

**Select Committee Into the Misuse of Drugs Act 1981**

# **FINDING THE RIGHT BALANCE**

**Working together as a community to  
prevent harm from illicit drugs and to help  
individuals and families in need**

Presented by Mr Christopher Baker MLA, Chairman  
Laid on the Table of the Legislative Assembly  
on 20 August 1998

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## Chairman's foreword

During the course of its inquiries under the second term of reference, the Select Committee dealt with a large volume of information that provided a wide spectrum of views and approaches for dealing with the use of illicit drugs. The breadth of this information has made the Select Committee's investigation into the adequacy of the provision of health, educational and community support services a surprisingly more complex process than was originally anticipated.

This complexity has meant that whereas in the Interim Report there was substantial agreement by members on many of the areas addressed, under the second term of reference there was at times a divergence of opinion by members of the Select Committee on a number of issues. However in producing the Final Report, members have managed to achieve a consensus on the major issues. This collaboration has enabled a more thorough and careful consideration of all matters and resulted in a coherent overall framework that comprehensively addresses the harms associated with illicit drug abuse in WA.

The report underlines the need for a commitment by all relevant organisations and government departments dealing with problems caused by drugs, to support unambiguous messages about the serious harms caused by the use of both licit and illicit drugs. This approach is an integral part of the School Drug Education Project, which provides drug education across all stages of the curriculum, from year 1 to year 12. A major achievement of the School Drug Education Project is that it has been formulated as a result of a collaborative approach, involving the Association of Independent Schools, the Catholic Education Office and the Education Department of WA, which incorporates drug education into the school health education curriculum.

In the Select Committee's view, the strength of the School Drug Education Project is that it is a continuous process involving a school's teaching staff thus avoiding the shortcomings of being 'one off' or periodic events. Most importantly the School Drug Education Project seeks to involve families and the community in supporting the aims of drug education in schools to ensure gains of the project are not lost or diminished.

On the basis of experiences interstate and overseas, the Select Committee recognises that the problems associated with the abuse of drugs will not substantially diminish in the short term. As indicated in the Select Committee's Interim Report, international developments are significant factors in domestic manifestations of drug problems. The growing sophistication of the international nature of the marketing and distribution of illicit drugs such as heroin means that the community must be responsive to unexpected shifts in the type of illicit drugs that become available for consumption.

There are a number of examples of how new trends in drug use can quickly spread. For instance, the recent rapid proliferation of designer drugs in Europe and the serious law enforcement and health problems due to the abuse of cocaine reported in a number of US cities, underpin the need for mechanisms for governments to quickly detect new fashions or trends in drug use and be able to deploy resources to limit the harmful effects of such drugs on young people. As indicated in the Interim Report, any success in dealing with drug problems in this State is substantially reliant on a significant investment by the Commonwealth in better methods of intelligence gathering within and outside of Australia in conjunction with cooperative arrangements between all law enforcement bodies within Australia.

In the course of its visit to Sydney the Select Committee, through the generous assistance of various New South Wales drug law enforcement personnel, received a first hand exposure to street level heroin dealing. This experience was very disturbing, as it involved the highly visible selling of high grade heroin, mostly involving young people, most of whom were clearly dependent users. Clearly this market is able to operate because there is a substantial level of demand for heroin from significant numbers of users from the wider Sydney area.

While the prospect of such an extensive heroin market developing in Perth appears remote, nevertheless some of the similar underlying socio economic and other factors exist here. These include large numbers of socially marginalised individuals located in specific geographic areas, high levels of unemployment, the perception of few support structures for young people to engage in positive recreational and leisure pastimes, and concerns about the location and types of intervention services and family and community support structures.

This experience means that in this State we must ensure that while emphasis should be given to assisting those directly and indirectly affected by drugs, it is equally important for the community to invest in those social and community infrastructures which encourage young people to become valued members of the community. The Select Committee believes that the existing treatment organisations in the metropolitan area are generally well resourced and are in most instances meeting the demands for service. In this State we are fortunate that community service agencies are able to receive capital funding from the Lotteries Commission. This has enabled the development of a number of high quality residential rehabilitation facilities in recent years in Perth and country areas.

However, it is the Select Committee's view that there is a need for additional services targeted at young people in the inner city area, the remainder of the metropolitan area and in regional centres elsewhere in the State. These additional services include the need to address accommodation issues for young people who are affected by drugs, the provision of a youth only sobering up facility to enable police to place intoxicated young people in a safe environment overnight, additional residential rehabilitation facilities and the development of two strategically located youth focused Community Drug Service Teams.

The Select Committee is particularly concerned that there is an apparent need for additional services in a number of major regional areas outside the Perth metropolitan region. While in some of these areas there has been support for programs over a number of years to assist those with alcohol dependencies, there appears to have been a comparatively lower investment in programs specifically targeted at those who use illicit drugs, possibly due to the unforeseen proliferation in their numbers.

In these non-metropolitan communities there appears to be very few private health and other service providers who are willing to assist those who are using heroin and other illicit drugs. Those few providers that do assist are generally ill equipped to respond to the demand for service. While some of these communities may view drug usage involving heroin and amphetamines as being big city problems, this is not the case. The Select Committee received some evidence of small and entrenched populations of those abusing these and other types of drugs.

In some areas, high incomes generated through mining and seasonal fishing industries, involving high proportion of single males, appear to be conducive to the toleration of the abuse of both licit and illicit drugs. Accordingly a recommendation has been made for funding of a community wide approach to drug use in these communities, along the line of the very successful approach that occurred in the Geraldton area following the establishment of the COMPARI project.

During the life of the Select Committee, the Government implemented a number of measures that entailed the devolution of the Alcohol and Drug Authority's community based programs by establishing Community Drug Service Teams which were awarded by competitive tender. At this stage, it is not possible to properly review the effectiveness of these new arrangements, as many of them have only been implemented since the beginning of 1998. However, I believe early tentative indications are that these will be quite successful.

It is the Select Committee's view it would be most appropriate to review these arrangements in conjunction with the review of the State's next Drug Abuse Action Plan. The Select Committee recommends that at the same time there be a review of the division of responsibilities between the WA Drug Abuse Strategy Office and the Mental Health Division of the Health Department.

Another significant development reviewed by the Select Committee since the tabling of its Interim Report is the release of the evaluation of the Victorian cannabis cautioning program

pilot. This review highlighted the divergence of opinions on how to address the issue of cannabis use in our community. The State government has responded to this development on 10 August 1998 by announcing a 12 month trial of a cannabis cautioning and education scheme in Mirrabooka and Bunbury. The Select Committee supports this trial and believes that any proper evaluation of its outcomes must also involve a thorough and considered recognition and analysis of the health, educational and community issues and not simply dollar savings in police resources.

Evidence was received of high levels of reported cannabis use, especially among upper secondary school students in this State. While it is apparent that much of this use is experimental or occasional in nature, nevertheless it raises the question of the extent of flexibility by the police in dealing with young people and others who are otherwise law abiding members of the community who are found to be in possession of small amounts of cannabis. As the consumption of cannabis has apparently become more prevalent in recent years, the Select Committee supports the implementation of the comprehensive public education and awareness strategy directed at the serious health consequences of consuming THC as the next phase of the WA Government's Drug Aware campaign.

As a result of its inquiries, the Select Committee believes that this State is at the crossroads of how to deal with the serious issue of illicit drugs. In terms of promoting the prevention of drug problems involving young people, the Select Committee believes that the WA government hand in hand with the broader community has travelled down the right path and that the WA community will reap substantial gains from the School Drug Education Project in the coming years.

In regional centres, there appears to be a need for an improved level of support for existing service providers and measures to assist communities who are beginning to experience increasing problems from the abuse of illicit drugs, particularly heroin.

In this final report, the Select Committee also deals with recent concerns that have arisen about the activities of police at a number of metropolitan and country high schools searching for drugs and other contraband and seeking to deter the possession or consumption of illicit drugs in our schools. It is the view of the Select Committee that there needs to be a clear framework for drug searches at schools to ensure that the support of the community and students is maintained and that the credibility of police is not tarnished.

In conclusion, I wish to express my sincere thanks to all members of the Select Committee, the Clerk of the Select Committee and research staff for their dedication to the Select Committee's wide inquiry on two very contentious and, at times, highly politicised terms of reference. I particularly wish to thank Mr Greg Swensen of WA Drug Abuse Strategy Office for his energetic devotion to the Select Committee's deliberations and his very high level of research and analytical skills.

Christopher Baker, MLA  
Chairman



# Table of contents

Committee members.....	i
Chairman's foreword.....	iii
Table of contents.....	vii
List of tables.....	xv
List of figures.....	xix
List of abbreviations and acronyms.....	xxiii
List of recommendations and findings.....	xxv

## Chapter 1: Introduction

1.1. Introduction.....	1
1.1.1. <i>Structure of this report</i> .....	1
1.2. Establishment of the Select Committee.....	3
1.3. Terms of Reference.....	4
1.4. Committee activities since 27 November 1997.....	4
1.4.1. <i>Service providers</i> .....	4
1.4.2. <i>School Drug Education Project (SDEP)</i> .....	5
1.4.3. <i>Visits to facilities</i> .....	5
1.4.4. <i>Intrastate visits</i> .....	5
1.4.5. <i>Interstate visits</i> .....	5

## Chapter 2: Audit of programs

2.1 Introduction.....	7
2.2. Cost of other drug abuse.....	7
2.3. Expenditure on services.....	9
2.3.1. <i>Overview</i> .....	9
2.3.2. <i>Alcohol and Drug Authority</i> .....	12
2.3.3. <i>WA Drug Abuse Strategy Office</i> .....	17
2.3.4. <i>Health Department of WA</i> .....	20
2.3.5. <i>Office of Aboriginal Health</i> .....	25
2.3.6. <i>Healthway</i> .....	26
2.3.7. <i>Education Department</i> .....	26
2.3.8. <i>Ministry of Justice</i> .....	27
2.3.9. <i>Police Service</i> .....	29
2.3.10. <i>Mix of services</i> .....	39
2.4. Comparative costs of treatment.....	43

## Chapter 3: Organisational issues

3.1. Introduction.....	47
3.2. Organisational arrangements in WA.....	48
3.2.1. <i>Up to June 1997</i> .....	48
3.2.2. <i>At December 1997</i> .....	48
3.2.3. <i>At December 1998</i> .....	50
3.3. Organisational issues.....	54
3.3.1. <i>Introduction</i> .....	54
3.3.2. <i>Duplication and overlap</i> .....	54
3.3.3. <i>Loss of corpus of knowledge and expertise</i> .....	55
3.3.4. <i>Loss of resources</i> .....	57
3.3.5. <i>Reduced access to non clinical services</i> .....	57
3.3.6. <i>Loss of independence of statutory body</i> .....	58
3.3.7. <i>Separate division vs Mental Health Division</i> .....	59
3.4. Administrative issues.....	60
3.4.1. <i>Centralisation of services</i> .....	60
3.4.2. <i>Detoxification program</i> .....	60
3.4.3. <i>Turning Point model</i> .....	60

3.5.	Commonwealth role.....	61
3.5.1.	<i>Introduction</i> .....	61
3.5.2.	<i>Evaluation of NDS</i> .....	62
3.5.3.	<i>National Drug Strategic Plan</i> .....	62
3.5.4.	<i>Ministerial Council on Drug Strategy</i> .....	64
3.5.5.	<i>Intergovernmental Committee on Drugs</i> .....	64
3.5.6.	<i>Funding arrangements</i> .....	64
3.5.7.	<i>Prevention</i> .....	65
3.5.8.	<i>National Drug Strategy</i> .....	66
3.6.	Victorian Drug Strategy.....	70
3.6.1.	<i>1993 Strategic Plan</i> .....	70
3.6.2.	<i>Pennington inquiry</i> .....	70
3.6.3.	<i>Turning the Tide</i> .....	70
3.6.4.	<i>Offenders</i> .....	74
3.6.5.	<i>Turning Point</i> .....	75

## Chapter 4: Treatment services

4.1.	Introduction.....	79
4.2.	ADA residential detoxification program.....	79
4.2.1.	<i>Introduction</i> .....	79
4.2.2.	<i>Type of admissions</i> .....	79
4.2.3.	<i>Gender</i> .....	80
4.2.4.	<i>Age</i> .....	80
4.2.5.	<i>Type of drug problem</i> .....	80
4.3.	All ADA programs.....	84
4.3.1.	<i>Type of admissions</i> .....	84
4.3.2.	<i>Gender</i> .....	84
4.3.3.	<i>Type of drug problem</i> .....	84
4.4.	Non government organisations.....	86
4.4.1.	<i>Cyrenian House</i> .....	86
4.4.2.	<i>Holyoake</i> .....	88
4.4.3.	<i>Palmerston</i> .....	93
4.4.4.	<i>Parent bereavement support program</i> .....	97
4.4.5.	<i>Custodial services adult program</i> .....	98
4.5.	Community Drug Service Teams.....	100
4.5.1.	<i>Overview</i> .....	100
4.5.2.	<i>Function of CDSTs</i> .....	101
4.5.3.	<i>ADA regional arrangement</i> .....	102
4.5.4.	<i>Concerns about CDST model</i> .....	104
4.5.5.	<i>SACS award</i> .....	106
4.5.6.	<i>Analysis by Health Zone</i> .....	107
4.5.7.	<i>COMPARI CDST</i> .....	111
4.5.8.	<i>Goldfields CDST</i> .....	116
4.5.9.	<i>South West CDST</i> .....	119
4.5.10.	<i>Great Southern CDST</i> .....	119
4.5.11.	<i>Kimberley CDST</i> .....	119
4.5.12.	<i>Pilbara CDST</i> .....	120
4.5.13.	<i>South Metro CDST</i> .....	120
4.5.14.	<i>South East Metro CDST</i> .....	120
4.5.15.	<i>North Metro CDST</i> .....	121
4.5.16.	<i>North East Metro CDST</i> .....	121
4.6.	Local Drug Action Groups.....	121
4.7.	Community based interventions.....	122
4.7.1.	<i>Introduction</i> .....	122
4.7.2.	<i>Strengthening community responses to drug problems</i> .....	123
4.7.3.	<i>Past interventions by HPS</i> .....	125
4.7.4.	<i>Current and ongoing interventions by HPS</i> .....	126
4.8.	Utilisation of services.....	127
4.8.1.	<i>COTSA survey</i> .....	127
4.8.2.	<i>WANADA survey of NGOs, 1997</i> .....	132

## Chapter 5: Responding to opioids

5.1.	Introduction.....	135
5.2.	Trends in heroin use.....	136
5.2.1.	<i>Pre 1960s.....</i>	<i>136</i>
5.2.2.	<i>1960s-1970s.....</i>	<i>136</i>
5.2.3.	<i>1980s-1990s.....</i>	<i>137</i>
5.3.	Prevalence in WA.....	137
5.4.	Indicators of abuse.....	138
5.4.1.	<i>ADIS telephone calls.....</i>	<i>138</i>
5.4.2.	<i>Admissions to ADA programs.....</i>	<i>140</i>
5.4.3.	<i>Admissions to hospitals.....</i>	<i>142</i>
5.4.4.	<i>Admissions to psychiatric hospitals and units.....</i>	<i>143</i>
5.4.5.	<i>Mortality.....</i>	<i>145</i>
5.5.	Pharmacology of opioids.....	150
5.6.	Risks.....	151
5.7.	Withdrawal.....	151
5.8.	Treatment of opioid dependency.....	151
5.8.1.	<i>Relapse prevention.....</i>	<i>152</i>
5.8.2.	<i>Substitution pharmacotherapy.....</i>	<i>152</i>
5.8.3.	<i>Detoxification.....</i>	<i>157</i>
5.9.	Methadone treatment.....	164
5.9.1.	<i>Introduction.....</i>	<i>164</i>
5.9.2.	<i>National Drug Strategy.....</i>	<i>166</i>
5.9.3.	<i>1969 to mid 1970s.....</i>	<i>167</i>
5.9.4.	<i>Mid 1970s to early 1980s.....</i>	<i>171</i>
5.9.5.	<i>Early 1980s to early 1985.....</i>	<i>174</i>
5.9.6.	<i>Early 1985 to present.....</i>	<i>176</i>
5.9.7.	<i>Treatment needs of women.....</i>	<i>178</i>
5.9.8.	<i>Overview.....</i>	<i>178</i>
5.9.9.	<i>Benefits.....</i>	<i>179</i>
5.9.10.	<i>Statistical overview.....</i>	<i>180</i>
5.10.	Notifications of drug addiction, 1982 - 1997.....	188
5.10.1.	<i>Overview.....</i>	<i>188</i>
5.11.	Psychiatric comorbidity.....	192
5.12.	Heroin overdoses.....	194
5.12.1.	<i>Introduction.....</i>	<i>194</i>
5.12.2.	<i>Opiate overdose prevention strategy.....</i>	<i>194</i>
5.12.3.	<i>Peer education project.....</i>	<i>195</i>
5.12.4.	<i>Emergency department (ED) project.....</i>	<i>196</i>
5.12.5.	<i>Relations with health care providers.....</i>	<i>197</i>
5.12.6.	<i>Young injecting drug users.....</i>	<i>198</i>
5.13.	Indo Chinese community.....	201
5.13.1.	<i>Introduction.....</i>	<i>201</i>
5.13.2.	<i>Case study - Cabramatta.....</i>	<i>202</i>

## Chapter 6: Responding to cannabis

6.1.	Introduction.....	207
6.2.	WA prevalence data.....	207
6.2.1.	<i>1994 survey of metropolitan high school students.....</i>	<i>207</i>
6.2.2.	<i>1993 WA Child Health Survey.....</i>	<i>208</i>
6.2.3.	<i>1996 ASSAD survey.....</i>	<i>209</i>
6.2.4.	<i>1997 survey of WA adults.....</i>	<i>209</i>
6.3.	National prevalence data.....	210
6.3.1.	<i>Overview.....</i>	<i>210</i>
6.3.2.	<i>Exposure to cannabis.....</i>	<i>211</i>
6.3.3.	<i>Lifetime prevalence.....</i>	<i>211</i>
6.3.4.	<i>Annual prevalence.....</i>	<i>212</i>
6.3.5.	<i>Age related trends.....</i>	<i>214</i>
6.3.6.	<i>Trends in consumption.....</i>	<i>216</i>

6.3.7.	<i>Age of initiation</i> .....	216
6.3.8.	<i>Adolescent cannabis use</i> .....	217
6.4.	Indicators of abuse.....	219
6.4.1.	<i>ADIS calls</i> .....	219
6.4.2.	<i>Admissions to psychiatric hospitals</i> .....	221
6.4.3.	<i>Admissions to ADA programs</i> .....	221
6.4.4.	<i>Mortality</i> .....	222
6.4.5.	<i>Charges</i> .....	223
6.5.	Health consequences.....	224
6.5.1.	<i>Major effects</i> .....	225
6.5.2.	<i>Acute effects</i> .....	225
6.5.3.	<i>Chronic effects</i> .....	225
6.5.4.	<i>Respiratory effects</i> .....	226
6.5.5.	<i>Cardiovascular effects</i> .....	226
6.5.6.	<i>Reproductive effects</i> .....	226
6.5.7.	<i>Neuropsychiatric complications and psychological dependence</i> .....	226
6.5.8.	<i>Physical dependence</i> .....	226
6.6.	Factors affecting cannabis use.....	226
6.7.	Young people and cannabis.....	227
6.7.1.	<i>Introduction</i> .....	227
6.7.2.	<i>Factors associated with use</i> .....	228
6.7.3.	<i>Alcohol and cannabis and deliberate self harm</i> .....	229
6.7.4.	<i>Why do young people use cannabis?</i> .....	230
6.7.5.	<i>Young people and the law</i> .....	231
6.7.6.	<i>Education and prevention</i> .....	232
6.7.7.	<i>Young people and families</i> .....	233
6.8.	Issues.....	234
6.8.1.	<i>Public education</i> .....	234
6.8.2.	<i>Assistance for people who are cannabis dependent</i> .....	235
6.8.3.	<i>The 'gateway theory'</i> .....	235
6.9.	Legal options.....	239
6.9.1.	<i>Introduction</i> .....	239
6.9.2.	<i>South Australian scheme</i> .....	239
6.9.3.	<i>Australian Capital Territory scheme</i> .....	240
6.9.4.	<i>Northern Territory scheme</i> .....	240
6.9.5.	<i>Other schemes</i> .....	241
6.10.	Impact of decriminalisation.....	241
6.10.1.	<i>Introduction</i> .....	241
6.10.2.	<i>Australian experience</i> .....	242
6.10.3.	<i>Effect on policing</i> .....	243
6.10.4.	<i>Community attitudes</i> .....	244
6.11.	Cannabis cautioning schemes.....	248
6.11.1.	<i>Victorian cannabis cautioning program pilot</i> .....	248
6.11.2.	<i>WA cannabis strategy</i> .....	251

## Chapter 7: Responding to other drugs

7.1.	Introduction.....	257
7.1.1.	<i>Indicators of abuse</i> .....	257
7.1.2.	<i>Prevalence</i> .....	258
7.2.	Overview.....	259
7.2.1.	<i>Introduction</i> .....	259
7.2.2.	<i>ADIS calls</i> .....	260
7.2.3.	<i>Admissions to hospitals – all causes</i> .....	265
7.2.4.	<i>Admissions to hospitals – poisoning</i> .....	268
7.2.5.	<i>Admissions to psychiatric hospitals</i> .....	271
7.2.6.	<i>Mortality</i> .....	281
7.3.	Psychostimulants.....	284
7.3.1.	<i>Introduction</i> .....	284
7.3.2.	<i>Prevalence</i> .....	284
7.3.3.	<i>Indicators of abuse</i> .....	286
7.3.4.	<i>Amphetamines</i> .....	290

7.3.5.	Cocaine.....	291
7.4.	Volatile substances.....	293
7.4.1.	Introduction.....	293
7.4.2.	Prevalence.....	294
7.4.3.	Indicators of abuse.....	295
7.4.4.	Patterns of use.....	299
7.4.5.	Harm.....	300
7.4.6.	Types of volatile substances.....	300
7.4.7.	Organic solvents and aerosols.....	300
7.4.8.	Petrol and fuel gases.....	301
7.4.9.	Volatile substance abuse and young people.....	302
7.4.10.	Gaps in the law.....	303
7.4.11.	Volatile nitrites.....	303
7.4.12.	Inhalational anaesthetics.....	304
7.4.13.	Methods of use.....	304
7.4.14.	Adverse consequences.....	304
7.4.15.	Physical effects.....	305
7.4.16.	Withdrawal effects.....	305
7.5.	LSD and other hallucinogens.....	306
7.5.1.	Introduction.....	306
7.5.2.	Prevalence.....	306
7.5.3.	Indicators of abuse.....	307
7.6.	Ecstasy and other designer drugs.....	308
7.6.1.	Introduction.....	308
7.6.2.	Prevalence.....	309
7.6.3.	Indicators of abuse.....	311
7.6.4.	Rave parties.....	312
7.6.5.	Other phenylethylamines.....	316
7.6.6.	Fentanyl derivatives.....	316
7.6.7.	Meperidine derivatives.....	316
7.6.8.	Analogues of the future.....	317
7.7.	Prescription drugs.....	317
7.7.1.	Introduction.....	317
7.7.2.	Prevalence.....	317

## Chapter 8: Special issues

8.1.	Parent groups.....	323
8.1.1.	Introduction.....	323
8.1.2.	Community based supports for parents.....	323
8.1.3.	Family based policies.....	325
8.1.4.	Cyrenian House.....	326
8.1.5.	Palmerston.....	326
8.1.6.	Families and Friends for Drug Law Reform.....	327
8.1.7.	Drug Aid.....	328
8.1.8.	Anna Wood drug and alcohol education project.....	330
8.1.9.	Damien Trimmingham Foundation.....	331
8.1.10.	Parents Reaching Youth Through Drug Education.....	332
8.2.	Youth.....	333
8.2.1.	Introduction.....	333
8.2.2.	Interventions.....	334
8.2.3.	Surveys of drug use and other health related behaviours.....	336
8.2.4.	Risk factors and protective factors.....	345
8.2.5.	Health Promotion Services programs.....	346
8.3.	Treatment and support programs.....	347
8.3.1.	Overview.....	347
8.3.2.	Yirra.....	349
8.3.3.	Holyoake.....	361
8.3.4.	Palmerston.....	363
8.3.5.	Trinity Youth Options.....	364
8.3.6.	Teen Challenge.....	367
8.3.7.	Interstate programs.....	367
8.4.	Services for women.....	370

8.4.1.	<i>Introduction</i> .....	370
8.5.	Blood borne viruses.....	377
8.5.1.	<i>HIV</i> .....	377
8.5.2.	<i>Hepatitis B</i> .....	384
8.5.3.	<i>Hepatitis C</i> .....	385
8.5.4.	<i>Needle and syringe program</i> .....	390
8.6.	Indigenous people.....	406
8.6.1.	<i>Introduction</i> .....	406
8.6.2.	<i>Injecting drug use</i> .....	407
8.6.3.	<i>National surveys</i> .....	407
8.7.	Indo Chinese community.....	408
8.8.	Harm minimisation.....	410
8.8.1.	<i>Introduction</i> .....	410
8.8.2.	<i>West Australian approach</i> .....	411

## Chapter 9: School based drug education

9.1.	Introduction.....	415
9.2.	History.....	415
9.2.1.	<i>Health Education K-10 Syllabus</i> .....	415
9.2.2.	<i>WA school health project</i> .....	416
9.2.3.	<i>Other influences</i> .....	416
9.2.4.	<i>School Drug Education Project</i> .....	417
9.3.	Developing a school drug policy.....	423
9.3.1.	<i>Introduction</i> .....	423
9.3.2.	<i>Principles</i> .....	424
9.3.3.	<i>Definition of a drug</i> .....	424
9.3.4.	<i>A comprehensive approach</i> .....	424
9.3.5.	<i>Prevention and intervention</i> .....	425
9.3.6.	<i>Advantages of an effective school drug policy</i> .....	425
9.3.7.	<i>Steps in developing a school drug policy</i> .....	426
9.3.8.	<i>Development of policy and response to drug use incidents</i> .....	427
9.3.9.	<i>Making the policy work</i> .....	427
9.4.	Issues.....	429
9.4.1.	<i>Students' possession of illicit drugs</i> .....	429
9.4.2.	<i>Students' possession of cigarettes</i> .....	429
9.4.3.	<i>Students' possession and consumption of alcohol</i> .....	430
9.4.4.	<i>Students' use of solvents</i> .....	430
9.4.5.	<i>Search of students' possessions</i> .....	430
9.4.6.	<i>Police and schools</i> .....	430
9.5.	Drug education in current health curriculum.....	433
9.5.1.	<i>K-10 drug education</i> .....	433
9.5.2.	<i>Year 11 &amp; 12 drug education</i> .....	433
9.5.3.	<i>Drug education for Aboriginal students</i> .....	433
9.5.4.	<i>Details of K-10 drug education</i> .....	433
9.5.5.	<i>Interstate perspectives</i> .....	438

