

IN CONFIDENCE

DEPENDENCE ON ALCOHOL AND OTHER DRUGS

IN WESTERN AUSTRALIA

THOMAS BEWLEY, M.A., M.D., F.R.C.Psych., F.R.C.P.I.

Consultant Psychiatrist (Dependence)
St. Thomas' and Tooting Bec Hospitals,
Consultant Adviser on Dependence,
Department of Health and Social Security
Dean, Royal College of Psychiatrists,
London, England.

July, 1979.

RPH
Western Australian Alcohol and Drug Authority,
25 Richardson Street,
West Perth 6005,
W. Australia.

C O N T E N T S

	Page.
I. INTRODUCTION	3
(a) <u>Introduction</u>	3
(b) <u>Present size of the problem</u>	3
(i) Alcohol	
(ii) Tobacco	
(iii) Other drugs	
II. FUTURE PRIORITIES	5
(a) <u>Need for a separate Alcohol and Drug Authority</u>	5
(b) <u>Future Service Developments</u>	8
(i) Dependence on tobacco	
(ii) Expansion of out-patient services for alcoholics	
(iii) Facilities in remote areas for alcoholics	
(iv) Excessive drinking by Australians of Aboriginal descent	
(c) <u>Liaison with other services</u>	12
(d) <u>Siting of clinics and facilities</u>	13
(e) <u>Voluntary Agencies</u>	14
III. ADMINISTRATIVE	15
(a) <u>Staffing and Salary Proposals</u>	15
(i) Director	
(ii) Deputy Director	
(iii) Medical Staff in training	
(iv) Clinical Psychologists and Psychologists	
(v) Social Workers	
(vi) Nurses	
(vii) Librarian	
(viii) Research Staff	
(b) <u>Accommodation: State School Teachers Union Building</u>	20
(c) <u>Records</u>	21
IV. CLINICAL	21
(a) <u>Review of Current facilities</u>	21
(i) Aston Hospital	
(ii) Ord Street Hospital	
(iii) Quo Vadis Centre	
(iv) Out-patient facilities (Carrellis Centre)	
(v) William St Clinic	

	Page.
IV. CLINICAL (continued)	
(b) <u>Specialised Services for patients dependent on drugs</u>	26
(i) Introduction	
(ii) Methadone maintenance	
(iii) Methods of dispensing methadone	
V. RESEARCH	28
(a) <u>Introduction</u>	28
(b) <u>Current Research Plans</u>	29
(c) <u>Possible future research projects</u>	29
(d) <u>Applied Clinical research</u>	30
VI. EDUCATION	30
(a) <u>Educational Function of Authority</u>	30
(b) <u>Relationship with Health Education Council</u>	32
VII. SUMMARY AND RECOMMENDATIONS	34
(a) <u>Summary</u>	34
(b) <u>Recommendations</u>	35
(c) <u>Acknowledgements</u>	40
VIII. APPENDICES	41
APPENDIX I. Recent United Kingdom Reports	41
APPENDIX II. Drinking Problems of Australians of Aboriginal Descent	48
APPENDIX III. References	52
APPENDIX IV. List of people seen, places visited and speaking engagements	53

I. INTRODUCTION

(a) Introduction

An Honorary Royal Commission was set up in 1972 to inquire into and report upon the Treatment of Alcohol and Drug Dependents in Western Australia. Following the report of the Commission in 1973 the Western Australian Alcohol and Drug Authority was set up in 1974. The Authority has been functioning, since that date, as set out in its annual reports. The pattern of provision of services is similar to that found in Toronto, Canada, where the Addiction Research Foundation has the responsibility for research, education and the provision of services for the treatment of dependence on alcohol and other drugs. I have been asked to review the current activities of the Authority and advise on possible future developments.

(b) The Present Size of the Problem

(i) Alcohol

"Alcohol is the major drug of abuse in Australia and constitutes a problem of epidemic proportions." The Report from the Australian Senate Standing Committee on Social Welfare (1977) made this comment and drew attention to the following:

"Alcohol has been a major factor causing the death of over 30,000 Australians in the last 10 years."

"Deaths from cirrhosis of the liver have risen 75 per cent in the last 10 years."

"From 1965 to 1976, the per capita increase in the consumption of beer has been 27 per cent, of wine 122 per cent and of spirits 50 per cent."

"Over one-quarter of a million Australians can be classified as alcoholics."

"One million two hundred thousand Australians are affected personally or in their family situations by the abuse of alcohol."

"One in every five of our hospital beds is occupied by a person suffering from the adverse effects of alcohol."

"Two in every five divorces of judicial separations result from alcohol induced problems."

"In 1972-73, problems directly related to alcohol, including industrial accidents and absenteeism, cost the national economy more than \$500m."

"Some 73 per cent of the men who have committed a violent crime had been drinking prior to the commission of the crime."

"Alcohol is associated with half the serious crime in Australia."

"Alcoholism among the young is increasing dramatically and as many as 10 per cent of school children between the ages of 12 and 17 get 'very drunk' at least once a month."

The sheer size and multiplicity of problems caused by heavy consumption of alcohol calls for a response from almost every member of society whether in his professional capacity or as a concerned citizen. Recent reports on the problems of alcohol and alcoholism in the United Kingdom have drawn attention to the wide range of responses that are necessary and their main recommendations are summarized in Appendix 1.

In Western Australia, with a population of 1,200,000 there may be as many as 30,000 men and 6,000 women seriously affected by alcohol. The per capita consumption of beer, wine and spirits in Western Australia has been steadily rising for many years. The Honorary Royal Commission gave the following information:-

ALCOHOL CONSUMPTION PER HEAD (GALLONS)

	<u>1939</u>	<u>1949</u>	<u>1959</u>	<u>1969/70</u>
Wine	0.6	1.3	1.1	2.0
Beer	11.7	16.9	22.7	27.1
Spirits	0.2	0.3	0.3	0.4

(ii) Tobacco

Smoking is the greatest preventable cause of illness and death in the Western world today. That it causes lung cancer, bronchitis and heart disease is generally accepted. That it is an addiction is less well-known. Assuming that Western Australian patterns of smoking do not differ greatly from those in other States, it seems likely that 43% (170,000) of men over 18 years and 29%(115,000) of women over 18 years are habitual smokers. Surveys in various parts of the world have suggested that up to 50 per cent of regular smokers may have wished to give up at some time. There is difficulty in doing so (because of the element of dependence/addiction) and only 15 per cent are likely to be successful. These figures suggest that there might be approximately 100,000 people in Western Australia who would like to cease smoking if they could.

(iii) Other Drugs

In the past few years the major concern about the use of drugs in Western Australia has been with heroin addiction. The exact number of those dependent on drugs is not known, but of 1,500 addicts to all drugs who have entered treatment at one of the Authority's facilities, 70 per cent have been heroin addicts.

Prescribed drugs can also give rise to problems of dependence, and sedatives and minor tranquillizers are increasingly widely prescribed in all developed countries. It would be desirable to try and estimate the size of this problem in Western Australia, possibly in association with the Commonwealth and State Public Health Service, which monitors the prescribing of all types of psychoactive drugs.

Another form of drug misuse arises from over consumption of drugs which may be obtained without a prescription including some anti-pyretic analgesics, cough medicines and antihistamines. Again it would be desirable to review this problem and consider what prevention and treatment might be required.

II FUTURE PRIORITIES

(a) Need for a separate Alcohol and Drug Authority

The reasons for continuing to have a separate Authority to deal with the problems of dependence on alcohol and other drugs include the following:

- (i) The need to have an identifiable concentration of information and expertise.
- (ii) The problems posed, not being solely health problems, are such that prevention must rely on education, both of professionals and the public; some of the responses to these problems will need to be non-medical. New methods, and hopefully more effective methods, must be devised. It would be desirable to have a body whose primary function is to consider and devise such responses.
- (iii) There has been (and is continuing to be) an increase in the scale of problems which are such that they cannot be dealt with effectively in isolation by any single Health Agency. Changes include:
 - (a) an increase in overall level of per capita consumption of alcohol (as in all the other developed countries) with a marked increase in the harm and damage associated with this,
 - (b) a new awareness of health problems caused by continuing smoking and most recently the recognition that the element of dependence (addiction) is a major element in the failure of many people to be able to stop. (Cigarette smoking itself cannot be defined as illness, though continuing use leads to illness. Intervention is required which will change behaviour at a stage before ill-health develops. Prevention will not be effected by early treatment of morbidity, but may be helped by education and skilled intervention directed towards people who are dependent and wish to stop.),

(c) there has been a change in the pattern of misuse of drugs obtained illicitly in many countries in the world, with an increase in poly-drug misuse and heroin addiction. Because of these new problems it has proved difficult to provide adequate treatment and preventive services, which necessitate major investment and time to allow new professional skills to be developed and expertise to be acquired.

(d) there has also been an increase in dependence on drugs obtained on prescription, and from "over the counter sales" from pharmacies.

(iv) The excessive use of drugs, alcohol and tobacco are very definitely political problems, but hopefully not party political ones. It is necessary for society to be informed of the costs of certain behaviour (drinking, smoking and drug taking), the costs of the remedial measure necessary, and the costs of prevention. These last include the need to change knowledge of, attitudes to, and behaviour with all types of substances which may produce dependence. This is an area where strong feelings are held and where there is much misleading information. (In some countries it has led to a situation where those courting public popularity have recommended wasteful and ineffectual remedies. It is desirable that Government should be aware that little is ever gained by trying to politicize these issues.) The problems are wider than those of health alone.

