T R A N S C R I P T

LAW REFORM, ROAD AND COMMUNITY SAFETY COMMITTEE

Inquiry into drug law reform

Melbourne — 21 August 2017

Members

Mr Geoff Howard — Chair
Mr Bill Tilley — Deputy Chair
Mr Martin Dixon
Mr Khalil Eideh
Ms Fiona Patten
Ms Natalie Suleyman
Mr Murray Thompson

Witnesses

Ms Josephine Baxter, executive director, and
Mr Gary Christian, research director, Drug Free Australia *(via teleconference)*.

Necessary corrections to be notified to executive officer of committee

The CHAIR — We welcome you spending time with the committee this morning. You would be aware that we have been undertaking an inquiry into drug law reform now for a period of time and are following up with many of the people who have made submissions to us. We thank you for the submission you have made to us.

In speaking to us this morning, you would be aware that we will be recording the conversation and a draft copy of that will come back to you afterwards so that you can ensure that it is correct in terms of what was said. I think we will start with a few comments from either of you for perhaps up to 10 minutes, and then we will follow up with some questions with you beyond that — or it may be less that you want to share with us up-front. We will move straight to you to make some comments. I do not know whether Josephine or Gary would want to make comments first.

Mr CHRISTIAN — Make it Jo.

Ms BAXTER — Yes, I am happy to. First of all thank you so much for the opportunity. I feel very close to what is happening in Victoria because we have family there — quite an extensive family actually, as it turns out — and I have worked there in Odyssey House for some time, plus I did teach at a school in Chirnside. So I have actually had close ties and very current ties with what is happening to our communities and obviously our children and our young people, so this is a great opportunity.

The first term of reference that we addressed in our submission was that around making sure that we give some real thought to drug education in schools again and really getting serious about that — quality, high-impact drug education that can give kids a chance, probably at the middle school level, from year 6 even or year 7 right through to year 10. Even in senior schools there can be age-appropriate follow-ups, but something that gives them a chance to make informed choices around the very complex decisions they have to make now with their peers and all the influences that are in their lives.

It can work, and we hold Sweden up to you as one of the countries that did not consider education to be a poor cousin. Education was just as important as health, law enforcement and any other body and community voice as well that would be able to influence effective policy. That is the one I really would hope Victoria could lead the way in again and consider supporting, in the public school system and in all school sectors, the value of that as being part of school drug education.

Just to update you on something that quite surprised me recently, in my role on ANACAD, which is the Australian National Advisory Council on Alcohol and Drugs for the federal government, I have been up in Cairns and we spoke to a school there that had reverted from not just drug education but a lot of their work now is early intervention and actually trying to get kids off drugs, staying in touch with those that drop out of school because they are taking drugs or their families might be and therefore they are caring for their families. It is heart-rending, and it is quite frightening that it has reached that sort of proportion.

The interventions in our schools need to be primarily prevention, obviously, but need to include effective early intervention so that these kids can actually leave school feeling that they have attained the best possible potential for their future lives. We are losing too many of them, and it is happening rapidly. The vice-principal that spoke at one of the community forums we held was quite candid about the fact that, for example, methamphetamine rates have increased by 50 per cent in the schools up there just in a really quick space of time. It is not pressing any panic button; it is simply alerting you to the current and emerging trends that are happening in these sectors that we could do something about. That is my main point actually.

If you like, I will expand on that a little in that I am currently doing some statistics on the number of schools that are in each of our states and territories, the number of students — it is not just the students; it is the teachers, it is the allied health professionals that work with schools now — that are having increasing amounts of ADHD and all of those sorts of things who are needing extra attention and support. There is a huge catchment area that is being missed if we as responsible decision-makers cannot reintroduce the facts that are going on about drugs, the dangers of these illicit drugs and being aware that they are illegal because they are dangerous. So it is a catchment area that we cannot ignore anymore. We must not bypass it.

You will hear a mantra from time to time that drug education does not work, but that is certainly not the case in my experience as a teacher in a secondary school and also in my work at Odyssey House, where we did community education programs and turned a lot of lives around. Education does work when it hits the mark,

and each of the schools can have a say in what they need to do — but at least give them some resources and a chance to do it. I think these are the main points.

The CHAIR — Okay. We might come back to the education side of it with you in a moment in following up, Josephine. Are there any other particular comments you want to make before we go to Gary?

