that Drug Courts are able to deliver, however, depend heavily on the quality of treatment services and other support that they provide. The NSW Government is fully committed to the success of its drug court pilot, and has allocated \$12 million for a two year trial.

All States and territories should be encouraged to invest in this form of diversionary scheme, and it is imperative that the Commonwealth demonstrate national leadership on the issue.

The NSW Youth Conferencing Scheme also provides an ideal opportunity for early intervention and provides a mechanism for case management.

Commonwealth - What is being done:

In 1994 the Commonwealth National Drug Crime Prevention Fund commissioned a study of "diversion practice" by the Alcohol and Other Drugs Council of Australia. ADCA's report in 1997 recommended establishment of a "National Diversion Office" and a "National Diversion Fund", a "National Diversion Clearinghouse" and a funding for demonstration projects.

Little action appears to have flowed from these recommendations - other than a further examination of diversion practice by the MCDS and APMC.

What needs to be done:

The Commonwealth, States and Territories should develop a general diversion framework

targeting young people at all points in the criminal justice system, and providing for appropriate responses and management of at risk and vulnerable young people who may be using drugs, for example at the police level, in juvenile, youth or adult courts, in adult prisons, and in community corrections.

The Commonwealth should facilitate the establishment of a National Drug Court Network, including Juvenile Drug Courts, in each jurisdiction, with the Court and the additional treatment services required, funded jointly by the Commonwealth and the State or Territory on a dollar for dollar basis.

A National Youth Diversion Scheme should be established, funded by the Commonwealth to enable States and Territories to trial and evaluate targeted Youth Justice Diversion schemes linking at risk young people and young people using drugs with key support services, education services, training and employment opportunities.

Commonwealth and State Youth Diversion Schemes should particularly target areas of high youth unemployment, and should be linked with vocational education, and employment and training partnerships, and be evaluated on training, education and employment outcomes, as well as on crime reduction and drug use outcomes. Ideally they should also be linked with other support services such as housing and community services.

Prosecutorial Diversion Schemes should also be examined, and the Standing

Committees of Attorneys General should be asked to report on the effectiveness of these types of diversion schemes overseas.

COMMUNITY DRUG ACTION TEAMS

Objective:

To promote community based planning and collaborative action (mobilisation) on local drug issues, involving the local councils, community organisations, local businesses, and the local arms of State Government agencies through a network of Community Drug Action Teams in all jurisdictions.

A three year National Communities Drug Prevention Fund should be established to promote and assist these local problem solving teams across the country..

Rationale:

Community ownership and involvement in drug programs is essential. Flexible community based approaches enable a more effective targeting and pooling of available resources and are more likely to be sustainable, and resource efficient.

Drug use prevention and management needs to be tailored to the local area, taking into account local economic, social, environmental and cultural factors.

Both the USA (Community Coalitions) and the UK (Drug Action Teams) Governments have been promoting this model. In the US the aim is to build "community coalitions" to fight drug

abuse and develop new local initiatives to reduce substance abuse, particularly among youth. The US Government is providing \$20m for this each year for the next two years, rising to \$40m in 2001.

In the UK, Drug Action Teams are intended to be the main vehicle for ensuring local resource collaboration and joint action. The concept of community participation was also included in Victoria's Turning the Tide Report.

The National Drug Strategy Framework (1998/9 - 2002/3) identifies the building of partnerships between the three tiers of Government as a priority area for future action.

NSW - What is being done:

NSW is trialing Community Drug Action Teams in Fairfield and Redfern and is planning to trial additional teams in Dubbo and the Central Coast.

Broader local place management models to coordinate overall responses to strengthen local communities are also being encouraged through integrated place management projects in Cabramatta, Redfern, Kings Cross, Bankstown and Moree.

Commonwealth - What is being done:

The National Community Based Approach to Drug Law Enforcement Project has provided funding for trials of Drug Action Teams in Fairfield (NSW), Morwell (Vic) and Geraldton & Mirrabooka (WA). Evaluation is presently underway to assess the effectiveness of these trials.

\$4.8 million dollars of the total NIDS package has been allocated to fund community partnership initiatives.

What needs to be done:

All jurisdictions should promote the establishment of Community Drug Actions which:

- ▶ have good leadership
- ▶ broad inclusive membership
- ▶ build local partnerships
- ▶ have strong linkages to other local crime prevention, social development and employment initiatives
- ▶ link in with complementary Commonwealth and State initiatives, such as place management or regional coordination programs

The Commonwealth establish a specific National Communities Drug Prevention Fund to promote and assist local communities establishing Drug Action Teams. A budget of \$20 million over three years could prompt a significant local contribution in the fight against drugs.

Commonwealth, State and Territory arms of Local Government and Shires Associations should be asked to promote the establishment of these teams through local government.

DEFENDING OUR FRONTIERS: A NATIONAL STRATEGY (DISRUPTING AND REDUCING SUPPLY)

Objective:

To better resource, target and coordinate the defence of our frontiers in order to significantly reduce the quantity of illicit drugs coming into the country, and especially to prevent looming new threats such as cocaine and the use of new technologies which may facilitate trafficking and money laundering.

Rationale:

100% of heroin and 100% of cocaine in Australia is imported through our frontiers.

The limited effectiveness of law enforcement supply side initiatives to date must be recognised - about 90% of all drugs coming across our frontiers are getting in - police suggest only 10 % of imported drugs are intercepted, and even significant additional resources will not be able to achieve a radical change in this scenario.

NSW, especially Sydney, remains the favoured point of entry for heroin and cocaine, which represents 62% of all customs detections, 64% of the total weight of heroin detections, and 78% of the total weight of all cocaine detections in Australia. (Source : Australian Illicit Drug Strategy Report). The stabilising of demand for cocaine in US could also mean a higher targeting of the Australian market by cocaine traffickers. Amphetamine importation into Australia may also increase.

The 1995/96 Australian Illicit Drugs Report said "increased trade liberalisation in South east Asia with resultant expanding air and sea transportation routes, and the reductions in the number of Australian Customs service personnel at the barrier are also factors likely to facilitate the expansion of heroin trafficking in Australia."

Controls at the customs barrier are weak. In 1997, it was revealed that only 3 in every 10,000 cargo containers were searched by police and customs officials. In February 1998, the NSW Police Service advised that only 2% of all international flights entering Sydney are searched for heroin, cocaine and other illicit drugs. The ABCI has estimated that whereas Australian authorities search 0.03% of cargo entering Australia, the equivalent US figure is about 3%. That is, the US searches 100 times more incoming cargo containers on a proportional basis.

Commonwealth - What is being done:

The development of the National Heroin Supply Reduction Strategy and National Supply Reduction Strategy for Drugs Other than Heroin approved by the MCDS in 1998 provide a framework for national, coordinated and intelligence/technology based approach to supply reduction.

These strategies provide a good basis for a national approach to protecting Australia's borders

and with a commitment of funds, implementation could be fast tracked. The Commonwealth National Initiatives Drug Strategy restored some of the funding cuts to Commonwealth customs and law enforcement agencies but much more is needed.

What needs to be done:

The Commonwealth should make further strategic investments in defending Australian frontiers, to radically reduce supply coming into the country. In November 1997, the Federal Government restored \$43.9 million of \$110 million cut from Federal law enforcement agencies. In March 1998 another \$50 million was restored. A further \$100 million is required to further restore and meaningfully supplement previous budget allocations.

The Commonwealth needs to enhance our law enforcement capacities by :

- ▶ Increased funding for the Australian Federal Police
- ▶ Deployment of more AFP officers overseas to give Australia a greater intelligence presence at the source of drug imports
- ▶ Refocussing the NCA to make it a more effective operational law enforcement body, in line with the findings of the Parliamentary Joint Committee.
- ▶ Strengthening Interpol and other international law enforcement links to counter the international drug trade
- ▶ Promoting greater numbers of joint State and Federal task forces targeting drug traffickers - such as the Joint Federal/State Task force on Asian Crime Group in NSW.
- ▶ Promoting, with the States and Territories a "seamless web of investigations" by law enforcement agencies so that entire drug trafficking import and distribution networks are taken out in a coordinated way - and not just parts of the network

The Commonwealth need to stop more drugs at the border by :

- ▶ Increased funding for Customs Service so it can increase inspection rates and interception rates to US standards.
- ▶ Improved profiling to identify cargo likely to be concealing drugs
- ▶ Increasing the number of random searches of cargo and passengers
- ▶ Increase the number of drug detection dogs at international airports
- ▶ Strengthen air and sea surveillance resources around the coastline

The Commonwealth also needs to help States prevent drug trafficking and the violence associated with high level trafficking by :

- ▶ Closing loopholes in Commonwealth regulations governing firearms and prohibited weapons to reduce access to these weapons by drug traffickers
- ▶ Increasing the penalties associated with illegal imports of firearms, pistols and prohibited weapons into Australia - which are currently no different from smuggling any other illegal import
- ▶ Examine the current laws governing deportation of drug traffickers who are not citizens so that high level drug traffickers are automatically deported
- ▶ Investigate the possible capacity for drug trafficking and money laundering through the Internet and E Commerce
- ▶ Expanding Commonwealth powers to confiscate the assets of drug traffickers to the

standards set in NSW legislation.

