



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

**HOUSE OF
REPRESENTATIVES**

STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Reference: Impact of illicit drug use on families

WEDNESDAY, 28 FEBRUARY 2007

CANBERRA

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

INTERNET

The Proof and Official Hansard transcripts of Senate committee hearings, some House of Representatives committee hearings and some joint committee hearings are available on the Internet. Some House of Representatives committees and some joint committees make available only Official Hansard transcripts.

The Internet address is: **<http://www.aph.gov.au/hansard>**

To search the parliamentary database, go to:
<http://parlinfoweb.aph.gov.au>

HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON FAMILY AND HUMAN SERVICES

Wednesday, 28 February 2007

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

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

Terms of reference for the inquiry:

To inquire into and report on:

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

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

WITNESSES

BRYANT, Ms Jennifer, First Assistant Secretary, Population Health Division, Department of Health and Ageing..... 1

HART, Ms Virginia, Assistant Secretary, Drug Strategy Branch, Department of Health and Ageing..... 1

LEARMONTH, Mr David Andrew, Deputy Secretary, Department of Health and Ageing 1

VAN VEEN, Ms Laurie, Assistant Secretary, Communications Branch, Department of Health and Ageing 1

Committee met at 10.21 am

BRYANT, Ms Jennifer, First Assistant Secretary, Population Health Division, Department of Health and Ageing

HART, Ms Virginia, Assistant Secretary, Drug Strategy Branch, Department of Health and Ageing

LEARMONTH, Mr David Andrew, Deputy Secretary, Department of Health and Ageing

VAN VEEN, Ms Laurie, Assistant Secretary, Communications Branch, Department of Health and Ageing

Witnesses were then sworn or affirmed—

CHAIR (Mrs Bronwyn Bishop)—Welcome. I declare open this public hearing of the House of Representatives Standing Committee on Family and Human Services for its inquiry into the impact of illicit drugs on families. Today the committee will take evidence from the Department of Health and Ageing. I thank them for attending today and hope that we will gain an overview of the Commonwealth's policy on illicit drugs and the strategy for that policy. By way of background: we have already taken evidence from the Australian Institute of Health and Welfare, from Customs and from the Australian Federal Police Commissioner, Mr Keelty. I now invite you to make an opening statement.

Mr Learmonth—In the interests of the committee's time, we will not make an opening statement. However, we are happy to answer any questions.

CHAIR—I might begin by asking you the way in which your department plans to deliver—or is in the process of delivering—its strategy with regard to drugs. We are only dealing with illicit drugs in this inquiry, which is in accordance with the Prime Minister's statement. The statement that he made on 3 February 2004 on zero tolerance is a good starting place. He said:

We have an uncompromising approach to people who are involved in drug trafficking, we seek, when people need assistance, and especially when they seek it out, we seek to improve rehabilitation services that are available and finally and very importantly we seek to educate people against starting drug use in the first place.

He says that the people around Australia have found it to be a good policy, and he says:

... it has never ceased to amaze me how people can question the doctrine of zero tolerance towards commencement of drug taking in the first place or indeed dealing with the problem.

He makes several more very strong statements saying that zero tolerance is our policy.

Mrs IRWIN—That is the government's policy.

CHAIR—Yes, that is the government's policy. That is the only one we have got. I wonder if you could tell me how the department is going about the implementation of that. We might then discuss this particular document and how that is seen to fit with the Prime Minister's policy.

Ms Hart—The Prime Minister’s statement sits with the National Drug Strategy, which is Australia’s integrated framework for the policy and delivery of drug services across a range of areas. That operates until 2009. One of the key principles of the drug strategy is that there is a balanced range of measures that make up Australia’s approach to drug issues, whether they be illicit—which is what this committee is focusing on—or licit. That strategy balances across all levels of government—the federal government and state and territory governments—and there is a key role for community based and non-government organisations.

The issue of supply reduction does not fall within our portfolio as that is largely the responsibility of law enforcement agencies. However, that is fundamental to ensuring that we prevent illicit drugs from entering our shores and also from being manufactured within Australia.

The other areas that principally fall within our department and my program areas are around demand reduction, prevention and treatment strategies. As an Australian government department, we focus largely on frameworks that enable and support the agencies that deliver treatment and prevention activities. In the main, drug and alcohol services, including services for users of illicit drugs, are provided by state and territory drug and alcohol services. There is also a strong involvement of non-government organisations in the provision of drug and alcohol treatment services and prevention.

One key aspect that has driven the Tough on Drugs strategy since its inception is a very strong focus on prevention. The committee may wish to note that the drug strategy framework lists ‘prevention’ as the first priority for future action over the 2004-09 period. That is closely followed by ‘reduction of supply’.

The department has a strong reputation for delivering population based campaigns. These are broadly based and they seek to target the whole community. They are also supported by specific targeting around parents, children, and groups who may be at particular risk of taking drugs. We have had two phases of the national campaign focusing on illicit substances. We are in the process now of developing a third phase of the drugs campaign, which will go to air in late April.

CHAIR—Could you highlight what screenings are to go to air, without breaching—

Ms Hart—Although it is not directly within my area, I can state that the government has committed well over \$20 million to support the third phase—

CHAIR—Could you describe that third phase.

Ms Hart—It is an approach that tries to target the most commonly used illicit drugs of concern, so it deals with cannabis, ecstasy and speed, and we are currently looking at developments around ice. The growth in the use of methamphetamines is of concern. Ice in particular, as the committee is probably well aware, has been a cause of concern probably since the nineties, which is why it will be a component of the campaign. The executions are being developed at the moment; the campaign draws very heavily on the previous two phases of the—

CHAIR—What are they?

Ms Hart—I have here a report published in March 2006, which evaluates phase 2 of the campaign.

CHAIR—Perhaps the committee could have a copy of that.

Ms Hart—I am happy to provide that. I could give a headline summary of the campaign, but Laurie Van Veen can provide more details, as she looks after our campaign area.