(v) There is a need for a consistent response in the face of changing reaction to new problems. In many countries, when drugs first became a problem, there has been an anxious over-reaction both by professionals and by the public at large. This has sometimes led to expensive, ill-thought-out schemes which are then abandoned

as further (sometimes inappropriate) responses are developed. For this reason a low-key, thoughtful and consistent response which is not affected by current fashion has much to commend it. It is desirable that those who plan responses to new problems should keep in mind the need for consistency.

- (vi) For these reasons it appears that, having set up a specialist Authority five years ago, it would be desirable for the Government to support the Authority and encourage its sensible development rather than to restructure or re-organise it, or replace it with a branch of some other organisation. This does not mean that there is automatically some special merit in having a separate Authority for involvement with alcohol and drugs, and there is no reason why the Authority's functions could not be taken over by other bodies; but it appears to me that this would be inappropriate at present. The problems subsumed under the rubric "drugs and alcohol" are sufficiently complex, difficult and politically sensitive to warrant a body specially concerned with them. They are not solely health problems.

(b) Future Service Developments

(i) Dependence on Tobacco

The Authority was first set up in response to concern about problems of alcoholism and dependence on illicitly obtained drugs such as heroin. Nevertheless, tobacco, whilst not yet being recognised as such by the public at large, is also a strongly addictive drug. There are probably about 170,000 male and 120,000 female smokers in Western Australia. Surveys in various parts of the world have suggested that 50% of all smokers may wish to give up, but only 15% achieve this. Even if, only 40% of continuing smokers wished to do something about it, this would suggest that possibly

100,000 people might benefit from simple advice and support in trying to give up or lower the amount they smoke. It would be desirable to have such advice as widely available as possible throughout the State, provided by all types of professionals including general practitioners, social workers, counsellors, as well as any concerned member of the public. One of the Authority's roles could be to help to disseminate information widely to appropriate professionals, and to act as a resource and information centre for the Health Education Council.

A new outpatient facility which might be started by the Authority would be a Smoking Cessation Clinic, possibly in conjunction with the Health Education Council and combining educational and therapeutic functions. Recognition of the element of dependence on nicotine means that the specialised body dealing with dependence on alcohol and other drugs can be expected to offer its knowledge and expertise to help deal with the problems of addiction to tobacco.

There would be two justifications for this: the Authority would be an appropriate body to evaluate different treatment methods; and this would clearly make the point that smoking, which is a known hazard to health, is also an addiction. A smoking cessation clinic would have an educational as well as a therapeutic function.

(ii) Expansion of outpatient services for Alcoholics

At present, much emphasis is being given to inpatient treatment of alcoholism. Even if very successful methods of inpatient treatment were to be developed, which seems unlikely, the major thrust of future treatment must be towards outpatient support and advice from General Practitioners and other primary care providers. For this reason, there

is a need not only to provide, but also to measure the effectiveness of, the simplest and cheapest types of outpatient counselling. For the foreseeable future in Western Australia, outpatient counselling will be the only help available for the majority of people with alcoholism problems. For this reason I would recommend that consideration be given to gradually expanding the outpatient work of the Authority, and to explore further, simpler and cheaper methods of providing treatment, advice, help and support for those dependent on alcohol, tobacco or other drugs. It would be desirable when training all types of health professionals that they should view outpatient treatment and care as the most important part of their work.

(iii) Facilities in Remote Areas For Alcoholics

The problems associated with excessive alcohol consumption are so widespread that no group of specialists alone can deal effectively with them. It is therefore essential that the primary providers of care (general practitioners, social workers, nurses, counsellors) should be trained to provide specific care and advice for this difficult group. Not only in Perth, but in other Western Australian towns, it is essential to provide information, training and support for medical practitioners, social workers and all others who are in contact with people with alcohol problems. One method of developing services further would be to employ more liaison officers in other towns or regions. These could form the main link with the Authority and also act as a useful source of information, advice, counselling and support. Depending on the size of the community, they might be employed on a part or whole-time basis.

The second way that the Authority could help primary care providers in outlying areas, particularly the more remote areas, would be by providing further education for the professionals (and volunteers) concerned. The programmes which have been initiated should be given full support,

both through provision of formal courses and seminars and through arranging for short periods of secondment to the Authority's clinical facilities. I understand that a scheme of this sort is starting with General Practitioners and consideration should be given to its expansion through further, regular, formal courses.

(iv) Excessive drinking by Australians of Aboriginal Descent

I have written a short note on some of the special problems associated with excessive drinking by those of Aboriginal descent which is included as Appendix 2 to this report. The conclusions I have drawn in this Appendix are that:

1. In principle, anything that generally improves the status and position of those of Aboriginal descent should help with the problems of alcohol. The Authority needs to liaise and work closely with the Community Health Service Department of Aboriginal Affairs and the National Aboriginal Consultative Committee. The changes needed to bring about improvement in the problems caused by excessive consumption of alcohol by those of Aboriginal descent cannot be separated from the problems of Aboriginal life in Australia in general.
2. Anything that lowers the per capita consumption of alcohol by the population will be as beneficial for Aborigines as for anyone else. (In planning future pricing policies for alcohol, it would be worth considering a change in levels of taxation to encourage the use of beverages with a lower alcohol content, and to discourage the use of fortified wines).
3. In planning the provision of specific treatment services for Aborigines, local groups should be encouraged to take the responsibility for doing this themselves; the role of the Alcohol and Drug Authority might then be that of a resource providing financial support, advice and education, along with the training

of further counsellors and an expansion of what is already being done.

(c) Liaison with other Services

One problem that may occur when a separate Authority is set up is that this may seem to define the problem as one to be dealt with solely by that Authority and there may be a consequent tendency for other organisations to withdraw from the provision of treatment. This may have happened to a limited extent with drugs, as I have been told that, since the setting up of the Authority, some clinicians automatically refer all patients who may have a drug problem directly to one of the Authority's facilities. A second disadvantage is that there may be some reluctance by people offering themselves for treatment, if they can only come to a facility for treatment for alcohol or other drug dependence. If they went to a general hospital, this problem would be largely avoided. A third problem is the inevitable isolation of staff working in separated units which leads to disadvantages of two types: staff working in the general and mental hospital units may be unaware of what staff in Alcohol and Drug Authority hospitals do; and staff in the Authority hospitals may have less liaison with those in other hospitals.

Careful consideration should be given to the importance of establishing good liaison between the Mental Health Services, the General Hospital services, the Alcohol and Drug Authority and other bodies. It is essential that close links should be encouraged since, without them, it is unlikely that other bodies will continue to be adequately involved in providing treatment, education, and research into the problems of dependence on alcohol and other substances. In the report of the Honorary Royal Commission in Western Australia no estimate was made as to the number of alcoholics at that time, although the Commission stated that they were told one estimate was that there might be 50,000. This seems high but if there were only approximately 30,000 - which is a very conservative estimate - this would be beyond the capacity of any Alcohol and

Drug Authority or any other single agency to deal with on their own. A current recommendation about providing services for the alcoholic is that (since it is such a widespread problem) it is essential that treatment should be given as widely as possible by all types of professionals and non-professionals, and that the role of "experts" should be at the secondary level i.e., providing education, advice, consultation and specialised second-level treatment.

It would be neither sensible nor possible for the Alcohol and Drug Authority to endeavour to provide services direct, in every community. Because of the size of the problem in Western Australia, the Authority should endeavour to provide no more primary care than is essential, but should rather see itself as a secondary level resource. (See Appendix 1.)

d) Siting of Clinics and Facilities

There are advantages in having specialised clinics for opiate addicts rather than providing treatment for them in general outpatient services because of the need to carefully monitor and control prescribing. It is desirable that such clinics, and those for alcoholics, should be close to other medical facilities where possible in order to make proper use of other specialists and to be able to provide advice about alcoholism and drug dependence for those working in the general medical services. It is a common pattern, when new services for drug dependence are set up, that physicians who deal with medicine, surgery and psychiatry become mildly alarmed and concerned that, if addicts are introduced to the hospital, this will lead to nothing but disruptive behaviour. This belief is reinforced by experiences in casualty departments. In practice, addicts need to be admitted for treatment of physical illness and, if those who are concerned with the treatment of addiction are remotely-sited, general hospital staff lack the availability of skilled help to deal with the drug dependence and with behavioural problems. In practice, when drug dependence treatment facilities are set up in a general hospital staff tend, after an initial period of apprehension, to find that the services provided by the alcoholism and drug dependence experts are such that they may begin to wonder why they did not arrange a specialised unit to be sited there sooner. Availability of advice

from nursing staff is particularly valuable. Consideration should therefore be given to the siting of both inpatient and outpatient facilities for addicts and alcoholics in the major hospitals where possible (e.g. at Fremantle, Sir Charles Gairdner, Royal Perth).

(e) Voluntary Agencies

Since much of the care provided in the field of dependence is provided by Voluntary Agencies, it is important that the Authority should have good liaison with them, both to provide financial support (as is done for counselling services such as Holyoake) and to act as a resource in providing information, further training and help with monitoring and evaluation of facilities so that the best use of resources is ensured. It might be appropriate to review the present links through the sub-committee of the Advisory Council and the Western Australian Council of Social Service Inc. to ensure that these are satisfactory. It would also be desirable for the Authority to produce a directory of all the Voluntary Agencies in the State that are concerned with providing help for those dependent on alcohol and other drugs.