The MCDS and the APMC should be asked to :

- ▶ expedite implementation of the National Heroin Reduction Supply Strategy and the National Supply Reduction Strategy for Drugs Other than Heroin;
- ▶ Urgently develop specific supply control strategies related to the looming threat of cocaine and amphetamines imports;
- ▶ Report annually on the effectiveness of the strategies, particularly in outcome terms, the resourcing requirements of the strategies and on any delays in implementation, to the Leaders Forum and COAG;

The Commonwealth, States and Territories should cooperatively promote the development of a single national crime database on the drug trade and the APMC should be asked to develop a proposal for action within 12 months.

A national cooperative drug surveillance system should be fast tracked and established as soon as possible. The MCDS should report on this matter to COAG at the next meeting of COAG.

Preventing Drug Trafficking and Money Laundering:

States and Territories recognize that the National Illicit Drug Strategy (NIDS) is providing funding for an Asia Pacific Money Laundering Secretariat, and for other anti tax evasion and money laundering initiatives.

However States and Territories have noted recent concerns expressed regarding the potential for possible misuse of new E Commerce and internet technologies, particularly as a potential means for E-commerce trade in drug and laundering of criminal profits through international transactions across the Internet.

The States and Territories urge the Commonwealth to investigate safeguards to prevent the misuse of such technologies, to develop appropriate means of investigating and prosecuting drug traffickers who use these technologies, and to establish appropriate cooperation with other countries whose citizens may be involved from offshore in crime in Australia.

APPENDIX 2

NSW Drug Summit 1999

Participants

MEMBERS OF NSW PARLIAMENT

Members of the Legislative Assembly

Allen MP, Pam
Amery MP, Richard
Anderson MP, James
Andrews MP, Marie
Aquilina MP, John
Armstrong OBE, MP, Ian
Ashton MP, Alan
Barr MP, David
Bartlett MP, John
Beamer MP, Diane
Black OAM, MP, Peter
Brogden MP, John
Brown MP, Matthew
Burton MP, Cherie
Campbell MP, David
Carr MP, Robert J
Chikarovski MP, Kerry
Collier MP, Barry
Collins QC, MP, Peter
Crittenden MP, Paul
Debnam MP, Peter
Debus MP, Robert
Face MP, Richard
Fraser MP, Andrew
Gaudry MP, Bryce
George MP, Thomas
Gibson MP, Paul
Glachan MP, Ian
Greene MP, Kevin
Grusovin MP, Deirdre
Harrison MP, Gabrielle
Hartcher MP, Christopher
Hazzard MP, Bradley
Hickey MP, Kerry
Hodgkinson MP, Katrina
Humpherson MP, Andrew
Hunter MP, Jeffrey
Iemma MP, Morris
Kernohan MP, Elizabeth
Kerr MP, Malcolm
Knight MP, Michael
Knowles MP, Craig
Lo Po AM, MP, Faye
Lynch MP, Paul
Maguire MP, Daryl
Markham MP, Collin
Martin MP, Gerard
McBride MP, Grant
McGrane OAM, MP, Tony

McManus MP, Ian
Meagher MP, Reba
Megarrity MP, Alison
Merton MP, Wayne
Mills MP, John
Moore MP, Clover
Moss MP, Kevin
Murray MP, John
Nagle MP, Peter
Newell MP, Neville
Nori MP, Sandra
O'Doherty MP, Stephen
O'Farrell MP, Barry
Oakeshott MP, Robert
Orkopoulos MP, Milton
Page MP, Donald
Page MP, Ernie
Piccoli MP, Adrian
Price MP, John
Refshauge MP, Andrew
Richardson MP, Michael
Rozzoli MP, Kevin
Saliba MP, Marianne
Scully MP, Carl
Seaton MP, Peta
Skinner MP, Jillian
Slack-Smith MP, Ian
Smith MP, Russell
Smith MP, Wayne
Souris MP, George
Stewart MP, Anthony
Stoner MP, Andrew
Thompson MP, George
Tink MP, Andrew
Torbay MP, Richard
Tripodi MP, Joseph
Turner MP, John
Turner MP, Russell
Watkins MP, John
Webb MP, Peter
Whelan MP, Paul
Windsor MP, Antony
Woods MP, Harry
Yeadon MP, Kim

Members of the Legislative Council

Breen MLC, Peter
 Bull MLC, Richard
 Burgmann MLC, Meredith
 Burnswood MLC, Jan
 Chesterfield-Evans MLC, Arthur
 Cohen MLC, Ian
 Corbett MLC, Alan
 Della Bosca MLC, John
 Dyer MLC, Ron
 Egan MLC, Michael
 Forsythe MLC, Patricia
 Gallagher MLC, Michael
 Gardiner MLC, Jenny
 Gay MLC, Duncan
 Hannaford MLC, John
 Harwin MLC, Don
 Hatzistergos MLC, John
 Jobling MLC, John
 Johnson MLC, John
 Jones MLC, Richard
 Jones MLC, Malcolm
 Kelly MLC, Anthony
 Lynn MLC, Charlie
 Macdonald MLC, Ian
 Manson MLC, Andrew
 Moppett MLC, Doug
 Nile MLC, Fred
 Nile MLC, Elaine
 Obeid OAM MLC, Edward
 Oldfield MLC, David
 Pezzutti MLC, Brian
 Primrose MLC, Peter
 Rhiannon MLC, Lee
 Ryan MLC, John
 Saffin MLC, Janelle
 Samios MLC, James
 Sham-Ho MLC, Helen
 Shaw QC, MLC, Jeffrey
 Tebbutt MLC, Carmel
 Tingle MLC, John
 Tsang MLC, Henry
 Wong MLC, Peter

FEDERAL MEMBERS OF PARLIAMENT

Payne Senator, Marise
 Plibersek MP, Tanya

NON PARLIAMENTARY DELEGATES

Bammer, Gabriele - National Centre for Epidemiology

and Population Health
 Barga, Jenny - Youth Justice Conferencing
 Barnes, Marilyn - Homestart
 Baume, Peter - School of Community Medicine
 Burke, Br Peter - St John of God Hospital
 Brack, Garry - Employers Federation
 Bramston, Troy - Premier's Youth Advisory Council
 Burgess, Mark - NSW Police Association
 Burney, Linda - Dept of Aboriginal Affairs
 Cashmore, Judy - Child Protection Council
 Costa, Michael - NSW Labor Council
 Crews, Bill - Exodus Foundation
 Currie, John - Westmead Hospital
 Davidson, Jill - Australian Association of Social Workers
 Dodds, Chris - Council of Social Services NSW
 Doyle, John - Prison's Officers Vocational Branch
 Dunn, Peter - the Gilmore Centre
 Gibson, Judy - Pryde
 Griew, Robert - Aids Council
 Herbert, Harry - Uniting Church Board for Social Responsibility
 Hewitt, Kate - Kamira Farm
 Hole, Margaret - NSW Law Society
 Howard, John
 Hurley, Patrisha - Country Women's Association
 Johnstone, William - Far West Ward Aboriginal Health Service
 Jones, Kevin - Dubbo City Youth Council
 Kelleher, Marilyn - Australian Catholic School Principals Assoc
 Leahy, Denis - Pharmacy Guild (NSW Branch)
 Loukas, Chrissa - NSW Bar Association
 Leulf, Barbara - Isolated Children & Parents' Association
 Madden, Annie - NSW Users & Aids Association
 Malouf, John - Australian Pharmacists Against Drug Abuse
 Matthews, Richard - C/- Corrections Health Service Long Bay Hospital
 McKay, Margaret - Keep Our Kids Alive
 McQueen, Rod
 Moait, Sandra - Nurses Association NSW
 Nguyen, Luat - Cabramatta Community Centre
 Noffs, Wesley - the Ted Noffs Foundation
 O'Grady, Paul
 O'Grady, Phil - Pharmacist
 Obeid, Mahadine - Barnados Aust
 Palmer, M J - Australian Federal Police
 Pearman, Jill - Prevention Resources Centre

NON PARLIAMENTARY DELEGATES

(continued)