Ms Van Veen—Virginia was just talking about the two phases of the campaign that have occurred to date. The first phase, in 2001, was an agenda-setting campaign to reach parents and support them in their conversations with their children about drugs, as well as to communicate with young people about the harms associated with drugs. That was followed in March 2005 with the launch of the second phase of the campaign. This phase provided practical information and tactics to parents to encourage them to continue to have conversations with their children about the harms associated with drugs and to highlight the important role they can play in preventing their child from taking drugs. There was also a major focus on communicating about the harms associated with the three substances that had the highest level of consumption at the time: cannabis, ecstasy and amphetamines. We can get you copies of the evaluation report.

CHAIR—That would be good, thank you very much.

Ms Van Veen—The report is also on our department's website, along with all of the campaign material. From our evaluation of the campaign, we have determined that it is really important that these ads are seen to be believable, credible and—

CHAIR—Are you now talking about phase 3?

Ms Van Veen—Yes, both the most recent campaigns and the ones we are developing. If we were to look at the campaign that was out there in 2005 and ask what it achieved—

CHAIR—Before you do that—and we are keen to have that response—I have to say that, as a member of parliament and as a mum and a punter, I have never heard of the phase 1 and phase 2 campaigns. So who did you reach with them?

Ms Van Veen—In terms of the campaign, the first phase had a national letterbox drop, to every household, of a booklet for parents about drugs and—

CHAIR—I do not want to use the term 'junk mail', but it would have gone in the mail like Woolies and Coles advertising.

Ms Van Veen—No. It was obviously very important with the advertising to have parents aware of the need to look out for this product. We actually ran the ads to, number one, put it on—

CHAIR—Is anybody at this table aware of those ads in that campaign?

Mrs IRWIN—Yes. I was aware of the campaign, with the booklets that were going out to people.

CHAIR—Did you ever see one?

Mrs IRWIN—I think I saw one. I was not overly impressed with it, I have got to be honest. There was a complaint from my community because it was not in various languages. I have 135 different nationalities in my electorate and I found a lot of them were throwing it out.

Mr QUICK—The booklets went out during our previous inquiry into substance abuse.

CHAIR—So there was a reason why you would be aware, because it was during the previous inquiry.

Mrs MARKUS—I think there were challenges of literacy and challenges for people with non-English-speaking backgrounds.

Mrs IRWIN—That was a complaint that I got.

Mrs MARKUS—A lot of people in my electorate would not have even been able to read it.

CHAIR—We will be pleased to see it. Let us hear about stage 3, because you have a new parliamentary secretary and things are happening for you.

Ms Van Veen—If I could just take your point on how many people saw those ads. We did nationally representative research with parents, and two in three parents felt that the campaign made it easier to talk to their kids about illicit drugs and, of those who recalled seeing the ads, 92 per cent reported taking action.

CHAIR—But how many people saw them?

Ms Van Veen—We have those figures here.

CHAIR—Thank you. Lovely.

Ms Van Veen—Stage 3 is coming out again to remind parents and to support them in meeting their information needs about drugs. There are new drugs on the community's radar, and there is concern around substances such as ice or methamphetamines. This has been a new issue since the previous campaign was designed. We are looking at advertising to support parents in dealing with that substance.

CHAIR—But what is the message?

Ms Van Veen—It is to communicate about the harms associated with using these drugs.

CHAIR—But harm is such a benign word, isn't it? 'Don't harm yourself, dear.' I will put it this way: we took evidence from the Australian Institute of Health and Welfare that the latest smoking campaign has been very effective. I am referring to that hideous photograph of the mouth cancer and the disfigurement.

Mrs IRWIN—There was also the HIV campaign earlier.

CHAIR—The HIV campaign was very successful because it scared the living daylights out of people, and there have been dramatic, measurable cuts. The Australian Institute of Health and Welfare also said that the main reason that people give for starting on drugs is curiosity. They are curious, so where is the information that we are giving them that says, ‘Do not do it, because it will scramble your brains’? There is none.

Mr QUICK—Is it possible to see the ads prior to them going out?

Ms Van Veen—That would be subject to government approval.

CHAIR—Can you inquire for us?

Ms Van Veen—I certainly can.

CHAIR—Commissioner Keelty said that he would welcome a campaign of that nature, a very big campaign saying, ‘This is going to scramble your brains,’ and something graphic—like the horrible, cancerous mouth.

Ms Van Veen—We have certainly got a long history of developing those campaigns, such as the National Tobacco Campaign. What is critical with these campaigns is that we do extensive focus testing with young people, because it is not about how the ads influence adults.

CHAIR—No, but it is the message.

Ms Van Veen—In terms of the message, we want to hold a mirror up to them and show them what damage these types of drugs can do to you. After the previous ads about cannabis, ecstasy and speed, two in three young people felt that the campaign had influenced what they do or think about drugs; most often, they were influenced to avoid drugs and to think about the consequences of using them. More than half felt that the campaign had made it easier to discuss illicit drugs with their parents.

We did pre-campaign testing, benchmarking and tracking research, through which we increased young people’s awareness of mental health and other problems associated with using marijuana, ecstasy and speed. We determined that fewer young people were at risk of accepting a friend’s offer of cannabis or speed after the campaign ran.

CHAIR—The problem is that cannabis use is slightly declining, heroin use is definitely declining and, from the evidence that we have heard, it is because heroin is not cool—it is dirty; it is about injecting; it is grubby; it is all those things—whereas popping a pill is. When public broadcasters such as the ABC talk about recreational drugs and party drugs, what do we expect? Is there a strong message in your ads?

Ms Van Veen—Yes.

CHAIR—How can we stop people on public radio and public broadcasting describing illegal drugs in those terms?

Ms Van Veen—It is a real challenge and certainly we work with the media by doing briefings with them, but it is a real challenge to control the media and how they—

CHAIR—The Prime Minister said:

There is no safe level of marijuana use, there is no safe level of the use of any kind of illicit drugs and the clearer that message can be communicated the better and that is why of course the Government, amongst other things, has an uncompromising approach at a federal level towards any resort to heroin injecting rooms ...

In other words, Tough on Drugs means just that. And yet, when I read this—

Ms Hart—Could I add something to Ms Van Veen's response, because the campaign area works very closely with the policy area that I look after. We are getting an increasingly good understanding of just how lethal ice is and the multitude of harms that are caused by ice.

CHAIR—How about we use the word damage?

Ms Hart—Damage? Damage is certainly—

Mrs MARKUS—And danger.

CHAIR—Danger and damage: harm is such a benign, safe word. I would rather use words like damage and destruction.

