

LEGISLATIVE COUNCIL

Tuesday 2 May 2006

MAIDEN SPEECH

The Hon. A.M. BRESSINGTON: I support the motion for the adoption of the Address in Reply. Mr President, I wish to congratulate you on your elevation to the position of President of the Legislative Council. I have not been here for very long at all, but I have been struck by your assistance and your willingness to assist during my adjustment period. I have faith in your integrity and decency and your intention to uphold the standing orders in the position of President.

I thank Her Excellency the Governor of South Australia for her speech opening the 51st session of parliament and also congratulate the new members of the Legislative Council. I take this opportunity to thank the following people: first, the Hon. Nick Xenophon for trusting me to go on the 'No Pokies' ticket at the recent election. I worked in the hospitality industry for 10 years as a gaming manager and saw first-hand the damage that was done in a short period to the people in the community because of the increased availability and accessibility of poker machines. I also saw the function of the local hotel change dramatically in that time—into places which focus more on drawing people into gaming rooms and training staff on how to influence their customers to gamble almost in a subliminal manner. The Hon. Nick Xenophon and I are in total agreement on two major issues affecting South Australians: the plight of problematic gamblers and the plight of addicts and their families.

Next I thank the Hon. Dean Brown, the former Liberal minister for health who provided DrugBeat of SA with initial funding and the premises to deliver much needed services to the marginalised sector of the community. Without his trust and his good judgment, this program would never have been launched and hundreds of addicts and their families would still be caught in the cycle of addiction. I also thank my immediate family who have made many sacrifices to allow me to pursue the work I have done and am about to do. Without their selfless and ongoing support, I would not have had the determination to persist.

I thank the dedicated and committed staff who remain at Shay Louise House in Elizabeth Grove, with whom I have worked for many years and who have made the commitment to continue the valuable work undertaken there as a tribute to those who have lost their lives, sanity or freedom to addiction and to the families who suffer equally. I thank the staff at Parliament House: Ms Jan Davis, the Clerk of the Legislative Council, and Mr Trevor Blowes, the Black Rod, for their availability, patience and assistance; and all the supporting staff whom I have had the privilege of meeting over the past weeks. I thank members of both sides of the council for introducing themselves and offering their support; and the many people who have written, emailed and telephoned to congratulate me to wish me well.

My journey to this place began in 1994 when I discovered that my only daughter Shay Louise was a heroin addict. I remember the sense of foreboding when I heard the news and recall saying to my partner, 'I just know if I don't do something she is going to die'. I had not lived a sheltered life and I had seen many of my friends experiment with drugs and fall into the vortex of addiction, with few surviving. I honestly never expected that any of my children would even contemplate taking drugs. My daughter's steep decline ended on 27 August 1998 with her death. My family and I had spent four years researching and learning as much as we

could, and Shay was only two days away from coming home to attempt to recover from her addiction when she died at the tender age of 22.

The death of a child is something that takes time to come to terms with, and for me the loss of my only daughter also meant the loss of that special connection that a mother has with a daughter and all things that go hand in hand with that relationship. Shay had the potential to go far in her life and, although her journey was not what I expected it to be, her experiences jolted me and woke me up, and I am forever grateful to her.

Many may believe that it is because of my daughter's death that I have moved away from the entrenched harm minimisation approach applied in the management of substance abuse. This in fact is very far from the truth. I have been told by some that this would be a long road for my daughter because heroin users like the drug and the lifestyle that goes with it. I decided that perhaps my daughter may be the exception to the rule, as most parents hope, so I began developing a survey to gather information for my own knowledge.

This survey contained 265 questions and, over a period of 18 months, we interviewed 1 120 active drug users in Queensland, New South Wales and South Australia. The results of this survey formed the basis of the DrugBeat of South Australia program. We found that 87 per cent of those interviewed were not in favour of heroin trials and shooting galleries; 82 per cent would have entered treatment if they could have; 37 per cent had tried the methadone program and found it wanting; 58 per cent had not even attempted treatment because of limited options and word on the street of the bad outcomes of others; only 19 per cent of those interviewed believed that they had their drug use under control; 40 per cent had tried counselling in one form or another; and 3 per cent were interested in programs that required any form of religious or Christian participation.