Ms BAXTER — I think we need to look at what is happening overseas. In the submission we also make the point that the UK drug strategy, albeit it a national strategy, was one that did put a big P for prevention first. They have switched around their policy, not unlike that of Sweden now, and they work at a community level. Victoria could be a leading jurisdiction in Australia to consider that.

You are no doubt familiar with, and I hope you would be reasonably impressed with, the Victorian parliamentary inquiry into methamphetamines that took place a couple of years ago. I know the government has changed since then and so forth, but this needs to be non-partisan. We have to consider what is best for our people and bring the truths out that have already been discovered through inquiries like that as well.

Drug Policy Futures is another one that we mention in our submission. That really is a group of people that have got together in various jurisdictions, mainly in Europe but it is also covered in the United States, and certainly in Australia we have joined forces with the principles that they uphold where the policies of drug prevention need to prevent the initiation of youth first of all. The UN rights of the child come into this as well. I do not want to skim over any of that. Anything you want us to drill down on further, we will do our best to do that.

The CHAIR — Okay. Does Gary have any comments to make before we go to some questions?

Mr CHRISTIAN — Not on those issues particularly. I am sort of looking at a different area.

The CHAIR — Sure. We will move onto your focus or the issues you want to raise with us.

Mr CHRISTIAN — I will try and get done within 10 minutes. Just by way of background, Drug Free Australia looked at and sampled documents that have been sent into the inquiry and we were concerned when we looked at those at the amount of science that was in there that was cited contradicting the available evidence base that we have at the moment. That included discredited, misconstrued, non-rigorous, conflicting or in some cases totally absent science.

I will give an example: pill testing. There is no science around this. The call for pill testing is saying that there is unknown purity in pills and that there are dangerous additives. When you go to the science on it and you consult coronial findings, you find that ecstasy is the thing which is named every time as the killer; it is not the additives, and it is not the purity. People are dying because of individual physiological reactions to the drug, or they are having it with drug cocktails. It is not purity that is the big issue, and it is certainly not additives that are the issue, certainly in Australia. So there is no science supporting that call. Our concern is the false sense of security that pill testing will give to people. They will still die from ecstasy as they always have, and there is no use trying to give them a sense of safety around that.

I will move to the injecting room. This is based on discredited science, and I would like to point out further that the bulk of the science that has been done for the campaign has been done actually by campaigners for these facilities, so they have a certain bias, if you like, towards their science. This is mainly in Vancouver and mainly in Sydney.

I will start with the overwhelming number of overdoses in these facilities and the researchers resolutely saying nothing about this. Between 2001 and 2005 there was an average of 316 overdoses per year inside the injecting rooms. Outside on the streets there were 120 ambulance call-outs per year, on average. So the injecting room was almost tripling the number of overdoses that we saw on the street, and yet they only had 5 to 7 per cent of all injections in Kings Cross. This means that people are using more heroin and more cocktails — more different kinds of drug cocktails — and that they are buying more drugs to be able to have all of those overdoses. That is incontrovertible. You cannot get around that, and that is enriching the local drug trade. It is a very important thing to recognise.

Number 2, the lives saved estimates are based on discredited science. These estimates are based on these inflated overdose figures in the room, which are not compared with the overdose figures on the street. This is totally inept science. It would not even pass science 101 at university. When you correct for this, you end up

with one life saved every two years at a cost of $5.6 million for an injecting room. Kate Seear and Burnet Institute cited a *Lancet* study where they said that there was 35 per cent less mortality around Insite, the injecting room in Vancouver, but this is a discredited study. The commander of the police corrected an outright factual error by the authors of that study which entirely discredited their conclusion. You will find the evidence for that at appendix B.

Ambulance call-outs — and many people cited this — is a discredited science as well. The claim is that the injecting room decreased or reduced overdoses and call-outs on the street by 80 per cent. The issue with this is that the rest of New South Wales dropped by 61 per cent at the same time because of the heroin drought. So that means that Kings Cross was 19 per cent better than New South Wales; however, at night, when the injecting room was closed, it was 29 per cent better than New South Wales. So it is not the injecting room that is improving the figures on ambulance call-outs — very clearly, 29 per cent better than New South Wales. It is clearly something else other than the injecting room which is going so well when it is closed.

There was no mention by the researchers of Darlinghurst, which was 16 per cent worse than the rest of New South Wales. It is a clear example of there being a displacement effect of drug users going from Kings Cross to Darlinghurst. Why? Because they had sniffer dogs, which were introduced only months after the injecting room was opened. That moved the dealers, the users and the overdoses to Darlinghurst. It was very clear. This is discredited science which has been relied on.