Penny, Ron - Centre for Immunology
 Pierce, Larry - NADA
 Pitts, James - Odyssey House
 Poppel, Garth - Australasian Therapeutic Communities Association
 Reuter, Peter - University of Maryland
 Richmond, Ray - Wayside Chapel
 Rowe, Normie - Symposium on International Drug Prevention 1998
 Ryan, Peter - Lyndon Community / NADA
 Scarlett, Stephen - C/- Bidura Childrens Court
 Shaw, Denise - Life Education Centre
 Sotiriou, Lafitani - Randwick Boys High School
 Stanley, Peter - Rural Communities Consultative Committee
 Starkis, Colleen - Many Rivers Regional Council
 Steele, Maureen
 Swan, Pat - Aboriginal Health Resource Co-operative
 Symonds, Ann
 Thursby, Peter - Australian Medical Association NSW
 Toohey, Kate - Western Area Adolescent Team Drug Abuse
 Trimingham, Tony - Family Drug Support
 Vy Tu, Lan - Ethnic Community Council
 Walsh, Richard - Ministerial Advisory Council on Alcohol, Tobacco and Other Drugs
 Wicker, Sue - Royal College of General Practitioners
 Wilson, Andrew - NSW Health Department
 Wodak, Alex - St Vincents Hospital
 Wood, Angela - Drug Watch Australia
 Wood, Justice - Supreme Court of NSW
 Woods, Peter - Local Government & Shires Association
 Woodward, Lionel - Australian Customs Service

ASSOCIATE DELEGATES

Allen, Raelene - Author & Journalist
 Barnes, Terry - Fairfield Council
 Bashir, Marie - Juvenile Justice Advisory Council
 Bell, James - the Langton Centre
 Chambers, Kevin - the Langton Centre
 Chapman, Simon - Department of Public Health & Community Medicine
 Chapman, Terry - Association of Independent Schools
 Collins, David - Macquarie University
 Croke, Brian - the Catholic Education Commission
 Fidge, Ros - Community Services & Health Industry, (Continued)
 Training Advisory Board
 Ford, Adrian - Benevolent Society
 Freeburn, Brad - Aboriginal Medical Service

Freed, Edgar - AMA
 French, Kristine - Manager Wollongong Crisis Centre
 Garcia, Roger - Ministerial Council on Aids
 Gill, Tony - Drug & Alcohol Service
 Grennell, Mary - Coordinator Glebe House
 Harvey, Tonina - Auburn Community Health Service
 Hay, Greg - Mayor of Newcastle
 Holliday, Dr Simon - Taree GP
 Lapsley, Helen - Economist University of NSW
 Latty, Joe
 Maher, Lisa - Faculty of Medicine
 Maley, Barry - Centre for Independent Studies
 Mattick, Richard - NDARC
 Menzies, Trish - Family Support Service Association
 Miller, Margaret - NRMA
 Mills, Deborah - Police Community Youth Clubs
 Morrirt, Fay - Family Drug Support
 Nicholls, Nancy - Canley Vale High School
 Nutbeam, Don - Department of Public Health & Community Medicine
 O'Dell, Garry - NSW Police Academy
 Pearson, Helena - Rainbow Lodge
 Rankin, Jim - Medicine & Public Health, University of Sydney
 Roude, Ali - Islamic Council
 Roumeliotis, Violet - Executive Officer CRC Justice Support
 Rowling, Louise - Faculty of Education
 Rynne, Katherine - Senior Nurse Manager the Drug Court
 Sharp, Trevor - Builders Trades Group D & A Committee
 Skinner, Peter - Barrister
 Spence, Nigel - Association of Child Welfare Agencies
 Treskin, Larissa - NSW Secondary Principals Council
 Walsh, Arianne - Former Member Student Representative Council, Sydney University
 Watson, Jan - Curran Schools As Community Centres
 Whittaker, Neil - National Rugby League
 Woodley, Warren - Deputy Mayor Tamworth City Council

SPEAKERS

Findlay, Mark - University of Sydney
 Hall, Wayne - Ndarc
 Hamilton, Margaret - Turning Point Alcohol & Drug Centre

SPEAKERS

Penington AC, David
 Reuter, Peter - University of Maryland At College Park

Ryan, Peter - Commissioner of Police
Stockwell, Tim - National Centre for Research Into the
Prevention of Drug Abuse
Thompson, Craig - Bankstown Court
Van Beek, Ingrid - Kirketon Road Centre
Vimpani, Graham - Hunter Child Adolescent & Family
Health Service
Watters, Brian - Salvation Army
Weatherburn, Don - Bureau of Crime Statistics &
Research
Webster AO, Ian - Alcohol & Other Drugs Council of
Australia

APPENDIX 3

NSW Drug Summit 1999

Final Communique

Resolutions

Preventing Drug Abuse:

The Summit recommends that:

- 1.1 There be an expansion of evidence-based prevention and early intervention services which strengthen all families with children, as a means of preventing drug abuse by children and young people now and in the future. These services should:
 - (a) provide practical and emotional support and encourage awareness of children's needs from the pre-natal stage and be a top priority until the child is five years of age,
 - (b) include universal home visitation to all first time parents,
 - (c) continue support with targeted interventions at critical developmental and transitional stages in the lives of children and young people so that the risk of drug abuse at any critical point is substantially reduced. The critical stages after early childhood are: school entry, transition to high school, and school leaving. Other life crises for families, like unemployment and divorce, will require appropriate intervention,
 - (d) provide additional support for families with higher needs which make their children more vulnerable to the risk of substance abuse,
 - (e) recognise the particular needs of families living in rural and remote areas and others with different cultural backgrounds, and
 - (f) be accessible for those in need.
- 1.2 The recently announced expansion of Families First and Schools as Community Centres across NSW continue with adequate resourcing.
- 1.3 The establishment of models similar to Schools as Community Centres to cater to the needs of children transitioning from primary schools to high schools, and those leaving school, and their families.
- 1.4 A National First Three Years Foundation be established as a partnership between governments, businesses and the community. The proposed Foundation would promote the vital importance of the first three years of life through research, policy and communication activities.
- 1.5 Arrangements be made for the systematic and comprehensive sharing of data and research across Australia and overseas on prevention and early intervention. These arrangements should include:
 - (a) the establishment of an information clearing house at a recognised research or learning institute,
 - (b) a national agreement and protocol for sharing existing data and research on early intervention services and programs by relevant Ministerial councils,

- (c) the development of national longitudinal data sets on children and young people, and
 - (d) short and long term evaluation on the impacts of prevention and early intervention programs (for example, Families First).
- 1.6 Further research be conducted to identify ways of developing the social capital of communities, including the development of longitudinal studies on the social capital of communities that can be reported annually to inform policy and practice.
 - 1.7 Additional resources be provided to ensure adequate emergency and short-to-medium term accommodation for families and young people is equitably distributed across NSW.
 - 1.8 A code of conduct be developed with the media to guide the reporting of issues about drug use and addiction, such as currently exists with the reporting of suicide.
 - 1.9 Knowledge and skill development of service providers, for example health workers, police, teachers, family support workers and medical practitioners, who have face to face contact with families and individuals suffering the impact of drug abuse, be promoted and expanded.
 - 1.10 There be an expansion of appropriate models of community drug action teams similar to those in the United Kingdom, Western Australia and Aboriginal controlled health services, to link primary carers and service providers in supporting young people at risk.
 - 1.11 A framework for prevention and early intervention programs should be developed to inform policy and practice on a whole of government basis and throughout the community.
 - 1.12 The policy framework should recognise the importance of common effort around agreed goals. It should provide leadership in promoting the values, attitudes, life skills and attributes which will prevent drug abuse. Those values will include a strong sense of community and care and respect for self and others.

Young People And Drug Abuse

The Summit recommends that:

- 2.1 It should be recognised that the reasons that young people use drugs are complex and varied, including the alienation of some young people from society and their belief that society does not value them. An effective response to illicit drug use by young people has to be a holistic approach as complex and varied as the needs it addresses. It must seek to prevent, minimise and manage harm caused by drug use and must be provided to and involve young people in the context of their family, peer group, school and community, and not in isolation from these factors.
- 2.2 Funding agreements for drug programs and activities should include young people in decision making about planning and delivery of the services and activities, and demonstrate a capacity to address the needs of children and young people on a local basis.
- 2.3 The Department of Education and Training, Catholic and Independent schools and other related agencies should enhance strategies to retain problematic students in the educational

process, increase access to alternative education settings and ensure the ongoing education of young offenders following their involvement in the Juvenile Justice system.