Ms Hart—I take your point, and we understand that it is a highly destructive drug. I think we now have a very good and clear message coming through the campaign in terms of both psychological and psychiatric harms. We know that the potential for transient psychosis is 11 times higher than in the normal population.

CHAIR—Most people are not going to know what transient psychosis is.

Ms Hart—No, but—

CHAIR—What sort of terminology are you going to use to tell them?

Ms Hart—Basically it is people losing the plot, to put it in common parlance. When we are looking at—

CHAIR—A fried brain.

Ms Hart—the speed execution, we see people who are raging out of control, who have lost their capacity to tell what is going on in the world and who are uncontrollable. They are very difficult for family, friends, and even accident and emergency workers—ambulance, police and nurses. They are raging out of control and it is attributable to ice. I think that we have got a very clear message around that.

CHAIR—But do you show what happens to them? Look at the Paris Hilton stuff; the kids who want to be Paris Hilton. What about how Paris Hilton would look in perhaps 10 years time, or how they are going to look in 10 years time? In other words, not the cool kids popping pills but the person with their mind gone, face hideous, and body sagging?

Ms Hart—Yes.

CHAIR—Because the kids think it's cool.

Ms Hart—That is true, and often holding up the evidence about those long-term dangers and the whole degradation of your physical functions and appearance is an important part of this. We have fed in a lot of advice that has come not only from focus groups, as Ms Van Veen said, but also from some very prominent clinicians and advisers from the Australian National Council on Drugs.

CHAIR—I am going to ask my committee for questions in a minute, but first I want to ask this: the Prime Minister has been absolutely uncompromising in what he believes is the policy. The Deputy Chair of the Australian National Council on Drugs, Margaret Hamilton, has written that it was unfortunate that the Prime Minister has a zero tolerance approach to drugs, but we have managed to handle him by saying that it only applies to education. How dare she? How can we have an effective policy when the Prime Minister has spelt out the policy and the deputy chair says, 'We have handled the Prime Minister; he was a bit of a problem for a while'? How dare she? Who are you listening to, the Prime Minister or her?

Ms Hart—Obviously we are adhering to government policy but there are a range of views represented on the ANCD.

CHAIR—Are you? I pick up this—

Mrs IRWIN—We do live in a democratic society.

CHAIR—This is a department which answers to the government. Here is something they want to do:

Explore the link between tobacco and cannabis smoking by determining the prevalence of tobacco smokers who became dependent on nicotine by smoking cannabis mixed with tobacco ...

'We don't care if they are addicted to cannabis, but it would be dreadful if they were addicted to nicotine'!

Ms Hart—I think that is trying to get at the issue that we care about both the drug strategy that tries to deal with—

CHAIR—One is legal; one is illegal.

Ms Hart—Yes, and we have different mechanisms for handling illegal drugs.

CHAIR—When somebody asks kids, ‘Why do you take this stuff which is going to fry your brains? If you’ve got to smoke something, have a cigarette,’ I have had evidence of them saying, ‘Oh no, that might kill me.’ This document is full of harm minimisation. The Prime Minister said that he is opposed to harm minimisation and that we do not have it. And yet his deputy chairman is saying that here is a problem. I will stop asking my questions there. My colleagues will have questions to ask.

Ms Van Veen—I will make an undertaking to the committee, to follow up on some of your themes, that we will provide you with a complete set of the ads from the second stage of the campaign, and I think you will see that they are very hard-hitting. I will get you the evaluation report. I would also be happy to provide you with the recently launched advertising, targeting youth on smoking.

CHAIR—No. We are looking at illicit drugs.

Ms Van Veen—That is fine.

CHAIR—I want to make a distinction between legal and illegal drugs. We would like to have that briefing on the ads that are to go out, and I would like to see the words ‘damage’, ‘destroy’, ‘dark’, ‘harm’.

Ms Van Veen—I can tell you, from having seen one of the scripts this morning, that none of our ads have referenced harms. I think that we are just talking about it in the broadest sense of what we are conveying. The word ‘destroy’ is in there.

CHAIR—One of the reasons that I get so passionate about it is the number of parents who come in the door to my office to say, ‘Mrs Bishop, do you support the production of more mental health services and more beds at Manly Hospital?’ And I say, ‘Yes, I could support that, but what is the problem?’ They say, ‘The problem is my son’ or ‘The problem is my daughter.’ I say, ‘Is it marijuana?’ ‘Yes.’ ‘Is it psychosis?’ ‘Yes.’ One of them has a son who was a trained nurse. Now he can only get a job sweeping the driveway at an RSL for two hours a week. That is why I get passionate. Sorry.

Mrs IRWIN—I want to ask a few questions about the third phase of the campaign. You have stated that it is going to air and that it is going to cost \$20 million. I gather that the campaign is for television and radio?

Ms Van Veen—At this stage we are still finalising the media mix. It will be predominantly television because of its effectiveness in reaching mass audiences. I expect that there will be radio, print advertising and supporting strategies.

Mrs IRWIN—Right. Are we looking at getting booklets, pamphlets or leaflets into letterboxes again, like you did in phase 2?

Ms Van Veen—At this stage a final decision has not been made about that. We are certainly looking at a range of options.

Mr QUICK—You have targeted parents so that they can talk to their kids and know what the kids are dealing with. Due to modern technology—mobile phones, iPods and downloading—how many kids read newspapers? Only a handful read them. We are talking about 14- to 25-year-olds, who are using ice in epidemic proportions. How the hell are we going to target them, because they live and die by their mobile phones and their MP3s and their iPods? Have you factored that into stage 3? Have you spoken to young kids in, say, senior secondary colleges to ask, ‘What is the best way to get a message to you guys that is really going to get into your face so that you are going to talk about it over a rum and Coke?’

Ms Van Veen—Certainly the research that we have been doing with young people has been critical. Importantly, the research is with young people across all drug using sectors, from those who are not at risk—and we want to keep them there—to those who are thrillseekers and very interested, through to those who are more actively involved in drugs. We have been looking at exploring with them the messaging, the advertising and the mix of media channels. We would never use newspapers to reach youth; you are absolutely right. We look at a range of strategies. Television is still very much a part of the mix, as well as internet strategies—they are very active users of the net—targeted magazines and radio. We have not gone into SMS text messaging. There are some privacy issues for us with some of those strategies. But we are looking at the most effective strategies in terms of reaching the largest number of youth across the different drug segments.