## Chapter 10: Matters arising from Interim Report

10.1.	Introduction.....	443
10.2.	NSW Crime Commission.....	443
10.2.1.	<i>Forfeiture of assets of a serious crime offender</i> .....	443
10.2.2.	<i>Effective control provisions</i> .....	444
10.2.3.	<i>Illegally acquired property</i> .....	444
10.2.4.	<i>Serious criminal activity</i> .....	444
10.2.5.	<i>Forfeiture of serious crime derived property</i> .....	444
10.2.6.	<i>Proceeds assessment order</i> .....	445
10.2.7.	<i>Calculation of amount of Proceeds Assessment Order</i> .....	445
10.2.8.	<i>Control and seizure orders</i> .....	445
10.2.9.	<i>Hardship provision</i> .....	445
10.2.10.	<i>Reasonable living expenses</i> .....	446
10.2.11.	<i>Reasonable legal expenses</i> .....	446

10.2.12.	<i>Confiscated funds</i> .....	446
10.2.13.	<i>Examinations</i> .....	447
10.2.14.	<i>Production orders</i> .....	447
10.2.15.	<i>Search warrants</i> .....	447
10.2.16.	<i>Monitoring orders</i> .....	448
10.2.17.	<i>Communications of information by financial institutions to the NSWCC</i> .....	448
10.2.18.	<i>Management of the confiscation function within the NSWCC</i> .....	448
10.2.19.	<i>Source of matters for consideration</i> .....	448
10.2.20.	<i>Criteria for assessing whether to commence proceedings</i> .....	449
10.2.21.	<i>Commencement of proceedings</i> .....	450
10.2.22.	<i>Financial investigation</i> .....	450
10.2.23.	<i>Main purpose of financial investigation</i> .....	450
10.2.24.	<i>Timing of referral to the NSWCC</i> .....	450
10.2.25.	<i>Basic financial checks</i> .....	451
10.2.26.	<i>Limitations to basic checks</i> .....	451
10.2.27.	<i>Search warrants for financial documentation</i> .....	451
10.2.28.	<i>Assistance available to police from the NSWCC</i> .....	451
10.3.	<b>Police Integrity Commission</b> .....	451
10.3.1.	<i>Introduction</i> .....	451
10.3.2.	<i>Integrity procedures and drug law enforcement</i> .....	452
10.3.3.	<i>NSW Police Integrity Commission</i> .....	452
10.3.4.	<i>Category 1 complaints</i> .....	453
10.4.	<b>Drug use in prisons</b> .....	454
10.4.1.	<i>Introduction</i> .....	454
10.4.2.	<i>Use of drugs in NSW prisons</i> .....	454
10.4.3.	<i>Prisoners and blood borne viruses</i> .....	455



## List of tables

Table 2.1:	Total economic costs of drug abuse, Australia, 1988 - 1992.....	7
Table 2.2:	Tangible costs of other drug abuse, Australia, 1988 - 1992.....	9
Table 2.3:	Summary of expenditure by government on drug related services, 1996/97 - 1997/98.....	10
Table 2.4:	Summary of expenditure (\$) on treatment and support services, 1975/76 - 1997/98.....	11
Table 2.5:	Details of expenditure by ADA by major activities, 1996/97 - 1998/99.....	17
Table 2.6:	Summary of WADASO purchasing, 1996/97 - 1998/99.....	18
Table 2.7:	Community Drug Service Teams, 1997/98 – 1998/99.....	19
Table 2.8:	NGOs excluding sobering up centres, 1996/97 – 1997/98.....	19
Table 2.9:	Sobering up centres, 1996/97 - 1997/98.....	20
Table 2.10:	Summary of HDWA purchasing for drug programs, 1996/97 - 1997/98.....	20
Table 2.11:	Purchasing of drug programs by Public Health Division 1996/97 - 1997/98.....	24
Table 2.12:	Purchasing of drug programs by Office of Aboriginal Health 1996/97 – 1997/98.....	25
Table 2.13:	Income received by Education Department for SDEP, 1997/98.....	27
Table 2.14:	Purchasing of drug programs by Ministry of Justice 1996/97 - 1997/98.....	29
Table 2.15:	Details of Police Service expenditure, 1996/97 – 1998/99.....	30
Table 2.16:	Community based approach to drug law enforcement.....	37
Table 2.17:	Outpatient and outreach counselling services.....	40
Table 2.18:	Telephone information and counselling services.....	40
Table 2.19:	Counselling and education services for offenders.....	41
Table 2.20:	Services provided by day support centres.....	41
Table 2.21:	Methadone program service providers.....	41
Table 2.22:	Parent and family support services.....	41
Table 2.23:	Sobering up centres.....	41
Table 2.24:	Rehabilitation and support accommodation services.....	42
Table 2.25:	Services to prevent heroin overdoses.....	42
Table 2.26:	Services to reduce BBVs.....	42
Table 2.27:	Services providing training & skills development.....	42
Table 2.28:	Services provided by self help organisations.....	42
Table 2.29:	Comparative operating costs of residential and non residential programs, 1996/97.....	44
Table 3.1:	First instalment NIDS funding, November 1997.....	68
Table 3.2:	Second instalment NIDS funding, March 1998.....	69
Table 3.3:	Summary of number services.....	72
Table 3.4:	Summary of youth programs.....	73
Table 4.1:	New annual admissions to all ADA programs by principal drug problem, persons, 1988 - 1997.....	85
Table 4.2:	New annual admissions to all ADA programs by principal drug problem, males, 1988 - 1997.....	85
Table 4.3:	New annual admissions to all ADA programs by principal drug problem, females, 1988 - 1997.....	85
Table 4.4:	Number of clients attending Holyoake outpatient counselling program, 1996/97.....	92
Table 4.5:	Activity indicators, Palmerston Centre, 1996 - 1997.....	95
Table 4.6:	Activity indicators, Palmerston Farm, 1996 - 1997.....	95
Table 4.7:	Number of discharges from Palmerston Farm, 1996 - 1997.....	96
Table 4.8:	Participation in Palmerston pre release program, 1997.....	99
Table 4.9:	Participation in Palmerston post release program, 1997.....	99
Table 4.10:	WADASO purchasing for CDSTs, 1997/98 - 1998/99.....	107
Table 4.11:	Estimated purchasing of treatment services by WADASO by Health Zone, 1997/98.....	108
Table 4.12:	Estimated cost of total drug related beddays by Health Zone and major drug group, 1995.....	109
Table 4.13:	Estimated total number of drug related hospital admissions by Health Zone and drug group, 1995.....	109
Table 4.14:	Estimated cost per capita of drug related hospital admissions by Health Zone and drug group, 1995.....	110
Table 4.15:	Number of alcohol and other drug FTEs vs mental health FTEs in non metropolitan Health Zones.....	111

Table 4.16: Drug related admissions to Geraldton Regional Hospital by drug group, 1996/97.....	112
Table 4.17: Drug related admissions to Kalgoorlie Regional Hospital by drug group, 1996/97.....	116
Table 4.18: COTSA survey, primary drug problem by age group and sex June 1995.....	129
Table 4.19: COTSA survey, primary drug problem by average age and sex June 1995.....	129
Table 4.20: COTSA survey, type of treatment by primary drug problem, June 1995.....	130
Table 4.21: COTSA survey, average age of injecting drug use in past 12 months, June 1995.....	130
Table 4.22: ADA methadone population by age group and sex, June 1995.....	130
Table 4.23: Total treatment population, primary drug problem by sex June 1995.....	131
Table 4.24: Total treatment population by sex and type of treatment, June 1995.....	132
Table 4.25: Total treatment population by postcode, June 1995.....	132
Table 4.26: Utilisation of NGO services, 1997.....	134
Table 5.1: Quarterly ADIS illicit opioid related telephone calls, 1986 - 1998.....	139
Table 5.2: Opioid related hospital admissions by sex, WA, 1982 - 1992.....	142
Table 5.3: Opioid related hospitalisation due to poisoning, WA, 1982 - 1992.....	143
Table 5.4: Age standardised rate of opioid related hospitalisation due to poisoning, WA, 1982 - 1992.....	143
Table 5.5: First ever admissions to psychiatric hospitals and units due to opioid abuse, WA, 1988 - 1997.....	144
Table 5.6: Age standardised rates of hospitalisation due to opioid dependence, 1981 - 1992.....	145
Table 5.7: Trends in opioid related mortality by jurisdiction persons aged 15 to 54, 1988 - 1996.....	146
Table 5.8: Quarterly opioid related deaths due to heroin/morphine and all opioids, WA, 1995 - 1998.....	150
Table 5.9: Pharmacology of drugs used to treat opioid dependence.....	153
Table 5.10: Annual admissions to WA methadone program, 1973 - 1997.....	182
Table 5.11: Number of males and females participating in all methadone programs by quarter, 1997 - 1998.....	183
Table 5.12: Annual direct costs ADA methadone program, 1990/91 - 1996/97.....	185
Table 5.13: Quarterly totals of ADA methadone daily doses by dispensing outlet, 1993 - 1998.....	187
Table 5.14: Number of persons participating in community based methadone program by quarter, 1997 - 1998.....	188
Table 5.15: Annual notifications of drug addiction by age group, persons, 1982 - 1997.....	189
Table 5.16: Annual notifications of drug addiction by age group, males, 1982-1997.....	189
Table 5.17: Annual notifications of drug addiction by age group, females, 1982-1997.....	190
Table 5.18: Annual notifications of drug addiction by mode of drug use, 1995 - 1997.....	191
Table 5.19: Average age of notifications of drug addiction by mode of drug use, 1995-1997.....	192
Table 6.1: Prevalence (%) of WA adolescent cannabis use by age group and sex, 1993.....	209
Table 6.2: Prevalence (%) of cannabis use by WA school students, by age group and sex, 1996.....	209
Table 6.3: Prevalence (%) of WA adult cannabis use by age group and sex, 1997.....	210
Table 6.4: Prevalence (%) of cannabis use in the past 12 months by age group, Australia, 1988 - 1995.....	213
Table 6.5: Prevalence (%) of cannabis use by age group, Australia, 1988 - 1995.....	214
Table 6.6: Frequency (%) of consumption by those who have used cannabis in past 12 months, Australia, 1988 - 1995.....	216
Table 6.7: Use of cannabis (%) by age of initiation, Australia, 1993 - 1995.....	217
Table 6.8: Frequency (%) of cannabis use among adolescents, Australia, 1988 - 1995.....	218
Table 6.9: Quarterly ADIS cannabis related telephone calls, 1986 - 1998.....	220
Table 6.10: First ever admissions due to cannabis abuse, 1988 - 1997.....	221
Table 6.11: New cannabis related admissions to all ADA programs by age group, 1988 - 1997.....	221
Table 6.12: All cannabis related admissions to ADA residential detoxification programs by age group, 1988 - 1997.....	222
Table 6.13: Number of charges by drug group, Operation Final Dose, 11 August - 5 October 1997.....	224
Table 6.14: Use of cannabis and other substances by young people, 1993.....	228
Table 6.15: Schedule of fees of expiable offences, South Australia.....	240
Table 6.16: Threshold quantities (grams) of cannabis for NT infringement notice.....	241
Table 6.17: Cannabis use in different parts of Australia, 1995.....	243
Table 6.18: Adjusted ever use (%) of cannabis by jurisdiction, 1985 - 1995.....	243
Table 6.19: Adjusted weekly use (%) of cannabis within each jurisdiction, 1988 - 1995.....	243

Table 7.1: Prevalence (%) of use of at least one illicit drug used in past 12 months by age group, Australia, 1988 – 1995.....	260
Table 7.2: Annual licit and illicit drug related calls, 1986 – 1997.....	262
Table 7.3: Annual licit drug related calls by drug group, 1986 – 1997.....	262
Table 7.4: Annual illicit drug related calls by drug group, 1986 – 1997.....	263
Table 7.5: Monthly drug related calls from parents, March 1997 – March 1998.....	265
Table 7.6: Annual admissions to hospitals due to drugs other than alcohol, 1982 - 1992.....	265
Table 7.7: Hospital admissions due to drugs other than alcohol, by type of drug and sex, 1982 - 1992.....	266
Table 7.8: Age standardised rates of hospitalisation due to drugs other than alcohol by sex, 1982 - 1992.....	267
Table 7.9: Hospital admissions due to poisoning by type of drug and sex, 1982 - 1992.....	269
Table 7.10: Male age standardised rates of hospitalisation due to drug caused poisoning by type of drug, 1982 - 1992.....	270
Table 7.11: Female age standardised rates of hospitalisation due to drug caused poisoning by type of drug, 1982 - 1992.....	270
Table 7.12: First ever admissions of drug related mental disorders by sex, 1988 - 1997.....	272
Table 7.13: First ever admissions of drug related mental disorders (drug dependence and non dependent abuse) by type of drug and sex, 1988 - 1997.....	273
Table 7.14: Annual first ever admissions of drug related mental disorders by type of drug related cause, 1988 - 1997.....	273
Table 7.15: First ever admissions of drug related mental disorders due to drug dependence (excluding alcohol) by type of drug and sex, 1988 - 1997.....	274
Table 7.16: Annual first ever admissions of drug related mental disorders due to drug dependence (excluding alcohol) by type of drug, 1988 - 1997.....	275
Table 7.17: First ever admissions of drug related mental disorders due to drug dependence (excluding alcohol) by sex and age group, 1988 - 1997.....	276
Table 7.18: First ever admissions of drug related mental disorders due to non dependent drug abuse by type of drug and sex, 1988 - 1997.....	277
Table 7.19: Annual first ever admissions of drug related mental disorders due to non dependent drug abuse by type of drug, 1988 - 1997.....	278
Table 7.20: First ever admissions of drug related mental disorders due to non dependent drug abuse by sex and age group, 1988 - 1997.....	279
Table 7.21: First ever admissions of drug related mental disorders due to self inflicted injury (excluding alcohol) by sex and age group, 1988 - 1997.....	279
Table 7.22: First ever admissions of drug related mental disorders due to drug psychoses (excluding alcohol) by sex and age group, 1988 - 1997.....	280
Table 7.23: Annual estimated number of estimated drug caused deaths by type of drug, WA, 1984 - 1994.....	282
Table 7.24: Annual estimated number of male deaths caused by drugs other than alcohol or tobacco, 1984 - 1994.....	283
Table 7.25: Annual estimated number of female deaths caused by drugs other than alcohol or tobacco, 1984 - 1994.....	283
Table 7.26: Annual estimated number of all deaths caused by drugs other than alcohol or tobacco, 1984 - 1994.....	283
Table 7.27: Prevalence (%) of illicit amphetamine use in the past 12 months by age group, Australia, 1988 - 1995.....	285
Table 7.28: Quarterly ADIS psychostimulant related telephone calls, 1986 - 1998.....	287
Table 7.29: Psychostimulant related hospital admissions by sex, 1982 - 1992.....	288
Table 7.30: Psychostimulant related hospital admissions due to poisoning by sex, 1982 - 1992.....	288
Table 7.31: Age standardised rate of hospitalisation due to poisoning by psychostimulants, 1982 - 1992.....	288
Table 7.32: Annual first ever admissions of drug related mental disorders due to amphetamine abuse, 1988 - 1997.....	289
Table 7.33: Age standardised rate of hospitalisation of drug related mental disorders due to psychostimulant related psychoses by sex, 1981 - 1992.....	290
Table 7.34: Adverse effects of psychostimulant abuse.....	293
Table 7.35: Quarterly ADIS volatile substance related telephone calls, 1986 - 1998.....	296

Table 7.36: Volatile substance related hospitalisation due to all causes by sex, 1982 - 1992.....	296
Table 7.37: Volatile substance related hospitalisation due to poisoning by sex 1982 - 1992.....	297
Table 7.38: Deaths caused by volatile substances by age group, Australia, 1980 - 1988.....	299
Table 7.39: Commonly abused volatile substances.....	301
Table 7.40: Quarterly ADIS hallucinogen related telephone calls, 1986 - 1998.....	308
Table 7.41: Prevalence (%) of ecstasy (or other designer drug) use in the past 12 months by age group, Australia, 1988 - 1995.....	310
Table 7.42: Quarterly ADIS ecstasy related telephone calls, 1986 - 1998.....	312
Table 8.1: Frequency (%) of alcohol use of adolescents by age group, WA, 1993.....	339
Table 8.2: Frequency (%) of cannabis use of adolescents by age group and sex, WA, 1993.....	341
Table 8.3: Proportion (%) of adolescents aged 14 to 19 who have never used illicit drugs in the past 12 months, Australia, 1985 - 1995.....	342
Table 8.4: Age trends (%) of clients attending Yirra, 1995/96 - 1996/97.....	353
Table 8.5: Trends in drug taking by clients attending Yirra, 1995/96 - 1996/97.....	353
Table 8.6: Trends in major services utilised by clients attending Yirra, 1995/96 - 1996/97.....	353
Table 8.7: Participation in Palmerston youth program, 1997.....	364
Table 8.8: Number of individuals and contacts with young people attending Trinity Youth Options, 1997.....	365
Table 8.9: Drug use by young people attending Trinity Youth Options, 1997.....	366
Table 8.10: Attendances at Antenatal Chemical Dependence Clinic, (KEMH) 1994 - 1997.....	371
Table 8.11: Number of admissions to Perth Women's Centre by drug group 1994 - 1997.....	372
Table 8.12: Quarterly female admissions to Central Drug Unit by age group, 1993 - 1995.....	373
Table 8.13: Quarterly female admissions to Central Drug Unit by age group, 1996 - 1997.....	373
Table 8.14: Female illicit opioid admissions to Central Drug Unit by age group, 1993 - 1995.....	376
Table 8.15: Female illicit opioid admissions to Central Drug Unit by age group, 1996 - 1997.....	376
Table 8.16: New females to all ADA programs, 1988 - 1997.....	377
Table 8.17: All HIV/AIDS notifications by risk group, WA, 1983 - 1997.....	380
Table 8.18: Annual HIV/AIDS notifications by risk group and year of first diagnosis, WA, 1983 - 1997.....	381
Table 8.19: Annual male HIV/AIDS notifications by risk group and year of first diagnosis, WA, 1983 - 1997.....	381
Table 8.20: Annual female HIV/AIDS notifications by risk group and year of first diagnosis, WA, 1983 - 1997.....	381
Table 8.21: Quarterly HIV testing, ADA methadone program, 1986 - 1991.....	383
Table 8.22: Quarterly HIV testing, ADA methadone program, 1992 - 1997.....	384
Table 8.23: Number of HCV notifications, 1993 - 1997.....	389
Table 8.24: Annual distribution of needles and syringes by type of outlet, WA, 1987 - 1997.....	396
Table 8.25: Quarterly distribution of needles and syringes by type of outlet, WA, 1987 - 1992.....	397
Table 8.26: Quarterly distribution of needles and syringes by type of outlet, WA, 1993 - 1997.....	397
Table 8.27: Annual distribution of needles and syringes by type of outlet, metropolitan area, WA, 1987 - 1997.....	399
Table 8.28: Annual distribution of needles and syringes by type of outlet, country areas, WA, 1987 - 1997.....	399
Table 8.29: Quarterly distribution of needles and syringes by metropolitan and country areas, WA, 1987 - 1992.....	400
Table 8.30: Quarterly distribution of needles and syringes by metropolitan and country areas, WA, 1993 - 1997.....	400
Table 8.31: Annual distribution of needles and syringes by selected country areas, WA, 1993 - 1997.....	401
Table 8.32: Number and crude rates of distribution of needles and syringes by selected non metropolitan areas, WA, 1997.....	402
Table 8.33: Annual distribution of needles and syringes ranked by 6 non metropolitan areas, WA, 1993 - 1997.....	403
Table 8.34: Mean age first used illicit drugs, indigenous and non indigenous peoples, Australia, 1994.....	408
Table 10.1: Realisable values of confiscation orders under CARA 1990/91 - 1996/97.....	447

## List of figures

Figure 2.1: Summary of expenditure on treatment services, 1975/76 - 1997/98.....	11
Figure 3.1: Overview of alcohol and other drug services in WA and relationship with MCDS at June 1997.....	49
Figure 3.2: Overview of alcohol and other drug services in WA and relationship with MCDS at December 1997.....	51
Figure 3.3: Organisational structure of WA Drug Abuse Strategy Office at June 1998.....	52
Figure 3.4: Overview of alcohol and other drug services in WA and relationship with MCDS at December 1998.....	53
Figure 3.5: Organisational arrangements of the National Drug Strategy at June 1998.....	67
Figure 3.6: Framework for providing alcohol and other drug services in Victoria.....	71
Figure 4.1: All admissions to ADA residential detoxification programs by quarter and sex, 1988 - 1998.....	82
Figure 4.2: All admissions to ADA residential detoxification programs by quarter and admission status, 1988 - 1998.....	82
Figure 4.3: Average age of all admissions to ADA residential detoxification programs by quarter and sex, 1988 - 1998.....	83
Figure 4.4: Admissions to ADA residential detoxification programs by quarter and principal drug problem, 1988 - 1998.....	83
Figure 4.5: New annual admissions to all ADA programs by principal drug problem, 1988 - 1997.....	86
Figure 4.6: Age distribution of clients attending Holyoake outpatient counselling program, 1996/97.....	92
Figure 4.7: Linkages between WADASO, CDSTs, regional advisory groups and other organisations.....	102
Figure 4.8: Estimated cost per capita of drug related hospital admissions by Health Zone, 1995.....	110
Figure 4.9: Number of admissions by age group and type of drug related hospital admission, Geraldton, 1996/97.....	113
Figure 4.10: Organisational structure of COMPARI CDST.....	114
Figure 4.11: Number of admissions by age group and type of drug related hospital admission, Kalgoorlie, 1996/97.....	117
Figure 5.1: Quarterly opioid related calls to ADIS, 1986 - 1998.....	139
Figure 5.2: New admissions to all ADA programs by age group – illicit opioids 1988 - 1997.....	140
Figure 5.3: Admissions to ADA residential detoxification programs by quarter for licit and illicit opioids, 1988 - 1998.....	142
Figure 5.4: Age standardised rates of hospitalisation due to opioid dependence, WA, 1981 - 1992.....	144
Figure 5.5: Trends in opioid related mortality, NSW, Victoria, Queensland, ACT and Australia, persons aged 15-54, 1988-1996.....	147
Figure 5.6: Trends in opioid related mortality, Western Australia, South Australia and Australia, persons aged 15 to 54, 1988 - 1996.....	148
Figure 5.7: Annual deaths due to licit and illicit opioid drugs, WA, 1984 - 1997.....	149
Figure 5.8: Quarterly opioid related deaths due to heroin/morphine and all opioids, WA, 1995 - 1998.....	150
Figure 5.9: Annual trends in hospitalisation for opioid dependence and admissions to methadone treatment, WA, 1982 – 1992.....	180
Figure 5.10: Annual admissions to WA methadone program, 1973 - 1997.....	181
Figure 5.11: Number of males and females participating in ADA methadone program by quarter, 1978 - 1998.....	183
Figure 5.12: Number of males participating in ADA methadone program by age group and quarter, 1990 - 1998.....	184
Figure 5.13: Number of females participating in ADA methadone program by age group and quarter, 1990 – 1998.....	184
Figure 5.14: Mean length of stay (months) of persons participating in ADA methadone program by quarter, 1986 - 1998.....	186
Figure 5.15: Mean length of stay (months) of persons who ceased participation in ADA methadone program by quarter, 1986 - 1998.....	186

Figure 5.16: Annual notifications of drug addiction by age group, males, 1982-1997.....	190
Figure 5.17: Annual notifications of drug addiction by age group, females, 1982-1997.....	191
Figure 6.1: Percentage of current and ex users of cannabis by year of schooling, WA metropolitan high school students, 1994.....	208
Figure 6.2: Trends in exposure to cannabis, Australia, 1985 - 1995.....	211
Figure 6.3: Trends in prevalence of cannabis, Australia, 1985 - 1995.....	212
Figure 6.4: Prevalence (%) of cannabis use in the past 12 months by age group, Australia, 1988-1995.....	213
Figure 6.5: Ever use (%) of cannabis by age group and sex, Australia, 1985 - 1995.....	215
Figure 6.6: Use (%) of cannabis in past 12 months by age group and sex, Australia, 1985 - 1995.....	216
Figure 6.7: Age trends in adolescent lifetime prevalence of cannabis use based on school surveys, NSW and Victoria, 1992.....	218
Figure 6.8: Trends in adolescent exposure to and use of cannabis, Australia, 1985 - 1995.....	219
Figure 6.9: Quarterly cannabis related calls to ADIS, 1986 - 1998.....	220
Figure 6.10: New cannabis related admissions to all ADA programs by age group, 1988 - 1997.....	222
Figure 6.11: Trends in public opinion towards legalising cannabis in Australia, 1977 - 1996.....	245
Figure 6.12: Trends in public opinion towards legalising cannabis in NDS Household Surveys, 1985 - 1995.....	246
Figure 6.13: Respondents (%) in favour of cannabis decriminalisation by gender and whether decriminalisation explained, WA, December 1993.....	247
Figure 6.14: Respondents (%) in favour of cannabis decriminalisation by age group and whether decriminalisation explained, WA, December 1993.....	248
Figure 6.15: Age distribution of those cautioned during Victorian cannabis cautioning program pilot, July 1997 - January 1998.....	249
Figure 7.1: Prevalence (%) of use of at least one illicit drug in the past 12 months by age group, Australia, 1988 - 1995.....	260
Figure 7.2: Quarterly licit and illicit drug related calls, 1986 - 1998.....	263
Figure 7.3: Quarterly psychostimulant and illicit opioid related calls, 1986 - 1998.....	264
Figure 7.4: Age standardised rates of hospitalisation due to drugs other than alcohol by sex, 1982 - 1992.....	267
Figure 7.5: Male age standardised rates of hospitalisation due to drug caused poisoning by type of drug, 1982 - 1992.....	269
Figure 7.6: Female age standardised rates of hospitalisation due to drug caused poisoning by type of drug, 1982 - 1992.....	270
Figure 7.7: First ever admissions of drug related mental disorders due to drug dependence (excluding alcohol) by sex and age group, 1988 - 1997.....	275
Figure 7.8: First ever admissions of drug related mental disorders due to non dependent drug abuse by sex and age group, 1988 - 1997.....	278
Figure 7.9: First ever admissions of drug related mental disorders due to self inflicted injury (excluding alcohol) by sex and age group, 1988 - 1997.....	280
Figure 7.10: First ever admissions of drug related mental disorders due to drug psychoses (excluding alcohol) by sex and age group, 1988 - 1997.....	281
Figure 7.11: Prevalence (%) of illicit amphetamine use in the past 12 months by age group, Australia, 1988 - 1995.....	286
Figure 7.12: Quarterly psychostimulant related calls to ADIS, 1986 - 1998.....	287
Figure 7.13: Age standardised rate of hospitalisation of drug related mental disorders due to psychostimulant related psychoses by sex, 1981 - 1992.....	290
Figure 7.14: Quarterly volatile substance related calls to ADIS, 1986 - 1998.....	295
Figure 7.15: Age standardised admission rates of hospitalisation due to poisoning by volatile substances by sex, 1982 - 1992.....	297
Figure 7.16: Annual admissions to psychiatric hospitals due to volatile substance dependence, 1981 - 1992.....	298
Figure 7.17: Quarterly hallucinogen related calls to ADIS, 1986 - 1998.....	307
Figure 7.18: Prevalence (%) of ecstasy use in the past 12 months by age group, Australia, 1988 - 1995.....	311
Figure 7.19: Quarterly ecstasy related calls to ADIS, 1986 - 1998.....	312
Figure 7.20: Prevalence (%) of tranquilliser and sedative use by sex and age group, Australia, 1989 - 1990.....	318