Professionals informed me that recovery was not difficult, that withdrawal was no worse than a bad dose of the flu. They were in fact not talking about recovery but about detoxification, and as time passed I came to realise the narrow and limited view that many professionals had on the process of recovery. I soon learnt that addiction cannot be treated with addiction. I also learnt that the drug cannot be the focus of recovery, that the adjustment of attitudes, behaviours and the reconciliation of negative emotions are the be-all and end-all of recovery and, of course, well trained competent therapists play an integral role.

At no time did any professional explain to me that the psychological and emotional symptoms experienced were so much harder to recover from than the physical, and that those psychological and emotional side effects are much longer lasting. In saying this, I would not minimise the physical withdrawal experience because I do believe that any person would not want to go through this. It is a trauma in itself and the medications given to assist in withdrawal were ineffective and left the person confused and anxious, which eventually led back to relapse.

I remember having a conversation with my daughter when I told her that I was actually lobbying for heroin trials and shooting galleries at the very beginning, when I was driven by fear and I needed to do something to assist my daughter, and the words she said to me were, 'How sad it is that you think that this is all I will be, that I want to be more than living for the feel of the steal. This is actually a degrading lifestyle. I want out. All the counselling revolves around whether I go on to the methadone program or not and I simply just want to stop.'

The statement made by my daughter that she wanted out came after eight months of abuse and after I had made a trip to Queensland because she rang me telling me that she was going to kill herself because it was all too hard. Eight months of addiction and the party was over! It took three years after that to be able to find any kind of treatment that could assist her, and in that time she had developed significant addictions to prescription medications as well. I was forced to treat my own daughter under medical supervision using naltrexone, because there simply was no other option offered.

The saddest part of all was that, when we tried to find a counsellor who could see her on a regular basis, the best that could be done was a monthly session, until they were informed that she was actually on naltrexone and then the response was, 'We don't really know anything about naltrexone, so we would be reluctant to take her on.' We needed a treatment program that focused on a drug rather than on the psychological and emotional recovery from addiction.

It was difficult in those days because my only motivation was to become a well informed parent to assist my child, and because I had gone public on a number of occasions I was being approached by drug users and their families for assistance. They, like myself and my daughter, were looking for a solution to addiction.

As more and more people approached me, and as I learned more from the real teachers, the drug users, it was obvious that there were huge gaps in the system. It seemed that the drug treatment system was based on the wants of drug users who did not want to stop rather than on the needs of those who did want to stop and who wanted to be able to get their lives back and be free of their addiction. This was and still is a national problem.

Harm minimisation does not take into consideration that many drug users want to recover, and it seems that the value of recovery has been minimised to a point where treatment services that do not support safe use and recreational use of drugs are funded with the crumbs, the left-overs of government money. It also appears that we are in a state of denial that addiction actually even exists, and that will not change for a long time. The United Nations Narcotic Control Board Report for 1997 states:

The abuse of drugs is becoming an increasingly difficult endeavour, at least partly because of the rapid and growing spread of messages in the environment that promote drug use. Many of them can be regarded as public incitement and inducement to use and abuse drugs.

The report goes on to say:

To maintain balance in the public debate, policies that offer alternatives to drug legalisation and reliable information on the likely effects of such legalisation need to be presented.

How could anyone possibly oppose the three prongs of harm minimisation: to reduce harm, to reduce supply and to reduce demand? These appear to be worthwhile objectives when we hear them, and anyone who says they are opposed to harm minimisation is automatically labelled as uncaring and callous, someone who would rather see drug users treated like criminals. This is in fact not true. Few people fully understand how those objectives have been corrupted and have moved away from the original purpose and towards

decriminalisation and legalisation. Justice Athol Moffitt, QC, was the Royal Commissioner examining the infiltration of organised crime into Australia. He sat as a Supreme Court judge for 24 years, 10 years of which he was President of the New South Wales Court of Appeal. He stated in the book *The Drug Precipice*, first published in 1998:

The decriminalisation of use of one or more drugs, for example, cannabis and heroin, will lead to a large increase in use. The consequence will be to fuel the black market and greatly increase the wealth. . . power and corruption of organised crime . . . and. . . make the detection of its operations. . . and action against it more difficult and more costly. The enormous increase in the demand for drugs (especially new drugs) in recent times has coincided with the activities of well-organised, aggressive, pro legalisation advocates who minimise their dangers and call for more lenient policies. In consequence, the wealth and power of. . . drug traffickers have more than doubled over the past 20 years.