Mrs IRWIN—Would you also be telling them where to turn for help?

Ms Van Veen—Absolutely. There is a three-layered strategy: first, to communicate about the harms associated with drugs; second, to put forth some positive messages about experiencing other thrills in life and other ways you can be active in life; and, third, to address support and connectedness by putting them in touch with a range of services—not just drug and alcohol services—to help them no matter whether they are looking for accommodation, mental health services or Lifeline. We provide all of those phone numbers. So there are a range of elements in the strategy. When we put together the phase 2 campaign activities paper, it will show you the elements and the products that were generated. We are building onto that for the third phase of activity.

Mrs IRWIN—Another thing I come across is families being frustrated with not knowing where to turn for help. Their child might be going in for treatment and they may not be kept informed about that treatment. They may not be told how to handle the situation when their child comes back to the family home. Their biggest gripe is not knowing where to turn.

Ms Van Veen—That information is in the booklet for parents, right down to the phone numbers of the local alcohol and drug information services. The advertising will have a 1800 number for people to call when they are in immediate need of help. There will be links to alcohol and drug services so we will be able to get people in touch with counsellors as they require them.

Mr QUICK—You can have as many phone numbers as you like displayed on little cards at places like Youth Link, but they are open only five days a week.

Mrs MARKUS—Exactly.

Mr QUICK—The number of rehab beds available across Australia has not gone up. The Commonwealth government is putting chaplains into every school. Are they part of this communication mix and, therefore, able to be a referral point? My daughter is a high school teacher at a tough school in Melbourne. Are you going to involve schoolteachers, some of whom face violence every day in school as a result of kids taking ice?

It needs a total package. Having been a member of this committee for a long time and having also served on its predecessor, I am well aware that families and kids want instant answers. It is no good saying, 'We can fit you in next Friday,' if their child is off his face destroying the home and harming the social fabric of his family and school. What has been learnt from phases 1 and 2, and how will phase 3 be different so that something is actually achieved?

Ms Hart—I might try to answer that because your question goes beyond campaign activity, which is just one segment of what we do across the whole policy vista. It touches upon what we are doing to try to improve the capacity of services to respond. As you have said, these issues do not occur only between 9 and 5; they often occur, and need a response, in the middle of the night or on weekends. The services that people need to use to get treatment—whether it is for themselves directly or for their families—are primarily run at the state and territory level. We have tried to develop guidelines to assist state and territory drug and alcohol workers and people working in non-government organisations to provide an immediate response. We have developed some guidelines for ambulance services, which are frequently called into play when someone has a violent and immediate drug reaction. We have a number of activities to help general practitioners work with drug users and family members, although there are sometimes disclosure barriers to consider. We have also developed some guidelines for use by the police and by accident and emergency services because people requiring after-hours assistance will often go to an A&E department.

To add to the array of treatment options, we also provide funding to non-government organisations. We currently fund about 170 services ranging from residential rehab, which allows people to get away from the environment that may have caused their addiction, to spend several weeks or months detoxifying and learning new skills to cope with life—

Mrs IRWIN—Sorry to interrupt you but could we have a copy of that and information on how much funding those groups are getting, so that we are aware of what the groups are getting. Please take that on notice.

Ms Hart—I would be happy to.

Mr QUICK—The mission statement talks about improving outcomes by 'preventing the uptake of harmful drug use'. Are you being provided with the numbers by the states? People are talking about an epidemic of ice use in Australian society. You are putting out phase 3 of a three-staged approach. Are you getting the numbers from the state health departments to say, 'Before we started this, the baseline in 2000 was X number of heroin users and X number of young people using marijuana. There were no people using ice, because it was not fashionable or the in-thing. Now in 2006 we have spent X zillion dollars. Yes, there is an epidemic and we have to change phase 3 as a result of all this information'? Or are the states doing what they usually do and saying 'We are not going to provide the Commonwealth with that information; this is something within our own little neck of the woods'? Is there that cooperation so that you can tell

me what the baseline numbers are, state by state, for the last five years; so you can then say, 'The uptake is horrendous; the uptake is 10 per cent over what it was last year,' or, 'Our campaign is successful because the numbers are such and such'?

CHAIR—Perhaps you can take that on notice and come back to us with that information. That would be terrific.

Ms Hart—I am happy to do that. As a very brief comment, we have a national drug survey that involves about 30,000 households and we produce quite a lot of statistics by substance.

CHAIR—Perhaps if we can have that as well; that would be very helpful.

Ms Hart—I am happy to provide that. In terms of our dynamics with state and territory governments, they have been very responsive to any local or state based collections. Obviously we need to work collectively. There are national initiatives and there have to be state and territory based initiatives dependent on local conditions and local drug service treatment arrangements. The drug strategy has always been characterised by a pretty cooperative exchange between the Australian government and state and territory governments, both policy makers and service providers.

Mr CADMAN—As a member of the former committee, I have to say I was pretty disappointed with the long delay we had in receiving a response to our report and with the quality of the response. That is my own opinion. Having taken evidence for two years and having seen providers and gone around Australia—going to areas that I do not know whether or not you visit—the committee had formed a view on behalf of the people we represent, and it appeared to us that the department had a view which was superior, in their opinion, to ours. We are very determined to see that there is a change to the process and philosophy that you are adopting—I am, anyway.

I have searched your website and I cannot find the words 'tough on drugs' anywhere on the department of health's website. Is that right? You used the words today. That is the first time I have heard an official from the department of health use those words. Others use them.

Ms Hart—I would need to have a look at the website.

Mr CADMAN—It is in none of these documents you have given us today.

Ms Hart—We certainly refer to a package of measures—which I think is now about \$1.3 billion on the supply side and on the treatment and prevention side—as part of the Tough on Drugs strategy.

Mr CADMAN—I would like to see it in writing somewhere, because it is not there now. I have noticed you are going into this publicity campaign and I wonder whether you are aware of the Mental Health Council of Australia's recent figures that the average age of first-time cannabis users is now 14.9. Are you aware of those figures?

Ms Hart—Yes, I am.