Figure 7.21: Duration of use (months) of psychotropic drugs by Australian women, 1995.....	319
Figure 7.22: Duration of use (months) of major groups of psychotropic drugs by Australian women, 1995.....	320
Figure 8.1: Adolescents (%) who have drunk alcohol more than once or twice by age and sex, WA, 1993.....	340
Figure 8.2: Proportion (%) of adolescents aged 14 to 19 who have never used illicit drugs in the past 12 months, Australia, 1985 - 1995.....	342
Figure 8.3: Age of Trinity Youth Options service users, 1997.....	366
Figure 8.4: Quarterly female admissions to Central Drug Unit by age group, 1993 - 1997.....	374
Figure 8.5: All female admissions to Central Drug Unit by drug group and age group, 1993 - 1997.....	375
Figure 8.6: Quarterly female illicit opioid and alcohol admissions to Central Drug Unit, 1993 - 1997.....	375
Figure 8.7: Quarterly female illicit opioid admissions to Central Drug Unit by age group, 1993 - 1997.....	376
Figure 8.8: Annual HIV/AIDS notifications by risk group and year of first diagnosis, WA, 1983 - 1997.....	382
Figure 8.9: Annual proportion (%) of IDU risk groups of all HIV/AIDS notifications, WA, 1983 - 1997.....	382
Figure 8.10: Annual distribution of needles and syringes by type of outlet, WA, 1987 - 1997.....	396
Figure 8.11: Quarterly distribution of needles and syringes by type of outlet, WA, 1993 - 1997.....	398
Figure 8.12: Quarterly distribution of needles and syringes by metropolitan and country areas, 1987 - 1997.....	398
Figure 8.13: Crude rates of distribution of needles and syringes by selected non metropolitan areas, WA, 1997.....	402
Figure 8.14: Quarterly distribution of needles and syringes, 1993 - 1997 Kalgoorlie - Boulder postcode area.....	404
Figure 8.15: Quarterly distribution of needles and syringes, 1993 - 1997 Mandurah postcode area.....	404
Figure 8.16: Quarterly distribution of needles and syringes, 1993 - 1997 Bunbury postcode area.....	405
Figure 8.17: Quarterly distribution of needles and syringes, 1993 - 1997 Geraldton postcode area.....	405
Figure 8.18: Quarterly distribution of needles and syringes, 1993 - 1997 Busselton - Margaret River postcode area.....	406
Figure 8.19: Quarterly distribution of needles and syringes, 1993 - 1997 Albany postcode area.....	406
Figure 9.1: Model of health promoting schools.....	421



# List of abbreviations and acronyms

ADA	Alcohol and Drug Authority
ADCU	Alcohol and Drug Coordination Unit
AIHW	Australian Institute of Health and Welfare
AISWA	Association of Independent Schools of Western Australia
AMA	Australian Medical Association
ANCD	Australian National Council on Drugs
ASR	Age standardised rate
ASSAD	Australian School Students' Alcohol and Drugs national survey
BBVs	Blood borne viruses
CAP	Crisis Accommodation Program
CATF	Confiscated Assets Trust Fund
CCES	Cannabis education and cautioning scheme
CCPP	Cannabis cautioning program pilot
CCTO	Combined custody and treatment order
CDO	Community development officer
CDST	Community drug service team
CDU	Central Drug Unit
CEIDA	Centre for Education and Information on Drugs and Alcohol
CEN	Cannabis Expiation Notice
CPCPC	Community Policing Crime Prevention Committee
CSAP	Center for Substance Abuse Prevention
DAPPU	Drug and Alcohol Policy and Planning Unit
DAT	Drug action team
DLE	Drug law enforcement
DRG	Drug reference group
DV	domestic violence
EAP	Employee assistance program
EBA	Enterprise bargaining agreement
EDWA	Education Department of WA
FCS	Family and Children's Services
FFDLR	Families and Friends for Drug Law Reform (ACT) Inc
FOPP	Funder owner purchaser provider
FTE	Full time equivalent
FP	focus program
GRAFEC	Grief Recovery and Funeral Education Centre
HDWA	Health Department of WA
HMDS	Hospital Morbidity and Data System
HPELAS	Health and Physical Education Learning Area Statement
HPS	Health Promotion Services
HS	Health Service
HSOA	Hospital Salaried Officers Award
HZ	Health Zone
ICD	Intergovernmental Committee on Drugs
JJT	Juvenile Justice Team
LDAG	Local drug action group
MCDS	Ministerial Council on Drug Strategy
MHS	Mental Health Services
MHSB	Metropolitan Health Services Board
MHZ	Midwest Health Zone
NCADA	National Campaign Against Drug Abuse
NCBADLE	National Community Based Approach to Drug Law Enforcement
NCRPDA	National Centre for Research into the Prevention of Drug Abuse
NDARC	National Drug and Alcohol Research Centre
NDS	National drug strategy
NDSC	Nation Drug Strategy Committee
NHMRC	National Health and Medical Research Council
NIDE	National initiatives in drug education
NIH	National Institute of Health
NMG	National methadone guidelines

NPMT	National policy on methadone treatment
NSEP	Needle and syringe exchange program
OAH	Office of Aboriginal Health
ONDCP	Office of National Drug Control Policy
pa	per annum
PAMS	Perth Aboriginal Medical Service
PCM	Perth City Mission
PDAC	Premier's Drug Advisory Council
PIC	Police Integrity Commission
PPP	prison to parole program
PSIP	Police/schools involvement program
PYLL	Person years of life lost
PYRDE	Parents reaching youth through drug education
RCIADIC	Royal Commission Into Aboriginal Deaths In Custody
RIORB	Rapid Induction of Opioid Receptor Blockade
SACS	Social and Community Services Industry Award
SAMHSA	Substance Abuse and Mental Health Services Administration
SAS	Special Access Scheme
SCON	Simple Cannabis Offence Notice
SDETF	School drug education task force
SDEP	School drug education project
SHP	Smoking and Health Program
SRO	school resource officer
SUC	Sobering up shelter
SUSDP	Standard for the Uniform Scheduling of Drugs and Poisons
TACS	Tobacco and Alcohol Consumption Survey
TAIDCS	Tobacco, Alcohol and Illegal Drugs Consumption Survey
TGA	Therapeutic Goods Administration
THC	delta-9 tetrahydrocannabinol
THCA	Carboxytetrahydrocannabinol (major metabolite of cannabis)
TYO	Trinity Youth Options
UROD	Ultra rapid opiate detoxification
WASH	WA school health project
YPP	Young peoples program
YSAS	Youth Substance Abuse Service

# List of recommendations and findings

Pursuant to Standing Order 378, the Select Committee directs the Minister for Family and Children's Services, the Minister for Health, the Minister for Police, the Minister representing the Attorney General and the Parliamentary Secretary to the Minister for Justice be required within not more than three months, or at the earliest opportunity after that time if Parliament is in adjournment or recess, to report to the House as to the action, if any, proposed to be taken by the Government with respect to any recommendations of the Select Committee which fall within their jurisdictions.

## Recommendations

### Chapter 2: Audit of programs

#### **Recommendation 1** [page 22]

That there be a greater emphasis in health campaigns dealing with the harms associated with illicit (as compared to licit) drugs, especially in relation to young people and that such campaigns closely coordinate with the School Drug Education Project.

#### **Recommendation 2** [page 27]

That the Ministry of Justice develop and maintain a comprehensive information system in relation to expenditure on all education, counselling and treatment programs which are directed at juvenile and adult offenders and prisoners with alcohol and other drug related problems.

#### **Recommendation 3** [page 27]

That the Ministry of Justice maintain a comprehensive database on all drug treatment program outcomes, including a wide range of measures, including results of previous treatment, an assessment of severity and the extent of alcohol and other drug problems, goals stipulated in agreed treatment plans, participation in treatment, results of urinalysis testing and organisational responses to outcomes.

#### **Recommendation 4** [page 28]

That the Ministry of Justice undertake a review of the adequacy of funding and resources to enable the Substance Use Resources Unit to adequately provide appropriate treatment services to the State's metropolitan and regional prisons.

#### **Recommendation 5** [page 28]

That the Ministry of Justice provide adequate levels of funding to purchase programs from service providers in all regions of the State so that all offenders under its care who have pre existing or current substance abuse related problems are able to receive appropriate levels of ongoing assistance for such problems.

#### **Recommendation 6** [page 28]

That as a matter of priority the Ministry of Justice release its Drug Strategy to ensure that it develop a framework for purchasing an appropriate mix of services from the network of alcohol and other drug providers in the metropolitan area and in each of the State's regions.

#### **Recommendation 7** [page 29]

That the Ministry of Justice target assistance for those in custodial settings in the period immediately prior to their release, so that on release such individuals can be transferred to established service providers to provide relapse prevention measures.

#### **Recommendation 8** [page 31]

That the WA Police Service upgrade the seniority of its officer in charge of its Alcohol and Drug Coordination Unit to the level of Inspector, so that the Unit be appropriately represented in the senior management structure of the Service.

**Recommendation 9** [page 45]

That a methodology for evaluating long term outcomes in illicit drug treatment programs be developed that utilises a set of standardised measures so that comparisons can be made between all such programs as to their relative effectiveness in achieving treatment outcomes.

**Recommendation 10** [page 45]

That a methodology similar to the COTSA approach be developed to provide information on at least an annual basis of utilisation of all treatment services, and that the feasibility be determined of whether such a survey include a questionnaire to measure client satisfaction.

### Chapter 3: Organisational issues

**Recommendation 11** [page 60]

That a review of the management and general effectiveness in the delivery of alcohol and other drug services within the Mental Health Division of the Health Department of WA be effected in conjunction with the next WA Drug Abuse Strategy Action Plan.

**Recommendation 12** [page 65]

That the Commonwealth be requested to consider re-establishing the confiscated Assets Trust Fund.

### Chapter 4: Community services

**Recommendation 13** [page 107]

That the WA Drug Abuse Strategy Office rearrange the zones for country and metropolitan CDSTs so that they coincide with the same boundaries used for each of the State's Health Zones.

**Recommendation 14** [page 118]

That the WA Drug Abuse Strategy Office undertake a feasibility study into establishing a range of services targeted at injecting drug users and other groups of illicit drug abusers in the Goldfields, including funding a peer based outreach program, a needle and syringe exchange program and a residential detoxification and rehabilitation facility.

**Recommendation 15** [page 125]

Subject to an appropriate review by WADASO of the provision of drug and alcohol services in the Goldfields, that a COMPARI style organisational model be considered to implement a project to mobilise the community in the Goldfields to address the abuse of alcohol and other drugs and be evaluated through a partnership with a university based consortium.

### Chapter 5: Responding to opioids

**Recommendation 16** [page 157]

That the HDWA monitor and report on the alternative pharmacotherapies as they become available in the treatment of illicit drug abuse.

**Recommendation 17** [page 193]

That the WA Drug Abuse Strategy Office develop a pilot project in metropolitan and regional centres with the object of examining ways to improve the skills and knowledge of health providers in treating opioid dependents with dual diagnoses.

**Recommendation 18** [page 195]

That there be increased funding and support for the OOPS Project and the Emergency Department Project, and consideration of additional funding of peer education and innovative outreach programs as part of a comprehensive strategy to reduce the number of heroin overdoses in metropolitan and country areas, and to reduce the transmission of BBVs.

## Chapter 6: Responding to cannabis

### **Recommendation 19** [page 235]

That the WA Drug Abuse Strategy Office research and implement a treatment service for problematic cannabis users, modelled on the cannabis intervention project in Victoria, and administered by an appropriately funded and skilled body, for example, CDSTs.

### **Recommendation 20** [page 255]

That the Government give consideration to amending section 39 of the *Sentencing Act 1995* to provide upon conviction for a first simple cannabis offence that unless the court is convinced to the contrary, that a spent conviction be recorded.

### **Recommendation 21** [page 255]

That the *Spent Convictions Act 1988* be amended to create a new category of lesser convictions solely relating to those convictions for offences relating to the possession and use of small quantities of cannabis (max. 50 grams) with the period of any non offending prior to having any such conviction capable of being declared spent be 5 years, and such declarations shall apply automatically, as a matter of law, without the need for the person concerned to make any written application in respect thereof.

### **Recommendation 22** [page 255]

That at the conclusion of the comprehensive media health campaign on cannabis targeted at the broader community, the WA Drug Abuse Strategy Office comprehensively assess its outcomes.

## Chapter 7: Responding to other drugs

### **Recommendation 23** [page 298]

That the WA Drug Abuse Strategy Office review currently available West Australian information about the extent of volatile substance use, identify areas for additional research and establish a working party to determine additional services and strategies to reduce the use of volatile substances in the metropolitan and regional areas.

### **Recommendation 24** [page 301]

That a working party consisting of the key stakeholders and agencies be established to consider the feasibility of developing a sobering up program especially targeted at young people who are affected by volatile substances and other illicit drugs.

### **Recommendation 25** [page 302]

That a working party be established to consider the merits of legislating to prohibit the sale of substances to those who are suspected or known to abuse volatile substances.

### **Recommendation 26** [page 314]

That the Health Department of WA review its operational guidelines for rave parties, concerts and large public events to incorporate the recommendation of the NSW Health Department as endorsed by the NSW Coroner in the Anna Wood case, dealing with the risks that arise with the excessive or under consumption of fluids associated with use of ecstasy at rave/dance parties.

## Chapter 8: Special issues

### **Recommendation 27** [page 322]

That the WA Drug Abuse Strategy Office ensures that community based resources are developed to assist parents concerned about their children's use of drugs, and that a network of qualified and experienced counsellors and therapists with a high level of skills in assisting families be actively promoted as a front line service for families.

### **Recommendation 28** [page 324]

That the WA Drug Abuse Strategy Office include specific sets of principles and values which support healthy and drug free families and that appropriate resources and targets be developed as part of this strategy.

**Recommendation 29** [page 334]

That the School Drug Education Project be enhanced by including strategies which would enable schools to identify students at an early age (including those diagnosed with ADHD) who are at a high risk of becoming problematic drug users and to provide resources to schools to assist these students and their families.

**Recommendation 30** [page 345]

That a ‘youth friendly’ sobering up facility targeted at young people be established in Perth to enable intoxicated youth to be diverted into a safe environment and to establish relationships between young people and the mainstream alcohol and other drug treatment programs, police and mainstream youth focussed welfare programs.

**Recommendation 31** [page 345]

That the Select Committee draws the State Government’s attention to the apparently inadequate nature of the accommodation services for young people with serious levels of drug abuse and dependency and requests the Minister for Family and Children’s Services to report to Parliament on how such accommodation services can be improved to better meet the special needs of this group.

**Recommendation 32** [page 346]

That the WA Drug Abuse Strategy Office address the need for additional residential rehabilitation programs targeted at young people with serious levels of drug abuse and dependency.

**Recommendation 33** [page 346]

That consideration be given for the funding of a project in the inner city area that has similar objectives and outcomes as contained in the *On Track* proposal.

**Recommendation 34** [page 347]

That high priority be given to establishing two new youth focussed Community Drug Service Teams, the first to be located in the inner Perth city area and the other, capable of being deployed on short notice to problematic areas, targeted at the whole metropolitan area and regional areas, and that these teams employ a range of medical, health, youth and welfare personnel able to assist young people who have serious levels of drug problems.

**Recommendation 35** [page 359]

That the proposed restructure of Yirra receive appropriate support from the WA Drug Abuse Strategy Office, as it provides a valuable framework to improve access by a combination of tailored programs determined by cost effective outcomes and the model be utilised to expand the provision of alcohol and other drug services to young people and their families in the metropolitan area.

**Recommendation 36** [page 409]

That there needs to be a range of measures which specifically target the Vietnamese community to address treatment and preventive aspects. These measures need to be developed at a number of levels, including NSEB stipulations in contracts with designated service providers, engagement of local networks and community groups, and the employment of workers from the community, especially those able to engage young people.

## **Chapter 9: School based drug education**

**Recommendation 37** [page 432]

That the Education Department develop, in conjunction with the Police Service, independent schools and the Catholic school system a set of legally sanctioned guidelines for police to follow when they undertake searches for drugs at schools.

## Chapter 10: Matters arising from Interim Report

### **Recommendation 38** [page 444]

That the Select Committee reaffirms Recommendation 40 in its Interim Report concerning the need for non conviction based forfeiture legislation and urges the Attorney General to expedite the drafting and passage of the same into law.

### **Recommendation 39** [page 456]

That the Ministry of Justice gives priority to implementing innovative educational and appropriate treatment programs which give the highest priority to the prevention of blood borne viruses in the prison population associated with the use of drugs in West Australian prisons and that appropriate legal coercion be used to assist in achieving realistic outcomes in all such programs.

## Findings

### Chapter 3: Organisational issues

#### **Finding 1** [page 59]

Several members of the Select Committee expressed some concerns at the demise of the Alcohol and Drug Authority as a dedicated drug agency, of the consequent fragmentation of drug services across a number of government organisations and of the transfer of responsibility for former ADA functions to the Mental Health Services Division.

It was also the view of these members that there was a need for a sharply focussed drug agency to effectively lead the fight against illicit drugs in the community. However, the Select Committee is of the view that given these reforms have only occurred at the beginning of the 1997/98 fiscal year it was too soon to come to a view on this issue.

### Chapter 4: Treatment services

#### **Finding 2** [page 124]

That the COMPARI model is an excellent organisational framework for linking and coordinating the provision of drug treatment and counselling services and engaging community based organisations. The Select Committee commends in the highest possible terms all those who have played a role in the establishment, expansion and continued operation of COMPARI in the Mid West Health Zone.

### Chapter 5: Responding to opioids

#### **Finding 3** [page 157]

Despite divergent views on the issue, and while accepting there will and needs to be a fully informed ongoing community debate on possible ways for dealing with the heroin problem, it was noted that current Federal Government policy would not allow a free heroin treatment program or trial. Accordingly the majority of the Select Committee is of the view that any recommendation on this issue would be pointless.

### Chapter 6: Responding to cannabis

#### **Finding 4** [page 255]

That the Select Committee endorses the Government announcement of a trial cannabis cautioning scheme in WA, particularly given its focus on health and education aspects of consumption of cannabis.

## Chapter 9: School based drug education

### **Finding 5** [page 423]

That the School Drug Education Project is a very sound and well researched program, which when implemented in its entirety will undoubtedly make a significant contribution in providing children and their families with the requisite skills, insights and attitudes to be able to make appropriate choices about using drugs. The Select Committee commends the Education Department of WA, the Catholic Education Office and the Association of Independent Schools of WA for formulating and promoting the School Drug Education Project.

# Chapter 1: Introduction

## 1.1. Introduction

In its Interim Report, the Select Committee outlined a framework for strengthening the legal and administrative processes to be implemented to make it unprofitable for those who continue to deal and traffick in drugs. In this report, the Select Committee is concerned with the other side of the equation, those measures which by educating young people about the harms of drug use aim to prevent the adverse health and social consequences on both individuals and the community. As it is often difficult to evaluate the impact of preventive programs targeted at school students and the wider community, outcomes can be difficult to measure.

The other purpose of publicly supported programs is to assist those individuals and their families who have been directly affected by drug use. While usually the most serious end of the spectrum of drug use obtains the greatest attention and most resources, the Select Committee believes that concerns regarding experimental and recreational drug use should be addressed.

Heroin must continue to be a major priority in the development of treatment and rehabilitation programs, as it can readily cause fatal overdoses and poses a considerable risk to people attracted to its initial effects. In this regard, the Select Committee believes that a greater emphasis needs to be placed on heroin by the Health Promotions Services to develop and implement public health campaigns to make this drug increasingly unattractive, particularly to young people.

In this State there have been a number of recent significant reforms in the delivery of treatment services, with the devolution of community based programs from the ADA to service providers who have successfully tendered to provide a Community Drug Service Team in a particular region. The approach of CDSTs is to build stronger regional relationships involving a wide range of departments and organisations to harness a wider spectrum of input beyond the previously narrow focus on treatment priorities.

At this time the Select Committee is of the view that it would be wise to give these new arrangements a reasonable period of time to operate, so that informed judgements can then be made about the likely gains and possible shortcomings of the CDSTs and organisational framework for managing alcohol and other drug problems.

Whilst the Select Committee's Interim Report essentially dealt with the law and order response to the apparent proliferation in the consumption of illicit drugs in Western Australia, this Final Report focuses on various harm minimisation strategies targeted at specific age and risk groups, their families and the broader community. This requires clear messages addressing the harms arising out of drug use aimed at reducing the likelihood of young people becoming involved in illicit drugs.

There is also the recognition that many illicit drug users go on to develop problematic dependencies. Accordingly, this group requires ready access to appropriate public health programs to assist them in being able to exercise a rational choice to either continue with their use of illicit drugs with the least health risks and attendant law and social consequences, or to engage in treatments aimed at improving their rehabilitation, or even abstinence.

### 1.1.1. Structure of this report

This report is divided into nine main chapters with additional material included as Appendices.

**Chapter 2** contains data on the costs of drug abuse to the community and the results of an audit of recurrent expenditure by the major departments on alcohol and other drug programs.

**Chapter 3** of the report sets out an overview of past, present and intended administrative arrangements by government to deal with drug problems. The chapter contains details about the

## **Select Committee Into Misuse of Drugs Act 1981**

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Victorian drug strategy and information concerning broad areas to be addressed in the Commonwealth's recently announced initiatives in relation to illicit drugs.

**Chapter 4** contains a description of the major programs that have been established in this State for those requiring assistance because of problems caused by the use of alcohol and other drugs.

**Chapter 5** addresses the specific issue of the abuse of opioids and includes a consideration of the various approaches to dealing with the serious problems due to the abuse of heroin and other opioids.

**Chapter 6** deals with the issue of cannabis, the most widely used illicit drug. To assist in developing a better understanding of trends, the chapter summarises results from recent State and national prevalence surveys to outline age and gender related features of patterns of use. Since the Select Committee's formation there has been developments in the way police in Victoria deal with simple cannabis offences, with the announcement of a State wide cautioning scheme in that State. To take account of this development the chapter also deals with the issue of civil penalties for those who commit minor non commercial offences which involve use, possession or cultivation.

**Chapter 7** contains a detailed discussion of psychostimulants, volatile substances, LSD and other hallucinogens, ecstasy and other designer drugs and prescription drugs. Data is provided for each of these drug groups by analysis of indicators of harm, where available, based on information derived from inpatient hospitalisation data, admissions to psychiatric hospitals, drug related telephone calls, admissions to treatment programs and mortality.

**Chapter 8** deals with a number of special issues, including assistance for parents, young people, blood borne viruses, services for women, indigenous peoples and a discussion of the concept of harm minimisation as developed in this State.

**Chapter 9** provides an overview of school based drug education programs, with particular reference to the School Drug Education Project, which is presently being implemented as a major initiative throughout the State.

**Chapter 10** contains a discussion of matters arising from the Interim Report concerning the NSW Crime Commission and the Police Integrity Commission, and the issue of blood borne viruses in WA prisons.

**Appendix 1** contains copies of the text of West Australian material developed in relation to the use of drugs in school environments. There is a copy of a sample school drug policy and responses to incidents of drugs use, and two actual school drug policies, developed by Willetton Senior High School and Sacred Heart College.

**Appendix 2** contains copies of the request for tender, and the specifications for service for metropolitan and country Community Drug Service Teams.

**Appendix 3** contains copies of guidelines for police when attending incidents of overdose in Western Australia, Victoria and South Australia.

**Appendix 4** contains guidelines for police relations with NSEPs for Victoria and Western Australia.

**Appendix 5** contains a copy of the outline and description of the Victorian cannabis warning pilot project prepared by the Policy Research Unit of the Victorian Police. The text on the back of the cannabis cautioning notice that is handed to an offender outlines the legal status of cannabis and a number of adverse health and other consequences from the use of cannabis. The police and offender copies of the cautioning notice are also included in the appendix.

**Appendix 6** contains a copy of the operational guidelines for rave parties, concerts and large public events that were drawn up by the Health Department of WA. These guidelines now require

those who conduct such events to adhere to a wide range of bylaws and minimum standards to ensure the safety of young people who attend.

**Appendix 7** contains a fact sheet which contains health facts about the immediate effects, the implications for a pregnant person, the consequences from continued or heavy use, and modes of use, in relation to 11 major groups of drugs. The drugs covered are tobacco, caffeine, amphetamines, cocaine, MDMA and ecstasy, alcohol, minor tranquillisers, opioids, cannabis, volatile substances and hallucinogens.

**Appendix 8** contains the text of submission for funding for an innovative program called *On Track, Safe Transitions Youth Project*. Its purpose was to provide support to the police and other frontline services which deal on a daily basis with vulnerable youth in the Perth inner city area. The proposal was prepared by Perth City Mission. The information contained in the proposal, which was unsuccessful, highlights the problems that face those who work with young people who have serious levels of drug and other social and health problems.

**Appendix 9** contains a list of the major alcohol and other drug resources which have been identified by the Select Committee which constitute the matrix of treatment, preventive and other services in this State that deal with the health, social and other problems caused by alcohol and other drugs. The information provides a brief summary of the type of resources and activities that are provided by the agencies and bodies.

**Appendix 10** contains the text of the *Alcohol and Drug Authority Act 1974*.

**Appendix 11** contains the text of the WA Drug Strategy, *Together Against Drugs*, which was released in June 1997.

**Appendix 12** contains text which outlines some of the major features of the British Drug Strategy, *Tackling Drugs to Build A Better Britain*, which was released in April 1998.

**Appendix 13** contains a number of tables containing detailed data which is referred to in the text. This includes tables with summaries of data from recent studies of prevalence of drug use of adults and young people. These summaries include comparisons between this State and other Australian jurisdictions.

**Appendix 14** outlines the recommendations from the Pennington Inquiry.

**Appendix 15** provides a list of published material consulted for this report.

**Appendix 16** contains details of financial expenditure incurred by the Select Committee in the course of its inquiries.

**Appendix 17** lists those organisations and individuals who had made written submissions.

**Appendix 18** is a list of witnesses who appeared before the Select Committee at hearings conducted at Parliament House, Perth.

## 1.2. Establishment of the Select Committee

The Legislative Assembly of the Parliament of Western Australia resolved to establish the *Select Committee into the Misuse of Drugs Act 1981* as a result of a motion that was moved by the Member for Joondalup and was passed on 26 June 1997. The motion as passed reflects a bi-partisan concern of the need to:

- examine mechanisms to prevent and ameliorate illicit drug problems through the application of effective legal sanctions; and
- to provide and promote educational, health services and community support structures to assist those who are affected by the use or abuse of illicit drugs.

When it was accepted that it would not be possible to comprehensively deal with the large range of issues encompassed by the two terms of reference, particularly the second term of reference, it was agreed to produce an interim report which generally dealt with the “law and order” term of reference. It was tabled in the Legislative Assembly on 27 November 1997.

### **1.3. Terms of Reference**

1. That a Select Committee be appointed to inquire into and report upon -
  - (a) the adequacy of the provisions of the Misuse of Drugs Act 1981, and associated State or Federal legislation (and their inter-relationships), in achieving the objective of the detection, investigation, prosecution and sentencing of illicit drug dealers or traffickers in Western Australia and in particular, without derogating from the above, the Committee is to inquire into and report upon the efficacy of enacting or amending legislation so as to assist in attaining this objective; and
  - (b) the provision of health, educational and community support services to deal with the consumption of illicit drugs, particularly heroin.
2. That the Committee have the power to send for persons and papers, to sit on days over which the House stands adjourned, to move from place to place and to report from time to time; and
3. That the Committee finally report on 20 August 1998.