When it comes to bloodborne diseases, there are so many submissions that claim success for the injecting rooms in this area, but there is not one of the official evaluations, the government-funded ones, that found a positive effect on bloodborne diseases. Hep C actually went up. HIV, which is mainly transmitted sexually diseases, did go down, but you can tell from hep C that the injecting room was not making a difference.

Number 5, public amenity. This is an absent science. There were so many claims amongst the submissions to your inquiry that cited the 48 per cent drop in needles on the street, and yet there was no mention in that evaluation that did that study about the heroin drought reducing heroin use by 60 per cent. In actual fact the needles on the street should have dropped by around 60 per cent, not 48 per cent. This is inadequate, absent science.

When it comes to referrals, only 11 per cent in the injecting room were sent for treatment. I spent many years in senior management with Mission Australia and ADRA Australia — charities — and I would close a centre if that was under my control.

When it comes to needle and syringe programs, this is an example of non-rigorous science. Many people claim success for these things, but if you go to the real science, it does not have that success. The most authoritative review is the US Institute of Medicine, and it promoted needle exchanges in 1997 to the US government before rigorous studies were done. By 2007 they had rigorous studies that were done, and at that stage they reviewed the evidence and they actually found no great success in needle exchanges. They said the evidence was limited and inconclusive regarding HIV. They also said that there were multiple studies that do not reduce hepatitis C. They also said that ecological studies cannot demonstrate causality, which wipes out a number of our famous Australian studies on the success of needle exchange, which are based on, believe it or not, ecological studies. So these were false claims by our Australian researchers.

In 2010 the European monitoring centre did a study which upgraded the conclusions of the Institute of Medicine, but they were only able to do that by ignoring the fact that one of the reviews that they were covering had errors in it that the Institute of Medicine had pointed out. They just ignored those errors by the World Health Organization review and upgraded the findings to make it look as if needle exchange had some level of success, but it was based on errors.

When it comes to needles in prisons, the European monitoring centre found insufficient evidence to form a judgement on that, but Drug Free Australia would note that there is a culture of sharing needles as a ritual amongst users, which will happen in prison as it will outside. This is why they have the best needle exchange programs in the world but we do not have decreasing HIV or HCV.

Quite a number of the submissions mention Portugal's decriminalisation as a success, but this is based on anything but the science. Drug use actually rose between 2001, when they introduced decriminalisation of all

drugs, and 2007. It went up by 9 per cent. Speed and ice actually quadrupled for 19 to 34-year-olds. Cocaine use for that age group doubled. Ecstasy, cannabis and LSD use increased for that age group.

Drug use did decrease between 2007 and 2012, and went to 21 per cent below the level that they had back in 2001; however, these decreases were entirely in line with the decreases that they had across most of Europe. At the same time in Australia between 1998 and 2007 we had a decrease of 39 per cent, and we did not bother decriminalising. You have got to say that our approach was far better than any success that they talk about in Portugal. High school students in Portugal — —

The CHAIR — Gary, I am just thinking that the time is slipping away. We want to ask you and Josephine some questions in just a second, so if you can round off.

Mr CHRISTIAN — Okay. I will just mention the high school students in Portugal. Drug use between 2001 and 2011 was up 36 per cent. Let us not have any talk about success in Portugal. There are other things which are in submissions, but I am sure we will cover those. I am very happy to go to questions right away.

Ms PATTEN — Thanks, Gary, and thanks, Josephine. We have just been hearing from ReGen from the Uniting Church, and we touched on drug education in our conversations with them. Their position is that what we are doing now when we are teaching kids about resilience and teaching kids about self-responsibility is a far more effective program for drug prevention than any of the programs in the past where we were talking about the dangers of drugs. I wonder if you would care to comment on that.

Ms BAXTER — Definitely, yes. I do not agree with that at all. I think that there is no one silver bullet, and nothing can be siloed. I think that a lot of kids are misinformed about drugs, and that is where the correction needs to be made. It would be very easy to bring in an effective drug education program that did include the building of resilience and the building of independence and self-esteem — that kind of thing — and that helped kids to understand that they have a right to their own decisions. But if they have not got the facts about the dangerous substances in an effective way — of how it does impact on the brain, of how for some there is no turning back, particularly with ice — if they do not know that and are not exposed to that line of thinking, they cannot make complete choices that would be effective for their healthy way forward. While I agree with ReGen to a point, I think that by putting our heads in the sand about the facts — about the harms of these drugs — we are actually denying our kids an effective education program.