In many regions and areas of the United Kingdom, Liaison Committees which deal with either drug dependence, alcoholism or sometimes both, have been set up. Where these relate to new or increasing problems this may be a useful way to mobilize local resources. It is rare that extra facilities can be provided but the setting up of a Liaison Committee which includes physicians, psychiatrists, nurses, social workers, probation officers, policemen and pharmacists, may ensure the best use being made of existing resources. The pattern in the United Kingdom has been that such Liaison Committees have proved very valuable initially, proving less necessary after a certain amount of expertise has been acquired. They have worked best when there has been a suitable, knowledgeable person to act as Secretary and to service such a Committee (at times this has been the Liaison Officer who also runs the local Alcoholism Counselling Service and Information Centre). It would appear that,

in towns outside Perth, such a role might be filled by a Liaison Officer from the Alcohol and Drug Authority.

III ADMINISTRATIVE

(a) Staffing and Salary Proposals

(i) Director

The appointment of the next Director is the single most important task for the Alcohol and Drug Authority to consider at present. As the present Director will be retiring in the next two or three years, it is appropriate to consider what might be required of a future Director. Although it is not essential to have a Medically qualified Director, it seems likely that such a person will be appointed. (The Addiction Research Foundation in Toronto, Canada, was headed by an exceptional Social Worker for many years). There would be few people of the appropriate calibre and experience who were not medically qualified, who could adequately fill this post. It would not be essential for the person appointed to be a psychiatrist, though it is likely that most applicants for the post will have that specific training. A candidate of sufficiently high calibre with limited experience in the drug and alcohol field might be appointed Assistant Director as soon as possible and then sent for periods to the United States, United Kingdom, Canada and Europe for further specialised experience if necessary, prior to appointment to the Director's post. There is no reason why the Director of the Authority if appropriately qualified should not also hold a University appointment, possibly eventually becoming a Reader or Professor of Addictive Behaviour. This has recently occurred at the Addiction Research Unit at the Institute of Psychiatry in London. If a sufficiently strong candidate can be found there would be much to commend this course of action.

Pay Scale for Director

There is a serious problem with pay scales for doctors working for the Authority, which are currently lower than those covered by the Metropolitan

Teaching Hospital Salary Agreements. If the Authority is to develop satisfactorily, it will be essential to attract staff of the highest calibre; and it will not be possible to do this if pay scales are substantially lower than those elsewhere. There are other (medical and political) considerations to be taken into account; but I would be concerned lest the Authority might develop as a second class service relying on employment of occasional people of good will without achieving the breadth of applicants which other medical positions can attract. If only a few doctors apply for posts, inevitably there is a danger of an appointment being made, which would later be regretted. There is evidence of only a limited number of applications being received for posts with the Authority in the past, and the threat of this happening in the future.

It is particularly important that the post of Director should be seen to be one of high status which will attract well motivated and capable applicants. For this reason, it is essential to give urgent consideration to the pay scale for this post, which should not be in any way inferior to that in the General Medical Service; and close attention should be given at the same time to future academic links.

It is not for me to suggest what the appropriate pay scale for the Director should be. I can merely point out that I view this as a highly important post, with the Director having responsibility for an organisation and budget considerably larger than those of an equivalent Consultant in the Hospital Service; and that it would be "spoiling the ship for a ha'porth of tar" to economise by offering a salary substantially lower than would be received by a Clinical Professor.

Liaison

A special problem arises with the isolation of the Methadone Clinic at Perth. In the United Kingdom, when Methadone Clinics were first set up, their Clinical Directors met regularly (initially at the Department of Health,

later at the Home Office) which facilitated exchange of information and discussion about policies. This would obviously be more difficult in Australia because of travelling costs, but regular meetings would still be desirable (at the very least, an annual meeting of Directors of Drug Dependence Treatment Clinics, if this does not already occur). Some regular meetings with colleagues working in the field are essential.

(ii) Deputy Director

At the time of my visit to the Authority, the post of Deputy Director was vacant. Elsewhere I have suggested that urgent consideration should be given to the appointment of a future Director and that it might be appropriate initially for such a person to be appointed to the post of Assistant Director, i.e. the proleptic appointment of a Director with an initial period as Assistant Director, the exact function of the Assistant Director's post will need to be clarified and thought might be given at this stage to the Deputy Director being Clinical Co-ordinator also.

(iii) Medical Staff in training

The training of junior psychiatrists in the problems of alcoholism and drug dependence are severely limited at present in Western Australia. There is a need for all junior psychiatrists in training to obtain formal experience in this field as part of a rotational training system. It should be possible to arrange this in the near future, if the Authority can establish one rotational registrar post.

(iv) Clinical Psychologists and Psychologists

In all parts of the world there have been gradual changes in the work of psychologists who are very properly becoming autonomous in this. At times this may lead to difficulties in their relationships with other staff about what they can and should do. Clinical Psychologists are involved in research, evaluation and

therapy and in a number of other activities for which they are appropriately qualified by their training. Their role differs from that of medical practitioners in that doctors continue to care for patients even where there is no specific treatment, having a continuing responsibility for care as well as cure. Clinical Psychologists do not have the same responsibility for general on-going care when they are not directly involved in providing treatment. Because of this, they are more concerned than doctors with bringing about measurable changes which can be evaluated and found to be effective. On-going care and support are more likely to be the responsibility of the medical and nursing professions. Because of this, psychologists are most appropriately employed by the Authority in those areas where treatment is more important than management. It is important to keep their functions under review and to consider whether psychologists other than clinical psychologists might also usefully be employed by the Authority. Clinical Psychologists would have a smaller part to play in the management of alcoholics with long term problems, such as those at Quo Vadis, but could have the paramount part to play in the organisation, provision and evaluation of treatment provided in a smoking cessation clinic. It is important to regularly review how best to use the skills of psychologists of all sorts.

(v) Social Workers

The Authority's Social Work Department which has responsibility for social and welfare work generally, for the work of Aboriginal Liaison Officers and of the Authority's Field Officers, appeared to be functioning satisfactorily. Fears were expressed to me that it might not be possible to continue to provide a satisfactory service if the Authority was to endeavour to become the primary treatment facility for alcoholism and drug dependence in the State. However, as I have emphasised above, in my opinion this would not be a desirable development nor is it likely to occur. Members of the Social Work Department saw their role as part of a model programme which could provide expertise to help in the training of social and other workers.

(vi) Nurses

There are three units each with a Director of Nursing and the possibility of a post for a Senior Director of Nursing above these. If such an appointment were to be made, there is a danger that there might be insufficient work. Consideration might alternately be given to upgrading one of the three senior nurses (currently Directors) so that one Unit Director was senior to the holders of the other two posts. There is no reason why the person appointed could not be based at any of the three units (though there might be more difficulty because of distance if the Senior Director were at Quo Vadis). Consideration might be given to inviting all three of the present senior nurses to apply for the post of Senior Director. In the future the units might be staffed by a Charge Nurse or Sister-in-Charge, under a Director of Nursing.

(vii) Librarian

There is an urgent need for the Authority to develop a Library and Information Service to provide the backup necessary to perform its educational functions, as was submitted in the last budget estimate. I would strongly recommend that consideration be given to the appointment of a full-time librarian and/or information systems officer. It would be desirable for the Authority to develop a small library and information resource material with a selection of specialised books, journals and other material on alcohol and drug dependency. The advantage of the appointment of a technically qualified individual would be that they could make use of the services of other libraries and information systems. This would also ensure that the time of other staff is not wasted in collecting and collating information, reprints and so forth, as is happening at present without proper indexing. It would be desirable to review the best method of providing an adequate resource (library/technical information), possibly in conjunction with the Public Health Department Library.

(viii) Research Staff

In a recent memorandum to the Director, the Research Psychologist reviewed

possible approaches to research staff. One would be to keep the number of full-time research staff to a minimum, and to allow selected clinical staff such as medical officers, social workers, clinical psychologists, and senior nursing staff, to have reduced case loads for varying periods of time in order to undertake specific research projects. An alternative would be to increase (perhaps to three) the number of full-time professional research staff together with clerical support, and have these officers perform all the Authority's research studies. The Research Psychologist took the view that the first alternative should be adopted because it would encourage the clinical staff to develop a critical attitude towards their work and, by allowing them to participate in research and policy making, would encourage a higher level of morale. This would also enable the Research Psychologist to devote all his time to research rather than administration. I would support this recommendation. However, this does not mean that it might not also be appropriate to consider a larger research unit with more full-time research workers in the future, and it would be sensible automatically to review the functions, activities and policies of all sections of the Authority at regular three to five year intervals.

(b) Accommodation - State School Teachers Union Building

I have been shown the plans for the consolidation of the Authority's activities at the State School Teachers' Union Building in Murray Street. There would be many advantages if it were possible to implement this plan and by using the property at 6 Ord Street to be used for a model halfway house. In view of likely future developments, it would be desirable to ensure that all the space would be available for the Authority within a certain specified time. It did not seem to me that the Venereal Disease Control Branch of the Public Health Department could be accommodated there, nor did it seem sensible to develop five rooms for the Chest and Tuberculosis Services Branch of the Public Health Department (unless this were done with a specified limited tenure of not more than three years, when they would revert to the Authority). I understand the various reasons why the Chest Branch of the Public Health Department should be

there now, but this is an appropriate time to review the site needs of all concerned.

(c) Computerised Patient Record System

Whether patient records are computerised or not is less important than their being compatible with those of the Hospital Service in general; certainly no expense or effort should be incurred to provide any separate system. They should be standardised with the Hospital records.