- 2.4 In order to provide more appropriate services to over-represented cultural groups in the Juvenile Justice system, there must be greater community consultation and involvement in the training of police, judicial, juvenile justice and correctional staff and in the provision of culturally appropriate programs and ongoing support systems for young offenders and their families.
- 2.5 There should be established a pilot program for a Children's Drug Court as part of the Children's Court system, to be adequately resourced for the treatment and rehabilitation of young people with alcohol and other drug problems.
- 2.6 There should be resources to provide additional alcohol and other drug detoxification, treatment and rehabilitation services for young people, both community based and residential. These services must also be available to incarcerated drug offenders and continue after they leave the detention centre. They should be appropriately linked to mental health services.
- 2.7 Mentoring should be recognised as an important support for young people. Best practice guidelines should be established for peer support programs to strengthen the effectiveness of support for students at significant transition points within their school career.
- 2.8 Government at all levels and communities should provide young people with activities, entertainment and public space which fits their culture, is responsive to their needs and maybe structured or unstructured.
- 2.9 Government at all levels, in partnership with employers, should ensure that young people have access to jobs by providing appropriate and relevant skills and training and job creation opportunities.
- 2.10 Schools should provide professional development for school counsellors and teachers to:
 - (a) identify the signs of drug abuse,
 - (b) refer young people to appropriate services, and
 - (c) develop supportive/therapeutic protocols to help school communities find better ways of addressing drug use in the school environment.
- 2.11 There is a need for a continuum of government and non-government services for drug abuse including prevention, early intervention, detoxification, rehabilitation and follow up. These services should:
 - (a) be accessible and timely,
 - (b) recognise the importance of assisting drug users and also their families,
 - (c) be youth acceptable, and
 - (d) look at the whole person's needs not just their drug addiction, including mental health, employment and accommodation.
- 2.12 All youth services need to be youth accessible and youth acceptable.

- 2.13 A comprehensive needs analysis and review of services across all government and non-government service providers should be completed. This should also be used to compile a database so that young people and parents can access information and support services.
- 2.14 Innovative ways of delivering services to young people in regional and rural NSW be developed (for example, telelink, mobile services) to ensure the provision of appropriate and accessible services.
- 2.15 There should be more treatment, training and service integration facilities for young people with both mental health and alcohol and other drug problems.
- 2.16 An adolescent specific phone line be established to provide referral and other support for young people experiencing difficulties with drugs.
- 2.17 There be an investigation into, with a view to establishment of, a youth accessible and acceptable website that brings together young people and their families and professionals for information, referral and support services.

Health Maintenance And Treatment Services

The Summit recommends that:

Service delivery

- 3.1 Service delivery for the treatment of substance misuse should operate within an integrated framework supported by a comprehensive range of services. These services should be available and readily accessible within all metropolitan, regional and rural geographic areas and indigenous communities.
- 3.2 These services would include assessment and referral, alternative pharmacotherapies, methadone and abstinence based residential and outpatient services, and alternative interventions which support the harm minimisation principle.
- 3.3 These services will reflect the quality needed to attract and where possible retain clients in treatment so that they receive the best treatment that can be offered supported by current research.
- 3.4 These services will be offered along a continuum which may include current interventions and the willingness to examine other options which are not part of current service delivery including within the correctional services system.
- 3.5 This will require:
 - (a) adequate funding allocation to provide comprehensive services including pharmacotherapies,
 - (b) improved co-ordination among all agencies involved in services to drug dependent persons including agencies outside of the health sector,
 - (c) improved co-ordination at an administrative level in NSW Health including strengthening

of the drug and alcohol services group to include clinically experienced staff,

- (d) funding for the role of public health services in case management and co-ordination of services for persons with drug dependency,
- (e) appropriate location of services to facilitate access including co-location of detoxification and other services,
- (f) availability of support services to deal with co-morbidity including dual diagnosis,
- (g) commitment to examine new approaches and to rapidly deploy new approaches where these are shown to be beneficial,
- (h) establishment of specific programs to develop and implement treatments for cannabis, cocaine, amphetamines and other addictive illicit drug dependency,
- (i) ensuring the full range of treatment options is available to high need groups including prisoners, and
- (j) increasing the number of detoxification places (including in prisons) and commensurately the number of rehabilitation places.

Role in health services

3.6 Drug dependency and misuse be recognised as major health issues. As such, the Summit encourages all health care providers to recognise that the provision of services to drug and alcohol dependent individuals is a core responsibility and should be integrated into their daily practice or business. A greater involvement of mainstream health providers, including Area Health Services and their hospitals and community services, general practitioners and pharmacists, will improve capacity to provide brief and early interventions and treatment and to thereby reduce drug use and harms associated with it.

3.7 To facilitate this:

- (a) drug dependency services need to be adequately and specifically funded,
- (b) health practitioners including general practitioners and pharmacists require support in obtaining adequate training in managing patients with drug dependencies,
- (c) there should be ready access for primary health care workers to specialist support in managing clients,
- (d) models of care that involve primary health care workers, such as shared care, should be promoted,
- (e) medical practice in the drug dependency field should be recognised as a legitimate medical specialty with a training program, continuing medical education requirement and remuneration consistent with that status,

- (f) general practitioners and pharmacists should be encouraged to assist with the methadone program, and
- (g) all health workers must recognise their role in identification of drug dependency at every clinical encounter and be able to easily refer the individual for treatment where appropriate.

Minimum data

- 3.8 Collection of a minimum data set (which aims to provide comparable and consistent data on those entering treatment and the treatments they enter) be required of all services providing treatment or rehabilitation for drug dependency, to improve monitoring and understanding of the treatment services and their outcomes.

Quality

- 3.9 In recognition of widespread concerns over regulation, quality and accountability of clinics delivering methadone treatment, rapid detoxification and other drug and alcohol treatments:
- (a) regulatory standards be developed to oversee the operations of such clinics,
 - (b) these clinics be licensed, and
 - (c) the conditions of license include participation in a prescribed quality assurance program, adequate physical facilities, levels of appropriately trained staff, documentation of compliance with regulatory standards and jurisdictional guidelines, and documentation, monitoring and reporting of outcomes.

Health maintenance

- 3.10 Recognising that drug use is a chronic and relapsing condition, it be acknowledged that:
- (a) Drug users have a range of health needs in addition to treatment for addiction. These needs include access to comprehensive medical care, and psychological and social support.
 - (b) An individual's goals of treatment will vary at different stages of his or her drug use. Therefore a diversity of objectives, based on harm minimisation principles, and ranging from safer drug use to achieving abstinence, is required.
- 3.11 To achieve this, there is a need for:
- (a) additional specialist primary health care facilities in areas of high need that are more likely to attract, retain and provide comprehensive care for drug dependent or illicit drug using groups,
 - (b) expansion of the needle and syringe programs, preferably incorporated with a broader range of health maintenance facilities,
 - (c) clinicians and public health workers through the Area Health Services and participants in the Pharmacist Guild schemes to have discretion in determining the range of injecting equipment

provided,

- (d) open dissemination of information regarding resuscitation of overdose victims and increased availability of the reversal agent Naloxone in areas where drug users congregate; and
- (e) support for intersectorial approaches to marginalised and health disadvantaged groups.

Community education

3.12 There is a need for greater public awareness about the nature of illicit drug use and its treatment. To achieve this the Government should support a community education campaign highlighting that:

- (a) drug addiction involves both medical and social issues, and that medical treatment must be linked with other forms of support if the successful, long term, rehabilitation of a drug addicted person is to occur,
- (b) addiction is a chronic, relapsing condition,
- (c) there is no single one-size-fits-all cure,
- (d) drug misuse occurs with varying levels of severity,
- (e) while abstinence is the desired endpoint, many users may require several attempts at cessation,
- (f) minimising harm to the community and the drug user during this process is a central part of drug treatment, and
- (g) a comprehensive range of treatment and health maintenance services is available.

Resourcing and accountability

3.13 Based on current unmet service demand and comparisons of funding levels with other States, there is a need to substantially increase current expenditure.

3.14 There is a need for greater transparency and accountability with regard to the size, funding and management of the illicit drug problem in NSW. To achieve this requires:

- (a) clear statements of the goals and purpose of different programs in the drug and alcohol field,
- (b) clearer reporting on funds allocated for drug prevention and treatment, separating tobacco, alcohol and illicit drugs, and non-government and government components,
- (c) improved timeliness and scope of surveillance data,
- (d) improved monitoring of demand, treatments undertaken and outcomes of treatment across the treatment and rehabilitation field, and

- (e) establishment of a whole of government Ministerial council on drugs supported by an expert advisory committee that includes community representation.

Medically supervised injecting rooms

- 3.15 The Government should not veto proposals from non-government organisations for a tightly controlled trial of medically supervised injecting rooms in defined areas where there is a high prevalence of street dealing in illicit drugs, where those proposals incorporate options for primary health care, counselling and referral for treatment, providing there is support for this at the community and local government level. Any such proposal should be contained in a local Community Drug Action Plan developed by local agencies, non government organisations, volunteers and community organisations. These should be submitted to full public and community consultation processes (such as those used in urban planning law) and preferably a local poll. They must be part of a comprehensive strategy for local law enforcement, health, community and preventative education initiatives.
- 3.16 Appropriate protocols for the exercise of police discretion be established within the Police Service to allow for the proper and effective operation of self administration facilities.