#### **Membership**

Mr CJ Baker MLA, Member for Joondalup (Chairman)  
Mr DF Barron-Sullivan MLA, Member for Mitchell (Deputy Chairman)  
Ms MI Anwyl MLA, Member for Kalgoorlie  
Mrs K Hodson-Thomas MLA, Member for Carine  
Mr JA McGinty MLA, Member for Fremantle

The Select Committee was assisted by Mr Nigel Lake (Clerk to the Committee), and Mr Greg Swensen (Research Officer) and Ms Susan Jones (Research Assistant), who were seconded on a part time basis from the WA Drug Abuse Strategy Office.

### **1.4. Committee activities since 27 November 1997**

The Select Committee met formally on 43 occasions. A total of 160 hours were utilised for evidence hearings, investigate visits and deliberative meetings.

The Select Committee conducted hearings from 1 April to 24 April 1998, sitting on five separate days. This involved attendances by a total of 20 witnesses, covering the areas outlined below. Testimony given at these hearings was transcribed by Hansard.

In addition, the Select Committee undertook an interstate visit where it met with departmental officials who were involved with issues concerned with policy and funding, health, research, law enforcement and correctional services. Meetings were also held with medical practitioners, treatment providers and with members of the Victorian Parliamentary Drugs and Crime Prevention Committee, and the New South Wales Joint Select Committee Into Safe Injecting Rooms.

#### **1.4.1. Service providers**

**Royal Australian and New Zealand College of Psychiatrists**

Dr Mark Rooney (Chairperson)  
Dr Helen Slattery (Consultant Psychiatrist, Dept of Psychiatry Sir Charles Gairdner Hospital)

**WA Drug Abuse Strategy Office**

Mr Terry Murphy (Executive Director)  
Mr Emmanuel Stamatiou (Acting Manager, Service, Funding & Development)

**Mental Health Services Division, Health Department of WA**

Mr Carlo Calogero (General Manager ADA, representing Professor George Lipton)

**Trinity Youth Options**

Ms Martine Noonan (Coordinator)  
Michael and Peter

**Teen Challenge**

Mr Malcolm Smith (Executive Director)  
Mr Stephen Nurse (Director)

**Perth Aboriginal Medical Service**

Ms Heather D'Antoine (Deputy Director)  
Ms Colleen Knight (Coordinator, Needle and Syringe Exchange Van)

**Mirikai**

Ms Mary Alcorn (Director)

**1.4.2. School Drug Education Project (SDEP)**

Ms Cheryl Vardon (Director General, Education Department of WA)  
Mr Richard Crane (Coordinator, SDEP)  
Mr Ian Cameron (Chairperson, SDEP)  
Ms Shelley Beatty (Researcher, Centre for Health Promotion Research, Curtin University of Technology)  
Mrs Audrey Jackson (Executive Director, Association of Independent Schools)  
Ms Margaret Trinder (Association of Independent Schools)  
Ms Diane Alteri (Coordinator, Catholic Education Office)

**1.4.3. Visits to facilities**

Casuarina Prison  
Rangeview Remand Centre  
Palmerston Farm  
Yirra (Perth City Mission)

**1.4.4. Intrastate visits**

Geraldton  
Kalgoorlie

**1.4.5. Interstate visits**

**1.4.5.1. New South Wales Crime Commission (NSWCC)**

Mr Philip Bradley (Commissioner, NSWCC)  
Mr Mike Lulan (Senior Financial Investigator, Asset Forfeiture Division, NSWCC)  
Mr Michael Drury (Asian Organised Crime, Deputy Commissioner Crime Agencies, NSW Police Service)  
Detective Superintendent Jeff Owens (Commander Joint Task Force, NSWPS/AFP) [Representing Clive Small, Commander Crime Agencies]  
Ms Deborah Munroe (Deputy Director, Police and Community Drug Education, NSWPS)

Mr Andy Natrass (Director Operations, Police Integrity Commission)  
Mr Dennis Lenihan (Information Manager, Police Integrity Commission)

#### **1.4.5.2. New South Wales Department of Corrective Services**

Ms Catriona McComish (Assistant Commissioner, Inmate Management)  
Ms Deborah Allen (Manager, Alcohol and Other Drug Services)  
Mr Tony Hodgetts (Deputy Superintendent, Investigations)  
Ms Suzie Morris (Alcohol and Other Drug Services)

#### **1.4.5.3. National Drug and Alcohol Research Centre**

Professor Wayne Hall (Executive Director)  
Mr Shane Darke (Lecturer)  
Mr Paul Dillon (Information Officer)

#### **1.4.5.4. Medical practitioners**

Dr Andrew Byrne (private medical practitioner)  
Dr Alex Wodak (Director, Drug & Alcohol Services, St Vincents Hospital)

#### **1.4.5.5. Parliamentary Committees**

New South Wales Joint Select Committee into Safe Injecting Rooms  
Victorian Drugs & Crime Prevention Committee

#### **1.4.5.6. Treatment providers**

##### **Turning Point**

Ms Alison Ritter (Deputy Director)  
Dr Nick Linterzis (Director Clinical Services)

##### **Youth Substance Abuse Service**

Mr Paul McDonald (Director)

#### **1.4.5.7. Victorian Police Service**

Chief Inspector Paul Ditchburn (OIC Drug and Alcohol Policy Coordination Unit)  
Chief Inspector McKoy (OIC Drug Squad)  
Inspector Rob Hardie (OIC Asian Crime Operations Squads)  
Senior Constable Abe Haddad (Analyst)  
Ms Christine Vincent (DAPCU)  
Ms Deborah Owen (DAPCU)  
Mr Greg Denham (DAPCU)  
Ms Marianne Mahony (DAPCU)  
Ms Laurel Sutton (Manager, Police Schools Involvement Program)  
Inspector Steve James (Policy & Projects)  
Ms Anna Rados (Policy & Projects)  
Chief Inspector Tim Cartwright (OIC Legal Research & Review)

#### **1.4.5.8. Victorian Human Services Department**

Mr Ray Judd  
Ms Laurie Bebbington

## Chapter 2: Audit of programs

### 2.1 Introduction

The State has the major responsibility for providing law enforcement, educational, preventive and treatment programs. A major proportion of expenditure for providing alcohol and other drug programs is assumed by the State. However, the Commonwealth does provide a significant amount of the funds in specific areas, such as the cost of services provided by the health system for inpatient treatment through hospital cost sharing under the Medicare agreements.

### 2.2. Cost of other drug abuse

The consequences of drug abuse are wide reaching, involving a combination of economic and social costs. These consequences are difficult to measure as they include both tangible and intangible costs. The overall cost of drug abuse to the community has been considered in a recent econometric analysis which quantified the tangible and intangible costs of drug abuse in Australia.<sup>1</sup>

The Collins and Lapsley study estimated the tangible and intangible economic cost of drug abuse in Australia was \$18,844.9 million in 1992, of which \$12,736.2 million (67.3%) was due to tobacco smoking, \$4,494.5 million (23.8%) was due to alcohol abuse and the remaining \$1,683.6 million (8.9%) was due to the abuse of other drugs. The cost of \$18.8 billion represented an increase of 26% on the total cost of \$14.9 billion from four years earlier, in 1988 (Table 2.1).

**Table 2.1: Total economic costs of drug abuse, Australia, 1988 - 1992**

	Alcohol		Tobacco		Other drugs		All drugs	
	1988 \$m	1992 \$m	1988 \$m	1992 \$m	1988 \$m	1992 \$m	1988 \$m	1992 \$m
Tangible	3,147.1	3,536.9	4,929.1	6,537.6	908.4	1,248.2	8,959.1	11,289.4
Intangible	848.6	957.6	4,817.8	6,198.6	297.5	435.4	5,935.8	7,555.6
<b>Total</b>	<b>3,995.7</b>	<b>4,494.5</b>	<b>9,746.9</b>	<b>12,736.2</b>	<b>1,205.9</b>	<b>1,683.6</b>	<b>14,894.9</b>	<b>18,844.9</b>
% of total	26.7	23.8	65.2	67.3	8.1	8.9	100	100

Note: The sum of the individual costs of all drugs exceeds the 'All drugs' total as a result of adjustment for the effects of aggregation of the individual aetiologic fractions.

Tangible costs are those drug related costs which impact directly on the health care system, such as hospitalisation episodes, ambulance and emergency services. Tangible costs have been defined as the value of the net resources unavailable to the community for consumption or investment purposes as a result of the effects of past or present drug use.

The intangible total of \$7.6 billion that is included in the \$18.8 billion represents the burden on the community of prevention, treatment of drug related illness, loss of productivity in the workplace, property crime, theft, accidents and law enforcement. However, excluded from these costs are intangible consequences of drug abuse, such as family breakdowns or the pain and suffering caused by abusers to themselves and others.

Intangible drug related costs are difficult to measure as it is not possible to place a value on those costs which directly or indirectly impact on the individual, their family, and the community such as trauma and loss, family and community breakdown, and the pain and suffering experienced.

<sup>1</sup> Collins DJ, Lapsley HM. *The social costs of drug abuse in Australia in 1988 and 1992*. Canberra, Australian Government Publishing Service, 1996.

## **Select Committee Into Misuse of Drugs Act 1981**

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Indeed, in both their 1991 and 1996 studies, Collins and Lapsley acknowledge it is impossible to estimate the value of pain and suffering attributable to drug abuse, with the single exception of pain and suffering related to road accidents.

In addition to the health and social costs to individuals, the family and the community, there are a number of economic costs felt individually through the direct purchase of tobacco, alcohol, other licit and illicit drugs. The increasingly high economic burden on individuals and their families arising from the purchase of particular drugs also directly impacts on the wider community.

The economic cost of other drug use in the Australian population, including lost productivity, treatment and law enforcement, was estimated at \$1.25 billion for 1992 (Table 2.2). In the most recent Collins and Lapsley analysis an expanded definition of production costs was adopted to include those both in and not in the workforce to take account of the value of non market services provided to the rest of the community. The calculation of production costs also took account of illicit drug consumption, to estimate the value of resources used in addictive consumption.<sup>2</sup>

It is to be noted that a relatively large proportion of the costs associated with illicit drugs relate to law enforcement, the courts and corrections systems of Australia. It has been estimated that \$451 million was expended nationally on the enforcement of illicit drug laws in 1992, an increase of nearly 41% on expenditure in 1988.

Expenditure on enforcement of illicit drug laws far exceeds funding on the entire National Drug Strategy. For instance, in 1992 expenditure on illicit drug law enforcement was nearly nine times greater than the estimated combined Commonwealth and State expenditure of \$50.8 on drug strategies.<sup>3</sup> These are likely to be conservative estimates, as much of this cost is in relation to illicit drugs and insufficient data is available to quantify the costs of property crimes committed by drug dependent individuals.<sup>4</sup> The inclusion of intangible costs indicates that the total cost of other drug abuse in Australia was \$1.68 billion in 1992 (Table 2.1).

It is estimated that on a pro rata basis, the tangible cost of drug abuse to the community in this State was a total of \$1,070.2 million, in 1992 dollars.<sup>5</sup> By drug group the tangible cost due to:

- alcohol abuse was \$335.3 million;
- tobacco smoking was \$619.8 million; and
- other drugs was \$118.3 million.

The magnitude of these costs means government must utilise available resources to target and prioritise appropriate and informed prevention strategies which reduce the health and social effects associated with the abuse of drugs by different groups of the population.

The impact of the abuse of illicit drugs falls especially on young people, with some of these drugs, such as heroin and amphetamines, being of great concern as they readily produce physical dependence and are likely to lead to serious illnesses such as hepatitis C, if used intravenously.

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<sup>2</sup> Ibid, 23.

<sup>3</sup> Consisting of \$12.5 million NDS expenditure, \$19.2 million Federal matched grants to the States and \$19.2 State expenditure. Cf Collins DJ, Lapsley HM. *The social costs of drug abuse in Australia in 1988 and 1992*. Canberra, Australian Government Publishing Service, 1996, 61.

<sup>4</sup> Collins DJ, Lapsley HM. *The social costs of drug abuse in Australia in 1988 and 1992*. Canberra, Australian Government Publishing Service, 1996, 24.

<sup>5</sup> Estimated that the population of this was 9.48% of the population of Australia at 30 June 1992. Australian Bureau of Statistics. *Population by age and sex, Australian States and Territories. Cat. No. 3201.0*. Canberra, Australian Bureau of Statistics, 1997.

**Table 2.2: Tangible costs of other drug abuse, Australia, 1988 - 1992**

	1988	1992	1988 -1992
	\$m	\$m	%
Production costs	399.1	538.5	+34.9
Health care			
Net medical services	5.5	8.8	+60.7
Net hospital beddays	20.1	25.4	+26.5
Net nursing home beddays	2.2	8.5	+286.5
Total health care	27.8	42.7	+54.0
Law enforcement			
Australian Federal Police	41.7	43.6	+4.6
National Crime Authority	12.2	19.9	+63.7
Australian Customs Service	8.6	9.0	+5.1
State police	63.8	83.5	+31.0
Prisons	139.9	230.5	+64.7
Courts	54.0	64.1	+18.8
Total law enforcement	320.0	450.6	+40.8
Resources used in addictive consumption	161.6	216.4	+33.9
<b>Total tangible costs</b>	<b>908.4</b>	<b>1,248.2</b>	<b>+37.4</b>

Source: Collins and Lapsley 1996. The social costs of drug abuse in Australia.

## 2.3. Expenditure on services

### 2.3.1. Overview

The *recurrent expenditure* data contained in this section is based on information about alcohol and drug related activities undertaken by seven major departments and statutory bodies for the 1996/97 and 1997/98 fiscal years. The data for the 1998/99 fiscal year, which is provided for the Alcohol and Drug Authority and the WA Drug Abuse Strategy Office (WADASO), is projected expenditure, based on forward estimates. Shortcomings and limitations in some of the financial data is addressed in the respective sections dealing with details of expenditure for each of the bodies surveyed.

The Select Committee's analysis has identified that a total of \$30.6 million will have been directly spent by the seven major departments in the 1997/98 fiscal year, this being an increase of 27% over the expenditure in the 1996/97 fiscal year (Table 2.3). The largest increase in expenditure by any organisation was recorded for the WADASO, which increased its expenditure by 93% from 1996/97<sup>6</sup> to 1997/98.

The large increase in the WADASO expenditure in the 1997/98 fiscal year is due to a number of factors, including the purchasing of \$1.3 million for CDSTs (pro rata of the full year amount of \$2.5 million), the establishment of the School Drug Education Project, and the employment of a full complement of staff following the relocation of WADASO to refurbished offices at the end of February 1998.

<sup>6</sup> The WADASO has been costed for the full 1996/97 year, as it had operated as the Central Drug Coordination Office as an interim measure following the release of the report of the Task Force on Drug Abuse in October 1995.

## Select Committee Into Misuse of Drugs Act 1981

**Table 2.3: Summary of expenditure by government on drug related services, WA, 1996/97 - 1997/98**

	1996/97	1997/98	1996/97 - 1997/98
<b>Alcohol &amp; Drug Authority</b>			
Treatment services	6,287,287	6,863,900	
Prevention	2,103,846	2,103,000	
<b>Sub total</b>	<b>8,391,133</b>	<b>8,966,900</b>	+6.9%
<b>WA Drug Abuse Strategy Office</b>			
NGOs	2,906,142	3,719,511	
Sobering up centres	1,863,007	2,016,871	
CDSTs	nil	1,260,372	
Community action	78,100	298,758	
SDEP	nil	1,572,000	
Education other	nil	623,176	
Administration	450,000	716,476	
<b>Sub total</b>	<b>5,297,249</b>	<b>10,207,164</b>	+92.7%
<b>Health Department of WA</b>			
Office of Aboriginal Health	756,983	750,000	
Public Health Division	4,034,480	4,560,634	
<b>Sub total</b>	<b>4,791,463</b>	<b>5,310,634</b>	+10.8%
<b>Healthway</b>			
Alcohol and drug program	720,759	691,109	
<b>Sub total</b>	<b>720,759</b>	<b>691,109</b>	-4.1%
<b>Education Department</b>			
School drug education	nil	89,200	
<b>Sub total</b>	<b>nil</b>	<b>89,200</b>	
<b>Ministry of Justice</b>			
Metro area	337,418	349,758	
Country areas	81,450	67,060	
Substance Use Resource Unit	354,000	480,000	
<b>Sub total</b>	<b>772,868</b>	<b>896,818</b>	+16.0%
<b>Police Service</b>			
Drug Squad	2,945,921	2,826,655	-4.0%
Other drug related	1,208,500	2,071,000	+71.4%
<b>Sub total</b>	<b>4,154,421</b>	<b>4,897,655</b>	+17.9%
<b>Total</b>	<b>24,127,893</b>	<b>30,646,501</b>	+27.0%

Note: Expenditure for the Police Service for the 1996/97 fiscal year covers a seven month period.

It is estimated that in the 1997/98 fiscal year a total of \$17.4 million (ie 57% of the total expenditure of \$30,646,501 by government on all drug related services), will have been spent by the WADASO and the ADA on treatment and support services (Table 2.4). In this year 17% (\$5.3 million) of total expenditure involved activities by the Health Department of WA, 16.% (\$4.9 million) involved law enforcement activities by the WA Police Service, 3% (\$0.9 million) involved activities undertaken by the Ministry of Justice and 2% (\$0.7 million) involved activities with respect to the alcohol and drug program undertaken by Healthway.

It can be seen that over the 23 year period 1975/76 to 1997/98, per capita expenditure on services targeted at those requiring treatment and other forms of direct assistance rose from 84¢ per capita to \$9.69 per capita (Table 2.4; Figure 2.1). Adjusted for CPI<sup>7</sup> increases, the increase in real terms of per capita expenditure on treatment services over this period has increased four fold, from 84¢ per capita in 1975/76 (the base year) to \$3.22 per capita in 1997/98.

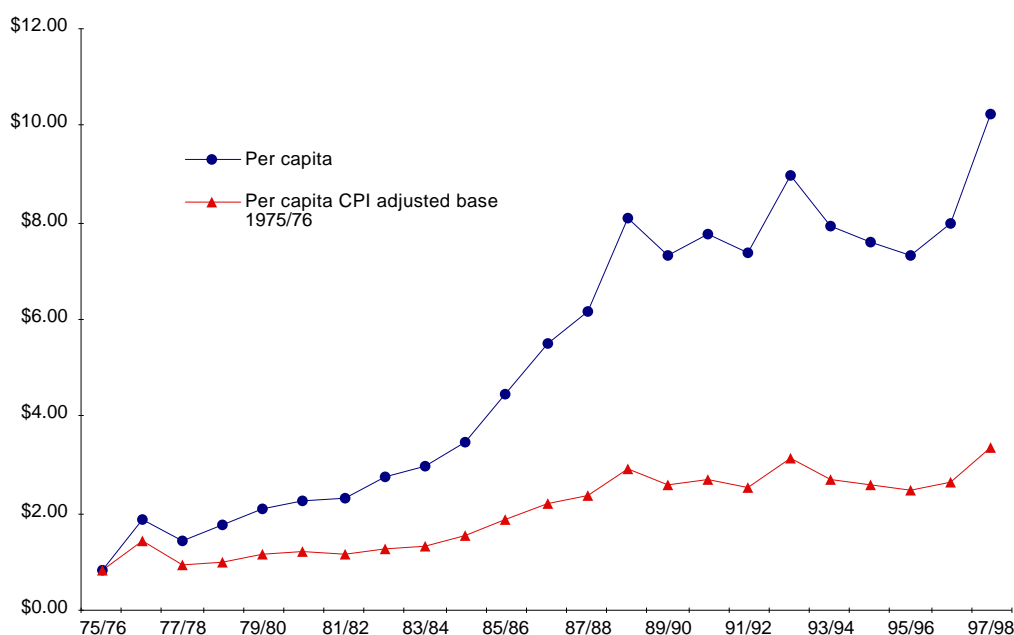
<sup>7</sup> CPI data from State capital breakdown - Perth. Australian Bureau of Statistics. *Consumer Price Index Cat. No. 6401.0.*

**Table 2.4: Summary of expenditure (\$) on treatment and support services, WA, 1975/76 - 1997/98**

Year	Non government organisations			Statutory bodies		Total expenditure			
	NGOs	SUCs	OAH	Total NGOs	ADA	WADASO	Total NGOs and statutory bodies	Per capita	Per capita Adjusted CPI
75/76	34,436			34,436	950,234		984,670	0.84	0.84
76/77	19,249			19,249	2,246,097		2,265,346	1.89	1.46
77/78	65,052			65,052	1,696,224		1,761,276	1.44	0.94
78/79	98,514			98,514	2,075,358		2,173,872	1.75	1.01
79/80	145,577			145,577	2,518,807		2,664,384	2.10	1.16
80/81	209,409			209,409	2,708,003		2,917,412	2.24	1.19
81/82	242,251			242,251	2,832,026		3,074,277	2.30	1.15
82/83	446,404			446,404	3,300,351		3,746,755	2.74	1.29
83/84	521,681			521,681	3,580,725		4,102,406	2.95	1.34
84/85	705,934			705,934	4,205,260		4,911,194	3.46	1.54
85/86	1,234,335			1,234,335	5,234,356		6,468,691	4.43	1.88
86/87	1,487,580			1,487,580	6,777,913		8,265,493	5.51	2.20
87/88	2,201,843			2,201,843	7,282,285		9,484,128	6.14	2.34
88/89	2,515,032			2,515,032	10,399,344		12,914,376	8.10	2.94
89/90	2,893,078			2,893,078	9,075,607		11,968,685	7.33	2.59
90/91	2,981,605	318,733		3,300,338	9,770,680		13,071,018	7.79	2.70
91/92	3,102,811	501,413		3,604,224	9,126,788		12,731,012	7.39	2.56
92/93	4,257,289	763,165		5,020,454	10,071,523		15,091,977	9.00	3.11
93/94	4,544,169	1,086,982		5,631,151	7,873,116		13,504,267	7.93	2.72
94/95	2,941,791	1,863,665		4,805,456	8,405,237		13,210,693	7.62	2.58
95/96	3,352,400	1,722,200		5,074,600	7,887,000		12,961,600	7.34	2.45
96/97	2,906,142	1,863,007	756,983	5,526,132	8,391,133	450,000	14,367,265	7.99	2.65
97/98	4,979,883	2,016,871	750,000	7,746,754	8,966,900	716,476	17,430,130	9.769	3.20

Note: SUCs = Sobering Up Centres; OAH = Office of Aboriginal Health; ADA = Alcohol & Drug Authority; WADASO = WA Drug Abuse Strategy Office; CPI = Consumer Price Index.  
In 1997/98 NGOs includes Community Drug Services Teams and Local Drug Action Groups.

**Figure 2.1: Summary of expenditure on treatment services, WA, 1975/76 - 1997/98**



## **2.3.2. Alcohol and Drug Authority**

### **2.3.2.1. Introduction**

The ADA is an independent statutory authority established in November 1974, whose functions and powers are provided in the *Alcohol and Drug Authority Act 1974*, the text of which is contained in Appendix 10. At the time of its establishment the ADA was also responsible for the administration of the *Convicted Inebriates' Rehabilitation Act 1963*. It is understood that after 1974, the powers under this Act for a court to sentence an inebriate to an alcohol treatment facility were never exercised. This act was repealed in 1989.<sup>8</sup>

Up to the early 1970s, those dependent on alcohol had few options for treatment. The dominant view was that abstinence was the preferred outcome, requiring an individual to embrace the precepts of an abstinence oriented philosophy, such as AA. Abstinence could be achieved voluntarily, such as with assistance of a sympathetic medical practitioner, by voluntary admission or by committal to a psychiatric facility in the case of those chronically dependent or by being sentenced by a Court of Petty Sessions under the inebriates legislation to a prison farm to be rehabilitated.

### **2.3.2.2. Williams inquiry**

The ADA was established as one of the recommendations of an Honorary Royal Commission, under the chairmanship of Hon RJL Williams MLC, which was established in May 1972.<sup>9</sup> One of the reasons for the establishment of this inquiry was to develop a more comprehensive framework for the treatment of those abusing drugs, especially those dependent upon alcohol. The Williams inquiry paved the way for the development of a specialist alcohol and other drug treatment service provided by the ADA, which was initially established in Perth and subsequently expanded to non metropolitan areas.

There were a number of advantages in establishing the ADA as a separate statutory body. These included:

- removal of the stigma that dependence upon alcohol and other drugs was a mental illness;
- to enable closer relationships to be forged with mainstream health services and general hospitals;
- a greater investment in preventive strategies to minimise the serious health and social consequences of the abuse of alcohol and other drugs;
- being able to access Commonwealth capital and recurrent funding through the Community Health Program and hospital cost sharing programs which became available from 1973; and
- to give domestic effect as a result of Australia becoming a signatory to a number of United Nations instruments dealing with illicit drugs.<sup>10</sup>

### **2.3.2.3. 1970s**

Consistent with the practice in other jurisdictions, the emphasis in the ADA treatment programs was on developing integrated residential rehabilitation programs targeted at adults, predominantly males, with dependencies on alcohol. Specialist outpatient services were also developed to provide medical and other specialist assessment and counselling for those with medical, psychological and social problems due to the abuse of illicit drugs.<sup>11</sup>

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<sup>8</sup> *Convicted Inebriates Rehabilitation Repeal Act 1989*. (Assented 16 November 1989)

<sup>9</sup> Western Australia, Parliament, Honorary Royal Commission. *Report into the treatment of alcohol and drug dependents in Western Australia*. Perth, Government Printer, 1973.

<sup>10</sup> 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances.

<sup>11</sup> A more detailed history of the services developed by the ADA and private medical practitioners to assist those who abused illicit opioid drugs is contained in chapter 5.

At its inception the ADA operated a 26 bed short stay program, Ord Street Hospital, in West Perth, which provided intensive counselling and ongoing medical care for those who had less severe histories of substance abuse. An outpatient medical assessment and counselling service was provided by the ADA from Carrellis Centre in Ord Street, which adjoined the Ord Street Hospital.

The Prisons Department had been responsible for a number of years for the operation of a low security prison farm at Byford, which received those sentenced under the inebriates legislation.<sup>12</sup> This facility was transferred to the ADA on 1 June 1975. The ADA renamed this 126 acre farm 'Quo Vadis' and operated it as a medium term stay hospital for up to three months. This program was targeted at detoxified alcohol dependents who required an extended program of activity and other therapeutic support before their return to the community. This program largely catered for those who had abused alcohol over an extended period and had experienced some of its concomitant damaging social and medical consequences.

In February 1977 the ADA opened a 29 bed detoxification facility, Aston Hospital, in Colin Street West Perth. This was the State's first designated specialist public program to detoxify and manage those acutely intoxicated or dependent on alcohol and other drugs. In practice only a limited number of persons dependent on illicit drugs (such as heroin) or prescribed drugs (such as barbiturates or tranquillisers) were admitted at any time to this facility.

The following comment in the ADA 1978/79 Annual Report illustrates the early difficulties experienced in matching expectations to need and of managing a short term hospital so as to target those acutely intoxicated on alcohol and other drugs.