IV. CLINICAL

(a) Review of Current Facilities

(i) Aston Hospital (Short Term Admissions)

Aston Hospital functions as an acute detoxification hospital, having 29 beds and a staff of 34. During 1977/78, the bed occupancy was 61 per cent. There were 1,714 admissions with an average length of stay of 4 days. The total bed patient days during the year were 6,445. The average daily cost per occupied bed during the year was \$ 59. The majority of patients who were admitted had alcohol problems. The hospital is pleasant, morale appeared excellent, and a model programme of detoxification was being provided.

The possible areas of difficulty were:

- (a) there was some uncertainty as to the role of the hospital in the treatment of drug dependence. Staff were not sure whether this was the most appropriate place to admit drug addicts who wished to come off Methadone and other drugs.
- (b) there were potential difficulties with two different groups of patients of very different ages.
- (c) there might be problems of morale in the future, when the percentage of patients being re-admitted increased, and the percentage of first admissions decreased.

(d) a possible further problem which may arise with any isolated unit is that the expertise of the staff is not as readily available to other units as would be the case if it were sited in close proximity to other medical and social facilities. There would be advantages in siting a unit of this type in one of the Teaching Hospitals.

(e) care would be needed to ensure that those being treated did not substitute a sedative-type dependence for alcohol dependence if given sedatives during outpatient follow-up. Barbiturates, benzodiazepines, and other sedatives should not be prescribed after detoxification and discharge. Chlormethiazole can also lead to dependence if prescribed for outpatients.

(ii) Ord Street Hospital

Ord Street Hospital has 26 beds and is designed to provide more intensive treatment chiefly for alcoholics. There are 26 beds and in 1977/78 there was 84 per cent bed occupancy. There were 228 admissions during the year and an average length of stay of 32 days. The total bed patient days during the year was 7,942, and the average daily cost per occupied bed during the year was \$43. The hospital is run on specialised rather than generalised lines with an emphasis on providing specific types of treatment, mainly behavioural modification programmes in a group therapeutic atmosphere. Morale appeared to be good.

Future Developments :

There is some evidence to suggest that all forms of treatment of dependence are of value for a limited number of people. There is less evidence of the efficacy of any specific method of treatment. In a total programme it will only be possible to provide a limited number of different forms of treatment at any one time and it is desirable that all specialised types of treatment should be rigorously evaluated. Since the number of people who can be taken into the Ord Street inpatient programme is strictly limited there would be no difficulty (nor would there be any ethical problems) in

mounting randomised controlled trials of different types of treatment. It might be of value to see the function of Ord Street as a workshop where various different types of specialised treatment might be evaluated at different times. The clinical research component of the programme should be based here.

Other methods of treatment might be the subject of further clinical investigation, for example the use of such drugs as disulfiram (antabuse) and citrated calcium carbimide (abstem) in the management, control and treatment of alcoholism. Such experimental programmes might be very helpful to those physicians in all parts of the State who might wish to extend the advice and services they can provide for alcoholics.

(iii) Quo Vadis Centre (Long Term Admissions)

Quo Vadis, which provides a longer term rehabilitation programme, based on work therapy, is located at Byford, south of Perth, with its own farm. It has places for 37 patients and a staff of 41. In 1977/78 there was an 80 per cent bed occupancy. The average length of stay during the year was 53 days and there were 144 admissions. The total bed patient days during the year were 7,628. The average daily cost per occupied bed was \$64. Quo Vadis is an attractive unit with appropriate surroundings, good facilities and good morale. The emphasis is on work therapy and counselling (group and individual).

Problems :

- (a) Quo Vadis is more expensive in terms of staff and average daily costs, considering the number of patients treated each year. It seems that the number of staff has nearly trebled without a corresponding increase in number of patients. This unit had the smallest number of admissions of patients and was geared to provide less intensive treatment over a longer period of time. A unit of this type is essential in a model programme which aims to provide all types of treatment and support. Consideration should be given to exploring how a considerably larger number of people might be

treated, supported, looked after and rehabilitated, without throwing too many extra burdens on the existing staff. The recent purchase of small huts which might be made into single bedroom style accommodation is one way in which this could be developed. Thought might also be given to providing facilities for some alcoholics who might benefit from considerably longer term minimal support, treatment and advice with a low level of staff support, possibly for one or two years, rather than months, who could take advantage of facilities at Quo Vadis.

- (b) There could be future problems if the adjoining forest land were sold for development. If it were possible it would be desirable to purchase this now. If this is not done and development occurs in the area, it might later be purchased by someone else. (At this stage it would be more expensive for the Authority to buy, even if this were still possible.) It would be undesirable to have this unit surrounded, e.g. by a number of commercial, residential or recreational activities.
- (c) There is an unused house on the property which could be made habitable at relatively little expense. To introduce five drug addicts into the house when rehabilitated would be likely to lead to trouble. An alternative use might be as a group home. For example, it might be possible to select four or five long-standing, but now dry, alcoholics who had benefited from rehabilitation at Quo Vadis and put them together to look after themselves in this unit. They could first of all continue to take advantage of the rehabilitation facilities at Quo Vadis and, later, arrangements might be made for them to leave the house daily to go to outside work, if the problems of transport could be resolved. Later the patients could then move to rented accommodation in town, with outpatient follow up and support.
- (d) It has been suggested that some patients might go to Quo Vadis for 2 to 3 weeks after leaving Aston in order to start treatment before going to Ord Street. It

is hard to see how any therapeutic relationships could be developed with such frequent changes of staff and I suspect this would lead to confusion for both staff and patients.

(iv) Outpatient Facilities (Carrellis Centre)

At the time of my visit, outpatient facilities were in a state of transition with patients being seen both at Carrellis Centre and Ord Street Hospital. The Methadone Clinic was about to move to William Street. The current situation was not entirely satisfactory with overcrowding and mixing of two groups of patients (of different age groups, and different subcultures). With the passage of time, and ageing of the population, those dependent on drugs will be more like those needing treatment for alcoholism. At present it would be desirable as far as it is possible to hold separate outpatient clinics or clinic sessions for those dependent on drugs. Were a smoking cessation clinic to be started, it would be desirable that this should be run as a separate facility also. (This would not necessarily be in a hospital but could be in a Health Centre or other community facility). In the long run, consideration should be given to siting outpatient facilities close to other medical facilities. If some of the inpatient facilities were to transfer to the Queen Elizabeth II Medical Centre (Sir Charles Gairdner) site, there would be some advantages in considering the provision of outpatient facilities at the Fremantle Hospital site or the Royal Perth Hospital site. This would allow for early referral of patients with alcohol problems and advice between medical disciplines.

(v) William Street Clinic

This outpatient facility has not yet been opened and the Methadone Maintenance Clinic has been situated until now in the Ord Street Hospital. This has meant that the alcoholism treatment programme and the Methadone Maintenance Programme have been run very closely together. There may have been some advantages in the staff being available for both on the same premises, but also disadvantages in that two groups of patients of different ages in different types of treatment were in the same

place. This lead to overcrowding and some degree of uncertainty as to whether the same programme was suitable both for patients dependent on drugs and those dependent on alcohol.

(b) Specialised Services for Patients Dependent on Drugs

(i) Introduction

It is well recognised that a wide range of people can become dependent on drugs. They include : a large number of patients who have become mildly dependent on sedatives and minor tranquillizers unwisely prescribed; a smaller number of alcoholics who have acquired a sedative dependence following injudicious treatment (generally with symptomatic prescriptions of sedatives on an outpatient basis); there are also small numbers of therapeutic and professional addicts who have become dependent in the course of treatment, or because of too easy access to drugs. These groups are different from the opiate addicts or poly-drug misusers who have become dependent after obtaining illicit drugs. This last group are difficult to deal with except by a special facility, such as a specialised drug dependence treatment service, which provides specialised treatments such as Methadone Maintenance. Unlike alcoholism where the Alcohol and Drug Authority's role is to encourage professionals of all types to provide some degree of support and treatment for those with problems there are advantages in restricting the prescribing of opiates and other addictive drugs to addicts to a limited number of trained specialists. The Authority should provide second level advice about the first groups mentioned above but specialised services for heroin addicts and poly-drug misusers.

(ii) Methadone Maintenance

Methadone Maintenance is now a generally accepted method of treatment for opiate dependence (heroin addiction). The aims are to help some patients eventually to come off all drugs while others are helped to function better, despite remaining dependent on drugs. This improvement of functioning can be

measured by improvements in life style, stability, work record, decreased criminality and so forth. There will, however, be some clients who will respond badly to all attempts to help them who are for this reason likely to be in need of continuing medical and nursing care, (for example, because of complications such as sepsis overdose or intoxication, which may be combined with other social problems). Finally, concentrating the treatment of opiate addicts in one facility helps to contain the problem and makes it easier to deal with possible additional problems such as addicts obtaining drugs from other doctors on various pretexts.

Whether or not patients should be allowed to take away Methadone in a container for consumption later is a matter for clinical decision in the light of the local scene. In the United Kingdom, where Methadone Clinics have been in operation for over 10 years, the current pattern is that - when a new patient is started on Methadone - the dose is gradually increased to the level which has been decided. At this time the patient attends a clinic daily but, when he is regularly receiving the full dose, arrangements are made so that he can pick up his dose of Methadone from a named chemist. He can take his daily dose away and consume it at home or at work as he wishes. It is possible that some Methadone prescribed in this way may be introduced into the black market, but the amounts are small and most of the Methadone that is diverted is thought to go to other addicts. (It is accepted that addicts at some stage may circulate drugs between themselves.) It is not possible to prevent some diversion of opiates by allowing a clinic only to prescribe a drug for consumption on the premises, since many addicts are highly skilled at obtaining other drugs, including opiates, from non-clinic doctors. The majority of drugs that are diverted in the United Kingdom at present are opiates which are obtained from General and Private Practitioners who have unwittingly prescribed them for addicts. It is not possible to prevent those dependent on opiates from misusing drugs by self-injection, and the disadvantages involved in trying to get patients to take all their drugs consistently under supervision outweighs the slight gains from marginally decreasing the rate of self-injection.