Case Management, Co-ordinated Care, Service Standards

The Summit recommends that:

- 4.1 The concept of 'Support Co-ordination' be tested in at least three regions in NSW including rural and metropolitan locations. Two groups should be targeted in these pilots:
 - (a) high and multiple need clients, and
 - (b) moderate need clients who are likely to achieve stability in treatment with support in other areas of need.
- 4.2 These projects involve:
 - (a) Assessment, referral and linkage of clients to a range of services including health, education, legal advice, housing, family support, child care, child protection, financial advice, employment and training.
 - (b) The expectation that government and non government agencies would be equipped to respond to client needs.
 - (c) Assessment of family and carer needs and encouragement of their participation, if appropriate.
 - (d) Investigation of models of good practice.
 - (e) Exploration of the feasibility and potential for support agreements between clients and service providers built upon the premise of rights and responsibilities. This could involve grievance mechanisms.

- (f) Recognition that families of drug users can play an important role in supporting their relative in avoiding harm, withdrawing from use and maintaining a drug free lifestyle, and recognition that families can undergo severe distress when facing harmful drug use, and benefit from a supportive community. Accordingly, pilots should include drug strategies to support the families of drug users. Such support should include locally available expertise for support in crisis, personalised information and advice for parents, support for family members, support for self help groups, and linkage to specialist services (for example, drug teams) where necessary.
 - (g) Monitoring and evaluation of the pilot program.
- 4.3 A system of accreditation should be developed to include service effectiveness and quality.

Training Requirements: Building Skills

The Summit recommends that:

Co-ordination of training initiatives

- 5.1 Given the current fragmented approach to training requirements in the drug and alcohol field, there is a need for a whole of government approach to the establishment of training priorities, the targeting of resources and monitoring implementation.
- 5.2 An inter-agency body be established with membership from relevant government and community organisations to achieve co-ordination and to ensure action on these recommendations and the range of issues identified in the distributed Summit reference material on training requirements.

Resources

- 5.3 Adequate resources be allocated to the implementation of all areas of training: pre-service, in-service, professional development and that provided in workplaces. Such resources should be explicitly identified.

Training requirements

- 5.4 All professions and agencies providing drug and alcohol prevention, rehabilitation, crisis intervention and management services must include for their frontline workers and volunteers appropriate quality training. This training should include a set of core skills underpinned by relevant knowledge, and should be accredited nationally. It must also incorporate practical or workplace experience in a variety of contexts.
- 5.5 All generalist health professionals have a specialist drug and alcohol component within their core professional education and training and access to ongoing 'in service' and further education programs.
- 5.6 All generalist community service workers have a specialist drug and alcohol component within their pre-service training and access to ongoing 'in service' and further education programs.

Support of training

- 5.7 Health, welfare and other frontline services should develop policies, programs and protocols to support the implementation of skills and knowledge gained through core training in alcohol and other drugs.
- 5.8 The expansion of numbers working in the alcohol and drug field should be encouraged by the creation of appropriate career structures supported by post graduate training.

Content of training

- 5.9 Training must include content specific to various occupations and roles and must at least address:

Worker requirements

- key competencies and skills
- team work with other disciplines
- working with coerced clients
- working with young drug users
- clear delineation of roles
- application of skills in a variety of contexts

Interventions

- comprehensive assessment of substance use
 - protocols for treatment
 - early intervention procedures
 - home based interventions
 - management of intoxication
 - management of aggression
 - management of withdrawal states.
- 5.10 The breadth, mix and delivery mode of training should be varied to reflect the client group and the work context, especially work with Aboriginal and Torres Strait Islander communities and in cross cultural contexts.
- 5.11 Continuing education must be provided for doctors, nurses and other professionals involved in clinical management of patients who use pharmacotherapies.

Target groups

- 5.12 Priority in training must be accorded to general health and community service workers and to those workers in early intervention programs targeting groups at high risk for substance abuse (for example, child protection programs and programs involving families at risk).

Standard of training

- 5.13 In order to improve the standard, quality and effectiveness of training, priority must be given

to a series of professional development programs for prospective educators and trainers in each of the professions and other community service and health occupations.

Training modules

- 5.14 All occupational health and safety modules included in current TAFE or other training provider courses should incorporate and/or expand content relevant to drug and alcohol issues.
- 5.15 Drug and alcohol training modules aimed at raising community and family awareness must be developed for use by community organisations in a range of delivery modes.
- 5.16 Appropriate support materials for assisting families and communities in drug and alcohol awareness programs should be disseminated to relevant organisations.

Workplace

- 5.17 Practical work place training targeted at supervisors, human resource managers and others in key occupational health and safety roles should be designed to facilitate early identification and intervention.

Breaking The Drugs And Crime Cycle

The Summit recommends that:

General principles

- 6.1 The Cabinet Office conduct a study into the need for whole of government co-ordination of drug services in order to achieve an integrated approach to combat the drug problem.
- 6.2 The development of drug law enforcement policies should:
 - target solutions to specific problems,
 - reflect a commitment to evaluation of and full cost accounting of all programs, and
 - include an appropriate resource allocation 'mix' across a range of strategies.

Diversion

- 6.3 Existing research be reviewed to determine best practices in diversion, including the best point of intervention (for example, pre-arrest, post-arrest, pre-sentencing, first offence) to divert users into a treatment or diversion program. This review should include all existing mechanisms, including the use of Griffith bonds.
- 6.4 Existing police discretionary powers to caution minor drug offenders be identified, clarified and formalised, and public support demonstrated for the exercise of police discretion. There is a need to explore how police prosecutors, the Director of Public Prosecutions and the courts can exercise appropriate discretion to divert offenders from prosecution and custodial sentences.

- 6.5 The *Young Offenders Act 1997* should be amended to cover minor drug offences, to allow warnings, cautions and conferencing.
- 6.6 There are recognised health risks associated with cannabis use and as such there should remain in place legislation to deter its widespread sale and use.
- 6.7 In relation to minor drug offences involving cannabis (committed by juveniles or adults):
- (a) The police power to caution offenders be formalised and protocols developed to govern prosecutorial discretion. The protocols should be developed having regard to the following matters:
- the offender was found in possession of, or using not more than, a small quantity of cannabis, or in possession of items of equipment for cannabis administration,
 - the cannabis was held for personal use,
 - the offender admits to having committed the offence,
 - the offender consents to being cautioned, and
 - on receiving a caution, the offender is referred to an education or drug referral service.
- (b) There be a commitment to diversion of offenders to education and/or treatment before charge.
- (c) The Court's power to refer offenders to education and/or treatment be encouraged. The development of this policy should have due regard to the Victorian experience. The effectiveness of the use of police and prosecutorial discretion would be reviewed after two years based on criteria settled in advance.
- 6.8 The program referred to in 6.7 be considered and trialed for possession and use of other drugs.
- 6.9 There should be no gaol penalty for possession of cannabis, cultivation of a small number of cannabis plants or the possession of implements used to administer the drug. Custodial penalties should be removed for the following offences:
- (a) possession and use of not more than small quantities of cannabis,
- (b) possession and cultivation of not more than small quantities of cannabis plant,
- (c) possession of items of equipment for use in the administration of cannabis, and
- (d) sale, supply and display of water pipes.
- 6.10 An adult conferencing program be established in relation to drug-related and non-violent offences and evaluated after two years. This program should have the following features:
- (a) there should be discretion as to whether conferencing is appropriate,
- (b) the offender must admit the offence and consent to their participation in the program,

- (c) the victim should have a full right to participate in conferences and development of the 'outcome plan', and
 - (d) the victim should have the right to veto the 'outcome plan'.
- 6.11 The current Drug Court trial be expanded to be available at other venues in NSW and the Children's Court be given comparable diversionary powers to the Drug Court.

Self administration and use of equipment

- 6.12 Section 11 of the *Drug Misuse and Trafficking Act 1985*, dealing with use or possession of equipment for use in the administration of a prohibited drug, should be repealed.
- 6.13 Section 12 of the *Drug Misuse and Trafficking Act 1985*, dealing with self administration of a prohibited drug, should be repealed.