Mr CADMAN—Will they be a group targeted by your education program?

Ms Hart—I might just refer to—

Mr CADMAN—I am asking specifically about that age group. I do not want a whole generalisation about the program again, just that age group.

Ms Hart—That age group will be one of the targets that we will be looking at in a subsequent campaign which is trying to deal with the—

Mr CADMAN—So not this next one?

Ms Van Veen—They will be reached by this campaign.

Mrs IRWIN—That will be in phase 4.

Ms Van Veen—They will be reached by this campaign.

Mr CADMAN—You need to be specific with your words, because when you say ‘at a later stage’ it leads me to believe that it will not be in the stage 3 rollout.

Ms Van Veen—There are two campaigns. Obviously one is the drugs campaign, which we have been talking about, and there are messages in the current advertising materials which link to the effects on mental health. However, there is another budget measure, a campaign which will alert the community to the links between illicit drugs and mental illness. That campaign is being developed and will give people a better understanding of the connections between drug abuse and the development of mental illness.

Mr CADMAN—Most of this committee would say that that is about four years too late.

Ms GEORGE—I ask for a couple of things to be taken on notice as well. I was a member of the former committee, and one thing that caused me a great deal of concern, locally and across the nation, was the lack of readily available detoxification places when families were desperately wanting attention. It is no use when someone is in the frame of mind to try and break their habit to say, ‘Come back in two or three months time.’ I was mildly surprised that a project to map the availability of detox and rehab places on a national basis had not been concluded some two years ago, so I would like to know what progress has been made in knowing how many beds we have for detox, where they are located, how much we spend and how that project is going, so that when people in the community need to avail themselves of access to a bed they know where to look. Do we have some comprehensive data on that, and what progress has been made?

Secondly, I do not think that enough money is going into supporting community organisations that are dealing with this problem at the grassroots level. For example, the Salvation Army in Wollongong has made numerous applications to your department and to the Department of Families, Community Services and Indigenous Affairs. They run concrete, on-the-ground programs with the families and the grandparents—who often have responsibility for children in these difficult situations. I would like to know by what percentage the government has increased support over the last five years or so, what amount of money is going to support organisations at

the grassroots level and whether there has been a substantial increase in funding. Often it is these NGOs and church and welfare organisations that are really filling the gaps in provision of support in the public health system for people who want to break the habit. A lot more needs to be done to make places available for people who want to kick the habit. So if you could take that on notice, I would be pleased to see what progress has been made in those areas.

Ms Hart—I am happy to. Did you want me to address your earlier questions now or take them all on notice?

Ms GEORGE—Yes.

Ms Hart—The overall map of services, available beds and places, and access to treatment services at the state and territory level is provided through ADIS, which is a referral mechanism. Obviously, the clients and their families need to be mapped to ensure the availability of services, particularly when there is an urgent condition that needs to be met. We are in the process of working with all the states and territories to have a national picture of that.

Ms GEORGE—We were told that two or three years ago.

Mrs IRWIN—Virtually nothing has happened.

Ms Hart—We have now pulled that information together. We are aiming to have it available by the middle of the year. Prior to that, my understanding is that there were central referral points in each of the states and territories, and we certainly mapped that network of referral points through the state based systems, which are called ADISs.

Ms GEORGE—Will you be able to tell us midyear how many places across Australia we have for detox vacation purposes and for long-term rehabilitation? Do we in the community know how many such places exist for the population of illicit drug users?

Ms Hart—That is managed by the states and territories because they plan and roll out services based on a formula around need, population and predictions—it is not held centrally by the Australian government. But the mapping process that I just talked about will give an overview and description of the services and how access can be achieved for individuals and families.

Ms GEORGE—Presumably you would be able to access a number of places state by state in the different categories. Could you factor that into the mapping please.

Ms Hart—We could have a look at that.

Mrs IRWIN—Is there any indication about the waiting time, because in some of our electorates we are hearing that young people seeking treatment have to wait two or three weeks to get that service. Do you have that sort of information as well?

Ms GEORGE—They often have to go to out of the region.

Mrs IRWIN—That is correct.

Ms GEORGE—There are no long-term rehab places in the Illawarra at all.

Mrs IRWIN—That is the most frustrating thing.

CHAIR—I am going to give the chair to Julia for a moment while I go next door and establish a quorum.

ACTING CHAIR (Mrs Irwin)—If you could just take that on notice, Ms Hart.

Mrs MARKUS—There are a few points that I would like to raise. Before entering this place I worked for 26 years as a social worker, in prisons and in governmental and non-governmental organisations, with families and individuals that were affected by drugs. So I have some grassroots credibility.

I think that the terminology you are using is not strong enough. It may be in the ads, but when I hear ‘harm minimisation’ I think to myself that it is not working. On the one hand we would like to keep those using drugs safe so that they can get off drugs, but there are not enough services, as has already been mentioned. There is not enough focus on families; there may be individual treatment, but I would like to know how you are pressing for there to be a shift to a focus on everybody who is involved in the equation, because when one person is affected by drugs there are about 10 other people around them—family members, extended family members and communities—who are also affected.

Page 2 of the National Drug Strategy talks about harm reduction strategies to reduce drug related harm to individuals and communities. Individuals and communities in parts of my electorate—and I am sure in parts of the electorates of many of the people at this table—do not feel safe and they do not have easy access to services. I know that in many cases this is the responsibility of the state government, but you mentioned that the federal government does deliver some services. There is a clash between the federal government’s tough on drugs approach and the state government’s harm minimisation approach. This means that there is a clash in the approach to the delivery of services and the approach to policing drug related offences, as well as the approach to families, individuals and, of course, health services. That is something we need to take leadership in. How are you, as a federal department, going to take leadership in directing or influencing how services are delivered and how we change the approach? There might be some reduction, but at the coalface, families, individuals and communities are not seeing the changes that they want.

I would also like to ask about the illicit use of methadone and whether you have any information and statistics on that. Are you focusing on that? You mentioned earlier that the department is focusing more on the drugs that young people are more likely to use—I think you mentioned three drugs. But in many of the communities in Western Sydney and across New South Wales, where the methadone program has been a state government approach, we are now seeing the dealing and selling of methadone. This impacts lives; young babies are dying. What is the federal government doing, what is your department doing, in relation to that?