Ms PATTEN — Thanks.

Mr CHRISTIAN — There is an excellent program in Iceland that has been going for at least 15 years now, and it has had some of the best successes with school-age education. They use a resilience model, so it is not just information. They are using connectedness and all of those kinds of things which we know work so well.

Mr DIXON — Jo, being an education person myself, obviously early intervention is extremely important, but it is only one pillar, obviously, in helping issues with drugs. How do you actually measure the long-term success of early intervention programs? It is a very inexact science — it is very hard to do — and not only intervention but the difference between the various intervention programs. As you said, they cannot be siloed, but people have strong views about some versus others. So how do you do the long-term measurement on that?

Ms BAXTER — Yes. There are a couple of very good examples of that. Gilbert Botvin in the United States developed — probably 20–30 years ago now, but it is still going strong — the LifeSkills program. He did that in partnership with Cornell University, and that has conducted long-term evaluation. Also the data has been corroborated by other academic institutions and universities, so that is one that I would hold up as worth considering. It is a resilience-based program. It does rely on the teachers in the schools to do most of the work and to build a rapport with the kids, but it has integrity within its program, because one of the problems of having just any teacher rather than a specialist deliver some of the information can be that the bias of the teacher could be detrimental to the children, in fact, and even to the relationship with the children. That program is a good blend of specialists being invited in at certain points to convey the message and then for follow-up with the teachers so that there is ongoing reinforcement.

The program in itself has reinforcement as well so that the kids do not just get a tick and flick, where they do a program and then it is done for the year. It actually carries over a term or a semester, and then they follow that

up and boost it for the next year. I think it starts in about year 6 and then goes right through to senior high school years. So that one is rather a good one to think about.

I was involved with Life Education at one point at the national level as well as in South Australia. We always made sure that we evaluated, based on the UK Life Education model. We looked at the attitude of the children before the program — their attitude to drugs — and their knowledge as well. Their knowledge and attitude were both surveyed, and then at the end of that program we surveyed them again. We could measure, then, the impact that had certainly on the knowledge transfer, but also on their feelings towards those drugs and the fact that they did not feel they had to be told by their friends that they should try this because this will give them a thrill because they are in charge of their own bodies. So those sorts of approaches were quite helpful.

Mr CHRISTIAN — I would have to say, to Martin's question, that a lot of the school education at the moment is ad hoc. If the Victorian government was to standardise its drug and alcohol education right across the state, then you could actually look at the alcohol survey every three years to see whether there was an improvement.

Ms BAXTER — That is a very good point. Schools — as you would know, Martin — are busy places with crowded curriculum. It is up to the leaders, within perhaps the state or the jurisdiction — they have to make that a priority. Let's take the SunSmart campaign that has existed in our schools for quite a long time now. That in itself has generated a whole attitudinal change, with kids slip-slop-slapping and going out. They cannot even go out to play without a hat on now, and they do not even complain about it. I can tell you it is an amazing generational change that has occurred. It cannot occur quickly, but it can happen.

Ms SULEYMAN — I have got two questions. What is the view of Drug Free Australia in relation to the abuse of prescription drugs?

Mr CHRISTIAN — Yes, I think that is pretty relevant to heroin on prescription, which some submissions are pushing for. You have seen the evidence yourself. I think it was the coroner who said that 80 per cent of the deaths at the moment in Victoria are from prescription drugs. The obvious issue is that we were told that heroin, which is illegal, was, you know, putting it in the hands of criminals, and now we have more deaths that are coming from prescription drug abuse.

Ms BAXTER — I concur with what Gary has said. It is interesting that those that would push to legalise all substances have dismissed this fact — that the ones that are already legal are actually the ones more accessible and attracting more people. Once something is legal the message is that it is safe. Whether we like it or not, it is something to give great consideration to. Our alcohol use is high. Tobacco has now gone down: the Quit campaign has been effective over 20–25 years, so the education aspect of tobacco has really helped our people. But prescription drugs are a huge concern, and it is because they are legal.

Mr CHRISTIAN — We also back the calls to your inquiry for there to be much better monitoring of the prescription in the first place, so we definitely back that.