Drugs In Correctional Centres

The Summit recommends that:

- 7.1 Subject to continuing evaluation and analysis of needs, the Drug Court should be expanded and include juvenile offenders.
- 7.2 The Department of Corrective Services investigate the circumstances under which a greater proportion of drug affected offenders may be referred to the probation and parole service for evaluation for suitability for home detention, in the context of enhanced case managed treatment and support and supervision by government and non-government agencies.
- 7.3 The role of the Independent Commission Against Corruption and the Department of Corrective Services in investigation and monitoring of drug related corruption in prisons be acknowledged, and that such a strategy be maintained.
- 7.4 The Department of Corrective Services should continue every endeavour to prevent the availability of illicit drugs in correctional centres while emphasis is nevertheless placed upon the enhancement of drug therapies and programs.
- 7.5 The Corrections Health Service detoxification and stabilisation programs should be expanded to all inmates who require them. Services should be supported by appropriately trained staff and evaluated through a co-ordinated research program.
- 7.6 The range, effectiveness and cultural sensitivity of alcohol and other drug services and programs for juvenile detainees, including the provision of designated detoxification beds at larger juvenile remand centres, should be reviewed and evaluated by a panel including representatives of the Department of Juvenile Justice and the Department of Health. The recommendations of the report on the detection and management of illicit drugs in juvenile detention centres (the DAMOID Report) are noted.
- 7.7 The Department of Corrective Services' urinalysis program in correctional centres be recognised as an important management tool for custodial and health staff. Positive test

results will usually lead to sanctions, but such results should also lead to referral for initiation of treatment or modification of existing treatment, and Corrections Health Service should provide appropriate feedback to the Department of Corrective Services.

- 7.8 The range of alcohol and other drug programs in correctional centres should be reviewed with a view to the more systematic introduction of evidence-based treatment programs and strategies which minimise harm, are culturally and gender appropriate, and are supported by a training and research program.
- 7.9 The Department of Corrective Services should implement a pilot scheme to establish drug free zones as a program option within the correctional system. Such a program should operate on a principle that inmates enter into a contract to avoid drug-using behaviour and to participate in programs that will assist their eventual integration into the community.
- 7.10 Because the risk of recidivism and relapse is much higher among released drug-affected offenders who have not entered community programs, greater emphasis should be placed upon measures for closer co-operation between government and non-government agencies to ensure continuity of care, treatment and rehabilitation both before and after the release of inmates from prison. A trial 'through care model of service delivery' including post release support services should be developed by the Department of Corrective Services in partnership with the following organisations: Corrections Health Service, Aboriginal Medical Service, Probation and Parole Service, Department of Juvenile Justice, Department of Housing, non-government agencies including those operating under the Department of Corrective Services Community Grants Program, and other government departments.
- 7.11 A joint working party, comprising the Corrections Health Service, the Department of Corrective Services and the Department of Juvenile Justice, develop a methodological framework to evaluate the efficacy of drug and alcohol programs. This framework would include the development of robust health outcome measures and performance indicators.
- 7.12 An advisory body to the Premier and Ministers be established, comprising high level independent experts to review policy and to advise on strategic direction and other drug related initiatives. The Chair should be a non-political, distinguished and highly respected legal or medical figure, appointed by the Premier after consultation with the Leader of the Opposition. The advisory body should include young people and/or a young offender.

Drugs And Community Action

The Summit recommends that:

- 8.1 It be acknowledged that:
 - (a) some communities and families feel overwhelmed and hopeless and are looking for leadership and positive ideas - a shared game plan - for how to deal with illicit drugs,
 - (b) the community as a whole needs to better understand, discuss and take ownership of the issue and the solutions, and be empowered to address its causes and impacts,
 - (c) communities need to show compassion toward people who engage in harmful drug use,

- (d) communities need to recognise drug users as part of the community,
- (e) community action can take various forms depending on the particular needs of different communities, both cultural and locational, and
- (f) on-going leadership and the collaboration of community interests is required to sustain effective community action.

Community education and information

8.2 There be a concerted campaign, based on best practice models to inform the community, especially local governments, parents, young and older people, and community organisations, about illicit drugs. This should:

- (a) provide information on:
 - the patterns and impacts of harmful drug use,
 - the factors that can cause illicit drug use and addiction,
 - the links between licit and illicit drug use,
 - policies and programs relating to illicit drugs,
 - initiatives that can reduce drug-related harms,
 - sources of support and information,
 - the role of parents, family members, elders, peers and others in inhibiting harmful drug use,
 - evidence of successful strategies, and
 - what communities can do,
- (b) target at risk young people and inform the broader community (especially local governments, parents, young and older people, and community organisations) about the dangers of and strategies for dealing with illicit drugs. It should promote the messages that:
 - drug misuse is not desirable,
 - drug misuse is harmful,
 - drug misuse is endemic,
 - drug misusers are part of the community and are themselves victims of criminal activity,
 - drug misusers require compassion, resources and maximum opportunities to enable them to stop using drugs, and
 - there should be a commitment to a range of strategies to reduce the harm of drug misuse to the community and individuals, including:
 - law enforcement,
 - prevention of initiation to drug misuse,
 - providing drug treatment from maintenance to abstinence, and
 - strategies designed to reduce specific harms related to drug misuse,
- (c) utilise a variety of media including advertising, direct mail (such as brochures inserted in council rate notices and utility bills), an on-line drugs information clearinghouse (along the lines of the Drug Summit web site), and tool kits as an aid to community action,
- (d) involve a 'champion' or 'champions', including high profile positive role models from a range of backgrounds, especially sport and the entertainment industry,

- (e) be conducted as a partnership between the government, community interests (such as sporting bodies), and business interests (such as those in the health, insurance and advertising sectors), and
- (f) maximise the input and involvement of young people in the design of peer education advertising.

Community leadership, co-operation and co-ordination

8.3 The importance of community leadership, co-operation and co-ordination be recognised, and that community leaders and organisations at all levels and in all sectors be encouraged to:

- (a) Provide direction and opportunities for communities to determine how they can take constructive action in relation to the supply, distribution and abuse of drugs. This might involve the development of local community drug action strategies - shared game plans - to deal with the causes and incidence of illicit drug use and to reduce its harms.
- (b) Co-operate across government and community agencies, service providers, businesses and others in a partnership approach at local, regional, state and national levels.

8.4 Support be given to the proposal in the Premier's 7 Point Plan for additional Community Drug Action Teams. These should:

- (a) operate in all regions of NSW, under the auspices of the Regional Co-ordination Management Groups of the Premier's Department's Regional Co-ordination Program,
- (b) operate also at local levels where and when appropriate,
- (c) bring together key agencies with key stakeholder representatives,
- (d) facilitate community awareness campaigns in their areas,
- (e) facilitate community involvement in setting priorities and in developing initiatives through local community drug action strategies,
- (f) link with other whole of government co-ordination initiatives such as place management projects which utilise outside, skilled facilitators, and
- (g) link whenever possible with other social development (such as Families First, Schools as Community Centres and volunteer programs), crime prevention and economic development initiatives.

Community support and action

8.5 The importance of community support for a wide range of responses to the causes, incidence and harms of illicit drug use be recognised, and that communities be encouraged to make concerted efforts to raise awareness and take constructive action.

8.6 The need for a multi-faceted, collaborative and integrated approach to the causes, incidence

and impacts of illicit drugs be endorsed. This should involve:

- (a) Each region or area providing a core or basic level of Drug and Alcohol services. Such programs can be provided through the public health system, community and welfare agencies, government and non-government agencies. They should be consistent with best practice standards, be properly supervised and include:
 - assessment, counselling and referral,
 - case management,
 - detoxification - residential and non-residential,
 - residential rehabilitation programs (therapeutic communities),
 - methadone and opioid substitution programs (LAAM, buprenorphine),
 - early and brief intervention,
 - training and education,
 - prevention and community development programs, and
 - programs to address special needs groups like Aboriginal people, people from non-English speaking backgrounds, women and youth, for example specific detoxification for Aboriginal or Indo-Chinese youth.
 - (b) More access points at a local level to maximise paths to advice and other services.
 - (c) Central contact points to broker placement in rehabilitation facilities.
 - (d) Additional treatment and post-detoxification places, especially for adolescents.
 - (e) Greater use of peers as a positive means of reducing harmful behaviours.
- 8.7 Local Community Drug Action Plans be developed with local agencies, non-government agencies, volunteers, residents and community organisations, using the combined resources of Local and State Government. These should be submitted to full public and community consultation and negotiation processes (such as those used in urban planning law). These negotiated plans may include all lawful options as part of a comprehensive strategy for local law enforcement, health, community and preventative education initiatives. The Government should consider any legislative amendments needed to facilitate such plans.
- 8.8 The need to strengthen communities, and to renew disadvantaged communities in particular, be recognised. Community development initiatives along the following lines should be supported:
- (a) local positive role models from all sectors of that community,
 - (b) projects which maximise job creation and vocational training and employment opportunities for young people, especially in areas of high youth unemployment,
 - (c) programs which support families, especially those with young children and children and young people at risk (such as Families First and Schools as Community Centres),
 - (d) initiatives to enhance local environments and facilities, and

- (e) local community-based initiatives (such as events) that can be sustained over time.