Ms Hart—Your question covers a lot of ground. I will try to answer as far as I can. For some of that, I may need to provide further information to the committee. In addition to what is provided by state and territory governments and the funding that we provide to non-government

organisations, we are strongly investing in expanding service capacity. In the last budget we had a number of measures that try to focus on particular areas that we know are a challenge or a weakness in the system. For example, funding was committed to university counsellors. We know that people at that age are prone to experimentation, and that may lead to later problems with addiction.

We are also funding a strategy to provide more money to the non-government sector so that they can expand their capacity to provide the full suite of services that they currently provide—just under \$70 million will be rolled out there. As well as that—and I think this maybe goes to the heart of your question about how services get delivered and what their nature and philosophy is—in recognition of the increasing problems with methamphetamines, we are in the process of trying to show national leadership around the development of a strategy which all state and territories will adopt. Obviously, as the Australian government, the federal government, we operate in the sphere of setting principles, standards, and directions. The states and territories then do the operational work of putting those into play and delivering services.

The methamphetamine strategy will concentrate very heavily on prevention, supply reduction and treatment. I think the approach recognises that there are barriers and difficulties with getting people who have already become users into a treatment service, and so we are looking at some outreach components so that people who would not identify themselves as having a problem can be reached. That may be through SMS messages or O-week support so that, at a time when 18-year-olds are going to university and being exposed to a range of influences, we can meet their need to have information and clear messages about the devastation that illicit drugs can cause in individuals' and families' lives.

The overall approach is to ensure that states and territories sign up to a framework document that embodies strong principles around the drug strategy to date. The other thing we add to that is a considerable level of investment that allows the service sector to have a full suite of responses and expands their capacity as much as possible. We do not deliver services directly; we fund other bodies, particularly NGOs, to deliver services. I am happy to provide the committee with details of those various programs.

The methadone program is run by states and territories. I know there are a variety of strategies to stop the diversion of methadone and the misuse that you described and that we are aware of. I would need to take that question on notice to provide the committee with more detail about how that operates.

Mrs MARKUS—In your discussions and while working with the states, is anybody looking at the actual transitional removal of the methadone program? I would say that it is a failure.

Mrs IRWIN—I am not going to get into that one either. I know of a lot of lives that it has saved.

Mrs MARKUS—Well, it has failed in terms of actually breaking the habit for many people and providing them with opportunities to develop full potential, so while I do not see methadone as a challenge if it is used to detox or provide someone with an opportunity to change their lifestyle, as a treatment it is really just creating a group of people that are now dependent long term on another drug. Obviously, if you are going to do that, if there were going to be a change

to that—again, I know this is the states' responsibility—is there anyone leading the charge, so to speak, to look at that and review it? Is it working? If it is not working, why isn't it working and what transitional arrangements could be made to introduce more effective approaches?

Ms Hart—We have three national research centres and, through the research centre based at the University of New South Wales, we certainly support the review of the effectiveness of pharmacotherapies, and we support the production of clinical guidelines for clinicians who are prescribing interventions for opioid dependence. The Australian government funds buprenorphine through the PBS scheme. We have supported the review of a set of guidelines for doctors and drug and alcohol workers so that they are well aware of methadone alternatives and can match the correct pharmacotherapy to the client's needs. The other area where we are supporting alternatives is around naltrexone implants; so, through the NHMRC, there is a controlled clinical trial of naltrexone implants to look at the effectiveness of those compared to oral naltrexone treatment, with which, obviously, there is a problem.

CHAIR—Where is that being done? Is that in Perth?

Ms Hart—That is the Perth based trial, I am pretty sure. It is due to conclude at the end of this year or the beginning of next year. Obviously, you need a range of interventions to suit people both at chemical and social-psychological levels. We are supporting, as much as we can, trials of alternatives and looking at their effectiveness. With new drugs, we need to go through the full procedure to ensure safety and efficacy of a clinical trial.

Mr TICEHURST—With the methadone and with the amphetamines in general, apparently, from what I understand, the first hit can cause brain damage at the start. Picking up on Mrs Bishop's comment earlier about this shock advertising: have you looked at the effectiveness of that drinking and driving advertisement, in which they show a fellow's brain being affected right from the first drink through? That is not such a shock; it is heading along the way. Have you looked at having an advertisement that would create that shock, so that people do not feel tempted to even try the drugs in the first place?

Ms Van Veen—That is certainly what we are looking at. I suppose one of the encouraging things that we are seeing in this research is that amongst youth there are a number of concerns about methamphetamine and ice, even amongst those people who use ice. There are some real negative associations there. There has been a lot of coverage in the media about some of the experiences that people have had; the rage and the scenes that we have seen at accident and emergency settings.

Mr TICEHURST—Does that get to the kids, though? If they are not reading papers or watching some of those TV news programs, do they get that message?

Ms Van Veen—They certainly are quite aware of it. We are seeing a very different response to ice in these focus groups. They are asking for tougher messages, so we are looking at powerful scenes, powerful depictions. You used the example of drink-driving and the effect on the brain. Whatever we do has to be factually based; we have to draw from what we know here. Certainly, the depictions that we are looking at are quite powerful. We have not been able to use the one you have suggested.

Mr TICEHURST—You said earlier that you send mail-outs around on these programs. When you are doing that, are you sending them to post-office boxes as well as actual households?

Ms Van Veen—At this stage we are still working on the distribution strategies for the parent booklets. I do not have that detail right now. When we did the first campaign, it went out to all letterboxes so that we would be looking at a national distribution. There was a question earlier with respect to distribution and schools. We send out kits to schools and let schools know when we are running these campaigns to give them an advance warning of it. Often they will use that to springboard off and do classroom based activities.

Mr TICEHURST—Do you do primary schools as well?

Ms Van Veen—We have not done primary schools. Our focus has been on high schools, but there have been a range of strategies that DEST have been responsible for to do with the National School Drug Education Strategy and funded school drug education activity that they have rolled out over several years. I do not have that detail with me.

Mr TICEHURST—What about grandparents? There are a number of constituents coming to me who are actually grandparents. Their kids are also affected by drugs, so as parents they are hopeless in this campaign. How do you approach that?