(iii) Methods of Dispensing Methadone

In the Authority's drug dependence outpatient clinic, Methadone is dispensed for consumption on the premises, in the form of oral Methadone (liquid). There has been some discussion in Perth as to whether it would be desirable to provide injectable Methadone. There is however no evidence from other countries that this provides any benefits. A study in England by Dr. Martin Mitcheson showed that there were no advantages in prescribing injectable heroin to addicts rather than offering them oral Methadone. I would recommend continuing to provide oral Methadone (unless at some future date, there is incontrovertible evidence from further carefully controlled randomised clinical trials, that some other method of dispensing Methadone is superior. It seems most unlikely that this will occur). The best option appears to be to prescribe oral Methadone, but not to insist on its consumption under supervision after a period of two to four weeks of supervised taking of the drug.

In general, experience in the United Kingdom suggests that it is desirable to develop a standardised and consistent policy for prescribing; that oral Methadone should be prescribed; that it is reasonable for patients to take away a daily dose without consuming it under supervision; that there is much to commend having a standard dosage schedule; that dosages should not be altered nor lost Methadone replaced; and that nothing would be gained by prescribing drugs to be taken by injection.

V. RESEARCH

(a) Introduction

In view of the Authority's limited research resources, priority is being given to applied research. Theoretical research has been omitted from the proposed future research programme both for this reason and because a substantial amount of such research into alcohol and drug programmes is already being conducted in various parts of the world.

(b) Current Research plans

The Authority's proposed research programmes for the next two or three years encompass the following, some of which have already been planned or are under way :

1. Descriptive and evaluative studies of the Authority's current rehabilitation programmes with the aim of ensuring that the existing resources of the Authority are being used to maximum advantage.
2. Implementation and evaluation of procedures for the identification and rehabilitation of the drinking driver. This area of research originates from the recommendations of the Committee Appointed to Consider Medical Fitness in Relation to the Driving of Motor Vehicles and subsequent Cabinet decisions.
3. Surveys of the extent of alcohol and drug problem in Western Australia. The aim of each survey will be to describe a specific problem area with the view to the implementation of appropriate counter measure programmes.
4. Evaluation of the educational and publicity activities of the Authority and related organisations.
5. Provision of help to other organisations wishing to monitor and evaluate the effectiveness of their activities, (for example, an evaluative review of the Wandering "Kulila" Alcohol Rehabilitation Project).

(c) Possible future research projects

Other projects which have been considered include :-

1. An evaluation, in conjunction with the Health Education Council, of a publicity campaign aimed at one of two similar Western Australian towns served by different media networks, to measure the effectiveness of this promotion of information about drugs of dependence (including alcohol and tobacco).

2. Studies of problem drinking by women and the misuse of sedatives, analgesics and minor tranquillisers by both sexes of all ages.
3. Consideration of alternatives to imprisonment for persons convicted of drug related offences or of drunken and disorderly behaviour.
4. Controlled drinking studies and evaluation of their effectiveness, particularly in those groups who drink more than is recommended as a safe level of consumption who would not however be classed (nor would they class themselves) as alcoholics.
5. Evaluation of industrial alcoholism programmes.

To organise such a programme of applied research appears to me to be a sensible and practical use of limited resources.

(d) Applied Clinical Research

The Ord Street Hospital should be considered as a valuable research facility where different inpatient methods of treatment could be evaluated (for example, 15 day programmes might be compared with those of 60 or 120 days). It will also be necessary to closely evaluate all forms of outpatient support and treatment in order to identify the simplest and cheapest forms; and also those treatments that can best be carried out by others, particularly those providing primary care in all parts of the State.

VI. EDUCATION

(a) Educational Function of the Authority

- (i) The Authority should provide: specialised training in the problems of alcoholism and drug dependence for members of all professions who are concerned with treatment and care. (Such programmes are currently being implemented.)

- (ii) the Authority should be a second level resource for other professionals involved with health education. General health education on a wide range of subjects would obviously be the primary concern of the Health Education Council. But this Council could not be expected to have the same detailed expertise in the problems of dependence as the Authority,
- (iii) if education in this field is to be useful and successful, it is necessary to try and identify those people and groups who are themselves involved in ongoing professional education, who can help to diffuse accurate knowledge and skills in this field,
- (iv) many requests for general education about drugs (for example, from parents' groups) come to the Authority, as presumably to many other bodies. The Authority's role should be to channel inappropriate requests away from the Authority itself, and from such bodies as the police, who may be ill equipped for this task; and to ensure that the most appropriate people concerned accept responsibility instead. This might be done in two ways: by referring some requests to the Health Education Council (and possibly offering financial assistance) and by courses and seminars for teachers, or instructors in Teachers Training Colleges,
- (v) the Authority has a part to play in the general education of the public. This would not be by mounting educational campaigns which would be better done by other groups. The role of the Authority should rather be that of a reliable, low key, trusted authoritative source of accurate information on dependence of all types; which could be made available to educators, journalists, and others looking for accurate information in this field. This role is already beginning to emerge,
- (vi) another educational function of the Authority is the in-house, on-going education and training of its own staff. Thought should be given to the best methods of achieving this. In view of the expense of air fares, it

will not be easy to second staff to attend clinics, seminars and conferences frequently; though it is essential that they should have this opportunity. Thought has been given to more use of experts from outside Western Australia being brought in to give seminars and tutorials, which would seem a sensible use of limited resources,

(vii) there is an obvious overlap between the educational, technical information and library services of the Authority. It is desirable that the Authority should possess and be able to make readily available such resources as reading lists, simple factual information, literature reviews and so forth, for interested enquirers. There is much available already in such units as the Institute for the Study of Drug Dependence in London, and another educational function would be to channel this to those needing it in a more systematic way,

(viii) an important part of the educational role is to provide correct information and change attitudes and help people unlearn wrong beliefs and also to discourage the spread of inaccurate knowledge about alcoholism and drug dependence. It would be desirable to regularly review and monitor as well as "grade" some of the material that is currently in use: this might be a task for a subcommittee of the Advisory Panel. An effective Films, Book and Materials Review Committee could help to improve the quality of some of the material available.

(b) Relationship with Health Education Council

In the field of Health Education, the Authority should on the whole not be directly involved. It should be the professional body which sets standards for drugs and alcohol education, and be a second level resource for teachers and exemplars. It should be only indirectly involved in health education of a general nature which would more properly be the responsibility of the Health Education Council.

One final point which is relevant is that the problems associated with the use or misuse of alcohol and drugs are not purely medical, nor are they purely matters of health. Traffic accidents, raising of revenue, aggression leading to social problems such as breakdown of marriages, are all subjects intimately involved with the consideration of the substances which are the Authority's concern. For this reason also, the Authority should act as a second level resource for educators other than those solely in the field of health.

The Educational Liaison Officer will need further supporting staff if all of the above functions are to be successfully carried out. It would also be helpful if the present holder of the post could be relieved of those activities which would more properly be the responsibility of a Librarian, as soon as such is appointed.

VII. SUMMARY AND RECOMMENDATIONS

(a) Summary

It is not essential to make a summary of a short report which can be briefly read without difficulty. I have however itemised all the specific recommendations that occur in the report with the appropriate page number. These are in the order in which they occur in the report and vary from major to minor importance. I would draw attention to the following major recommendations:

- 1) The present structure of the Authority seems appropriate and it should be supported in its present form and sensibly developed, rather than replaced, restructured or radically re-organised.
- 2) It is essential to consider the criteria for the appointment of the next Director of the Authority. The current pay scale is unrealistic and this should be urgently reconsidered. Consideration should be given to the Director having a linked University Appointment.
- 3) The role of the Authority needs to be kept under continuous review (with automatic reviews of the activities and policies of all sections of the Authority at three to five year intervals). The Authority should predominantly be a second level resource, and not endeavour to provide all the services that will be needed.

Most of the other recommendations are for small improvements in current practices or changes in emphasis, since in general I thought the Authority was carrying out the duties assigned to it effectively.

(b) Specific Recommendations

1. It would be desirable to try and estimate the extent of dependence on prescribed sedatives and minor tranquillisers. (Page 5)
2. It would be desirable to review the extent of overconsumption of non-prescription drugs (including anti-pyretic analgesics, cough medicines and anti-histamines) and consider what preventive measures might be needed. (Page 5)
3. In view of the need for a consistent response to changing problems and the wide ranging variety of these problems, the Alcohol and Drug Authority should be supported in its present form and sensibly developed, rather than replaced restructured or radically reorganised. (Pages 5-8)
4. In view of the size of the problem of dependence on tobacco, the Authority should play a larger part in providing second level support and advice to other professionals in their field and should set up a model smoking cessation clinic. (Pages 8-9)
5. In view of the size and widespread dispersal of problems associated with overconsumption of alcohol, more emphasis should be given to outpatient methods of providing support and advice and to evaluation of the effectiveness of these simpler and cheaper outpatient methods of providing treatment, advice, help and support. (Pages 9-10)
6. To act as a second level resource to facilities in remote areas, an expansion of the work of Liaison Officers would be necessary.