*"During the period under review, only 6.7% of total beddays relate to the drug dependent group ... There appears to be a basic misunderstanding by general medical practitioners, social agencies and other referral sources, that (Aston Hospital) will provide accommodation to any person intoxicated with alcohol. This is not so, and the staff are continually referring patients to voluntary agencies to provide basic shelter for the sobering up period. The facilities at Aston Hospital are not appropriate unless the person is in an acute state from the effects of excessive alcohol or drug consumption."<sup>13</sup>*

### 2.3.2.4. 1980s

The ADA experienced pressure to shift away from a reliance on expensive longer term residential programs to lower cost community based programs. The advantage of shifting resources to outpatient programs was that larger numbers of individuals could be assisted at an earlier stage of their drug using career. This also involved a shift in philosophy to utilise a package of more flexible treatment options and to maximise the individual family relationships and social supports, a so called 'horses for courses' approach to treatment.

An evaluation of the Quo Vadis program was released in October 1981, which highlighted the relatively high cost of residential treatment of those with alcohol dependencies. The ADA instituted changes in this program, which

*"shifted the emphasis from rehabilitation and recovery from alcoholism to the provision of long term residential care and basic treatment in a therapeutic setting aimed at facilitating an individual's gradual re-entry into society."<sup>14</sup>*

The Quo Vadis facility was finally closed in June 1984, with a Salvation Army program, Seaforth at Gosnells, receiving funding to provide a similar service. It is to be noted that the report of a Select Committee, chaired by Hon Gordon Hill MLA, which was tabled in the Legislative

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<sup>12</sup> The legislation provided that where a person was convicted summarily of an offence and drunkenness was an element, or a contributory cause, then a court could sentence him or her to an institution for up to 12 months. A court was required to obtain a medical assessment that a person was an 'inebriate' before an individual could be sentenced to the institution (s 4).

<sup>13</sup> Alcohol and Drug Authority. *Annual Report 1978/79*, 5.

<sup>14</sup> Alcohol and Drug Authority. *Annual Report 1981/82*, 10.

## **Select Committee Into Misuse of Drugs Act 1981**

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Assembly in May 1984, supported the shift away from expensive residential treatment such as Quo Vadis.<sup>15</sup>

The Select Committee also recommended a number of shifts in policy in this State, including:

- the development of complementary relationships between the ADA and NGOs;
- a greater emphasis on campaigns targeted at the wider community to promote the responsible use of alcohol;
- expanding the role of the ADA in training health care providers and other professions to assume a greater role in the management of those with alcohol and other drug problems; and
- closer collaborative relationships between the ADA and the public hospital system.

There was unexpected growth in the late 1970s in the number of persons dependent on illicit opioids and this resulted in the separation of the methadone program, which the ADA had operated in West Perth, to the William Street Clinic (WSC), located in renovated premises in Northbridge, in the early part of 1980.

The ADA shifted its activities from West Perth in March 1986 to an integrated inpatient and outpatient program located in Mount Lawley, in the renovated former Royal Perth Hospital Annexe. The relocated Carrellis Centre in Mount Lawley included a 22 bed residential unit targeted at those who required detoxification from licit drugs (ie alcohol and prescribed drugs), an outpatient day program and other counselling and medical support services.

A short stay residential detoxification program, which provided 10 beds specifically for those requiring detoxification from illicit drugs, was continued at the Aston Hospital site, until the ADA moved this program in January 1989 to purpose built premises in Moore Street East Perth. The relocated hospital was renamed the Central Drug Unit (CDU) and was initially targeted at only illicit drug abusers, and operated as a short stay residential detoxification program.

### **2.3.2.5. 1990s**

The ADA continued to operate inpatient and outpatient services for those dependent on alcohol and prescribed drugs at the Carrellis Centre until June 1991, when the CDU was designated as the ADA's only short stay detoxification facility for both licit and illicit drug abusers. The Carrellis Centre continued to provide a clinical service, only on an outpatient basis, to those seeking assistance for problems due to the abuse of alcohol and prescribed drugs.

There was a net loss of the aggregate number of beds for short stay detoxification at the CDU after amalgamation in June 1991. Previously there had been a total of 32 beds spread over the two detoxification units. Following amalgamation a total of 20 beds were provided at the CDU.

### **2.3.2.6. 1994/95 reforms**

The ADA had enjoyed a pre eminent role as both a provider and funder of alcohol and other drug services in this State up to 30 June 1994. However, following the implementation of the funder owner purchaser provider (FOPP) model by the Health Department of WA (HDWA) in conjunction with management reforms of the health system, from the start of the 1994/95 year the ADA's functions were reduced to that of a service provider. The responsibility for purchasing health services, including alcohol and other drug services, was transferred to the State Health Purchasing Authority (SHPA).

It is to be noted that following the transfer of the purchasing function to the HDWA, the ADA experienced the loss of a significant number of its key personnel. In August 1994 six FTEs were transferred to HDWA, including three members of the Executive (CEO, the Director Clinical Services and the Director of Regional and Community Services). Two of the six FTEs that were

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<sup>15</sup> Western Australia, Parliament, Legislative Assembly, Select Committee. *Report of the inquiry into alcohol and other drugs in Western Australia*. Perth, WA Parliament, 1984.

transferred continued to be primarily involved in the alcohol and other drug area, with the remaining four staff having a much more limited involvement, as they were placed in other positions in the HDWA.

From 1 July 1994, the ADA has performed two broad areas of functions, as follows:

- treatment services, such as the CDU, the methadone program and metropolitan community based services; and
- prevention services, such as training and regional services in non metropolitan regions.

### 2.3.2.7. 1997/98 reforms

In the 1997/98 fiscal year the ADA spent nearly \$7 million on treatment programs, about three quarters of its total budget (Table 2.5). At present it has an establishment of about 110 FTEs.

Following the release in June 1997 of *Together Against Drugs*, a number of changes were made to the ADA's functions which took effect during the 1997/98 fiscal year.<sup>16</sup> These included:<sup>17</sup>

- the purchasing by the WADASO of community based treatment and prevention services through competitive tendering for Community Drug Service Teams, in the place of the ADA's regional community based services in metropolitan and country areas;
- the transfer of functions related to solvent abuse and the management of Aboriginal Community Development Officers (CDOs) to the Office of Aboriginal Health;
- a reduction of a number of FTEs to enable the establishment of an Alcohol and Drugs Policy Unit (ADPU) in the HDWA, which is planned to be part of the Mental Health Division; and
- the integration of treatment services under the *Hospitals and Health Services Act*, to be administered by Graylands Selby Lemnos Special Services.<sup>18</sup>

At the time of the writing of this report, the arrangements for the absorption of the ADA's treatment services into a broader structure for metropolitan health services had not been finalised. It is believed that a total of 5.5 FTEs<sup>19</sup> will be transferred from the ADA budget to the HDWA to fund the establishment of the ADPU.

### 2.3.2.8. Details of current programs

It is understood that the ADA's treatment programs will be subsumed into the overall structure for the planned integration and management of metropolitan health services following the formation of the Metropolitan Health Services Board (MHSB). It is to be noted that in the 1998/99 year, the ADA will not be involved in providing programs for prevention activities in the country. Further details about a number of specific programs within the ADA portfolio are listed below.

#### ***Treatment services - specialist outpatient***

The objectives of this program include the provision of:

- comprehensive assessment and referral to a range of treatment options;
- access to a multidisciplinary specialist treatment team able to consult, assess and intervene in complex case management issues;
- alternatives to residential treatment;
- greater access to treatment for people with alcohol and other drug problems; and
- counselling and group work options in the treatment of alcohol and drug problems.

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<sup>16</sup> The text of *Together Against Drugs* is contained in Appendix 11.

<sup>17</sup> Alcohol and Drug Authority. *Annual Report 1996/97*.

<sup>18</sup> These functions will be incorporated into the new structure for the overall management of health services in the metropolitan area by the Metropolitan Health Services Board.

<sup>19</sup> To create the positions of Director, senior officers responsible for planning, purchasing, research, secretarial and 0.5 FTE for a medical officer.

## **Select Committee Into Misuse of Drugs Act 1981**

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These objectives will be achieved by a number of strategies, as follows:

- develop a comprehensive range of outpatient treatment modalities;
- facilitate community access to services through flexible hours of operation; and
- increase specialist consultancy options.

### **Treatment services – metropolitan community treatment**

The objectives of this program include the provision of:

- promotion of clinical services to meet client and community needs;
- development of and provision of specialist support and consultancy services;
- specialist services to key agencies; and
- education and training to local health and human service professionals.

These objectives will be achieved by a number of strategies, as follows:

- provision of direct client services;
- development of and provision of sessional services with key agencies;
- develop and provide education and training to meet the needs of service providers; and
- promote and participate in the development of local responses to alcohol and other drug issues.

### **Treatment services – clinical placements**

The objectives of this program include:

- acquiring direct clinical skills under expert supervision;
- providing placement opportunities for health and human service professionals;
- developing joint clinical initiatives with universities; and
- participating jointly in relevant postgraduate education in addiction studies.

These objectives will be achieved by a number of strategies, as follows:

- develop with universities clinical placements for specific groups;
- develop specialist training packages to enhance specific clinical competencies in health and human service professionals;
- provide opportunities for supervised clinical practice; and
- work cooperatively with professional groups to develop training initiatives to enhance clinical competence.

### **Prevention services – country**

The objectives of this program include the coordination, the development and provision of alcohol and other drug related clinical, educational and community development services at a regional level.

These objectives will be achieved by a number of strategies to:

- provide clinical services which include assessment and treatment;
- provide specialist consultation to health and human service professionals;
- provide a range of clinical education and training services to health and human service professionals; and
- target Aboriginal communities through the Aboriginal community development officers within each region.

**Prevention services – professional education and training**

The objectives of this program are to increase the knowledge, competence and confidence of health and human service professionals when working with clients having alcohol and drug problems.

These objectives will be achieved by a number of strategies, as follows:

- provide clinical education and training to health and human service professionals and volunteers;
- provide a regular calendar of events each year, and further individualised education and training for a range of organisations;
- develop education and training packages to support the provision of addictions education and training; and
- provide a consultancy service for health and human service professionals relating to addictions education and training.

**Table 2.5: Details of expenditure by ADA by major activities, 1996/97 - 1998/99**

	1996/97	1997/98	1998/99
<b>Treatment services</b>			
Specialist outpatient	565,878	508,000	
Residential detoxification (CDU)	1,684,996	1,798,000	
Methadone treatment	2,035,497	2,219,900	
Metro community treatment	991,062	1,223,000	
Clinical placements	435,271	447,000	
ADIS	574,583	578,000	
Emergency overdose	-	90,000	
<b>Sub total</b>	<b>6,287,287</b>	<b>6,863,900</b>	
<b>Prevention</b>			
Country	1,097,050	912,000	
Professional education and training	702,363	912,000	
Volatile Substance Project	197,433	108,000	
Library & information services	107,000	111,000	
Opiate overdose	-	60,000	
<b>Sub total</b>	<b>2,103,846</b>	<b>2,103,000</b>	
<b>Total</b>	<b>8,391,133</b>	<b>8,966,900</b>	<b>7,410,743</b>

Note: ADA funded a number of NGOs for volatile substance projects.  
 Difference in 1996/97 of +\$128,267 between total expenditure by individual programs and revenue received from government from 'Hospital Fund – Recurrent'.  
 Difference in 1997/98 of -\$436,000 between total expenditure by individual programs and revenue received from government from 'Hospital Fund – Recurrent'.  
 Detailed breakdown for individual programs not available for 1998/99.

**2.3.3. WA Drug Abuse Strategy Office**

**2.3.3.1. Overview**

Actual expenditure by the WADASO in the 1997/98 fiscal year was \$10,207,164, of which \$6,996,754 (just over three quarters of the total budget) was used to purchase treatment and support services from non government organisations (NGOs). The other major area funded under the budget was the School Drug Education Project, which in 1997/98 involved expenditure of \$1.6 million (Table 2.6). A more detailed breakdown of each of the major program areas follows (Tables 2.7 - 2.9).

Expenditure by WADASO increased overall by 92.7% from \$5,297,249 in the 1996/97 fiscal year to \$10,207,164 in the 1997/98 fiscal year. The NGO funding of \$2,906,142 for the 1996/97 fiscal year reflects the full year cost of funding of services as this function was transferred from the HDWA during the year.

## Select Committee Into Misuse of Drugs Act 1981

The expenditure allocated for CDSTs has been adjusted for the 1997/98 fiscal year to reflect that this program commenced operation at the beginning of 1998 (Table 2.7). On a full year basis, there is a total expenditure of \$2.6 million on CDSTs. With adjustment, there was a total expenditure of \$1,260,372 in the 1997/98 fiscal year.

A total of 51 FTEs will be employed by the 10 CDSTs. It is to be noted that overall two thirds of the expenditure in the 1998/99 fiscal year will involve non metropolitan CDSTs. More detailed information about specific CDSTs is provided in chapter 4.

In the 1997/98 fiscal year there was a total expenditure of \$3,719,511 for the purchase of treatment and support services *excluding* sobering up centres (SUCs) and CDSTs (Table 2.8). The purchasing of non metropolitan services accounts for \$54,505 (1.5%) of this expenditure. It was not possible to readily determine the number of FTEs employed in these organisations.

In 1996/97 a total of \$1,863,007 was provided to the NGOs who operated SUCs. In 1997/98 expenditure increased by 8.3% to \$2,016,871 (Table 2.9). A total of 56 FTEs were employed in the ten SUCs that operated in 1997/98. Overall, 91% of SUCs expenditure involved non metropolitan facilities.

**Table 2.6: Summary of WADASO purchasing, 1996/97 - 1998/99**

	1996/97	1997/98	1998/99
<b>Treatment and support services</b>			
Non government organisations	2,906,142	3,719,511	3,891,800
Community Drug Service Teams	nil	1,260,372	2,588,000
Enhancement of individual services	nil	nil	100,000
<b>Sub total</b>	<b>2,906,142</b>	<b>4,979,883</b>	<b>6,579,800</b>
<b>Sobering up services</b>			
Sobering up centres	1,853,420	2,011,916	2,524,900
Sobering up centre program development	9,587	4,955	443,500
<b>Sub total</b>	<b>1,863,007</b>	<b>2,016,871</b>	<b>2,968,400</b>
<b>Education</b>			
School Drug Education Project	nil	1,572,000	1,874,000
Practice development in mainstream services	nil	nil	63,000
Projects and campaigns		623,176	402,300
<b>Sub total</b>	<b>nil</b>	<b>2,195,176</b>	<b>2,339,300</b>
<b>Community action</b>			
Local Drug Action Groups	nil		
Funded by WADASO		26,500	
Joint WANADA/Lotteries Commission grants		58,837	
Sub total LDAGs		85,337	200,000
Projects (parents, leaders, research, etc)	nil	213,421	200,000
Sports partnerships	nil	nil	50,000
Other grants	78,100	80,224	nil
<b>Sub total</b>	<b>78,100</b>	<b>298,758</b>	<b>450,000</b>
<b>Administration</b>			
Salaries, rental, equipment etc	450,000	716,476	995,000
<b>Total</b>	<b>5,297,249</b>	<b>10,207,164</b>	<b>13,332,500</b>

Note: Estimated administration costs for 1996/97 reflect co location with Office of Youth Affairs.  
 SDEP expenditure of \$1,572,000 in 1997/98 included \$117,000 for Life Education.  
 For projects and campaign expenditure includes advertising and printing costs for Drug Aware illicit drug public education, host responsibility, parent booklet and Drug Aware pharmacy project.  
 CDST expenditure for 1998/99 does not include 4 FTEs funded by OAH and 1 FTE funded by Geraldton Health Service.

**Table 2.7: Community Drug Service Teams, 1997/98 – 1998/99**

Name of CDST	Agency	1997/98	1998/99
<b>Metropolitan area</b>			
South Metro	Palmerston Association Inc	160,975	272,000
North Metro	St John of God Community Services	128,912	272,000
South East Metro	Perth City Mission	161,275	272,000
North East Metro	Holyoake Institute	126,423	272,000
<b>Sub total</b>		<b>577,585</b>	<b>1,088,000</b>
<b>Country regions</b>			
South West	Centacare	94,317	189,300
Great Southern	Palmerston Association Inc	102,302	168,500
Goldfields	Centrecare	102,913	238,600
COMPARI	Geraldton HS & COMPARI	170,590	287,000
Kimberley	Kimberley Northwest Mental HS	130,485	238,700
Pilbara	East Pilbara HS	82,180	328,700
<b>Sub total</b>		<b>682,787</b>	<b>1,450,800</b>
<b>Total</b>		<b>1,260,372</b>	<b>2,588,800</b>

**Table 2.8: NGOs excluding sobering up centres, 1996/97 – 1997/98**

	Activities	1996/97	1997/98
<b>Metropolitan</b>			
ACRAH	R, A, M	36,500	38,700
ANSWA Inc	R, A	nil	20,800
COMPARI Inc	CE	nil	27,000
Cyrenian House	DF, O, I	433,700	556,550
Holyoake Institute	O, A, I, Y	675,000	712,575
Marillac (formerly Daughters of Charity)	DC, A, I	73,700	68,800
North East Regional Youth Council	Y, CB	nil	20,000
Palmerston Association Inc	DF, O, Y, I	442,200	603,390
Perth City Mission	R, O, Y, I	156,800	411,100
Perth Women's Centre	O, W, A, I	97,400	105,530
Salvation Army Bridge House	DN, A	271,700	288,880
Salvation Army (Harry Hunter Centre)	R, A	189,700	189,700
Serenity Lodge	R, A	278,300	282,450
St Bartholomews House	EA, A, I	43,500	43,500
St Patrick's Care Centre	O, A, I	44,100	43,160
Swan Emergency Accommodation	EA, Y, I	nil	38,000
WA Network of Alcohol & Drug Agencies	CE	24,000	96,071
Wanneroo Accommodation	EA, Y, I	nil	40,500
Wesley Central Mission (Hearth program)	H, A	78,300	78,300
<b>Sub total</b>		<b>2,844,900</b>	<b>3,665,006</b>
<b>Non metropolitan</b>			
Rosella House	R, A	33,042	27,245
Eastern Goldfields Halfway House	R, A, M	28,200	27,260
<b>Sub total</b>		<b>61,242</b>	<b>54,505</b>
<b>Total</b>		<b>2,906,142</b>	<b>3,719,511</b>

Note: R = residential; DM = detoxification medical; DN = detoxification non medical; O = outpatient counselling; A = alcohol only/mostly; I = illicit drugs; Y = youth; EA = emergency accommodation (short stay); DC = day centre; H = home rehabilitation service; W = women only; M = men only; CE = community education/prevention; DF = drug free (long term); CB = community based program for Aboriginal population.

## Select Committee Into Misuse of Drugs Act 1981

**Table 2.9: Sobering up centres, 1996/97 - 1997/98**

	1996/97		1997/98	
	\$		\$	FTEs
Perth (Salvation Army)	193,700		193,700	5
Broome	16,333		110,500	5
Derby	49,500		92,906	5
Fitzroy Crossing	132,000		134,950	6
Halls Creek	286,630		264,900	6
Kalgoorlie	199,100		200,100	5
Kununurra	242,306		259,100	6
Port Hedland	291,400		291,400	7
Roebourne	220,771		250,800	6
Wiluna	221,680		213,560	5
Sobering up centre statistical data development	9,587		4,955	-
<b>Total</b>	<b>1,863,007</b>		<b>2,016,871</b>	<b>56</b>

## 2.3.4. Health Department of WA

### 2.3.4.1. Overview

The summary of expenditure by the HDWA covers a number of programs concerned with access to and use of licit and illicit drugs. A breakdown of the nearly \$5.2 million estimated for the 1997/98 fiscal year, indicates that 85% of all expenditure is incurred by programs under the auspices of the Public Health Division (Table 2.10).

Of the total of \$2,354,700 of the expenditure allocated to the alcohol and other drugs program, \$1,251,200 (53.1%) is for programs within the smoking and health program, \$668,500 (28.4%) is for programs concerned with reducing the harm from alcohol use, and \$420,000 (17.8%) is for programs targeted at those who use illicit drugs. A detailed breakdown of the activities and sub programs undertaken within each of the major program areas is summarised in Table 2.11 at the end of this section. It is estimated that a total of 39.8 FTEs are utilised in providing programs undertaken by units in the Public Health Division.

There was an estimated expenditure of \$125,000 on programs and activities undertaken by each of the State's eight Public Health Units. It was indicated that over the course of a year all Units undertake a range of activities concerned with issues related to the abuse of alcohol and other drugs, depending on local needs and issues.

**Table 2.10: Summary of HDWA purchasing for drug programs, 1996/97 - 1997/98**

	1996/97		1997/98	
	\$	FTEs	\$	FTEs
<b>Office of Aboriginal Health</b>				
Funding of NGOs	756,983	na	750,000*	na
<b>Public Health Division</b>				
Alcohol and other drugs program		11.0		11.0
Alcohol program	759,800		668,500	
Smoking and health program	674,571		1,251,200	
Illicit drugs program	383,000		420,000	
Other alcohol & drug programs	100,000		15,000	
Medicines & poisons program	500,000	11.2	515,000	11.2
Public Health Units community based programs	1,000,000*	16.0*	1,000,000*	16.0*
BBVs (Disease Control Branch)	616,609	1.6	690,934	1.6
<b>Sub total</b>	<b>4,034,480</b>	<b>39.8</b>	<b>4,560,634</b>	<b>39.8</b>
<b>Total</b>	<b>4,791,463</b>		<b>5,310,634</b>	

Note: \* = estimate.

### 2.3.4.2. Public Health Division

#### **Introduction**

The Public Health Division of the HDWA is responsible for a number of activities concerned with drugs, the most important being programs conducted by the Health Promotion Services (HPS) for the alcohol and other drugs program. A number of sub programs, concerned with regulating the therapeutic use of medicines and access to poisons, are managed by other administrative sections of the Public Health Division. The alcohol and other drugs program, which conducts health promotion programs which aim to encourage Western Australians to adopt healthier lifestyles, encompasses four areas, alcohol, tobacco, illicit drugs, and medicines and poisons.

The WA Drug Abuse Strategy, *Together Against Drugs*,<sup>20</sup> establishes priorities for the State government to address and prioritise issues dealing with drug related harm. *Together Against Drugs* identifies a number of outcomes in relation to alcohol and other drugs through an action plan. A brief outline of those programs supported in the 1996/97 and 1997/98 years which are primarily concerned with addressing problems caused by drugs other than alcohol or tobacco follows. The cost of various initiatives and activities are listed in Table 2.11.

#### **Licit drugs program**

The *Alcohol program* has developed an Alcohol Action Plan to implement the strategies contained in *Together Against Drugs* and is consistent with the National Drug Strategic Plan and is used as the framework for a number of initiatives such as *Drinksafe*, *Respect Yourself* and the *100% Control* campaigns.

As cigarette smoking is the single largest preventable cause of death and disease in this State, the *Smoking and health program* aims to reduce the prevalence and incidence of disabling and fatal conditions, such as cardiovascular and lung diseases and cancer. This program implements a range of strategies targeting specific populations and settings within the community.

#### **Illicit drugs program**

##### **Drug Aware Campaign**

This campaign is supported by the WADASO with campaign expertise provided by the HPS. The first phase of the campaign aimed to raise awareness about the effects of commonly used illicit drugs and to encourage communication between parents and young people about illicit drugs.

In the 1997/98 fiscal year, the campaign will continue to focus on parents and their need to communicate with their children about illicit drugs. This will be in addition to information in the second phase of the Drug Aware Campaign which focused on heroin prevention. The third phase will be launched in 1998/99 and will focus on cannabis issues.

##### **Printed information**

Printed information about a number of groups of drugs is provided on request to the community. In excess of 100,000 items have been provided.

##### **Drugs in perspective**

This drug awareness course is targeted at parents. It operates by training community based people, including community nurses, teachers, drug and alcohol workers and police to conduct parent awareness courses about drugs.

The Select Committee was impressed with the high level of expertise and ability that has been developed over a number of years by the Health Promotion Service (HPS) in undertaking surveys, health awareness campaigns and developing innovative preventive and educational campaigns.

The HPS has an important ongoing leadership role in undertaking regular prevalence surveys of young people, through the ASSAD, health surveys of adults and through participation in national surveys. A campaign is planned during 1998 to address some of the specific health concerns about

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<sup>20</sup> The full text of *Together Against Drugs* is contained in Appendix 11.

cannabis. The HPS has also recently been involved in other campaigns, such as to prevent heroin overdoses.

***Recommendation 1***

***That there be a greater emphasis in health campaigns dealing with the harms associated with illicit (as compared to licit) drugs, especially in relation to young people and that such campaigns closely coordinate with the School Drug Education Project.***

**Other programs**

**Australian Student Survey of Alcohol and Drugs**

The fifth of a three yearly survey of drug use by 12 to 17 year old students was conducted in 1996.<sup>21</sup>

**1997 Tobacco, Alcohol and Illicit Drug Consumption Survey**

Some preliminary work was conducted in 1996/97 for the 1997 Tobacco, Alcohol and Illicit Drug Consumption Survey, which surveyed West Australian adults.<sup>22</sup>

**Health in schools magazine**

Three issues of a magazine for teachers, school health nurses and health promotion officers were produced. The content communicates information about best practice, resources and feedback about health issues, including drug education.

**Medicines and poisons programs**

**Drugs and poisons monitoring**

This responsibility involves the administration of the *Poisons Act 1964* and the *Poisons Act Regulations 1965* and includes:

- monitoring compliance with any conditions imposed on licences and permits issued under the *Poisons Act 1964*;
- investigating possible contraventions of the *Poisons Act 1964*; and
- monitoring controls associated with access and supply of controlled substances (including drugs of addiction) such as labelling and packaging of poisons to ensure public safety.

The drugs and poisons monitoring program has a number of important public health benefits, including:

- reducing premature death associated with accidental poisoning from drugs and chemicals;
- restricting the potential for the diversion to non therapeutic purposes of drugs of addiction and other drugs with abuse potential; and
- reducing the costs to the community from hospital admissions and ambulance callouts that can arise from poisoning by misuse of therapeutic drugs and poisons.

**Poisons Act licensing**

This program is concerned with issuing licences, permits and authorisations as required by the *Poisons Act 1964*.

Unrestricted access to poisons and drugs including drugs of addiction and prohibited substances will result in an increase in morbidity and mortality associated with the use of these substances. Controlled access is necessary with supervision by appropriately trained people.

The system of controls provided through Poisons Act licensing has a number of public health benefits, including reducing the:

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<sup>21</sup> Summary results for WA from the 1996 ASSAD survey is available in Tables 10 and 11, Appendix 13.

<sup>22</sup> Summary results for the 1997 TAIDCS is available in Table 1, Appendix 13.

- morbidity and mortality associated with accidental poisoning from drugs and chemicals; and
- diversion to non therapeutic purposes of drugs of addiction and other drugs with abuse potential.

### **Drugs of addiction monitoring**

This program monitors the usage of drugs of addiction by individual patients by establishing a reporting system and a register of persons notified as being addicted to drugs.