Ms Van Veen—Through mass-reach advertising. It is designed to communicate with parents, guardians or adults who have the ability to impact upon a young person's life. They can have a role to play in supporting that young person in their decision making. In addition to the paid advertising, obviously we look to supported public relations activities and to targeting different media channels—magazines et cetera—to cover the range of age groups. That work is currently being designed.

Mr TICEHURST—I was just thinking of that Grim Reaper ad. You said something about things having to be realistic. A lot of successful advertising is not necessarily along those lines. That Grim Reaper ad was very illustrative and did have that shock value. When you start to look at some of these first-time users who finish up dead, then you really need a powerful shock message.

Ms Van Veen—Absolutely. Ninety-seven percent of young people surveyed found the cannabis, ecstasy and speed ads to be believable. That is why we test and we test and we test.

CHAIR—I have not seen them.

Ms Van Veen—We will get you that package.

CHAIR—Is that the package to come?

Ms Van Veen—No. The ones that we ran in 2005.

CHAIR—Where did we run them?

Ms Van Veen—We ran them across Australia.

CHAIR—But on what media?

Ms Van Veen—Free-to-air television, pay television, magazines, outdoor advertising—

CHAIR—So it was on television?

Ms Van Veen—There was a \$13.5 million major campaign.

CHAIR—It passed me by.

Ms Van Veen—Obviously, with the youth campaign our primary target was younger ages.

CHAIR—How much did you spend on the smoking campaign and how much do you spend on the illicit drug campaign?

Ms Van Veen—We have spent—

CHAIR—If you do not have that, could you come back to us?

Ms Van Veen—We certainly can. Those two phases of drug campaign advertising have exceeded \$30 million.

CHAIR—Pursuant to standing order 234(a), could somebody move that we form a subcommittee consisting of Mr Fawcett and me to take evidence today for this inquiry, and that Mrs Bishop be the chair of that subcommittee.

Mr TICEHURST—I so move.

CHAIR—There being no objection, it is so ordered.

Mr FAWCETT—I have a few comments and questions around communications. Let us take you back to some of the earlier discussion about the media. We were talking about the mixed messages that the media were sending out with comments about ‘party drugs’ or ‘recreational drugs’. Am I correct in saying that your position is that that almost tacit endorsement of these things as an option for people is unhelpful?

Ms Hart—Yes, you are correct. The National Drug Strategy is governed by all federal, state and territory health and law enforcement ministers, and at their last meeting they agreed to a number of strategies to eliminate the use of terms like ‘recreational drugs’ and ‘party drugs’. We will be coming back to report on that. But you are correct: that is the position, and steps are being taken to eliminate, as much as possible, the use of terms which seem to glamorise and trivialise drug use.

Mr FAWCETT—If you had an option to control the media’s use of those words, would you exercise that because it would have a more positive outcome?

Ms Hart—We certainly do—certainly in all our input that is provided to the media we use those opportunities to correct the idea that the terminology does not matter.

Mr FAWCETT—Can I say that the same could be said about the National Drug Strategy and some of the language used by the department and the Deputy Chair of the Australian National Council on Drugs, who our chair talked about previously. The people who are actually taking drugs, particularly the first-time users, can be broken down into a number of categories, but often they are young. Often it is not 18-year-olds; it is younger teenagers. Ever since kids were racing around in chariots offending Socrates, they have been risk takers who think they are bullet-proof. There is an element that will always look for something that is outside the bounds. But there are also a substantial number of kids who end up taking drugs because of some emotional, psychological or physical damage due to relationship breakdown, bullying at school—you name it; there is a string of factors that you can bring together.

My concern is that if we are not consistent in our approach and in our message—and that goes right back to the fundamentals of even your mission statement and the messages passed on through organisations that are setting contracts and funding NGOs and others—then these kids are still left with the fact that this is an option. Whether you are talking about recreational drugs, party drugs, or whether you are talking about harm et cetera, it is like they are saying, ‘I am in real pain at the moment’—emotionally, psychologically, peer group pressure wise or whatever—‘and that looks like an option that might actually alleviate some of this pain.’ We need to unequivocally communicate to these kids that, yes, drugs are an option—just like standing in front of the semitrailer on a highway is an option—but you are going do yourself and your family incredible harm.

We need to start targeting the things that, at a very fundamental level, are important to these kids. If you look at any of the youth surveys around the place, the youth say that the thing that matters most to them is their relationships—not necessarily with peers but with family—their appearance and their self-image. Most kids, even the most damaged and dysfunctional, still have dreams of where they would like to be one day. These are the things that we need to be very clearly and unequivocally targeting. We need to be saying: ‘If you exercise a choice to go for this option rather than some of the others, these are the consequences for all these things that are important to you—and, by the way, it is illegal.’ At the moment, that message is not clear, either through the National Drug Strategy or in many of the options that are presented to kids. It is really important that we fundamentally say that we want our kids to stop taking these things. When I say ‘we’, I am talking about the government departments that are implementing the policy of a democratically elected government, which, in turn, is responding to the real needs and desires of the vast majority of the community who are impacted by drugs.

We have just discussed the fact that if you had the choice and the option, you would control the media to stop it sending mixed messages. As a government, if we look at the delivery mechanisms of our policy and see that we fund people and organisations that are deliberately sending mixed messages, is it not reasonable that we should say, ‘Perhaps we need to look at ways of stopping that’?

Ms Hart—I think that is reasonable and, at the federal level, that is what the commitment amounted to in terms of the use of those terms. We would then make sure that all of the organisations that were funded by us and through us adhere to that requirement. To go to your

question about broader distress, alternatives and choices: one of the things that the drug strategy and some broader Australian government initiatives try to do—as well as present the danger and the destruction caused by drugs—is to look at the positive side of the equation: how to enhance peoples functioning, capacity and relationships. There is a whole spectrum of ways in which we try to do that, including schools based drug education. A large component of that, as well as frightening children and having anti-drug messages, is about teaching them problem-solving skills, resilience, how to deal with peer pressure and how to stand alone if you are in a culture where there is pressure to do things that are dangerous. We do that at the early end.

In terms of the kinds of distress in people's lives that might point them in the direction of drug abuse, we have access through FaCSIA—not my department—to a range of things to support family resilience and individuals within families. If things progress to the point where there is manifest distress, we have a range of policies and funding for mental health services. As the committee would be aware, in our work with the states and territories, we have a \$1.9 billion package for supporting a whole range of mental health services, including intervention at the early end, before full-blown mental health disorders or problems develop.