Ms SULEYMAN — Okay. You probably heard that the Andrews government is introducing real-time monitoring on some of the prescription drugs.

Mr CHRISTIAN — That is a great move.

Ms BAXTER — That is great.

Ms SULEYMAN — Excellent. And just very quickly, the second question is: we have heard a lot and we have seen a lot in relation to medicinal cannabis and the positive effects that it has. What is the view of Drug Free Australia in relation to medicinal cannabis only?

Mr CHRISTIAN— We have always backed medicinal cannabis, but only in pharmaceutical form, which is where the federal government seems to be at the moment. We recognise that there are benefits. We think a lot of the benefits have been overstated by various players, but there are real benefits there and we look forward to the federal government and the state governments working together to get the right kind of formulations out.

Ms SULEYMAN — Thank you.

Ms BAXTER — Could I just add to that? Again on the role of ANACAD, I have been able to meet with the Tasmanian poppy-growing group and also the person in charge of drug control with regard to medicinal cannabis, and they are trying to very closely align the strategies that have worked with the poppy industry for a long time regarding security and diversion so that we will not have the topsy-turvy approach that has taken place in the United States, where there is a lot of diversion of medicinal cannabis in inappropriate ways. I think we are still quite confident that the, I guess, security measures that are being put into place and the care being taken with regards to growth could work if we are stringent enough about it.

Mr THOMPSON — Mr Christian, Ms Baxter, the ReGen report quoted Professor David Penington, who advocated for a system whereby Australians over 16 have access to a limited, regulated quantity of cannabis and ecstasy from a government-approved supplier once they registered on a confidential national register. Briefly, are you each able to convey your view as to that suggestion?

Mr CHRISTIAN — For me, both ecstasy and cannabis are dangerous drugs. I have already covered off the fact that it is moreso individual reactions to the drug. You can have people who are taking 30 times more tablets than a person who dies from an ecstasy pill. It is not the pill itself; it is just that they had an individual reaction. I do not think it is well understood, even yet, as to what exactly causes that individual reaction. Ecstasy and cannabis — we now know so many more of the dangers of this kind of drug, and I think we are much, much more knowledgeable than we were 10 years ago, even with cannabis. There are just so many studies. No, we do not want to be handing cannabis around. If it is in a medicinal form, that is fine, but we do not want to be encouraging the use of that drug.

Mr THOMPSON — Does Ms Baxter have a view on that statement by Dr Penington?

Ms BAXTER — I do. I guess it comes back to the fact that we are already dealing with issues around prescription drugs, and they are heavily regulated. Apparently now with the Andrews government it will be even more so in Victoria. We are dealing with alcohol and tobacco. The burden of disease in Australia is high on all of those, and I think this would only be opening a Pandora's box, almost a gateway to further regulation and legalisation, sending a message — an unintended message, I am sure — that these drugs are safe, and they are clearly not.

Mr CHRISTIAN — Yes, well said.

Mr THOMPSON — Just a quick second question. Mr Christian had referred to the Portugal example, where the use had risen 36 per cent between 2001 and 2011. Is there any more recent data from Portugal in relation to that matter?

Mr CHRISTIAN — The problem with Portugal is the time in years between the surveys that they do. Here in Australia we do them every three years. They did theirs in 2001, 2007 and 2012, or for the schools in 2011. So yes, unfortunately it is probably going to be a couple of years before we get some idea as to what is happening in 2017.

The CHAIR — Following on from the comments about Portugal, you would be aware that in Victoria we have a drug court that looks at diversion of people who come through the drug courts, for drug issues of course, to get them onto programs. I am wondering what you think about those and whether those programs are good and should be extended?

Mr CHRISTIAN — We are aware of a number of programs. Those kind of drug court programs are a decriminalisation measure, but at the same time we know that in Sweden when they send people off to treatment they actually get their drug use down not alone but on the basis of that and good education. So it is bound to be working better than any other approach.

Ms BAXTER — I would agree with that. I think in the United States the reports that I have seen indicate that they have an extensive network of drug courts that are having some great results, particularly with regard to recidivism and getting people into jobs, giving them a purpose. I think it is far more preferable. We know that our jails cannot cope with all of that sort of thing and that the diversion programs could be extended. I think another way for Victoria to lead the way is to extend the network of effective drug courts that do give people positive health outcomes.

The CHAIR — I also just wanted a comment from you in regard to your views about opioid replacement treatments.