Further education for professionals and voluntary workers from these areas might be provided by the Authority. (Pages 10-11)

7. The problems of aboriginal excessive drinking cannot be separated from the problems of aboriginal life generally and the excessive consumption of alcohol by the population as a whole.

- a) Anything that generally improves the status and position of those of aboriginal descent should help with the problems of alcohol.
- b) Any lowering of the per capita consumption of alcohol by the population as a whole will be as beneficial for Aborigines as anyone else.
- c) In planning future policies for alcohol it might be desirable to discourage the use of fortified wines by the use of fiscal measures.
- d) In planning specific treatment services local groups should be encouraged to take the responsibility for doing this for themselves.

(Pages 11 - 12 and Appendix II Pages 48 - 51)

8. It is essential to ensure good liaison between the Alcohol and Drug Authority and the Mental Health Services and the General Hospital Services. Good liaison with other statutory and voluntary organisations is equally essential. (Pages 12 - 13)

9. The role of the Authority should be a second level source of education, advice, consultation and specialised second-level treatment (Pages 12 - 13)

10. Consideration should be given to siting the Authority's outpatient and inpatient facilities in the major hospitals in Perth. (Pages 13 - 14)

11. The Authority should review (possibly through the subcommittees of the Advisory Council and the Western Australia Council of Social Service Inc.) their links with voluntary agencies. (Pages 14 - 15)

12. The Authority should produce a directory of all Voluntary agencies in the State concerned with providing help for those dependent on alcohol and other drugs. (Page 14)

13. Consideration should be given to setting up liaison committees in those areas in the State where it is necessary to further mobilise local resources. (Page 14)

14. It would be desirable to consider the criteria for the appointment of the next Director of the Authority.

A proleptic appointment might be made with an initial period as assistant director. (Page 15)

15. The current pay scale is unrealistic and the Director should not have a pay scale lower than those for consultants covered by the Metropolitan Teaching Hospital Salary Agreement. The appropriate salary scale would appear to that of a clinical Professor. (Pages 15-16)

16. Consideration should be given to the Director having a linked University appointment. (Page 15)

17. The Director should have the opportunity to have regular meetings with colleagues in similar positions elsewhere in Australia. (Page 16)

18. Consideration needs to be given to the future functions of the Deputy Director who might in the future also act as clinical co-ordinator. (Page 17)

19. Medical staff in postgraduate training programmes should have the opportunity to rotate through posts with the Authority. (Page 17)

20. The function of Clinical Psychologists needs to be kept under review to make the best and most appropriate use of their skills. They should be asked to advise on the organisation provision and evaluation of treatment provided in a smoking cessation clinic if such is set up. (Pages 17-18)

21. Consideration should be given to the employment of psychologists as well as clinical psychologists. (Pages 17-18)
22. A senior Nursing Director should be appointed. Consideration should be given to the possibility of appointing one of the three Unit Directors to this post, since it would appear that the post of Nursing Director could be combined with clinical responsibility. (Page 19)
23. There is an urgent need for the appointment of a Librarian and/or Information Systems Officer. (Page 19)
24. Selected clinical staff should be encouraged to participate in research (with reduced case loads for varying periods of time) in preference to increasing the number of full time research staff. (Pages 19-20)
25. The functions, activities and policies of all sections of the Authority should be automatically reviewed at three to five year intervals. (Page 20)
26. The future plans for the State School Teachers Union Building should be reviewed in the light of the site needs of all concerned. (Pages 20-21)
27. Records should be compatible with those of the Hospital Service in general. (Page 21)
28. Care is needed to ensure that those treated for alcohol dependence do not develop dependence on other sedatives. (Page 22)
29. Rigorous evaluation of inpatient treatment of alcohol dependence is necessary. Randomised trials of different types and lengths of treatment would be desirable. Further investigation of the use of such drugs as disulfiram might be considered. (Pages 22-23)

30. There should be an expansion of the numbers receiving rehabilitation at Quo Vadis. (Pages 23-24)
31. It would be desirable to purchase the forest land adjoining Quo Vadis. (Page 24)
32. The unused house on the Quo Vadis property might be used as a group home. It would be unsuitable for the treatment of addicts. (Page 24)
33. It would be undesirable for patients to go briefly to Quo Vadis before going to Ord St.Hospital. (Page 24)
34. Outpatient treatment of older alcoholics and younger drug addicts are probably best arranged separately. (Page 25)
35. The Authority should provide second level advice about the treatment of dependence on drugs in general but should provide specialist services for the treatment of heroin (opiate) dependence. (Page 26)
36. It would not be desirable to provide injectable drugs to addicts. (Page 28)
37. It is not necessary, and there are some disadvantages, in endeavouring to insist that all dispensed drugs are consumed on the premises where they are dispensed. (Pages 27-28)
38. It is desirable to have consistent policies for the prescribing of methadone to addicts. (Page 28)
39. Research should continue on the lines planned with priority being given to applied rather than theoretical research. (Pages 28-30)

40. Ord St.Hospital should be further developed as a clinical research facility.
(Page 30)
41. The Authority should be a second level educational resource for other professions concerned with Health Education. (Pages 30-32)
42. The Authority has a part to play in the Education of the Public, but generally as a second level resource. (Page 31)
43. There is a need for continuing in-house on-going education of the Authority's own staff. (Page 31-32)
44. There is a need for a more systematic provision of educational and other information to those who need it. (Page 32)
45. Consideration should be given to the setting up of a Films, Book and Materials Review Committee. (Page 32)

(c) Acknowledgements

I would like to formally record my thanks to the very many people in Western Australia who received me in such a kindly, helpful and hospitable way that my task of drawing up this report was made both as simple as possible and also a pleasure and profit to myself. I will not specifically name them as the list would be very long except to particularly thank Miss Wendy Kubinski for patiently and accurately typing my various drafts.

VIII. APPENDICES

RECENT UNITED KINGDOM REPORTS:

ADVISORY COMMITTEE ON ALCOHOLISM REPORTS

ROYAL COLLEGE OF PSYCHIATRISTS REPORT

An Advisory Committee on Alcoholism to the Department of Health and Social Security in the United Kingdom, has prepared two reports on Alcoholism. One on "Prevention" (1977) and one on "The Pattern and Range of Services for Problem Drinkers" (1978). The Royal College of Psychiatrists has prepared a report "Alcohol and Alcoholism" (1979). In this Appendix, I have briefly summarised some of the recommendations from these three documents.

A. Advisory Committee on Alcoholism : Report on Prevention

The Advisory Committee considered that there should be five main ingredients in a strategy aimed to prevent harm from the effects of alcohol consumption:-

1. Education designed to alert people to the dangers of alcohol to their health and to discourage excessive drinking should be encouraged and expanded.
2. The presentation of alcohol to society, particularly in advertisements and the media, should be modified to produce a less one-sided picture of its effects.
3. Fiscal powers should be utilized to ensure that alcohol does not become cheaper in real terms.
4. Legal restrictions on the availability of alcohol should be enforced rigorously and should not be relaxed until there is sufficient evidence that to do so would not cause increased harm.
5. People who may be developing a drinking problem should be encouraged to recognise their problem and to seek help.

B. Advisory Committee on Alcoholism : Report on the Pattern and Range of Services for Problem Drinkers

The Advisory Committee made the following specific recommendations:

1. Treatment and care for problem drinkers should be provided by statutory and voluntary agencies at both "primary" and "secondary" levels. Where possible, problem drinkers should be treated at the primary level. At the primary level there are professional staff and voluntary workers whose work involves dealing with drinking problems. At secondary level are professional staff and voluntary workers who have received special training relevant to problem drinking.
2. The main tasks of workers at the primary level are to:
 - a) recognise problem drinking and its causes and effects;
 - b) have an adequate knowledge of the help required by problem drinkers and their families;
 - c) give this help as far as it lies within their scope;
 - d) know when and where to seek expert help;
 - e) provide continuing care and support before, during and after any period of specialist treatment;
 - f) provide adequate follow-up.
3. The main tasks of the worker at the secondary level are to:
 - a) provide specialised knowledge, advice and support to those who need it at primary level;
 - b) interview problem drinkers and family members as a consultative service intended to provide a second opinion;
 - c) accept problem drinkers into secondary care, i.e., the direct involvement of specialists and the provision of treatment and care;
 - d) provide specialised treatment and care, such as medical or psychiatric treatment and intensive social support including, where necessary, residential accommodation.

C. Royal College of Psychiatrists' Report

A recent report, "Alcohol and Alcoholism", prepared by the Royal College of Psychiatrists in England, has pointed out that excessive use of alcohol leads to many forms of harm, some medical, some non-medical; and that alcoholism is only one of these. The report made the point that misuse of alcohol and alcoholism were everybody's concern, not merely that of members of the medical, legal or other professions. They made a number of recommendations of varying degrees of importance, which I have briefly summarised here to draw attention to the way in which new knowledge in the field has led to some changes in the ways that problems may be tackled. The report recommended that:

1. Health policies on alcoholism generally should give much greater attention to prevention than has previously been the case;
2. As a simple set of first level goals, there should be a commitment to:
 - a) preventing the national per capita alcohol consumption from rising above its present level;
 - b) preventing a further rise in any of the available indices of alcohol-related harm (with cirrhosis death rate perhaps, providing a particularly useful index);
3. It might further be suggested that as a minimal second-stage set of goals, some agreement should be reached as to the level to which alcohol consumption and indices of harm (including cirrhosis death rate) should if possible be reduced over the next decade.
4. Attention should be given to means of effecting improvement in consultation and working co-operation between different Government Departments so as to ensure an integrated, effective and evolving response to inter-related drinking problems.
5. There should be no further relaxation in the broad range of licensing provisions.