Mr President, I remind you that that statement was made in 1998. We have also seen the changing trends in drug use over the past six years where drugs like MDMA—or so-called Ecstasy and methamphetamine—are seriously impacting on the physical and mental health of our youth. We wasted so much time focusing on heroin trials and shooting galleries that the next wave of drugs swept over us and we had no plan or infrastructure in place within drug and alcohol or mental health services to cope with the onslaught—and, of course, it has been stated by politicians and police that the main distributors and manufacturers are, in fact, organised by gangs, just as predicted by Justice Athol Moffitt.

It must be acknowledged that recovery is not just a matter of stopping use, and drug users do require specialised support to recover well. It is also a fact that there are many drug users who want to move past their addiction but who are unable to access services that can assist them. For this group the harm cannot be minimised until they are able to receive a treatment rehabilitation program that can assist them to deal with the underlying issues of their drug abuse and to develop coping and living skills to replace the drugs that they have used to date. It is also a fact that drug users who do not aspire to abstinence find it far easier to access the services and supports that are in place to supposedly reduce the harm for them when, in fact, it keeps them trapped in the cycle of addiction.

The harm minimisation system is stacked against those who want to be drug-free—therein lays the imbalance. Health professionals and governments need to be aware that there are problematic users who are unable to self-regulate their behaviour—which is the basis of the theory of harm minimisation—and whose needs are not met with harm minimisation approaches. This group of users lives in a drug-hazed fog. They are stuck, confused and depressed, and they revert to emotional blackmail, intimidation and often violence to get what they want—which is usually money from their families—or to robbing some poor sod who is in the wrong place at the wrong time. Others, of course, simply give up and suicide. Many would agree that the level of addiction is out of control and the community feels powerless to protect itself against the threat that the behaviours inherent with addiction pose.

We can look to Sweden for guidance. This is a country that has developed and implemented an approach that is balanced, humane, practical and effective. In that country the per capita rate of substance abuse is 1/40th that of Australia for amphetamines and 1/15th that of Australia for marijuana. Given those statistics—which relate to drugs that are affecting our community at present, cannabis and methamphetamine—we need to give serious

consideration to how positive outcomes can actually be achieved in a country like Sweden, where the level of addiction had reached epidemic proportions during its implementation of harm minimisation policies. The National Institute for Public Health in Sweden released this statement in a report in 1993:

Sweden's adoption of permissive drug policy led it to become one of the highest drug using nations in Europe. It then reversed these reforms and replaced them with a restrictive drug policy including health and education measures. Sweden now is the lowest drug using country in the western nations and school age drug use is less than one-fifth of that in Australia.

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

We simply do not have enough effective treatment services that are funded to meet the demand, nor do we offer addicts who want recovery every opportunity to do so. Rather than funding programs appropriately to meet the demand and then logically reducing the demand and the harm, we continually try to plug holes in the bucket when perhaps all we need to do is invest in a new bucket.

In May 2001 I attended the World Conference on Substance Abuse in Sweden as a member of the Australian National Council on Drugs, the peak advisory body to the Prime Minister on drug policy. I had the opportunity to see what could be done if public opinion and political will moved in the same direction. In that country there was unified service delivery with total cooperation between health, welfare, police, the judiciary and the community. The infrastructure was in place, facilities were funded to assist people to recover, and the government recognised that to recover well individuals needed time and appropriate support.

The methadone program in Sweden had a beginning, a middle and an end. The most striking difference between Australia and Sweden was that the methadone program in Sweden was used as an intervention on the road to recovery rather than a long-term substitution program. Individuals on the program had expectations of them, that they would abide by some rules—very different to Australia. These were not difficult rules; they were in place to assist the addicts to restore a level of manageability and function to their lives and, importantly, to ensure that methadone was not used as a way of subsidising their addiction by receiving government funded drug substitution therapies and then topping up with illicit street drugs.

Following the conference in Sweden I travelled to Amsterdam and stayed for one week. I spoke with senior police officials, who informed me that crime was at an all-time high, that the city of Amsterdam had become a haven, a honey pot for drug users and dealers, and that juvenile crime and mental illness had increased exponentially over the past eight years. However, we heard none of that in this country from the advocates of harm minimisation and legalisation.

The Bureau of European and Eurasian Affairs reported the following in May 2005:

Despite intensified efforts by the Dutch government to combat production of and trafficking in narcotic drugs, the Netherlands continues to be a significant transit point for drugs entering Europe (especially cocaine), an important producer and exporter of synthetic drugs, notably MDMA (Ecstasy), and an important consumer of most illicit drugs.