Community resources

- 8.9 The Government and other institutions invest additional resources to help communities take action to address local problems. This should include:
- (a) mobilising resources from a range of sources including casinos, registered and sporting clubs, the corporate sector and community organisations,
 - (b) providing additional resources to frontline drug and related services, especially those for children, adolescents and families, and
 - (c) taking into account preventable costs in identifying priorities for resource allocation.
- 8.10 Wherever possible, there should be evidence-based criteria for policies and the allocation of resources, as well as outcome-based reports on initiatives in order to benchmark performance.

Drugs And Law Enforcement

The Summit recommends that:

Community expectations regarding drugs and law enforcement

- 9.1 There be a review of current policies and development of new policies to address the issue of community fear associated with reporting drug crime, including such factors as fear of retaliation and not wanting to be identified.
- 9.2 The community be informed of law enforcement issues associated with perceived delays in acting on complaints about drug crime and specific acts of drug-related criminal behaviour.
- 9.3 Community knowledge and debate be promoted about police powers concerning drug use and drug-related crime.
- 9.4 Law enforcement approaches to address drug use and drug-related crime in other communities internationally be identified, monitored and reviewed, and the efficacy of adopting similar law enforcement approaches in New South Wales be assessed.
- 9.5 The object of drug legislation and policing should be the reduction of the aggregate social harm caused by drug use.
- 9.6 Consideration be given to the feasibility of having legislated principles to guide police in the exercise of their discretion in relation to illicit drug enforcement.

Harm prevention, crime prevention and illicit drugs

- 9.7 Action be taken to ensure better co-operation between law enforcement bodies and agencies in the health and social services sectors, with particular regard to:

- (a) developing a whole of government approach that incorporates community participation,
- (b) confirming the role of the police and courts in addressing the social and criminal effects of drug use,
- (c) providing education, health and social support services aimed at preventing people from commencing drug use,
- (d) providing adequate drug treatment services to assist drug users to overcome their addiction,
- (e) clarifying the responsibilities of different agencies in the delivery of these programs and services, and
- (f) providing information as to the availability of drug treatment and rehabilitation services to police, the medical profession, and the courts (e.g., through the Computerised Operational Policing System, the Judicial Information Reporting System, mechanisms within the Division of General Practitioners, internet sites, and so forth).

9.8 It be recognised that there is inadequate research in crime prevention and mitigation, and that collaborative research should be undertaken into:

- (a) economic models of the drug industry investigating such aspects as the price sensitivity of demand of drugs,
- (b) cost-effectiveness of incarceration and incarceration alternatives,
- (c) background of incarcerated prisoners as part of a prospective look at outcomes to see where interventions would be most cost-effective,
- (d) delivery of methadone or similar substitutes, and
- (e) cost effectiveness of different law enforcement, prevention and treatment strategies to reduce drug-related harm.

9.9 The police, Customs and allied agencies be endorsed in targeting drug traffickers.

9.10 An assessment be made of the feasibility of establishing 'proclaimed treatment places' for drug-affected persons, including availability of treatment for misuse/addiction for both adults and young people.

9.11 The NSW Police Service develop an explicit set of performance indicators for drug law enforcement and annually report on performance against these indicators.

Law enforcement strategies

9.12 The provisions of the *Bail Act 1978* be reconsidered, with particular reference to the types of conditions that may be attached to the granting of bail (including, for example, coercive rehabilitation) in order to provide opportunities for diversion into treatment programs and to remove recidivist offenders from the community.

- 9.13 A determination be made of the efficacy of the role of police in drug use prevention activities in schools.
- 9.14 A broad review of the *Drug Misuse and Trafficking Act 1985* and the *Poisons Act 1966* be conducted.

Legislation relating to drugs and law enforcement

- 9.15 The law relating to electronic surveillance, listening devices, search warrants and controlled operations be urgently enhanced to assist police in quickly targeting drug traffickers.
- 9.16 A national approach be developed to the legislative control of the supply of pseudoephedrine and other precursor chemicals used in the manufacture of illegal drugs.
- 9.17 That there be a trial and evaluation of a children's drug court.
- 9.18 A broad range of diversion programs for drug users be developed, supported and evaluated. This should include consideration of the efficacy of using Griffith bonds and suspended sentences in conjunction with appropriate treatment programmes where deemed necessary as a diversionary treatment option for drug users and drug related crimes.
- 9.19 Support be given to the identification and provision of technology that aids police in the identification of those minor drug users who have been directed to education and/or treatment and documenting the actions taken. For example, the availability and use of field fingerprint scanners and other vehicle based computer capabilities.
- 9.20 Local courts be required to take fingerprints of offenders in cases where police have issued a court attendance notice.
- 9.21 An assessment be made of the possible use of the *Drug Offensive Act 1987* in providing a statutory framework for drug research and policy development.
- 9.22 Legislation dealing with the confiscation of the proceeds of crime be reviewed to maximise the impact on drug derived assets.
- 9.23 Money laundering provisions be tightened through representations to the Commonwealth and through State measures which attack assets in the names of persons other than the beneficial owner.
- 9.24 A review be undertaken of all the legislation relating to police powers in drug law enforcement to remove any ambiguities which may impede effective police action.
- 9.25 In line with Recommendation No. 7.11 of the Penington Report, research should be funded to establish a roadside test for the short-lived metabolites of cannabis.

Drug Education In Schools And The Community

The Summit recommends that:

School culture and values

10.1 All Government, Catholic and Independent schools should aim to exemplify the following:

- (a) a shared set of values and ethics, underpinning a school culture which is antithetical to the abuse of drugs in any form, being based on a whole school approach to health provision,
- (b) the pursuit of abstinence from illegal drugs as the safest and desired option,
- (c) the adoption of realistic strategies to reduce and prevent harm created by drug use,
- (d) the provision of access to referral and other support for young people who are experimenting or have become addicted,
- (e) the inclusion of students in establishing both the values and culture of the school, and the content of the drug education program, and
- (f) the provision of accurate and credible information on drugs and drug use to students, according to the needs they express.

Curriculum

10.2 All Government, Catholic and Independent schools should continue to expand and enhance the drug education programs in Personal Development, Health and Physical Education in kindergarten through to year 10, and years 11 and 12, with particular attention to the following considerations:

- (a) the values which underpin drug education need to be embedded in a whole school curriculum approach where the Personal Development, Health and Physical Education program is an important element, and
- (b) the specific provision of drug education must begin in the early years of primary schooling.

The drug education program must be appropriate to the level of cognitive development of the students, but flexible enough in its delivery and content to meet the requirements of school and student context. The drug education program must be on-going, self-renewing and internal, rather than based on external and one-off curriculum inputs (which are nevertheless useful supplements to school programs).

Characteristics of successful drug education programs

10.3 All Government, Catholic and Independent schools and systems should develop drug education programs based on the following characteristics of good practice:

- (a) the programs are part of a health education syllabus which provides accurate information and develops related skills and attitudes,
- (b) they are developmental and sequential, appropriate to the cognitive level of the students, and anticipate the need for education in advance of the risk of abuse,

- (c) they are based on current theory and research,
- (d) the teachers have the confidence, knowledge and skills to teach the program, and regularly undertake further professional development in this area,
- (e) the lessons are credible to students because the information provided is honest and consistent,
- (f) the programs are proactive rather than reactive and punitive,
- (g) the messages which are learned in the classroom are modelled consistently by staff, and supported by parents,
- (h) speakers and programs from outside the school are not used for one off events but are included as part of the planned curriculum, and
- (i) listening to students and the inclusion of students in the developing of the program.

Youth alienation and drugs

10.4 It be recognised that:

- (a) there is a relationship between poor school performance, low self-esteem, failure to complete secondary school, unemployment and being at risk of abusing drugs,
- (b) a sense of achievement in the compulsory years of schooling leads to improved self-esteem, the completion of secondary schooling, a substantially enhanced capacity to undertake further education and training or enter the workforce, and a reduced risk of drug abuse, and
- (c) the 15% of 15 to 19 year olds who are neither in education and training nor in any form of regular employment are at high risk of drug abuse.

10.5 For the reasons given in 10.4 there should be:

- (a) development of whole school programs from kindergarten through to year 12 to build confidence, resourcefulness and inner strength in all young people; to assist them to form strong and enduring relationships during and beyond their years at school; to foster their skills, talents and interests, and give them pride in their capabilities and achievements; and to build a foundation for a life-long perception of self-worth,
- (b) further development of peer support programs, nurturing programs and referral services, so that young people might at all times 'connect' to their peers, to adults whose support they value, and to assistance as and when required,
- (c) continued targeting of resources to address under-performance in literacy, numeracy and personal development, in both primary and secondary schools,
- (d) establishment of educational institutions and campuses at senior secondary level to provide a learning environment appropriate to young adults and the full range of curriculum in both

general and vocational education,

- (e) greater provision and recognition of vocational education and training in the Higher School Certificate by all Government, Catholic and Independent secondary schools, so that students completing Year 12 might also complete part or all of a traineeship within the Higher School Certificate while also being able to enter university, and
- (f) removal of restrictive practices which inhibit growth in the number of apprenticeships and traineeships.