Inappropriate access to drugs of addiction, such as pethidine, morphine and dexamphetamine will result in an increase in morbidity and mortality associated with their use. It also increases the potential for diversion of this group of drugs for non medical purposes as indicated in the Australian Royal Commission of Inquiry into Drugs.<sup>23</sup> The program is designed to reduce:

- morbidity and mortality associated with inappropriate use of drugs of addiction; and
- the potential for the diversion to non therapeutic purposes of drugs of addiction and other drugs with abuse potential.

The register of notified addicts enables the monitoring of:

- people who visit multiple medical practitioners and obtain prescriptions for drugs of addiction;
- medical practitioners who prescribe drugs of addiction inappropriately for registered drug addicts;
- people who obtain long term supply of drugs of addiction without authorisation;
- people who obtain supplies of drugs of addiction outside of their authorisation; and
- medical practitioners who prescribe drugs of addiction for self administration.

### **Community based methadone treatment**

This program is concerned with developing a comprehensive State wide community based methadone program which includes general practitioners assessing and providing ongoing care supported by a network of community pharmacies dispensing methadone on a daily basis to patients.

The impetus to increase the number of participants in methadone treatment through GPs stems from recommendations from the Task Force Report on Drug Abuse that methadone treatment be decentralised and made available through general medical practitioners.

There are a number of aspects to the program such as:

- training of medical practitioners and community pharmacists;
- authorisation of suitably trained medical practitioners to prescribe methadone;
- approval of community pharmacies to dispense methadone;
- advising medical practitioners and pharmacists of the statutory requirements;
- processing applications from medical practitioners for new patients;
- monitoring of patients' use of methadone (eg dose supplied, number of missed doses and number of take away doses).;
- providing statistical reports in accordance with the national data set required by the National Methadone Committee; and
- development and implementation of a plan for expansion of the program according to demand.

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<sup>23</sup> Conducted by Justice Williams and reported in 1980.

## Select Committee Into Misuse of Drugs Act 1981

**Table 2.11: Purchasing of drug programs by Public Health Division, HDWA, 1996/97 - 1997/98**

Name of program	1996/97	1997/98
<b>Alcohol program</b>	759,800	668,500
<b>Smoking and health program</b>	674,571	1,251,200
<b>Illicit drugs program</b>		
Drug aware campaign	340,000 <sup>24</sup>	350,000 <sup>25</sup>
Printed information	23,000	40,000
Drugs in perspective campaign	20,000	30,000
<b>Sub total</b>	<b>383,000</b>	<b>420,000</b>
<b>Other programs</b>		
Student survey of alcohol and drugs	75,000	-
Health in schools magazine	25,000	15,000
<b>Sub total</b>	<b>100,000</b>	<b>15,000</b>
<b>Medicines and poisons programs</b>		
Drugs and poisons monitoring		110,000
Poisons Act licensing		90,000
Drugs of addiction monitoring		190,000
Community based methadone treatment		125,000
<b>Sub total medicines and poisons</b>	<b>500,000</b>	<b>515,000</b>
<b>Regional Public Health Units (8 Units)</b>	1,000,000	1,000,000
<b>Blood borne viruses</b>		
Hepatitis C Council	131,609	131,934
<b>Needle &amp; syringe program</b>		
HDWA (1.6 FTEs)	85,000	85,000
Prevention & education materials (HDWA)	32,000	34,000
ADA BBV counselling & education program	120,000	60,000
WA AIDS Council NSEP	158,000	165,000
Perth Aboriginal Medical Service NSEP	90,000	90,000
WA Substance User's Assoc (from 1/10/97)	-	125,000
<b>Sub total BBVs</b>	<b>616,609</b>	<b>690,934</b>
<b>Total all programs</b>	<b>4,034,480</b>	<b>4,560,634</b>

Note: Expenditure by regional Public Health Units estimated at \$125,000 per year per unit. Hepatitis C Council received annual core funding of \$82,200, the balance of expenditure derived from additional funding for particular projects.

### **Needle and syringe program**

#### **Introduction**

The primary aim of the needle and syringe program is to reduce the transmission of blood borne viruses (HIV, hepatitis B, and hepatitis C) in people who inject drugs by reducing or eliminating the need for injecting drug users to share injecting equipment. Research evidence shows that needle and syringe exchange programs (NSEPs), in conjunction with other strategies, such as expansion of treatment programs, public education programs, and retailing of needles and syringes (N&S) through pharmacies, reduce the incidence of HIV and are not associated with negative outcomes, such as increased drug use.<sup>26</sup>

NSEPs are acknowledged as a critical harm reduction strategy in reducing blood borne virus transmission among the population who are injecting drug users (IDUs). This strategy occurs in parallel with other approaches aimed at reducing drug use, for example, by discouraging first drug

<sup>24</sup> WADASO funded \$305,000.

<sup>25</sup> Now fully funded by WADASO – estimated \$350,000 in 1997/98.

<sup>26</sup> Hurley SF, Jolley DJ, Kaldor J. "Effectiveness of needle exchange programs for prevention of HIV infection". (1997) 349 *Lancet* 1797-1800; Wodak A, Des Jarlais DC. "Strategies for the prevention of HIV Infection among and from injecting drug users." (1993) 45(1) *Bulletin on Narcotics* 47-60.

use, increasing access and availability of treatment services, and controlling the supply of drugs, for example, by law enforcement. The enabling legislation for the licensing of NSEPs is contained in the *Poisons Act Regulations 1995*.<sup>27</sup>

## 2.3.5. Office of Aboriginal Health

### 2.3.5.1. Introduction

The Office of Aboriginal Health (OAH) has assumed responsibility for the funding of a number of programs which encompass a range of preventive, education and treatment programs to address health and social problems in Aboriginal communities caused by the abuse of alcohol and other drugs (Table 2.12).

Up to 30 June 1994 the responsibility for funding services provided by NGOs had rested with the ADA. However, following the transfer of the funding role from the ADA to the Health Department from 1 July 1994,<sup>28</sup> the ADA retained responsibility for a relatively small amount of funding in relation to the Solvent Abuse Project.

Commencing the 1997/98 fiscal year, the OAH assumed responsibility for management and funding of the Solvent Abuse Project, and of six Aboriginal Community Development Officers formerly employed by the ADA. At the time of writing this report, it was not possible to obtain details of the range of alcohol and other drug programs now being funded and managed by the OAH.

**Table 2.12: Purchasing of drug programs by Office of Aboriginal Health, HDWA, 1996/97 – 1997/98**

	1997/98	1997/98
<b>Treatment and community based programs</b>		
Mawarnkarra Health Service (Roebourne)	356,600	
Noongar Alcohol and Substance Abuse Service (Perth)	139,400	
Milliya Rumurra Aboriginal Corporation (Broome)	40,800	
Ngnowar – Aerwah Aboriginal Corporation (Wyndham)	75,000	
Waringarri Aboriginal Corporation (Kununurra)	58,300	
Nunga Group Women's Aboriginal Corp	24,538	
East Pilbara Shire Council	33,800	
<b>Sub total</b>	<b>728,438</b>	
<b>Volatile Substance Project grants</b>		
Constable Care Child Safety Project – Ngaanyatjarra Lands	5,000	
Geraldton Regional AMS – Breakaway Today Project	2,045	
'Gibber' Magazine for Young Street People	1,500	
Meekatharra Community Health Centre – Healthy Life, Healthy Culture	2,500	
Ngaanyatjarra Lands Football Development Program	5,000	
North Eastern Regional Youth Council – Substance Inhalation Abuse Project	4,000	
Warburton Arts Project/Ngaanyatjarraku Tjanampa Music Festival	3,500	
Warburton Bush Skills Community Based Prevention Project	5,000	
<b>Sub total</b>	<b>28,545</b>	
<b>Total</b>	<b>756,983</b>	<b>750,000</b>

Note: 1997/98 expenditure is an estimate.

<sup>27</sup> Poisons Amendment Regulations 1995. *Government Gazette*. 26 May 1994, 2197.

<sup>28</sup> The purchasing of services was undertaken by the State Health Purchasing Authority – this has now been disbanded.

## **2.3.6. Healthway**

### **2.3.6.1. Introduction**

Healthway, the WA Health Promotion Foundation, was established under the *Tobacco Control Act 1990*. It is an independent statutory body governed by a Board with a mission to promote and enhance the health of West Australians with a focus on youth by supporting organisations engaged in activities which reduce the prevalence of smoking and encourage healthier lifestyles. A major priority of Healthway for its first five years was the replacement of tobacco advertising and sponsorship in WA.

Healthway receives a minimum of \$12.9 million from the State government each year. In 1998/99 the allocation will be \$15.0 million and will be indexed to account for inflation in future years. Responsibility for the overall management of Healthway, including decisions about funding, is held by a Board representing health, youth, sport, arts and country organisations from government and non government sectors.

In the 1996/97 fiscal year a total of \$720,759 was provided for a range of projects under Healthway's *alcohol and drug program*.<sup>29</sup> In the 1997/98 fiscal year a total of \$691,109 was provided for funding of the *alcohol and drug program*.<sup>30</sup> The major activities funded in 1997/98 were \$373,005 (54.0%) for health promotion projects, \$31,354 (4.5%) for health promotion research, \$238,950 (34.6%) for sponsorship, and \$47,800 (6.9%) for support sponsorship.

## **2.3.7. Education Department**

### **2.3.7.1. Introduction**

The School Drug Education Project (SDEP) was established in 1997, providing goals and targets for the period 1997 to 2000, and is part of the *Together Against Drugs* strategy. The SDEP has been developed to ensure effective drug education is provided in all Western Australian schools, and embraces the 12 principles of best practice in school drug education.<sup>31</sup>

The SDEP is a project of the Association of Independent Schools of Western Australia (AISWA), the Catholic Education Office and the Education Department of Western Australia. The implementation of the SDEP is being undertaken in a planned fashion, as provided in a strategic plan dealing with the period 1997 to 2000.<sup>32</sup> A detailed description of the school based drug education with particular reference to the SDEP is provided in chapter 9.

### **2.3.7.2. Overview**

There was a very limited contribution by the Education Department to the SDEP. Of the total expenditure of \$1,552,000, the WADASO contributed \$1,463,000, and Commonwealth funding of \$74,200 was provided to develop the CD ROM for teachers. The Department's contribution to the SDEP was \$15,000, for Aboriginal education (Table 2.13). An amount of \$129,284 carried over from the previous fiscal year has not been included, as this does not represent expenditure in the current year.

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<sup>29</sup> Additional \$2,928,864 expenditure on tobacco program.

<sup>30</sup> Additional \$2,430,690 expenditure on tobacco program.

<sup>31</sup> School Drug Education Task Force. *Strategic Plan 1997-2000*. Perth, Education Department of WA, 1997.

<sup>32</sup> School Drug Education Task Force. *Drug education: principles of best practice*. Perth, Education Department of WA, 1997.

**Table 2.13: Income received by Education Department for SDEP, 1997/98**

	1997/98
WADASO	1,572,000
Aboriginal education	15,000
CD ROM for teachers	74,200
<b>Total</b>	<b>1,661,200</b>

## 2.3.8. Ministry of Justice

### 2.3.8.1. Overview

The Select Committee experienced difficulty in being able to obtain comprehensive data of expenditure by the MOJ on services targeted at juvenile and adult offenders in community based and prison based programs. As each of the Ministry's centres operate their own budgets, information gathering required contact to be made with each unit by the Ministry's officer assisting the committee in this phase of investigations.

The Select Committee is of the view that it is vital that the Ministry is able to readily identify purchasing of alcohol and other drug programs by each unit/operational area, can quantify expenditure on such services and able to provide information about outcomes.

#### ***Recommendation 2***

***That the Ministry of Justice develop and maintain a comprehensive information system in relation to expenditure on all education, counselling and treatment programs which are directed at juvenile and adult offenders and prisoners with alcohol and other drug related problems.***

#### ***Recommendation 3***

***That the Ministry of Justice maintain a comprehensive database on all drug treatment program outcomes, including a wide range of measures, including results of previous treatment, an assessment of severity and the extent of alcohol and other drug problems, goals stipulated in agreed treatment plans, participation in treatment, results of urinalysis testing and organisational responses to outcomes.***

Based on the information provided it is estimated that the MOJ will have spent nearly \$900,000 in the 1997/98 fiscal year on programs provided by funded organisations or which are provided on a contractual sessional basis (Table 2.14). The Substance Use Resources Unit (SURU) is the principal program supported by the MOJ to promote and facilitate programs in prisons throughout the State.

As indicated in the Select Committee's Interim Report, the funding for the SURU appears to be grossly inadequate, when compared to the NSW equivalent. The WA unit has a total of 5 FTEs, compared to the 50 FTEs employed in the NSW unit. On a pro rata basis, taking into account the different size of the prison populations in the two states, about 20 FTEs should be employed in the SURU.

***Recommendation 4***

***That the Ministry of Justice undertake a review of the adequacy of funding and resources to enable the Substance Use Resources Unit to adequately provide appropriate treatment services to the State's metropolitan and regional prisons.***

A notable feature of many of the alcohol and other drug programs presently utilised by MOJ, is that many are provided at no cost to the MOJ. On a historical basis the ADA was a major source for referral and management of offenders with alcohol and other drug problems. For example, counselling services were usually obtained through ADA regional offices and some NGOs. The cost of urinalysis testing was also borne by the ADA through the Court Diversion Service. As indicated in correspondence from the MOJ, the historical rationale for these arrangements was that “*the philosophy being that offenders are part of the general community and should access community resources in similar ways to non offenders where possible*”.<sup>33</sup>

However, given the changes in the funding of the CDSTs by WADASO, NGOs who operate alcohol and other drug programs will need to recover some of the cost of their services from the MOJ. It may be feasible that future contracts for CDSTs specify service levels for offenders in regional areas where there are otherwise limited treatment services.

The community has an expectation that offenders under community based orders should obtain appropriate professional services to assist those with serious problems related to the use of licit and illicit substances. The Ministry accordingly needs to invest a much greater level of resources to ensure that offenders obtain the maximum benefit of their order, through entering into purchasing arrangements with the full spectrum of service providers.

***Recommendation 5***

***That the Ministry of Justice provide adequate levels of funding to purchase programs from service providers in all regions of the State so that all offenders under its care who have pre existing or current substance abuse related problems are able to receive appropriate levels of ongoing assistance for such problems.***

There needs to be a clear articulation of goals for offenders in both institutions and community based programs who engage in substance abuse over the duration of their order or confinement. The Select Committee believes that the community and service providers would have a clearer understanding of the Ministry's priorities and expectations in dealing with this issue if the MOJ's Drug Strategy was released.

***Recommendation 6***

***That as a matter of priority the Ministry of Justice release its Drug Strategy to ensure that it develop a framework for purchasing an appropriate mix of services from the network of alcohol and other drug providers in the metropolitan area and in each of the State's regions.***

The release of the Ministry's Drug Strategy would support the articulation of a framework for the MOJ's units and services to identify, assess and implement management plans for adult and juvenile offenders in custodial settings with substance abuse problems at the point of entry into programs. The Ministry also needs to ensure that gains in rehabilitation made by offenders during the course of their confinement are not lost after release. Rehabilitation of offenders with substance abuse problems needs to be understood as a long term process predicated on good working relationships between the Ministry and the network of service providers.

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<sup>33</sup> Letter from Keith Shiers, Acting Manager Planning and Development, Community Based Services re details of organisations funded or contracted, 15 May 1998.

**Recommendation 7**

*That the Ministry of Justice target assistance for those in custodial settings in the period immediately prior to their release, so that on release such individuals can be transferred to established service providers to provide relapse prevention measures.*

**Table 2.14: Purchasing of drug programs by Ministry of Justice  
1996/97 - 1997/98**

Name of provider	Target group	1996/97	1997/98
<b>Metro area</b>			
Holyoake	A, J	90,708	88,958
Yirra	J	60,000	60,000
NASAS		-	2,000
Palmerston	A, J	1,360	800
Relationships Australia (Steering Clear)	A	350	-
Court Diversion Service (ADA)	A	165,000	198,000
Drug ARM	J	20,000	na
<b>Sub total</b>		<b>337,418</b>	<b>349,758</b>
<b>Country area</b>			
Albany		nil	nil
Broome	A	12,970	-
Bunbury	A, J	7,000	7,000
Esperance (Teen Challenge)	J	20,000	20,000
Geraldton	A	11,400	11,400
Gascoyne	A	4,560	4,560
Murchison	A	1,800	1,800
Kalgoorlie	A	5,400	4,900
Northam	A	12,720	12,050
Pilbara	A, J	5,600	5,350
Other regions		na	na
<b>Sub total</b>		<b>81,450</b>	<b>67,060</b>
<b>Statewide</b>			
Substance Use Resource Unit	A	354,000	480,000
<b>Sub total</b>		<b>354,000</b>	<b>480,000</b>
<b>Total all programs</b>		<b>772,868</b>	<b>896,818</b>

Note: A = adult; J = juvenile.

Teen Challenge funded at \$40 per day for service at its Esperance facility - estimated total \$20,000 per year.

na = not available.

## 2.3.9. Police Service

### 2.3.9.1. Introduction

The total expenditure by the Police Service on earmarked activities concerned with drug law enforcement increased by 16.5%, from \$4,154,421 in the 1996/97 fiscal year to \$4,897,655 in the 1997/98 fiscal year. It is to be noted that \$2,271,000 (42.3%) of total expenditure in the 1997/98 fiscal year by the Police Service was concerned with other drug related expenditure (ie the Alcohol and Drug Coordination Unit and the network of District Alcohol and Drug Advisers).

Over the past two fiscal years the total expenditure by the Drug Squad decreased by 4.0%, from \$2,945,921 in 1996/97, to \$2,826,655 in 1997/98 (Table 2.15). A total number of 44 FTEs were employed for both years, consisting of 37 sworn officers and 7 unsworn officers. The slight

## Select Committee Into Misuse of Drugs Act 1981

reduction in expenditure by the Drug Squad in 1997/98 was due to the suspension (caused by internal inquiries) of some officers which resulted in reduced actual operational expenditure.

It is to be noted that the Task Force expenditure in both years was not entirely for the Drug Squad but was used to fund major drug inquiries within both the Drug Squad and other sections of the Police Service. The projected budget for the Drug Squad for the 1998/99 fiscal year was not finalised at the time this report was being prepared and thus is not included.

As police officers throughout the State are involved in detecting and prosecuting drug offenders as part of their ordinary duties, especially in relation to simple drug offences, overall expenditure on drug law enforcement exceeds total expenditure of the Drug Squad.

In 26 November 1996, following the dissolution of the former Liquor and Gaming Branch, responsibility for the policing of licensed premises and the administration of liquor licensing legislation was devolved to a regional and/or district level throughout the State. The present structure of the WA Police Service for dealing with problems associated with the abuse of licit and illicit drugs consists of a body located in the central business district, the ADCU, which provides a 'whole of service' perspective and a network of District Alcohol and Drug Advisers.

As outlined in the Interim Report, the Drug Squad is primarily engaged in operations which target the higher levels of the drug market, such as those engaged in organised crime, distribution and large scale cultivation. This group of offenders is referred to as 'providers', in contrast to those characterised as 'consumers', (ie small scale drug offenders) who are most likely to be dealt with at the district police level. The following information deals with the structure that is primarily designed to deal with consumer type of drug offences.

**Table 2.15: Details of WA Police Service expenditure, 1996/97 – 1998/99**

	1996/97	1997/98	1998/99
<b>Drug Squad</b>			
Wages	1,964,477	1,868,199	
Operational budgets	365,824	351,760	
Vehicles	115,620	106,696	
Task force funding	500,000	500,000	
<b>Sub total Drug Squad</b>	<b>2,945,921</b>	<b>2,826,655</b>	<b>na</b>
<b>Other drug related</b>			
Alcohol & Drug Coordination Unit	189,000	324,000	456,000
District Alcohol & Drug Advisers	727,500	1,455,000	1,409,000
Drug & alcohol law enforcement projects	292,000	292,000	292,000
<b>Sub total other drug related</b>	<b>1,208,500</b>	<b>2,071,000</b>	<b>2,157,000</b>
<b>Total</b>	<b>4,154,421</b>	<b>4,897,655</b>	<b>na</b>

Note: Data for other drug related expenditure 1996/97 year covers 7 month period, December 1996 – June 1997.

### 2.3.9.2. Alcohol and Drug Coordination Unit

As the Alcohol and Drug Coordination Unit (ADCU) was established in late November 1996, data for the 1997/98 fiscal year represents the first full year of operation. A total of \$2,071,000 has been allocated for activities to be undertaken in the 1997/98 fiscal year (Table 2.15).

The bulk of expenditure, \$1,455,000 (70% of the total), is for the employment of 34 FTEs based throughout the State in the 15 police districts, as district alcohol and drug advisers. A further 7 FTEs are employed in the ADCU, involving a total expenditure of \$324,000 (15.6%), with the remaining expenditure of \$292,000 (14.1%) for the conduct of small projects with drug law enforcement themes undertaken by police with the community which are developed at the police district level. The allocation of these funds is managed by a drug and alcohol project committee made up of health and law enforcement agencies.

Under the revised structure, there are a total of 7 FTEs in the ADCU, with an additional 34 FTEs based in the regional areas of Albany, Bunbury, Broome, Cannington, Fremantle, Geraldton, Joondalup, Kalgoorlie/Meekatharra, Karratha, Kununurra, Narrogin, Northam, Mandurah, Midland, Mirrabooka, Perth and South Hedland.

It should be noted that while the ADCU does not have any formal control over the district alcohol and drug advisers, there is an informal network that operates between all officers working in this area. The district alcohol and drug advisers work under the direction of the respective police district officer.

The primary function of the ADCU is to contribute to minimising the harms and hazards associated with alcohol and other drug use throughout Western Australia. It also has responsibility for a number of 'whole of service' functions, including policy development, training and education, as follows:

- Research and facilitate the development of corporate policies to deal with current and emerging trends related to alcohol and drug use in the community.
- Provide a centralised unit to coordinate the development of strategies and initiatives dealing with alcohol and drug law enforcement policies and issues.
- Develop and maintain a statewide network to facilitate the exchange of information and provide advice to police officers on proactive and reactive strategies regarding alcohol and drug issues.
- Develop strategic partnerships with government agencies, other external organisations and community groups to ensure an intersectoral response to alcohol and drug issues.
- Provide alcohol and drug education programs to police officers and community groups.
- Coordinate training and development of district personnel relating to investigation techniques in relation to the enforcement of licensing and gaming laws.
- Monitor and provide advice on matters of national drug and alcohol policy pursuant to the National Drug Strategy and provide representation on national and state forums.
- Prepare and assist in the submission of applications to state and national funding bodies for projects relating to reducing the harm associated with alcohol and drug related crime, violence and antisocial behaviour.

At its meeting with the Victorian Police, which included representatives from the Drug and Alcohol Policy Coordination Unit, the Select Committee noted that the Victorian unit was headed by an officer with the rank of Chief Inspector. It was pointed out that having an officer of such a senior rank meant the Victorian unit was able to have direct input at senior management levels and to have greater influence throughout the police service.

In WA the officer in charge of the ADCU is a senior sergeant. If this position was upgraded to that of inspector, this would cost an additional amount of about \$10,000 per annum.

***Recommendation 8***

***That the WA Police Service upgrade the seniority of its officer in charge of its Alcohol and Drug Coordination Unit to the level of Inspector, so that the Unit be appropriately represented in the senior management structure of the Service.***

### **2.3.9.3. District alcohol and drug advisers**

There are a number of identified roles and functions of police officers employed as district alcohol and drug advisers, reflecting their dual role as disseminators of education and preventive information and a more traditional law enforcement role with respect to alcohol and those drugs dealt with under the *Misuse of Drugs Act 1981*.

Of interest, the broader role of district alcohol and drug advisers includes both a proactive and reactive emphasis, as follows:

- Develop strategies to provide a reduction in alcohol and other drug related offences (crime, traffic, general offences).
- Provide intelligence, planning, auditing and execution of operations relating to the sale or consumption of alcohol and other drugs on licensed premises.
- Provide education, prevention and detection methods on alcohol and other drug related matters. These matters also include the responsible service of alcohol, industry responsibilities (community concerns), police duties and harm minimisation.
- Liaise with the liquor and gaming industries to prevent and deter criminal activity.
- Develop strategies to identify criminal activity on licensed premises, investigate complaints against licensed premises, and investigate the probity of liquor applications.
- Ensure compliance with legislative requirements in relation to suitability and/or conduct of licensees, disciplinary procedures and prosecutions, and intelligence acquisition and analysis.
- Coordinate training and education programs in accordance with district strategic plans relating to local accord agreements, crowd control agreements (staff and venues) and minimum training standards (policy and industry).
- Local analysis and surveys, including communicating results to staff and the local community.
- Developing district performance indicators and targets.

### **2.3.9.4. National Community Based Approach to Drug Law Enforcement Project**

#### **Background**

There has been an increasing awareness of the limitations of traditional drug law enforcement strategies in preventing drug related harm. It also appears that police practice at street level is inconsistent with police policy and the National Drug Strategy (NDS). There is mounting evidence to suggest that traditional law enforcement strategies alone do not reduce drug related harm, and in some cases, may exacerbate this harm. The release of recent reports evaluating various aspects of drug law enforcement support this view.<sup>34</sup> In the study by Sutton and James, *Evaluation of Australian Drug Anti trafficking Law Enforcement*, a number of observations were made about shortcomings in drug law enforcement practice due to the problems of divergence between day to day practice and policy.

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<sup>34</sup> Sutton A, James S. *Evaluation of Australian drug anti trafficking law enforcement*. Payneham, SA, National Police Research Unit, 1996; Weatherburn D, Lind B. *Drug law enforcement policy and its impact on the heroin market*. Sydney, NSW Bureau of Crime Statistics and Research, 1995; Green P, Purnell I. *Measuring success of law enforcement agencies in Australia targeting major drug offenders relative to minor drug offenders*. Payneham SA, National Police Research Unit, 1996.

*“There are three crucial needs. First, the capacity of drug law enforcement units to deal with major interjurisdictional drug crime needs to be enhanced. Existing problems in interjurisdictional cooperation reflect structural obstacles such as differing legislation, as well as cultural attitudes concerning unwillingness to work with particular agencies or unknown personnel. Second, the capacity of specialised State and Territory drug law enforcement agencies to engage in broader illicit drug control and harm minimisation activities needs to be improved. Third, the capacities of non specialised State and Territory drug law enforcement agencies to engage in both supply reduction and harm minimisation activities needs to be improved. These needs are best met through reformulated roles of specialised drug law enforcement units.”<sup>35</sup>*

On 5 July 1996, the Ministerial Council on Drug Strategy (MCDS) agreed to the development and evaluation of a national community based approach to drug law enforcement consistent with the *National Drug Strategy: the Directions in Australasian Policing* strategy and the recommendations of the *Evaluation of Australian Drug Anti-trafficking Law Enforcement* report. MCDS endorsed funding for three years to resource a range of programs aimed at reorienting illicit drug law enforcement towards activities which achieve reductions in drug related harms in the community. In particular, the findings of the *Evaluation of Australian Drug Anti-trafficking Law Enforcement*<sup>36</sup> have been highly influential in guiding the development of the Board of Control’s terms of reference and in the prioritising of projects for funding.