In the drug strategy area, we try to present positive messages in media campaigns and other programs. In past campaigns we have used sportspeople or people who are attractive to younger children in particular to represent the positive choices they could make with their lives. So, as well as directing our attention to the damaging and destructive effects, we try to provide a full spectrum of positive interventions that encourage resilience and psychological and social health, so that people are not driven into destructive choices like drug use.

CHAIR—I have here a book entitled *Drug Use in Australia*, edited by Margaret Hamilton, Trevor King and Alison Ritter, which I would like to make an exhibit to the inquiry. On page 137, in an essay entitled 'The case for harm minimisation', the essay's authors, Margaret Hamilton and Greg Rumbold, state:

Harm minimisation avoids the minefield of moralistic arguments about whether drugs use is inherently 'bad' or 'good'. Throughout Australia's history the debate about drug use has been heavily influenced by moral considerations—

which I would have thought was a good thing—

and the use of certain drugs has been considered to be immoral and a threat to society.

True! It continues:

One consequence of this has been the stigmatisation and marginalisation of people who use these drugs, as well as the use of punitive measures against these individuals ... From the perspective of harm minimisation, drug use per se is neither good nor bad. It does, however, have beneficial and harmful consequences. This morally neutral stance has made it possible to begin to move away from a punitive and condemnatory approach toward a more humane framework.

On page 139 it states:

... debate about—

harm reduction—

in the education area and to young people has continued. This has included the articulation by Prime Minister John Howard of an apparently inconsistent policy stance of zero tolerance in the drug area and a subsequent explanation that this referred to a policy approach in the school context.

This woman is a deputy chair of a government authority which is supposed to be carrying out zero tolerance policy in accordance with government policy.

Another document which I would like to make an exhibit to the inquiry is the *National Cannabis Strategy 2006-2009*. I am referring to both the National Cannabis Strategy and the National Drug Strategy Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2009, which complements the National Drug Strategy. It states that strategies should also include:

... strategies that address the inequalities with which the elevated rates of misuse are associated ...

That is, misuse! It further states:

These latter plans ensure a focus on the social determinants underlying substance misuse and emphasise a holistic approach ...

Use is illegal, not misuse! That implies that there is a good use of cannabis, and there is not. It is illegal and it is against policy. The language in that document accords with Margaret Hamilton's language and with the language of public broadcasting, which uses terms such as party drugs, recreational drugs and harm—which is a nice word, rhyming with calm. It is all very benign and neutral. How can we make this document and this book sit with both what the Prime Minister has said, and with our official policy? How can we do that?

Ms Hart—I can only outline what current policy is and that funding in the federal sphere under Tough on Drugs has focused very strongly on prevention to ensure that people do not begin to take drugs and, once they have begun to take drugs, on treatment to ensure they get off drugs. I think those commitments under the policy have been demonstrated by the type of investment that the federal government has made in particular areas.

CHAIR—I will accept that, Ms Hart, but I wonder how, from our federal perspective, we can make it happen, because we are sending the most terrible mixed messages. I have a tape back in my office which I will have a look at at a subsequent stage. It shows how subversive some of the efforts are to try and undermine this policy of government. I wonder if you could perhaps take it away and think about how we can possibly have a policy that the Prime Minister says is this, and then we get this sort of stuff. And presumably we appointed this woman.

Mr FAWCETT—I have another question for the representatives of the department. If the democratically elected government of the day comes up with a policy direction which is potentially at odds with the personally held beliefs of a recognised expert in the field, who has precedence? Is it the policy direction of the government or somebody working within the department who has their own beliefs about a direction?

Mr Learmonth—Mr Fawcett, we work only to the direction of the minister and the government. In doing so, we advise the minister and the government of a range of views, and we

draw from a range of expertise in forming our advice; but we act only in accordance with the policy direction of the minister and the government.

Mr FAWCETT—If you then saw actions within the department and its associated agencies that criticised or went against the direction of the government, would you feel obliged to take action?

Mr Learmonth—It would depend on the circumstances but, again, we act in accordance with the policy of the minister and the government, and we exercise and administer our programs accordingly. It is a very difficult question to hypothesise about, but that is the fundamental principle on which we do all our work.

Mr FAWCETT—I guess it is not so hypothetical in light of what the chair has just outlined.

CHAIR—I would accept what Mr Learmonth says. It is true that that is the way people work, but perhaps we have identified a few issues today that we can take up and find strategy to overcome. By the way, I think I had better put the Prime Minister's speech in too, while I am about it, and make that an exhibit to the inquiry as well.

As there are no further questions, I thank you very much for coming and for your evidence today, which has really been very helpful. If you could take away some of our concerns and think about things that you might want to send back to us, we would be delighted if you would come back and talk to us again. Those things that you have said you could supply us with would be terrific. If we could get to see the advertisements, that would also be terrific, but if we cannot we will just have to live with that. I simply say that we are very grateful for your coming today. It is a very complex area and there are many elements in it.

Mr Learmonth—If I may add a couple of points: firstly, of course, we would be very happy to provide whatever information the committee would like. We have listened very carefully to the points that you and your committee members have made and we will certainly reflect carefully on that. I have a very small point of clarification for Mr Fawcett. I will clarify one of the remarks of my colleagues in relation to questions of the media. It is certainly true, as Ms Hart said, that we have concerns with the use of 'party drugs', 'recreational drugs' and similar terms, and work is being undertaken to influence the use of those words. I suggest, though, that my colleague did not quite claim that we would control the media if we could; it is probably going a bridge too far.

Ms Hart—I hope I did not.

Mr Learmonth—I think we expressed some sympathy with the outcome insofar as we would like to see those terms eliminated, but controlling the media is probably a bridge too far.

Mr FAWCETT—I think it is a good thing that nobody, including the government, can control the media. I think we are a better place for it.

CHAIR—Maybe you could have a look at the ABC guidelines and whether they are meeting them in using those terms. Thank you again for your attendance today, and thank you also to Hansard.

Resolved (on motion by **Mr Fawcett**):

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

Committee adjourned at 11.40 am