5. There should be greatly enhanced Government commitment towards public education, persuasion and relevant research, so as to bring about a reduction in drinking problems.
6. Education on alcoholism directed to the general public should:
 - a) attempt continuously to provide the knowledge needed to inform public debate, so that acceptance may be won for the need for a broad range of preventive measures. The fact that alcohol is a drug should be made widely known; as should the meanings and implications of dependence, the nature and extent of resulting disabilities, the dangers of harm done to others, and the causes of harmful drinking. In particular, the relationship between national per capita consumption and the extent of a country's drinking problems should be brought to public attention;
 - b) inform the community that the use of alcohol in an attempt to relieve unpleasant feelings when people are apprehensive, dejected, depressed, lonely or bored, carries considerable risks;
 - c) encourage public disapproval of intoxication, and foster the attitude that it is bad manners to get drunk (rather than being bad manners to comment on drunkenness);
 - d) give clear information as to what constitutes safe or dangerous levels of drinking. The Royal College of Psychiatrists' report suggested that an intake of four pints of beer a day, four doubles of spirits, or one standard-sized bottle of wine, constituted reasonable guidelines for the upper limit of drinking. They stated that it was unwise to make a habit of drinking even at these levels; and that no-one should drink at all before driving a vehicle.

7. Research should be commissioned into the impact of liquor advertising, and such advertising should be curtailed if the evidence warranted this.
8. Government should take responsibility for examining the reliability of present indices of alcohol consumption and the incidence of alcohol-related disabilities, their improvement and collation; and should commission whatever additional research would be necessary for the continuing monitoring of preventive policies, either directly or through University Departments.
9. The possible impact that health-directed policies on alcoholism might have on the livelihood of any section of the community should be borne in mind. Those interests should be consulted, and efforts made to devise strategies to protect them.
10. Prevention at community and individual level is best designed in detail by the people immediately concerned. The Report made some preliminary recommendations:
 - a) every industrial or commercial undertaking should review the extent to which its employees are under pressure to drink; and then devise means for lessening this pressure (this is especially important where drinking may affect safety or responsible decisions);
 - b) special preventive programmes should be set up for high-risk trades or professions, in collaboration with trade unions or appropriate professional organisations;
 - c) a review should be made in every community of the extent to which leisure activities are available (particularly for the young) which are not associated with pressures to drink;
 - d) those responsible for organising official receptions and public functions would be wise to serve alcohol only in small quantities

- and non-alcoholic drinks should always be available also;
- e) those who entertain in their own homes should recognise that serving alcohol is a responsibility which cannot be treated casually. The amount of alcohol provided for each person should certainly not be in excess of the levels for daily intake mentioned previously; and non-alcoholic drinks should always be available;
 - f) ordinary members of the community should not ignore the person who is drinking excessively, but should show the same active concern as they would towards any other potentially dangerous behaviour;
 - g) every person should accept responsibility for his own personal prevention programme in terms of not exceeding the daily intake level that has been suggested and, if he is exceeding this level, he should review the reasons and circumstances and cut down on his drinking.
11. Skilled help should be available to the person with a drinking problem and in many instances, people should be persuaded to seek advice earlier than is at present happening. At the same time, the capacity of the individual with a drinking problem to help himself and modify his own behaviour needs to be much more heavily emphasized, as does the importance of the family and the wider society in responding to an individual's excessive drinking in a helpful way.
12. The evolution of policies on treatment services for alcoholism should be designed in terms of critical appraisal of:
- a) the appropriateness of the scale upon which that kind of treatment can be introduced within available resources;
 - b) the efficacy of any particular treatment;
 - c) the proportion of people with drinking problems who are likely to avail themselves of that particular treatment.

13. Treatment of alcohol related disabilities should frequently be left within the province of non-specialized agencies.
14. There is a continued place for specialized centres for treatment of some patients and for support and training of the generalist who will be dealing with drinking problems.
15. Each relevant caring profession should systematically examine the role which its members can play in the treatment of drinking problems, should review the present adequacy of training to meet these responsibilities and, in the light of such considerations, should formulate and institute appropriate training.
16. Government, Universities and other interests should set up the mechanism for an integrated planning of policies on alcohol and alcoholism research, and for definite periodic updating of that plan.

DRINKING PROBLEMS OF AUSTRALIANS OF ABORIGINAL DESCENT

General Problems

The Aborigines, who are the indigenous people of Australia, have been markedly affected by the introduction of diseases new to them, most significantly when European settlement started. Thousands died subsequently from smallpox, venereal disease, tuberculosis, whooping-cough, measles, leprosy and influenza. Dental decay was apparently unknown until the introduction of Western foods, such as sugar and flour. The introduction of alcohol to the continent has also had profound effects on this group.

There are genetic influences in the development of alcoholism. (It could be that a group who did not make or use alcohol might differ from other ethnic groups, such as those of European descent). Alcohol can be metabolized at different rates depending on the activity of such enzymes as alcohol dehydrogenases, which are concerned with the breakdown of alcohol. It might be that factors such as this are responsible for part of the genetic component in the development of alcoholism.

Some people believe that those of Aboriginal descent may be more exposed to the ill effects of alcohol because they react to it in a different way than those of European descent. I know of no firm evidence for this (unless the Australian Institute of Aboriginal Studies have something of which I am unaware, in their bibliography of the knowledge recorded about Aborigines). Although this might be a possible area for future research, it is unlikely to be fruitful, since any findings, though of academic interest, would be unlikely to be of much use in considering the planning of services or prevention.

A more important factor to be considered is the effects of the introduction of a drug to a people who are not used to it, as has happened with alcohol which has only been used by Aborigines following white settlement. Societies often

react badly to the introduction of a new drug of dependence, since they do not have the social and cultural controls on its use that are found when a drug has been used by a population over many generations. In the latter case there are social controls on such matters as who may drink or get drunk, when, and to what extent; and on what is considered an acceptable level of drinking, and what is unacceptable. (White populations in Australia and Europe have been faced with a similar dilemma following the introduction of marihuana and other drugs which are used by some groups for social purposes; where there is argument about what should be the appropriate controls over the new drugs, and whether any use at all should be acceptable). Aboriginals in Western Australia have only had a limited number of generations since the first white settlement, which is a short period in which to develop the necessary new social and cultural reactions and controls.

The Culture of the Aboriginals has been brought to an end in the last 200 years, following European settlement and exploitation of the environment. This has had a marked effect on a people who had lived a delicately-balanced, precarious existence in a changing and often harsh climate for many thousands of years. Lack of communication and understanding has contributed to the degradation of this group and to the extinction of many sub-groups. Although, today, attitudes are more enlightened, and efforts are being made to ensure that the Aboriginal has a rightful place in the community, it is still unclear what that place should be. Aboriginals generally are notably less healthy, poorer, worse-housed, and more poorly educated than the rest of the population. Ill-health and low immunity to diseases creates distress; inadequate housing leads to discontent, lack of job opportunity causes frustration. It is not possible to deal with problems arising from consumption of too much alcohol by this group without dealing with the many other problems of a despised minority of a different colour, in a racist world. Many of those today who have the label of 'Aboriginal' or 'ethnic minority' are of mixed descent, with further problems arising from a conflict of cultural backgrounds.

Specific Responses to the Problems

The pattern of treatment and care for alcoholism problems to be provided in areas outside Perth, particularly distant ones, must differ markedly from those in the metropolis. Although some orthopaedic services can be centred in Perth, so that a patient requiring a hip replacement might be flown in for treatment, it is obvious that such a pattern would be prohibitively expensive if it were to be used to try to deal with alcoholism. Firstly, there are no specific guaranteed therapies; secondly, all the pressures to start drinking again will be found in the place in which a person lives and works. For this reason, treatment must always eventually take place inside that community. There will be occasional exceptions, but the basic treatment of the alcoholism itself is unlikely to be much improved by the patient being flown to a distance (with the size of the State of Western Australia, and the high cost of internal airline tickets, it will be prohibitively expensive as well). An exception to this would be when a patient comes for specialised treatment, or when an alcoholic who has become abstinent requires further support, treatment and training in order to take part as a "recovered alcoholic counsellor".

The treatment of Aboriginal excessive drinkers is unlikely to be markedly more successful than that of other groups and there will be little to be gained by setting up expensive special treatment programmes if these turn out to be ineffective. Much thought is needed about the advice that might be given about making the best use of such facilities as those at Wandering (Kulila). It is possible that further use could be made of such a facility, other than simply bringing people there for treatment. For example, counsellors and those helping excessive drinkers might benefit from periods of further experience and training. Also, those alcoholics who had obtained sobriety for a certain period of time, who were themselves becoming future counsellors and helpers, might also benefit (Professor Kamien, who has had some experience of Aboriginal drinking, is of the opinion that the most helpful person in this situation is one of Aboriginal descent, who has had an alcoholism problem and who has obtained total sobriety).

It would be desirable for the Alcohol and Drug Authority to liaise and work closely with the Community Health Service, Department of Aboriginal Affairs as the body mainly responsible for Aboriginal health and with the National Aboriginal Consultative Committee, since many of the changes that must be brought about to cause any improvement in the problems caused by over-consumption of alcohol by those of Aboriginal descent, cannot be separated from the problems of Aboriginal life in Australia in general.