Mr CHRISTIAN — When it comes to methadone, unfortunately so many of the submissions seemed to think that it was a success in terms of reducing mortality and criminal behaviour. The gold standard in reviews, back in 2009, was the Cochrane review — it was done by an Australian, Richard Mattick from NDARC — and when he looked at the random controlled trials on methadone, they showed no such successes cited by so many of the submissions. It did not reduce opiate mortality or criminal behaviour beyond those people who were in no treatment at all. So it is not the success that it is painted to be. I think that the way that the Victorian government needs to be looking is at naltrexone, which has very clear signs of its success, and it is taking off in America at the moment in a big way.

Ms BAXTER — I would like to add to that. There is something to be investigated further, and perhaps Victoria could again lead the way with a trial on naltrexone implants as opposed to injected naltrexone. The Western Australian government has supported that work for many years, so at least it might be something that the Victorian government might consider investigating and making some inquiries with regard to what Western Australia has been doing. I think that is something to think about too.

Mr CHRISTIAN — We can give you all the contacts and all the times on that. We would be delighted to hand that on.

The CHAIR — The last question I would quickly ask is your views on alcohol then, because I noticed, Jo, you mentioned alcohol. The difference between alcohol and cannabis use, for example — what are your views on that? In fact we have talked about prescription drugs too. There seems to be a very different societal view to alcohol.

Ms BAXTER — There is. I guess alcohol has been used by many cultures for many years in terms of their cultural needs et cetera. I think Australia has reached a point, probably even in its early days when we had rum as part of the currency, where alcohol was put on a pedestal far higher and not treated with the caution that it needs to be treated with, particularly some of the spirits and high alcohol content products. There are two areas of caution. The first one is the science around cannabis and its link with mental health as a slow time bomb, as opposed to alcohol, which, when used in a so-called responsible way, does not seem to have the ill effect that can be attributed to tobacco and to anything smoked, particularly cannabis. But it is the mental health links that we are seeing in the science now that concern me about cannabis as well.

Mr CHRISTIAN — And many other things too. Keep going, Jo.

Ms BAXTER — Yes. I suppose that is the first thing to think about. The other thing is what I have said before: the more that we legalise or give consent to, the greater the burden of disease. There will be more uptake in our society because they will think it is safe. Where there are areas of caution and where there are scientific facts around the dangers, we need to make those really, really clear — not soften on them.

Mr CHRISTIAN — We also need to be clear that alcohol, a legal drug, is used by 90 per cent of Australians, according to our household surveys — the last one in 2016. With cannabis, which is illegal, it is now at 10 per cent. The reason it is at 10 per cent is most likely because it is illegal, and there are plenty of surveys that will bear that out.

The CHAIR — We had better move on. We have got more groups to hear from today. Thank you both for your contributions. That has been really useful. As I said, a draft of the discussion will come out to you in the next couple of weeks for approval.

Ms BAXTER — Is there time for me to ask a question?

The CHAIR — If you would like — quickly.

Ms BAXTER — Basically the main one is: is the committee considering doing any research in Victoria on cost comparisons of drug abuse treatment incarceration and then comparing what it would cost to put prevention in place at all levels so that we actually stem the tide of people going across to addiction? There has been a very, very good paper put out by the Drug Policy Alliance in New York and the New York Academy of Medicine. I have not sent the paper through to you, but along the lines of their research it would be very helpful for someone

in Victoria to do something similar and just look at what the costs are. I know that in rehab it can be about $28 000 for 12 weeks for somebody to start to renew their life. If those cost comparisons were made, it could be quite an interesting saving for the government.

The other thing I want to ask is: can the committee consider not competing the rehabilitation and treatment dollar with prevention but putting it on an even keel so that prevention can be placed in its proper place for the first time probably since about 2007?

The CHAIR — They are certainly issues that we are considering. Any of the issues associated with the economics of treatments and a range of strategies is something we are interested in and looking to get hold of any advice. We might as a recommendation of our committee recommend that further research be done in a range of areas. Of course we will be finalising our report towards the end of the year for presentation to the government in March next year. So there are a range of things that we are yet to discuss as a committee, but we are open to all input still.

Ms BAXTER — Congratulations on everything you are doing. It is not an easy task.

The CHAIR — Thank you, Josephine, and thank you, Gary.

Ms BAXTER — Thank you.

Mr CHRISTIAN — Thank you.

Witnesses withdrew.