The Dutch prosecutor's office reported in 2004, however, that the number of Ecstasy tablets seized in the United States linked to the Netherlands dropped to 1 million in 2003 from 2.5 million in 2002.... According to the interagency law enforcement Unit Synthetic Drugs (USD), 2003 synthetic drug seizures around the world related to the Netherlands involved almost 13 million MDMA tablets and more than 871 kilos of MDMA powder and paste.

Although there are some who would advocate that permissive drug policies will reduce harm, supply and demand, this report shows that in the Netherlands where these policies apply the black market continues to thrive, that internationally this country's laws have had a negative impact on neighbouring countries, and that extensive funds are still spent on joint international law enforcement efforts for narcotic controls.

Harm minimisation is not a treatment approach. It is a policy developed to assist governments to manage social problems, and the implementation of such management programs must be based on the needs of addicts at all levels of drug use, even those experimental users who have had enough before their drug use has plummeted them into the deep, dark hole of despair. It is simple: if someone requests a recovery-based program, it should be available to them within 24 hours, not six weeks or more. Anyone involved in treatment and rehabilitation will know that there is a small window of opportunity when addicts decide that they want assistance, and with each failed effort to access effective treatment their behaviour and lifestyle deteriorates dramatically.

What we are seeing now is an increase in the use of drugs and antisocial behaviour which is affecting the wider community, and addictive lifestyles which are being handed down from one generation to the next. In an independent research project in 2005, the Department of Sociology and Anthropology at Simon Fraser University in Canada, states:

Official harm reduction is characterised by dangerous acceptance of the present situation of drug users. Without a return to the socially and politically active analysis it began with, harm reduction offers little prospect for real long-term solutions to the increasing difficulty posed to society by drug use. Harm reduction has 'matured' into a conservative movement, an apology for the past. . . and. . . an effective means to carry that historic dysfunction into the future.

This statement is reinforced by the United Nations declaring Australia top of the charts for substance use in the Western developed world.

Although I have been dubbed an anti-drug campaigner, a prohibitionist and of late even a zealot, what I have fought for many years is just the restoration of balance. It is not difficult to look around and see that we have a serious drug problem, and many in the community feel that the government has just simply given up. Police officers do not fully understand their role where problematic drug users are concerned, and they are confused regarding what are their responsibilities. Welfare is unsure of what to do and is overwhelmed by the demands

that addicts make on its services. The judiciary does not want to punish people for an illness. Treatment services are few and far between and are overloaded by demand. Schools are watching on, powerless to address the level of substance abuse among our youth.

Child protection services are also dealing with numerous calls relating to children at risk. Services do not link up, and there are philosophical differences, often based on personal opinion, rather than evidence, that argue the rights of individuals to use drugs versus the rights of the community to live in a safe and secure environment. In my experience, when a problem continues to persist, it is a clear indication that confusion, not sensible, effective policy, is leading the way. After working in the field for 11 years, I can certainly vouch for the high level of confusion that exists out there.

With every right must come responsibility and, when one person has a negative effect on others, responsibility must come into play. It matters little whether it is that the individual recognises the need for change or that the system applies external control to ensure that it happens. The needs of the many far outweigh the wants of the few. Advocates of harm minimisation have failed to recognise the difference between drug use and addiction in their push for decriminalisation and legalisation, and that failure has caused confusion and has jeopardised public safety. The failure has also caused the wider community to develop a serious lack of empathy for addicts, who are among the victims of this system.

The following are not my objectives as a member of the Legislative Council: to promote locking up drug users and throwing away the key; to make criminals of sick and marginalised people; and to force drug users into institutions, where they will be treated in a substandard manner. What is my agenda? It is to assist addicts to access effective treatment in a timely manner and to assist the community to deal with the social issues that are all too often underpinned by substance abuse, such as youth suicide; teenage pregnancy; abortion; unemployment; welfare dependency; poor school retention rates; family breakdown; child abuse, neglect and abandonment; domestic violence; prostitution; crime; road rage; road fatalities; and even graffiti, believe it or not.

In the coming years of my time in the Legislative Council, I am hopeful that I will be able to work with all my colleagues to bring our way of life back into balance and to secure a better future for our children and grandchildren.

An honourable member: Hear, hear!