Prevention and Treatment.

In principle, anything that generally improves the lot of those of Aboriginal descent should help with the problems of alcohol consumption. Anything that lowers the total per capita consumption of alcohol by the population will be as beneficial for Aborigines as for anyone. Local groups should be encouraged to take the responsibility for planning the provision of treatment services for themselves; the role of the Alcohol and Drug Authority might be as a resource; providing financial support, advice and education for the training of further counsellors, and expanding what is being done at present.

Specific patterns of drinking by this group are similar to those seen among those American alcoholics who drink the cheapest fortified wines, which provide the highest amount of alcohol for the lowest expenditure, short of drinking non-beverage alcohols (this group of alcoholics in the United States of America are generally described as "winos"). In planning future pricing policies for beverage alcohol, it might be worth considering a change in levels of taxation to encourage the use of beverages with a lower alcohol content, and to discourage the widespread use of fortified wines.

REFERENCES

Report of the Honorary Royal Commission
The Treatment of Alcohol and Drug Dependents in Western Australia
W.C. Brown Government Printer Western Australia 1973
Annual Reports (for the year ending 1976 and 1977)
Western Australian Alcohol and Drug Authority, 25 Richardson Street, West Perth,
Western Australia.

Report from Senate Standing Committee on Social Welfare
Drug Problems in Australia - an intoxicated Society
Australian Government Publishing Service, Canberra, 1977

Advisory Committee on Alcoholism
Report on Prevention
Department of Health and Social Security and the Welsh Office, London, 1977.

Report by the Advisory Committee on Alcoholism
The Pattern and range of Services for Problem Drinkers
Department of Health and Social Security and the Welsh Office, London, 1978.

Report of a Special Committee of the Royal College of Psychiatrists
Alcohol and Alcoholism
Tavistock Publications, London, 1979.

Mitcheson, M. and Hartnoll, R.,
Conflicts in deciding treatment within drug dependency clinics
in Problems of Drug Abuse in Britain
Ed. West, D.J., Institute of Criminology, Cambridge, 1978.

A. LIST OF PEOPLE SEEN

Arndt, Mr. Frank, Psychologist, Busselton Health Centre

Bailey-Brooks, Mr. R., Psychologist, Alcohol and Drug Authority, Carrellis Centre

Bell, Dr. Fred, Director, Mental Health Services

Bellamy, Mr. Mike, Administrator, St. Thomas' Hospital, London
(seconded to Royal Perth Hospital)

Boothman, Mr. Peter, Alcohol and Drug Authority, Field Officer, Kalgoorlie

Boston, Dr. J. R., General Practitioner, Busselton Hospital

Brown, Mr. Tom, Secretary, Eastern Goldfields Halfway House Committee

Burvill, Professor Peter, Head of Department, Psychiatry, Royal Perth Hospital

Carmody-Sheehan, Mrs. Heather, Education Liaison Officer, Alcohol and Drug Authority

Carr, Mr. J. T., Executive Officer, Health Education Council

Christie, Dr. A. F., Medical Officer, Alcohol and Drug Authority, Aston Hospital

Cox, Mr. Phillip, Chairman, Broome Aboriginal Committee

Crocker, Mrs. P. Joan, Director of Nursing, Alcohol and Drug Authority, Aston Hospital

Cullen, Dr. Kevin, General Practitioner, Busselton Hospital

Djargween, Mr. Francis, Counsellor, Broome Aboriginal Committee

Farrelly, Dr. Frank, Board Member, Alcohol and Drug Authority and Boards of Management of Aston, Ord Street and Quo Vadis Hospitals also Acting Psychiatrist Superintendent Department of Corrections

Finlayson, Mr. Ray, Mayor, Kalgoorlie Shire

German, Professor Allen, Head of Department, Department of Psychiatry and Behavioural Science, Queen Elizabeth II Medical Centre (Sir Charles Gairdner Hospital)

Gibbs, Mr. Frank, Managing Secretary, Alcohol and Drug Authority, Quo Vadis Centre, Byford.

Hales, Mr. Will, Administrator, Busselton Hospital

Holman, Dr. L. J., Chairman, Alcohol and Drug Authority and Boards of Management of Aston, Ord Street and Quo Vadis Hospitals also Director-General of Health and Deputy Commissioner of Public Health and Medical Services

Howell, Mrs. Bette, Social Work Supervisor, Alcohol and Drug Authority, Carrellis Centre

James, Mr. David, Director of Nursing, Alcohol and Drug Authority, Ord Street Hospital

Jee, Dr. G. F., Senior Medical Officer, Alcohol and Drug Authority, Carrellis Centre

Jones, Dr. Henry, Deputy Director, Mental Health Services

Langoulant, Mr. Lou, Hospital Administrator, Kalgoorlie Hospital also Chairman, Eastern Goldfields Halfway House Committee

LIST OF PEOPLE SEEN - CONTINUED

Lee, Mr. Collyn, Project and Development Co-ordinator, Alcohol and Drug Authority

Lister, Dr. Tony, Psychiatrist, Mental Health Services

Modini, Miss Anne, Director of Nursing, Alcohol and Drug Authority, Quo Vadis Centre, Byford

Myint, Mr. Aung, Clinical Psychologist, Alcohol and Drug Authority, Ord Street Hospital

Newnham, Dr. W. A., Board Member, Alcohol and Drug Authority and Boards of Management of Aston, Ord Street and Quo Vadis Hospitals also Director, Special Treatment Clinic (Venereal Disease) Public Health Department

Owen, Mr. David, Director of Nursing, Kalgoorlie Hospital

Parker, Mr. Garry, Secretary, Alcohol and Drug Authority

Penman, Dr. John, Superintendent, Graylands Hospital

Porter, Dr. R.M., Director, Alcohol and Drug Authority

Quadros, Dr. Francis, Director, Community and Child Health Services

Rappeport, Mr. Lou, Pharmacist, Alcohol and Drug Authority, Methadone Clinic

Rollo, Dr. G. L., Psychiatrist Superintendent, Department of Corrections

Seow, Dr. S. W., Medical Officer, Alcohol and Drug Authority, Carrellis Centre

Smith, Mr. D. I., Research Psychologist, Alcohol and Drug Authority

Smith, Mr. G., Director, Christian Welfare Centre

Spargo, Dr. Randy, District Medical Officer, Community Health Services, Broome

Spencer, Dr. John, Medical Superintendent, Heathcote Hospital

Toup, Father Maurice, Catholic Welfare, Kalgoorlie (Also Grant's Patch)

Vodanovich, Mr. I. M., Chief Probation and Parole Officer, Probation and Parole Services

Wiggins, Sister Judith, Assistant Matron, Busselton Hospital

Young, Mr. R. L., Minister for Health and Community Development

Zorbas, Dr. A., Chairman, Australian and New Zealand College of Psychiatrists, also Consultant Psychiatrist, Queen Elizabeth II Medical Centre

B. LIST OF PLACES VISITED

Aston Hospital, Perth
Broome - Dr. R. Spargo, Community Health Services
Busselton Health Centre
Busselton Hospital
Carrellis Centre, Perth
Crime Prevention Council : Western Australian Branch
Cygnet Bay, Dampier
Eastern Goldfields Halfway House, Kalgoorlie
Fremantle Gaol
Grant's Patch, Kalgoorlie
Graylands Hospital
Kalgoorlie Hospital
Mental Health Services
Northam Rotary Conference
Ord Street Hospital, Perth
Probation and Parole Department, Perth
Queen Elizabeth II Medical Centre (Sir Charles Gairdner Hospital)
Quo Vadis Hospital, Byford
Royal College of General Practitioners of Western Australia
Royal Perth Hospital
Swanbourne Hospital
Western Australian Alcohol and Drug Authority Headquarters, Perth
Western Australian Council of Social Services (Christian Welfare Centre)
William Street, Methadone Clinic, Perth

C. SPEAKING ENGAGEMENTS

I was invited to speak at a number of meetings on the problems of Dependence on Alcohol and other Drugs and this gave me an opportunity for further discussion and exchange of views with many other people than those previously listed.

- April 3. Meeting with Western Australian Alcohol and Drug Authority
3. Lunch time meeting Sir Charles Gairdner Hospital
4. Royal Perth Hospital lunch time lecture
5. Meeting with WACASS Voluntary Agencies
Staff Lecture WAADA
Western Australian Division Royal College of Psychiatrists
6. Probation and Parole Department
7. Post Graduate Psychiatric Trainees
9. Staff Lecture WAADA
Meeting with Methadone maintenance patients group
10. Family Practitioner Group. Western Australian Division
College of General Practitioners
11. Staff Lecture WAADA
- 13 - 16. Visit to Broome and Cygnet Bay
18. Staff Lecture WAADA
19. Royal Perth Hospital, Psychiatry Unit
Australian Crime Prevention Council Meeting
21. Rotary Conference, Northam.
23. Medical Officers meeting WAADA
24. Board Meeting, WAADA
26. Medico-Legal meeting "Alternatives to imprisonment"
27. Lecture Kalgoorlie Hospital
28. Postgraduate Psychiatric Trainees
30. Visit to Busselton Hospital and Health Centre
- May 1. Meeting with Minister of Health
2. Sir Charles Gairdner Hospital, Psychiatry Department
3. Sir Charles Gairdner Hospital, Lecture
5. Post Graduate Psychiatric Trainees