### **The project**

The National Community Based Approach to Drug Law Enforcement (NCBADLE) is one project funded by the Board of Control to trial a new model of illicit drug law enforcement in four regions across Australia. In each region, a project coordinator employed by the police will establish a community based structure comprising a Drug Action Team (DAT) and a Drug Reference Group (DRG) with the general aim of reorienting local level illicit drug law enforcement (DLE) activities towards attaining drug harm reductive outcomes.<sup>37</sup>

The DAT will be made up of locally based government and non government service providers who have an impact on alcohol and other drug related issues. The DAT will bring these local service providers together to implement strategies which reduce the harms associated with drug use which are of concern to the particular local community. In general terms, these community based DATs will both provide feedback to local police concerning the impact of drug law enforcement activities on levels of drug harm in the community and offer a means by which police and other local service providers can coordinate their drug harm reduction efforts. The model is based loosely on a system currently in use in the United Kingdom.

More specifically the DATs aim to:

- identify local illicit drug related harms both to users and to the broader community;
- identify and implement intersectoral strategies to reduce those harms;
- monitor and document the impact of the strategies trialed, in conjunction with the evaluation consultants;
- provide/arrange for education and training concerning drug harm minimisation approaches for police and other service providers;
- facilitate and/or advocate such changes as policy change, improved services, improved court diversion processes, improved public health measures concerning blood borne diseases and changes both to the legislative frameworks and to the way in which those frameworks are applied by police;
- improve communication, cooperation and respect between services; and

<sup>35</sup> Sutton A, James S. *Evaluation of Australian drug anti trafficking law enforcement*. Payneham, SA, National Police Research Unit, 1996, 127.

<sup>36</sup> Ibid.

<sup>37</sup> A more detailed description of DATs and DRGs is contained in *A practical digest for Drug Action Teams*, prepared by the Central Drugs Coordination Unit, published as part of the Tackling Drugs Together initiative in the UK.

## **Select Committee Into Misuse of Drugs Act 1981**

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- make the best use of limited resources by prioritising issues and reducing overlap between agencies.

It should be noted that the primary focus of the NCBADLE program is on illicit drug law enforcement activities, but it is recognised that strategies to reduce licit drug related harm (in particular that associated with the use of alcohol) will impact significantly on project activities and outcomes.

In addition to the DATs, Drug Reference Groups (DRGs) will be established for each region. These will comprise high level officers from various organisations, including the jurisdictions specialist DLE agency, whose activities impact on alcohol and other drug related issues. The role of the DRG will be to provide advice, advocacy and support at the highest level from the range of agencies involved in the process.

In addition to establishing the DAT/DRG structure, project coordinators will also have a continuing role in the trial both in terms of the ongoing activities of the DAT/DRG and in terms of contributing to the evaluation of the trial as specified by the consultant. In particular, their role will be to:

- liaise with local services in the formation and maintenance of the DAT and the DRG;
- foster and maintain communication between the specialist drug law enforcement agencies, police policy units, local police and the DAT and the DRG;
- provide or arrange for training for police on drug harm reduction activities;
- maintain the direction and focus of the project including the DAT and the DRG;
- document the development of the project and the initiatives implemented; and
- collect such other data as is requested by the consultant for use in the evaluation.

The four project regions endorsed by the board for the trial differ in their demography and in the profile of drug problems which the locally based strategies will be addressing. This will enable the development of a profile of those regions in which this model is most likely to be successful and will identify the factors which enhance or detract from the successful implementation of the model.

In the first instance, project funding will be offered by Police Services for the trials for a period of four months to determine the feasibility of full implementation of the model in each region. Funding for a further period of 12 months will be made available to each region only if the feasibility studies indicate that the model is viable.

In light of the identified need for change, a model based upon one recently adopted as policy in the UK is to be trialed throughout Australia over a 16 month period in New South Wales (Fairfield/Cabramatta and Nimbin), Victoria (Morwell) and in WA (Mirrabooka and Geraldton).

### **Broad aims**

Using a harm reduction framework, the model being proposed seeks to better integrate the work of generalist police with other “hands on” service providers in specific local areas. Equally important, however, is the involvement of specialist DLE agencies in working with generalist police at local levels to reduce the harms caused by alcohol and other drugs. The broad aims of the projects are to:

- promote harm minimisation as the philosophical base of all DLE work;
- increase cooperation and coordination between generalist and specialist DLE officers;
- increase cooperation, coordination and understanding between police and other services in defined local areas through partnerships, ideas, resources and strategies to reduce drug related harm;

- implement, assess and document a range of intersectoral harm reduction strategies, which may be used as examples for other local areas wanting to reduce drug related harms;
- increase the involvement of generalist police in intersectoral harm reduction drug strategies (eg demand reduction strategies such as early intervention, diversion, referral and education);
- trial a range of indicators of drug related harm, that may be used to measure impact of community based drug law enforcement efforts; and
- educate generalist and specialist personnel involved in DLE about harm reduction and how to incorporate these strategies into their work.

### **Overview**

Over recent years there has been a number of trends in the use of illicit drugs especially heroin which have prompted the need for an improved DLE approach. In summary the main features of these trends are as follows:

- the number of younger heroin users entering the market has increased;
- smaller amounts of heroin are available at a cheaper price;
- a higher degree of purity of heroin at street level is becoming evident; and
- an increase in poly drug use (heroin, alcohol and benzodiazepines).

### **Project costs**

The estimated total cost of the two NCBADLE projects in WA will be \$172,448, consisting of \$81,932 for Geraldton and \$90,515 for Mirrabooka. The total duration of the projects is 16 months, made up of a four month feasibility period costing \$43,113 and a 12 month implementation period costing \$129,339. The feasibility period for the Mirrabooka trial commenced on 26 June 1998 and on 3 August 1998 for the Geraldton trial.

### **2.3.9.5. State Crime Prevention Strategy**

The Western Australian crime prevention initiative has implemented a tripartite approach to this problem. Many jurisdictions have seen crime prevention management and the development of initiatives as a local responsibility only. Others have seen it as a central strategic issue. This perception subsequently influences the strength (or otherwise) of the central strategic management structure.

In this State the approach is to establish an equal partnership between government, the community and police. This strategy is not dissimilar to the French crime prevention model that is built around a coalition of government, together with the community and police. The project is consistent with the Western Australian government state crime prevention strategy.

Prior to providing the plan it is necessary to explain where it fits within the big picture of the State Crime Prevention Strategy, the aim of which is to enhance community safety and reduce the fear of crime, thereby improving the quality of life for all Western Australians.

Crime prevention is most effective when the whole community, including relevant government agencies and the police, work in partnership to implement initiatives at the local level. There are two broad types of crime prevention, situational crime and criminality.

Situational crime prevention focuses on the crime scene – making it more difficult, more risky and less rewarding for offenders to commit a crime. Situational crime prevention relies on measures such as surveillance, property marking and general improvements to security. The second type of crime prevention, criminality prevention, targets criminal behaviour by addressing the underlying social and psychological causes of criminality.

## **Select Committee Into Misuse of Drugs Act 1981**

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Prevention of criminality aims to influence the attitudes and behaviours of those people who offend, or who are likely to offend. This is achieved by tackling factors that are known to be associated with criminality such as parenting, schooling, self esteem, alcohol and other drug abuse, employment and recreational opportunities, as well as the socio cultural values and beliefs of the community and groups within the community.

The causes of crime are often complex. Effective solutions therefore require both situational crime prevention initiatives and initiatives which address the underlying causes of law and order problems. Consolidating and mobilising all sectors of the community and government agencies will facilitate the conduct of a comprehensive and accurate identification of crime related issues, enabling effective solutions to be devised. This is the aim of the Western Australian Crime Prevention Strategy.

The most effective way to coordinate crime prevention initiatives at the local level in Western Australia will be to build on existing local community policing committees.

The crime prevention strategy is therefore based on key coordinating structures at local and state levels. The key components of the Crime Prevention Strategy at the local level are as follows.

- The establishment of 22 crime prevention and community policing groups comprised of the existing community policing committees and representatives from relevant state and local government agencies and police.
- The development by these groups of comprehensive community action plans, involving extensive community consultation and the use of police crime data to assist in identifying the specific crime problems of local areas.
- The development, from these plans, of a priority list of proposed initiatives to reduce and prevent crime.
- The crime prevention and community policing groups will be supported with information and professional assistance to help implement the local action plan.

The key components of the crime prevention strategy at the State level are as follows (Table 2.16):

- To ensure the necessary focus, ministerial responsibility will rest with the Minister for Police, supported by the Premier, through the Justice Coordinating Council.
- The establishment of a State Crime Prevention Advisory Council chaired by the Commissioner of Police, or his delegate, to provide policy coordination with the assistance of the Crime Prevention Bureau of the Western Australian Police Service.
- Close consultation with relevant expert groups, such as the Aboriginal Justice Advisory Council.

**Table 2.16: Community based approach to drug law enforcement**

	WA Strategy Against Drug Abuse	WA State Crime Prevention Strategy
Statewide coordination	Ministerial Council on Drug Abuse Strategy Drug Abuse Strategy Senior Officers' Group	Justice Coordinating Council (JCC) JCC Senior Officers' Group State Crime Prevention Advisory Committee
Regional coordination	Community Policing Crime Prevention Committees (CPCP) Police Health Justice Aboriginal Affairs Family & Children's Services Education Local government Community	Community Policing Crime Prevention Committees (CPCP) Police Health Justice Aboriginal Affairs Family & Children's Services Education Local government Community
Dedicated resources	Community Drug Service Teams	Community based approach to drug law enforcement project officers
Mode of operation	Drug Abuse Strategy on CPCP agenda Community Drug Service Team member of CPCP Regional drug abuse strategy action plan	Community based approach to drug law enforcement on CPCP agenda Project officer member of CPCP Regional action plan Diversion Community policing prevention activities Law enforcement local intelligence and action Localised information materials Links to broad community participation
Broad community participation	Local drug action groups	Neighbourhood Watch

The State crime prevention strategy demonstrates a strong government commitment to reducing crime throughout WA. The strategy is additional and complementary to existing criminal justice services provided to control crime; services such as the police, the courts, corrections and prisons, children and family services and Aboriginal affairs agencies.

The strategy is aimed at building a community in partnership approach to crime, in that it:

- allows members of the community to have a direct say in important quality of life issues in their own region;
- encourages community ownership and involvement in crime prevention;
- is based on a 'problem oriented' approach to crime prevention promoting specific localised solutions rather than relying on the 'theory' of criminology;
- provides a forum to introduce and manage many initiatives in a unified approach focusing on crime prevention;
- builds on the existing infrastructure of the local community policing committees and resource centres;
- establishes links with other management processes between the community and government;
- links crime prevention with justice management;
- creates a single, focussed source of direct policy advice to government on crime prevention;
- minimises the need for a dedicated government bureaucracy;
- enables the targeting of crime prevention measures; and
- provides an avenue for corporate involvement and sponsorship.

**Mirrabooka project**

The Mirrabooka Police District is on the northern corridor commencing on the outskirts of Perth and it encompasses eight police stations within thirty four suburbs. The district has a diverse population which includes exclusive areas, State Housing Commission areas, rental properties and

## **Select Committee Into Misuse of Drugs Act 1981**

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industrial regions. This multi cultural district has approximately 200,000 residents with 46 primary and secondary schools.

In 1995/96 approximately 1,300 charges under the *Misuse of Drugs Act 1981* were recorded in that region. In three suburbs of that district, with a total population of 42,085, there were 135,595 needles and syringes distributed during this period. In the period January 1996 to October 1996, there have been 11 heroin related overdoses in that district.

Although injecting drug use is a problem in these areas, there are also pockets of solvent users becoming a constant concern to police, in relation to both law enforcement and social issues. In addition, there are particular alcohol problems in this district due to high levels of unemployment and multicultural indifference. Alcohol would therefore form a part of the focus of this project, particularly with poly drug users.

The proposal is to utilise the Community Policing Crime Prevention Committee (CPCPC) in the trial district of Mirrabooka. The key government agencies that will be represented, on a regional basis, are:

- WA Drug Abuse Strategy Office;
- Aboriginal Affairs;
- Ministry of Justice;
- Department of Family and Children's Services;
- Education Department;
- Health Department; and
- Police (general and including Officer in Charge, Drug Squad).

There are also other service providers (eg local drug action groups (LDAGs), local government, Homeswest, and the Migrant Resource Centre) who would warrant inclusion in this process. The inclusion of both specialist and generalist police in this area will forge a supportive relationship between the two, along with other agencies (including local councils) and will assist in reducing drug related harm.

Incorporating these key agencies within the CPCPC will lead to a greater understanding of the ways in which their activities impact upon the work of other agencies and will expand the range of possible harm reduction strategies that might be used in response to drug issues.

Established LDAGs in the area may be involved in aspects of the project. However their roles should not be mistaken for the role of key agencies of the CPCPC. They will be used as a resource, only to assist in harm reduction strategies that would suit the charter suggested for them by the CPCPC. The CPCPC meets monthly in the Mirrabooka district, alternatively at each local council. A chairperson is selected and administrative support provided. This project will have a separate agenda item at the committee meetings.

Only agencies which will be in a position to implement strategies which reduce the harm associated with drug use in the defined district will be included on the CPCPC. As the regional representatives of their organisation, they will also have input into the development of any alcohol or other drug policies required within the trial region. The CPCPC reports to the State Crime Prevention Advisory Committee, which is the funding approval body for the State Crime Prevention Strategy. The State Crime Prevention Advisory Committee hold bimonthly meetings, or as required, and is chaired by the Assistant Commissioner, Traffic and Operations Support.

Over the duration of the project police will develop strategies across six major areas, as follows:

### **Police**

- Create a small unit of police to react to supply of drugs in and around schools.
- Endorsement of needle exchange policy.
- Extend operation final overdose.

- During contacts provide brochures to clients on counselling and support services, advice on safe disposal of used syringes and information on drug penalties.
- Further training on harm reduction and provide instructions and training to general duties police on local offender management and drug operations by the Drug Squad.
- Encourage media to report penalties of drug offences in lieu of dollar values.
- Collection of data on drug related occurrences.
- Continue to supply up to date information on new drugs or percentages.
- Diversion for alcohol related offences (juveniles) – 12 month trial.
- Factual script provided to juveniles committing offences under the *Misuse of Drugs Act 1981* – 12 month trial.
- Information kit to police vehicles.

#### **Parents and community**

- Access to regular drug education and awareness programs.
- Public forums consisting of professionals.
- Provide information brochure kits in shopping malls.
- Information on support agencies and crisis centres.
- Encourage role modelling.
- Education on harm reduction.

#### **Businesses**

- Regulate a sign to advise of “no money or drugs”.
- Information on security steps delivered to businesses.
- Regular police patrols on targeted premises.
- Encourage businesses to implement codes of conduct for supply of alcohol and solvents.
- Development of accords.

#### **Schools**

- Drug education in schools.
- Encourage homework on drug education with parent involvement.
- Further access to trained police in community drug education as guest speakers.

#### **Juveniles**

- Supply limited amounts of funding to students to create incentives/messages on anti drug achievements.
- Encourage interaction – juvenile/adult committee.
- All juvenile drug offenders to have access to drug education program.

#### **Users**

- Localised access of needle and syringes.
- Continuing access to disposable containers.
- Constant access to confidential counselling.
- WASUA and police to liaise regularly.
- First aid training.
- Encourage feedback to police of unreported drug problems.
- Expose areas of complaint regarding used injecting equipment.

### **2.3.10. Mix of services**

The devolution of the ADA’s community based services was flagged in *Together Against Drugs*, released in June 1997. The proposal to provide services through CDSTs was initially recommended in the report of the Task Force on Drug Abuse, which reported to the State

## Select Committee Into Misuse of Drugs Act 1981

Government in October 1995.<sup>38</sup> Contracts<sup>39</sup> were awarded in the latter part of 1997 and by the beginning of 1998 most service providers had been established in place of regional services operated by the ADA.<sup>40</sup>

The mix of major organisations which provide telephone, inpatient and outpatient services in the way of information, assistance, support, counselling and treatment, their broad target population and the location of their service is outlined in Tables 2.17 – 2.28. A description of specific organisations is contained in Appendix 9. This summary reflects the changes that have occurred in the provision of services throughout Western Australia, at the beginning of 1998.

**Table 2.17: Outpatient and outreach counselling services**

Agency	Location	Client groups
Holyoake	Metro	A, Y, F
Palmerston	Metro	A, Y, F
Cyrenian	Metro	A, Y
Noongar Alcohol & Substance Abuse Service Inc	Metro	A, Y, F
Waringarri Aboriginal Corporation	Kununurra	A, F
Ngnowar-Aerwah	Wyndham	A, F
Community Drug Service Teams		A, Y, F
North Metro CDST	Joondalup	A, Y, F
South Metro CDST	Fremantle	A, Y, F
North East Metro CDST	Midland	A, Y, F
South East Metro CDST	Maddington	A, Y, F
South West CDST	Bunbury	A, Y, F
Great Southern CDST	Albany	A, Y, F
Goldfields CDST	Kalgoorlie	A, Y, F
Gascoyne/Murchison CDST	Geraldton	A, Y, F
Pilbara CDST	Port Hedland	A, Y, F
Kimberley CDST	Broome	
Central Drug Unit (ADA)	Metro	A, Y
Perth Women's Centre	Metro	A, Y, F, W
Drug Arm	Metro	Y
Wesley Mission Heart Program	Metro	A, F

Note: A = adult; Y = youth; F = family; W = women only; M = men only.

**Table 2.18: Telephone information and counselling services**

Agency	Location	Client groups
Alcohol and Drug Information Service (ADA)	Statewide	A, Y, F
Parent Drug Information Service (ADA)	Statewide	F
Drug Aware Pharmacy Project	Statewide	A, Y, F

Note: A = adult; Y = youth; F = family; W = women only; M = men only.

<sup>38</sup> A similar approach of delivering services through regional service providers, known as Local Drug Action Teams, is contained in the British model. Cf *Tackling drugs to build a better Britain*, a summary of which is contained in the Appendices to this report.

<sup>39</sup> The text of the CDST tender documents are contained in Appendix 2.

<sup>40</sup> Details about the role of CDSTs and local drug action groups (LDAGs) is provided in chapter 4.

**Table 2.19: Counselling and education services for offenders**

Agency	Location	Client groups
Yirra (Perth City Mission)	Metro	Y
Palmerston	Metro	A, Y
Holyoake	Metro	A
Cyrenian	Metro	A
Noongar Alcohol & Substance Abuse Service Inc	Metro	Y
Court diversion service (Ministry of Justice, Holyoake, Cyrenian, Palmerston)	Metro	A, F

Note: A = adult; Y = youth; F = family; W = women only; M = men only.

**Table 2.20: Services provided by day support centres**

Agency	Location	Client groups
Daughters of Charity Marillac Centre	Northbridge	A
St Patrick's Care Centre	Fremantle	A

Note: A = adult; Y = youth; F = family; W = women only; M = men only.

**Table 2.21: Methadone program service providers**

Agency	Location	Client groups
General practitioners	Statewide	A
William St Clinic (ADA)	Metro/Statewide	A

Note: A = adult; Y = youth; F = family; W = women only; M = men only.

**Table 2.22: Parent and family support services**

Agency	Location	Client groups
Palmerston	South Metro	F
Cyrenian	North Metro	F
Holyoake	East Metro	F
Life Education	Outer metro	F
Teen Challenge	Metro	F
Yirra (Perth City Mission)	Metro	F
Noongar Alcohol & Substance Abuse Service Inc	Metro	F
Community Drug Service Teams	Statewide (as above)	F

Note: A = adult; Y = youth; F = family; W = women only; M = men only.

**Table 2.23: Sobering up centres**

Agency	Location	Client groups
Garl Garl Walbu Aboriginal Corporation	Derby	A
Junjuwa Community Inc	Fitzroy Crossing	A
Halls Creek People's Church	Halls Creek	A
Bega Garnbirringu Health Services	Kalgoorlie	A
Salvation Army	Metro	A
Port Hedland Sobering Up Centre Group Inc	Port Hedland	A
Roebourne Sobering Up Shelter Inc	Roebourne	A
Ngangganawili Aboriginal Community Controlled Health & Medical Service Aboriginal Corporation	Wiluna	A
Warringarri Aboriginal Corporation	Kununurra	A

Note: A = adult; Y = youth; F = family; W = women only; M = men only.

## Select Committee Into Misuse of Drugs Act 1981

**Table 2.24: Rehabilitation and support accommodation services**

Agency	Location	Client groups
Swan Emergency Accommodation	Midland	Y, F
Wanneroo Accommodation & Support Program	Wanneroo	Y, F
ACRAH	Metro	A, M
St Bartholomew's House	Metro	A, M
Eastern Goldfields Halfway House	Goldfields	A
Graeme St Hostel (Family & Children's Services)	Goldfields	Y
Palmerston Farm	Metro	A, Y, F
Cyrenian House	Metro	A
Bridge House (Salvation Army)	Metro	A
Yirra (Perth City Mission)	Metro	Y
Serenity Lodge	Metro	A
Teen Challenge	Metro	Y
Rosella House	Gascoyne/Murchison	A
Milliya Rumurra	Broome	A, F
Ngnowar-Aerwah	Wyndham	A, F
Maralum	Kununurra	A, F

Note: A = adult; Y = youth; F = family; W = women only; M = men only.

**Table 2.25: Services to prevent heroin overdoses**

Agency	Location	Client groups
OOPS program (ADA, WASUA)	Metro	A, Y
Accident & emergency program (ADA, WASUA)	Metro	A, Y

Note: A = adult; Y = youth; F = family; W = women only; M = men only.

**Table 2.26: Services to reduce BBVs**

Agency	Location	Client groups
WA Substance Users Association	Metro	A, Y
WA AIDS Council	Metro	A, Y
Hepatitis C Council	Metro (mobile)	A, Y

Note: A = adult; Y = youth; F = family; W = women only; M = men only.

**Table 2.27: Services providing training & skills development**

Agency	Location
ADA: Education & training services for health professionals	Statewide
University of WA: Faculty of Medicine; Department of Psychiatry	Metro
Curtin University: School of Nursing; Addiction Studies, Psychology Department	Metro
Edith Cowan University: School of Nursing; School of Public Health	Metro
WADASO: Practice development projects	Statewide

Note: A = adult; Y = youth; F = family; W = women only; M = men only.

**Table 2.28: Services provided by self help organisations**

Agency	Location	Client groups
Alcoholics Anonymous	Metro, active groups in some regional centres	A
Alateen	Metro	Y
Narcotics Anonymous	Metro, groups in few regional centres	A

Note: A = adult; Y = youth; F = family; W = women only; M = men only.

## 2.4. Comparative costs of treatment

The Select Committee obtained from a number of provider organisations financial information about the cost of running their treatment programs. This information is summarised in Table 2.29. It is to be noted that residential programs are comparatively much more expensive than non residential programs, as they have a much higher staff:resident ratio and often engage residents in long term rehabilitation programs.

The State contributes via recurrent funding which most agencies receive. In addition the Commonwealth indirectly supports most residential programs through reassigned social security payments which are utilised to meet daily accommodation charges. Most of the NGOs use volunteers, and without this contribution costs would be even higher. Government is the major contributor to the cost of running these programs from both Commonwealth and State sources.

The estimated cost of programs ranged between about \$3,500 and \$10,000 per year per resident, as follows:

- an average of about \$10,000 per resident per year for Teen Challenge's long term residential drug free program at Esperance;
- an average of \$6,842 per resident per year for treatment at Palmerston Farm's medium stay drug free program; and
- an average of \$3,324 per resident per year for treatment at Cyrenian House.

Perth City Mission reported an overall cost of \$2,176 per person per year for young people who attend the residential and non residential components of their Yirra program in Mount Lawley.

Costs of providing treatment for outpatient services ranged typically between an average of about \$270 and \$600 per individual per year. Costs of providing treatment at non residential programs were as follows:

- \$269 per contact per year by Holyoake across all of its programs;
- \$361 per person per year at Cyrenian House; and
- \$591 per person per year who received counselling at Palmerston Centre.

In 1996/97 the ADA's methadone program provided treatment to 1,364 unique individuals, who received a total of 328,824 daily doses. The average cost of treatment was \$1,025 per person per year or \$4.25 per daily dose.<sup>41</sup>

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<sup>41</sup> Methadone costs reflect the law under which medical practitioners, pharmacists and nursing are required to be able to prescribe and dispense medication and perform medical procedures.

## Select Committee Into Misuse of Drugs Act 1981

**Table 2.29: Comparative operating costs of residential and non residential programs, WA, 1996/97**

	Total cost	Output	Unit	Unit cost
<b>Palmerston</b>				
Residential (Farm)	\$376,326	55	individuals	\$6,842*
		3,159	beddays	\$119**
Non residential (Centre)				
Counselling	\$387,302	655	individuals	\$591*
		3,710	contacts	\$6 <sup>#</sup>
<b>Cyrenian House</b>				
Residential	\$442,112	133	individuals	\$3,324*
Non residential	\$262,264	727	individuals	\$361*
<b>Yirra</b>				
Residential & non residential	\$570,000	262	unique individuals	\$2,176*
<b>Holyoake</b>				
Residential & non residential	\$1.1 million	4,089	contacts	\$269 <sup>#</sup>
<b>Teen Challenge</b>				
Farm at Esperance	\$500,000	50	individuals	\$10,000*
<b>Alcohol &amp; Drug Authority</b>				
Methadone program	\$1,398,546	1,364	unique individuals	\$1,025*
		328,824	doses	\$4.25 <sup>##</sup>

Note: \* = per individual, \*\* = per bedday, # = per contact, ## = per dose.

The Select Committee appreciates the difficulty in measuring treatment outcome given the diverse range of treatment programs being offered. Understandably, agencies find it easiest to define 'success' according to participation over the course of a particular treatment episode, based on impression of staff and self report measures. However, a better measure of 'success' could be obtained if a set of standard appropriate measures were utilised which considered longer term outcomes.

Appropriate outcomes could include employment, social stability, offending, objectives measures of levels of drug use, injecting drug use and other high risks practices and participation in leisure pursuits. It is recognised that as mandated evaluation would represent a significant cost and resource burden for many agencies, it would be preferable if responsibility was placed with a major organisation with the expertise to undertake surveys.

There would be considerable interest by the community in the dissemination of data which had been obtained independent of the agencies, as it could provide comparisons, including cost effectiveness, between treatment modalities. It is possible that such information could help policy makers to make informed judgements about different types of programs to inform purchasing decisions.

The triennial COTSA surveys are a useful approach to obtaining data about clients across the spectrum of treatment organisations and have the advantage of obtaining detailed information at a low cost. The results of the 1995 COTSA survey, which are discussed in more detail in chapter 4, illustrate the advantages of mounting a multi agency survey over a short time frame.

It is considered important that client satisfaction about a service should also be emphasised, in common with many other community services which have begun to develop as part of the process for evaluating successful outcome. The Select Committee is aware of one agency, Holyoake, which has undertaken a client survey, and that this organisation plans to regularly undertake this type of survey.

***Recommendation 9***

***That a methodology for evaluating long term outcomes in illicit drug treatment programs be developed that utilises a set of standardised measures so that comparisons can be made between all such programs as to their relative effectiveness in achieving treatment outcomes.***

***Recommendation 10***

***That a methodology similar to the COTSA approach be developed to provide information on at least an annual basis of utilisation of all treatment services, and that the feasibility be determined of whether such a survey include a questionnaire to measure client satisfaction.***



## Chapter 3: Organisational issues

### 3.1. Introduction

This chapter is concerned with the organisational arrangements that have been established over recent years in this State to provide services to assist those with problems caused by alcohol and other drugs. The framework for delivering programs to address problems caused by alcohol and other drugs in this State is encapsulated in the WA Strategy Against Drug Abuse, *Together Against Drugs*, released in June 1997. In addition to an overview of the Commonwealth structures established through the National Drug Strategy which have impacted on WA, reference will also be made to the Victorian Drug Strategy, *Turning the Tide*.