Parent and community education

10.6 It be recognised that:

- (a) the attitudes and behaviour of parents and the community significantly influence the health choices of young people,
- (b) schools are the most numerous and widespread institutions in the State, and the hub of community activity, and therefore potential exists for schools to assist in the provision of information and education programs on drugs for parents and the general community, and
- (c) schools also have the potential to act as a catalyst for collaboration between a range of government agencies, local councils, non-government organisation, community groups and parents, all focused on their shared interest in and responsibility for children and young people.

10.7 All Government, Catholic and Independent schools recognise and act upon their potential for the provision of information and education programs on drugs and drug advice to parents and to the general community.

10.8 All parents (as well as their children) be provided with accurate, credible and relevant information on the identification and effect of all drugs currently available within the community.

10.9 Information programs be conducted for parents, setting out details of the schools drug education program and advising parents on their own roles in supporting their children.

10.10 Schools collaborate with other community and government agencies to establish a coordinating committee to ensure the fullest possible integration of actions to address drug-related problems at the local level.

10.11 Relevant Government agencies such as the Department of Health, the Department of Community Services and the Police Service, together with local Councils, non-government organisation, community groups and parent groups, be encouraged to use the schools as community centres for providing information on and conducting programs about drugs, drug abuse and support available to the community.

10.12 Schools establish linking programs with the Board of Adult and Community Education, and with religious, community and service groups to promote the informed provision of drug

education throughout the community.

- 10.13 All teachers should undertake a regular program of professional development in drug education, the universities should revise their teacher education programs to ensure that all teachers undertake at least four hours of training in drug related issues in their pre-service years, and that employers of teachers should give employment preference to those graduates whose teacher preparation has included such programs.
- 10.14 Because young people obtain information on drugs from a variety of sources, and respond to different role models and influences, schools should identify a range of ways of communicating with young people about drugs including participation and use of non-curriculum/informal education activities.
- 10.15 Sufficient funding be provided by the Government specifically for the purpose of supporting these recommendations, and this funding be provided openly and transparently.
- 10.16 A long-term research review be conducted to investigate links between the regular or occasional use of marijuana and adverse educational effects, and, if relevant research is not adequate, then further research be conducted. The study should have regard to, but not be limited to the effects of marijuana on:
 - (a) cognitive development,
 - (b) behaviour,
 - (c) student motivation, and
 - (d) educational outcomes.

Drugs In Rural And Regional NSW

The Summit recommends that:

General

- 11.1 A review group be formed to meet six-monthly and monitor progress of the NSW Drug Summit outcomes, with a specific brief to overview adequacy and equity in country areas.
- 11.2 The existing Ministerial Advisory Committee on Tobacco, Alcohol and Other Drugs (or any future similar advisory body) include regional, rural and remote representation of at least two positions and further that the Committee develop regional, rural and remote specific strategies to implement policy.

Prevention

- 11.3 New parents in regional and rural communities have access to co-ordinated, local support programs from the birth of their children and through early childhood.
- 11.4 Early prevention programs are sensitive to the needs of ethnic and Aboriginal families.

- 11.5 Drug education and prevention strategies, including graphic advertising campaigns (similar to anti-smoking), provide consistent, accurate and comprehensive information about the dangers of illicit drug use - for both parents and children.
- 11.6 Current education and prevention strategies be evaluated as a matter of priority, with particular consideration of their relevance, modality and success in regional and rural communities
- 11.7 Drug education and prevention strategies be designed to address the issue of rural and regional communities' general refusal to recognise the extent and nature of drug problems within their local community.

Local community strategies

- 11.8 Local councils, with community-based organisations and state agencies at a local and regional level, form community response strategies, including:
- (a) community education about the local drug problem,
 - (b) co-ordinated service provision for drug users and families, and
 - (c) reduced availability of drugs.
- 11.9 Leadership in formation of these strategies should be provided by local councils, which should be adequately resourced to undertake the task. Key state agencies include Health, Housing, Education and Training, Corrective Services, Aboriginal Affairs, Community Services, Premier's Department Regional Co-ordination Program, Police and Juvenile Justice.
- 11.10 Drug Action Teams, comprising key agency regional managers and service providers, be extended across regional NSW and operate through the Regional Co-ordination Management Groups established as part of the Premier's Department Regional Co-ordination Program.

Equity and Resources

- 11.11 (a) Expenditure benchmarks for drug and alcohol services be set for Area Health Services after budget shortfalls and inequities have been addressed.
- (b) Additional funding be allocated to allow Area Health Services to meet benchmarks.
- (c) In setting benchmarks, local community groups and health professionals be consulted and consideration be given to all available data, including research by the Network of Alcohol and Drug Agencies (NADA).
- (d) Drug and alcohol services funding be clearly identified and performance evaluated.
- 11.12 Benchmarks reflect the priority need for drug and alcohol services within regional and rural communities and the health care system as a whole.

- 11.13 A strategy be developed which most effectively utilises existing community-based health facilities and the Royal Flying Doctor Service in rural and regional communities for the delivery of drug and alcohol services.
- 11.14 Drug and alcohol programs receive increased funding to provide greater access for persons with addiction problems and secondly, that equality of service provision be given to residents of country NSW to redress current under-funding compared to metropolitan areas.
- 11.15 Initiatives to recruit and retain general practitioners and other health practitioners to rural and regional areas be continued, enhanced and co-ordinated.
- 11.16 The priority placement of additional drug and alcohol counsellors in all eight Area Health Service areas in rural NSW announced by the Government in April 1999 be welcomed, and implemented quickly and further enhanced.
- 11.17 Drug and alcohol managers and structures, including a medical staff specialist or medical officer, be established in all eight Area Health Service areas in rural NSW.
- 11.18 Representations be made to the Commonwealth Government to move quickly to develop mechanisms, including the use of geographic Medicare provider numbers, to encourage more general practitioners to locate to regional areas.

Treatment Services

- 11.19 Each regional and rural health area should be able to provide or have ready access to the following minimal level of drug and alcohol services:
 - (a) assessment, counselling and referral,
 - (b) detoxification (residential and non-residential),
 - (c) case management,
 - (d) residential rehabilitation programs,
 - (e) methadone treatment and other drug treatments (LAAM, naltrexone and buprenorphine),
 - (f) training and education,
 - (g) early and brief intervention,
 - (h) prevention and community development programs,
 - (i) Aboriginal drug and alcohol programs and programs for other special needs groups including women, children, youth, HIV/AIDS, Hepatitis C, and others, and
 - (j) management of medical complications from drug and alcohol use.

Training

- 11.20 Country general practitioners, who for various reasons are reluctant to participate in the provision of drug and alcohol services particularly methadone, be provided with increased and tangible counsellor support in the assessment, treatment and referral of patients under the new 'GP pilot project'. Further, the Federal Government be approached to provide incentives to increase drug and alcohol services by general practitioners by means of practice incentive program (PIP) grants or accreditation.
- 11.21 Initiatives to train general practitioners and other health practitioners in rural and regional areas be continued, enhanced and co-ordinated.
- 11.22 Area Health Services provide, in regional settings, continuing professional education in drug and alcohol treatments to private, non-government and public health professionals.
- 11.23 Area Health Services form partnerships with local education providers (for example, universities and TAFE colleges) to enhance access to quality drug and alcohol education for professionals.

Law Enforcement

- 11.24 Barriers to police taking up country posts be identified and a system of incentives developed to attract and retain police in regional, rural and remote areas to ensure that:
- police officers and their families become part of the community, and
 - skills and experience in a locality increase over time.
- 11.25 Police resources are not re-allocated from rural and regional NSW to high demand metropolitan areas.
- 11.26 Police officers located in regional, rural and remote communities be actively encouraged to initiate and support community-based programs (e.g. Police Citizens and Youth Club, Local Government Social Plans).
- 11.27 Locum police be available in regional, rural and remote communities for those police officers required to be absent to minimise the impact of officers covering large distances.
- 11.28 Diversion programs and a flexible drug court approach be introduced to regional NSW.
- 11.29 In order to free up police time, communication and information technology be fast-tracked for use in police reporting, representation and presentation of court evidence.
- 11.30 Police resourcing strategies recognise that rural centres with prisons present particular challenges in law enforcement relating to drug and alcohol use in those areas.
- 11.31 In order to keep family and social networks intact, strategies be developed to ensure that rural and regional families have reasonable access to family members in prisons. Such strategies should include consideration of transport issues and prison locations.