There has been an unprecedented level of debate in the Australian community since the mid 1990s about treatment and law and order options to reduce the scale of problems due to illicit drugs, especially heroin. Over the past year, following the formation of Select Committee, major reports have been tabled in the New South Wales<sup>42</sup> and Victoria Parliaments.<sup>43</sup> These reports have dealt with a number of issues, including the contentious matter of the establishment of approved safe injection areas.

At the Commonwealth level there has been intense debate about the magnitude of problems and of ways to deal with them. This has included the refusal by the Commonwealth to support a pilot heroin trial in the ACT, and release of its *Tough on Drugs* initiative at the end of 1997. The Commonwealth has now provided details of the level of funding for health and law enforcement activities and development of additional consultative mechanisms to be implemented through *Tough on Drugs*.

There have been close parallels in the process of reform that has occurred in Western Australia and Victoria, with the government in both instances commissioning a formal inquiry and consultation process with the community. Both States have implemented reforms in the funding of programs, through purchasing of services by competitive tendering and devolution of a number of public programs. While the overall thrust of reforms in both States has been similar, some differences in emphasis can be noted.

In this State there has not been the same magnitude of loss of public sector services, as it was recognised that the corpus of expertise that has been established over a number of years was unlikely to be adequately replaced by private providers.

Another difference between the two States has involved the police service. In Victoria there has been a comprehensive and well resourced strategy to encourage police to improve their effectiveness, expand their role and utilise a wider range of options especially in relation to illicit drugs. This emphasis has included education programs for serving police officers and encouragement of pilot projects to evaluate different approaches to community policing.

In both States there has been a difference in emphasis in the parliamentary sphere, with the Victorian Drugs and Crime Prevention Committee chaired by Hon Andrew Brideson MLC, overseeing the implementation of the government's drug strategy, *Turning the Tide*. The Brideson Committee has supported inquiries into a number of issues, including funding of research, and has acted as a forum for the articulation of community concerns.

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<sup>42</sup> New South Wales, Parliament, Joint Select Committee Into Safe Injecting Rooms. *Report on the establishment or trial of safe injecting rooms*. Sydney, NSW Parliament, 1998.

<sup>43</sup> Victoria, Parliament, Drugs and Crime Prevention Committee. *Inquiry Into the Victorian government's drug reform strategy*. Melbourne, Victorian Parliament, 1997.

## **3.2. Organisational arrangements in WA**

### **3.2.1. Up to June 1997**

An outline of the overall arrangements that operated prior to the devolution of the ADA are outlined in Figure 3.1. The relationship with the State Health Purchasing Authority, which had assumed responsibility for funding NGOs, is not indicated as this was shortlived before funding was assumed by the WADASO.

In these arrangements the ADA operated as a separate statutory body, accountable to the Minister for Health. The relationships between the State and the Commonwealth implemented following the National Campaign Against Drug Abuse in 1985 (renamed the National Drug Strategy) are indicated in Figure 3.1.

The Commonwealth State arrangements had two levels of representation. There was a Ministerial level of representation, through the Ministers for Police and Health, who were members of the Ministerial Council on Drug Strategy (MCDS). Details of the MCDS are provided later in this chapter.

There was also representation at the departmental level on the National Drug Strategy Committee (NDSC), with both police and health representatives.<sup>44</sup> The State had representation on the NDSC on behalf of the Commissioner for Police and the Commissioner for Health.

### **3.2.2. At December 1997**

The changes in the organisational arrangements for providing and administering the State's treatment services that occurred as a consequence of *Together Against Drugs* are outlined in Figure 3.2. The framework includes the Ministerial Council, a State government body which is in effect a Cabinet Sub committee (included in Figure 3.2), which meets about every quarter to consider major policy issues. These arrangements also reflect the changes instituted by the Commonwealth at the end of 1997.

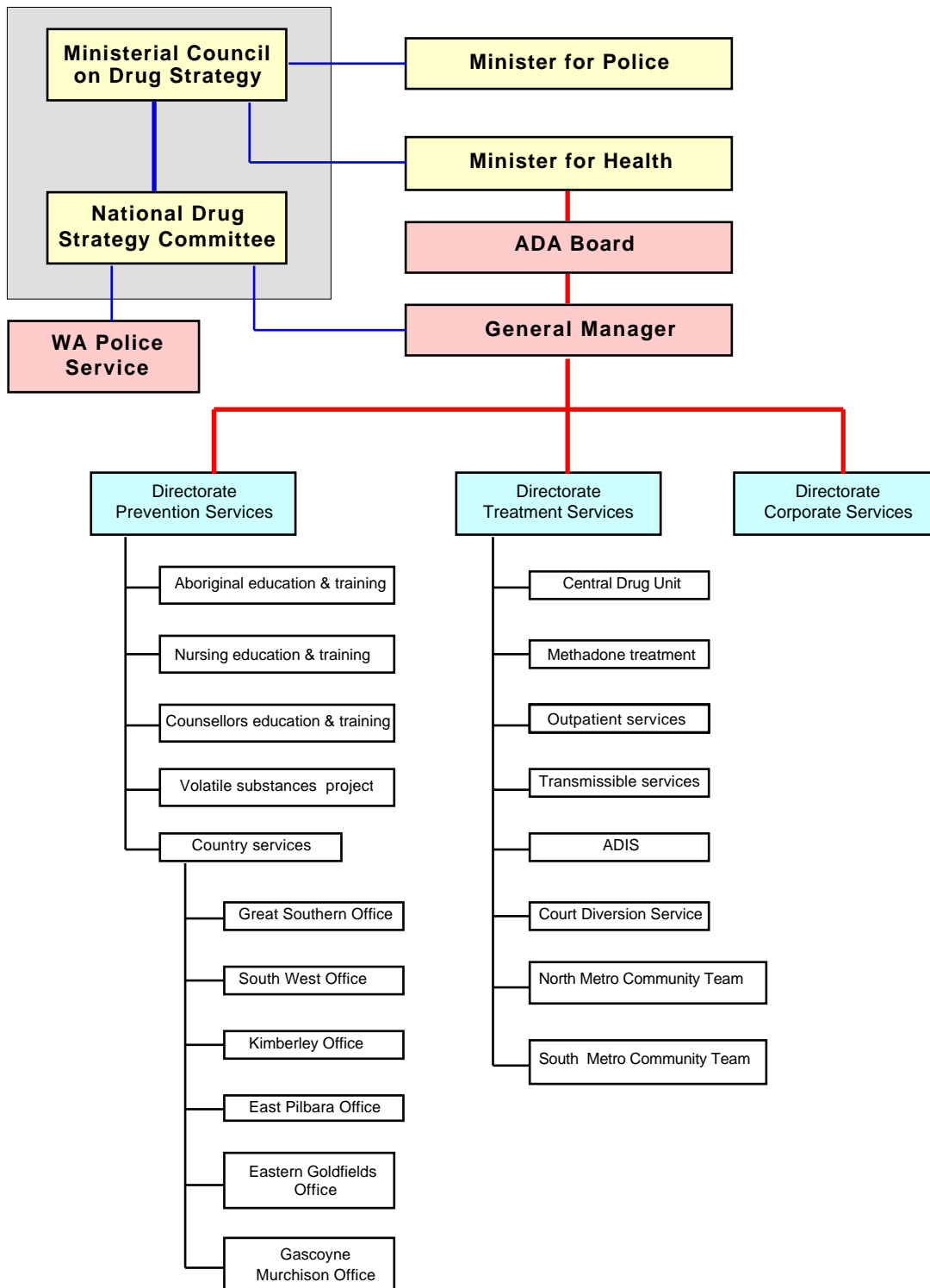
Figure 3.2 indicates how by the beginning of 1998 responsibility for addressing the State's alcohol and other drug problems was in effect divided between two organisations: the Health Department of WA (HDWA) and the WADASO.

The administrative structure of the WADASO is set out in detail in Figure 3.3. It employs a total of 15 FTEs. It is to be noted that the relationship between the WADASO and the Department of Family and Children's Services is relatively independent, as in practice the WADASO is directly accountable to the Minister, in effect operating as a separate branch that draws administrative support from the Department, such as payroll, accounts, etc.

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<sup>44</sup> Recently renamed the Intergovernmental Committee on Drugs

Figure 3.1: Overview of alcohol and other drug services in WA and relationship with MCDS at June 1997



### **3.2.3. At December 1998**

The arrangements that are proposed to be implemented by the end of 1998 are outlined in Figure 3.4. This arrangement will result in the ADA becoming the Specialist Alcohol and Drug Services under the Metropolitan Health Services Board. With the repeal of the *Alcohol and Drug Authority Act 1974*, day to day management will be from Graylands Selby Lemnos and Special Care Health Services.

#### ***Drug and Alcohol Policy and Planning Unit***

There will also be a separate functional entity, the Drug and Alcohol Policy and Planning Unit (DAPPU), that will be based in the Mental Health Division. While the DAPPU is located in the Mental Health Division, it will have a responsibility to coordinate alcohol and drug services across the HDWA. The activities of the DAPPU include collaboration with other sectors of the health system such as Divisions of General Practice and the non government sector to:

- provide a focus and lead the development of alcohol and drug policy and planning within the Health Department ;
- coordinate policy and planning issues across the health sector;
- articulate and establish the health sector alcohol and drug policy and planning framework and the development of priorities; and
- facilitate the development of policy that will inform the purchasing of services across the Divisions of the Health Department.

The object of the DAPPU is to:

- develop an understanding of the alcohol and drug services offered by the health sector;
- develop a comprehensive plan for addressing alcohol and drug problems within the health sector;
- develop clear statements of alcohol and drug related outputs and outcomes;
- facilitate the coordination of alcohol and drug purchasing practices across the health sector; and
- monitor alcohol and drug related conditions and interventions across the health sector.

The DAPPU will consist of 5.5 FTEs; a director, a senior planning officer, a senior contracts officer, a research officer and an administrative assistant. It is to be noted that additional dedicated drug and alcohol funds will continue to be held by the Divisions of Mental Health, Operations, Public Health and Office of Aboriginal Health. The DAPPU will work with these fund holders to link their purchasing and policy formulation with the Health Department's drug and alcohol policy.

Initial priorities of the DAPPU are to develop:

- an alcohol and drug planning framework that will direct policy and planning for the HDWA for the initial period of 1998 to 2001;
- decentralised alcohol and drug services in regional hospitals with a special emphasis on detoxification services and brief intervention;
- interventions to decrease alcohol related harm; and
- a set of health priorities in the alcohol and drug area.

Figure 3.2: Overview of alcohol and other drug services in WA and relationship with MCDS at December 1997

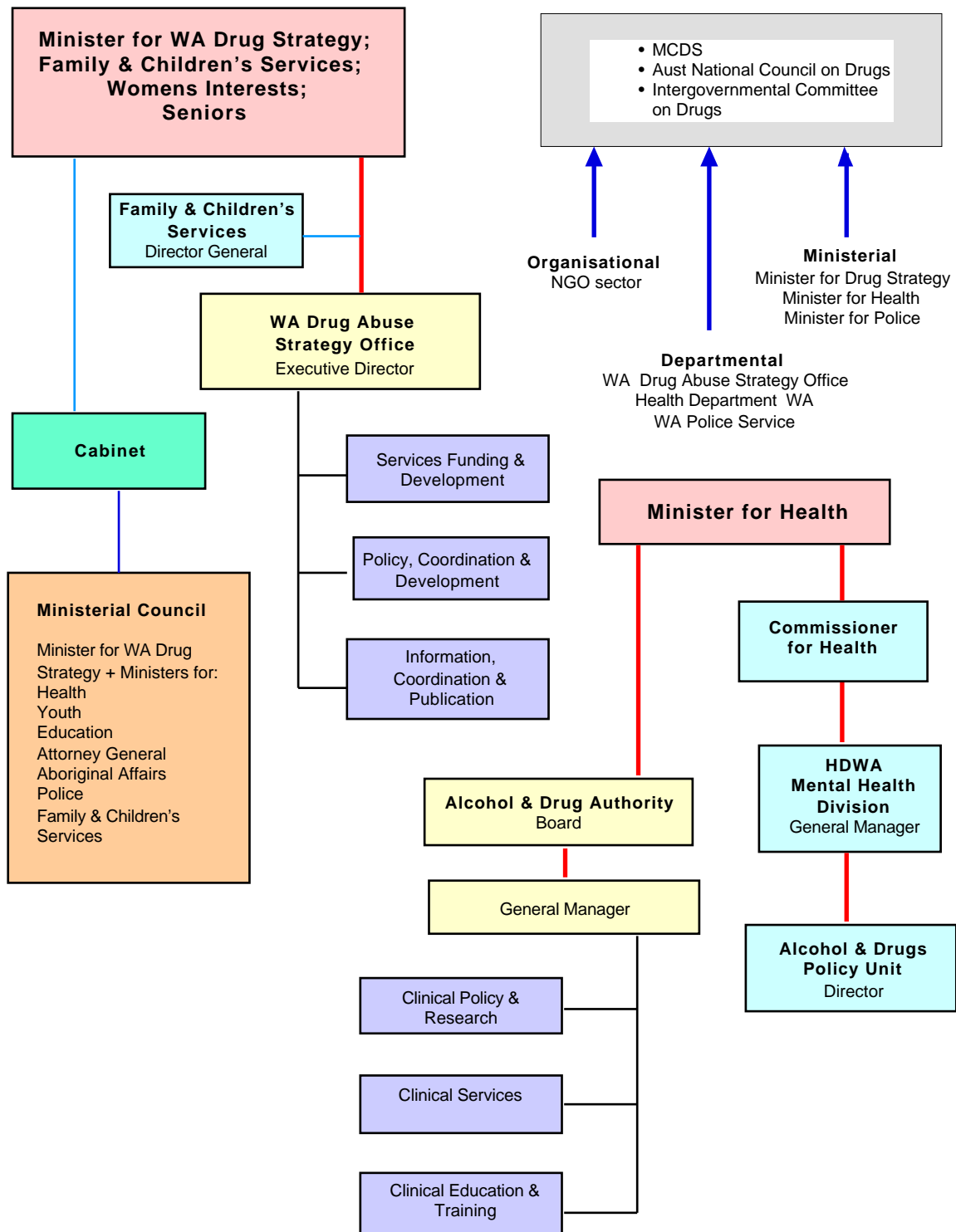


Figure 3.3: Organisational structure of WA Drug Abuse Strategy Office at June 1998

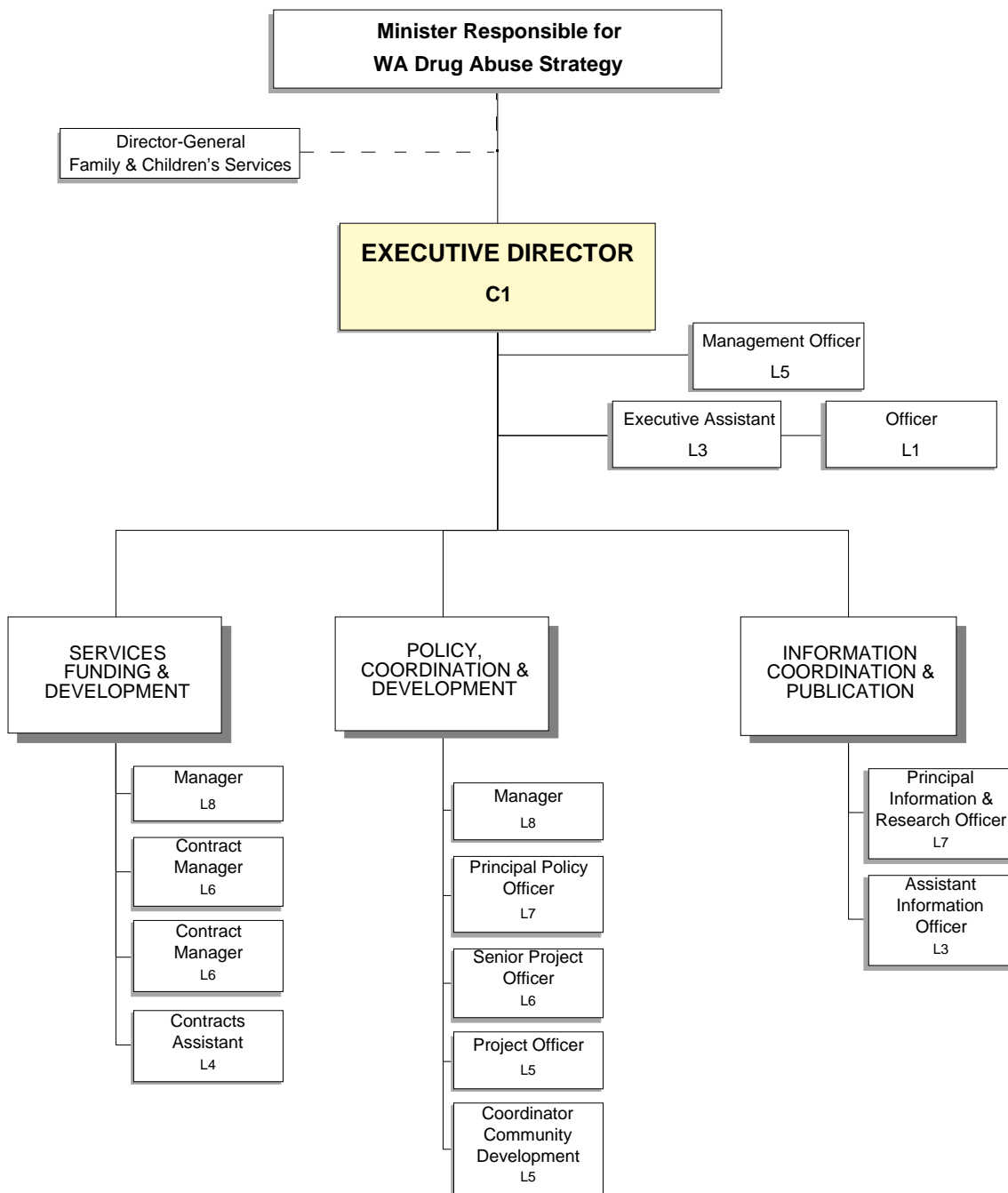
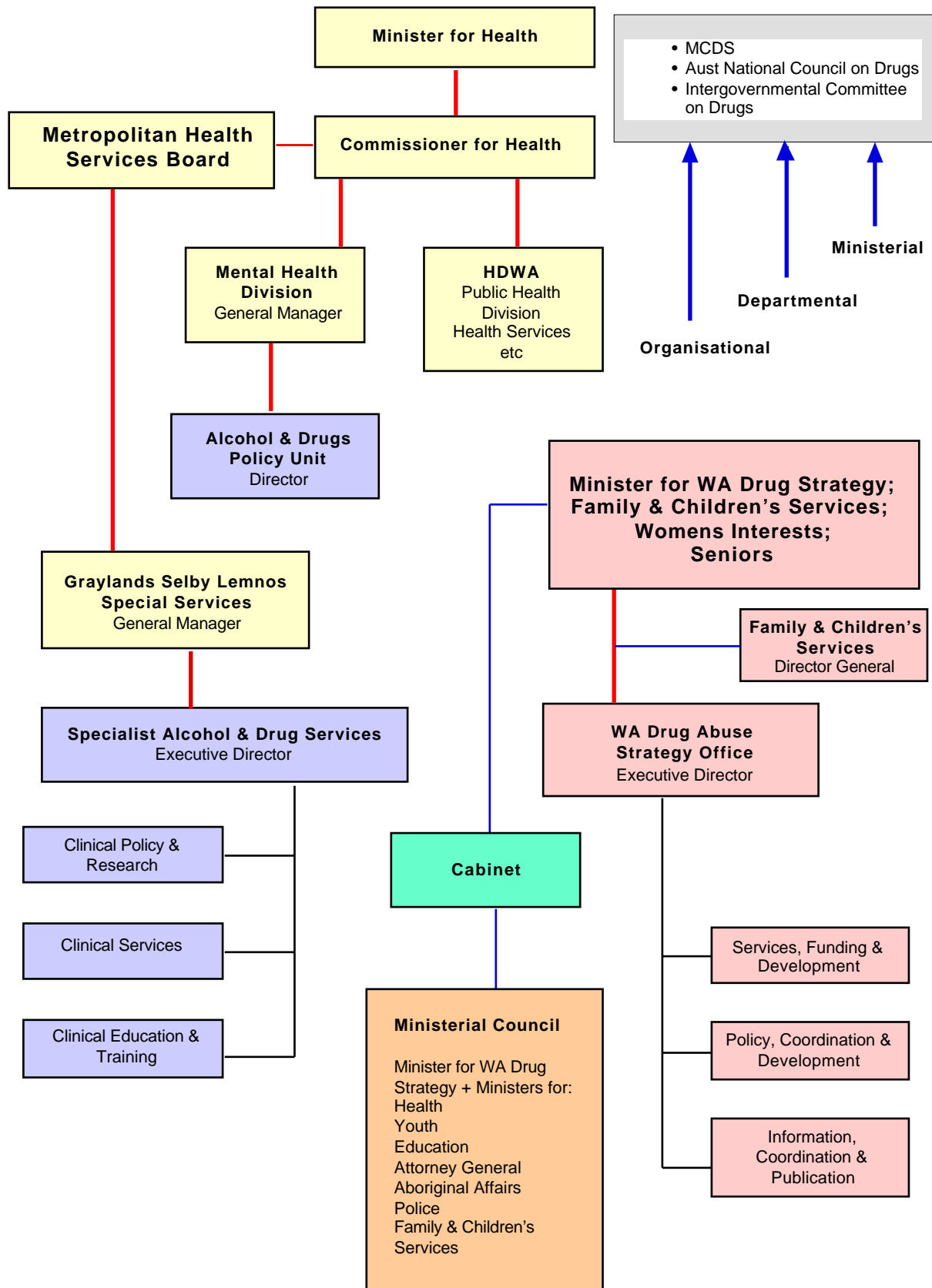


Figure 3.4: Overview of alcohol and other drug services in WA and relationship with MCDS at December 1998



### 3.3. Organisational issues

#### 3.3.1. Introduction

The Select Committee has identified some areas of concern in the organisational arrangements that have developed following the changes that have been implemented over the past year in this State.

#### 3.3.2. Duplication and overlap

Since the introduction of reforms at the beginning of the 1994/95 fiscal year there has been uncertainty and confusion about boundaries and responsibilities *vis a vis* the HDWA, the ADA and the WADASO. It is not clear that these would be resolved following the establishment of the Specialist Alcohol and Drug Services (ie former ADA) following the repeal of the enabling legislation.

The following response to a question by a member of the Select Committee dealt with the split of responsibility for policy and strategy with WADASO and for treatment services to be managed within the HDWA.

*“Mr McGinty: ... the central policy thrust of what is done with drugs seems to have been taken out of the ADA as a statutory authority ... and placed in what essentially is a political environment. It seems to place this important area of drugs into a populist arena rather than in an area where good policy will be formulated to meet the needs of the public.*

*Mr Calogero: The transition has been a little different from that. The Alcohol and Drug Authority gave up its responsibility for policy and strategy about three years ago when the Health Department decided there should be a split of that responsibility away from the Authority. Funding, contracting, strategy and policy were assumed within Health from the Alcohol and Drug Authority. Strategy and funding across all portfolios and government departments will occur out of the WADASO rather than it being disbursed across departments and portfolios. Although Health had the main responsibility, a major part of that responsibility will be coordinated across portfolios by the WADASO.”<sup>45</sup>*

The proposed arrangements at December 1998 could result in up to 25 FTEs involved in purchasing, policy, funding, research and related administrative functions. These positions would include the 5.5 FTEs in the DAPPU, 15 FTEs located in WADASO, and 4 FTEs in the Specialist Alcohol and Drug Services (ie Executive Director and three Directors of the major program areas).

There is the potential for inefficiency and duplication in activities undertaken by each of these organisations without a mechanism to coordinate projects and share resources. The process of maintaining such mechanisms is likely in itself to require ongoing investments of time to be effective. There may be a public perception that in this State there has been an excessive expenditure on administration and policy functions which could have otherwise been utilised to fund additional treatment programs.

The WADASO and the HDWA have engaged in a number of collaborative activities. One such project is to pilot a community based detoxification service in the south metropolitan area. Other activities that are being developed include a program to enable parents and families to find it easier to access support services and specialist programs for assistance when a family member has been using or become dependent on drugs.

Another instance of interagency collaboration is the Drug Aware Pharmacy Project. This was launched in early 1998 and aims to expand the role of community pharmacies as a contact point

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<sup>45</sup> Evidence to Select Committee by Mr Carlo Calogero, 25 September 1997, 55.

for those concerned about their own or a family member's use of licit or illicit drugs. Pharmacists will provide information about alcohol and other drugs and will facilitate contact with community support services, as required.

The expansion of community based methadone treatment is a partnership between the WADASO, HDWA, ADA, community pharmacies and GPs. It will enable GPs and pharmacists to develop management plans to stabilise those who are relinquishing their dependence on heroin use.

### 3.3.3. Loss of corpus of knowledge and expertise

With the development of the Specialist Alcohol and Drug Services as a separate body it is important to acknowledge that it continue to develop and maintain the function, formerly undertaken by the ADA, of a repository of skills and expertise to manage what is recognised as a difficult treatment population. Dr Mark Rooney, Chairperson of Royal Australian and New Zealand College of Psychiatrists, in evidence to the Select Committee stated

*“... it is appropriate to maintain a repository of medical expertise in the area of detoxification, which is primarily a medical specialty, but which also provides an entrée for people to appropriate rehabilitation. A significant proportion of that rehabilitation can be provided within mainstream mental health services, but I think a collaborative approach is preferable to the lumping together of quite disparate services.”<sup>46</sup>*

The Select Committee received evidence from other witnesses who appeared before it. Concerns about the loss of expertise as a result of the contracting out of the ADA's community based services were provided to the Select Committee by Associate Professor Bill Saunders from Curtin University.

*“Professor Saunders: ... When I came to WA 10 years ago the ADA had approximately 220 workers, most of whom were professionals. Next year only one doctor with any expertise will be funded by the State. One of the problems with mainstreaming drugs and alcohol is that it becomes everybody's business, which becomes nobody's business because nobody will be interested.*

*Ms Anwyl: ... In terms of the disbanding of the ADA, what do you consider will be the effect of those changes on that body of expertise and what will happen to the professional workers?*

*Professor Saunders: They have gone. ... The current situation with the ADA is that the best people have left it and gone elsewhere and it is left with the worst people. I am enormously pessimistic about the ability of ADA to run a Centre of Excellence. It does not have any experts in it. I am being very rude, but the quality of services offered by the ADA is very poor. The Central Drug Unit is an atrocious agency. It is like having cars coming down the freeway with each one having to go through one toll booth with one person in it. ...*

*Ms Anwyl: What will be the effect of the professional workers leaving? ...*

*Professor Saunders: It leaves a very dire situation. Addictions is a specialist business. ... There are no consultant psychiatrists or clinical psychologists working in the ADA. I am not saying that is all you need. You need the gamut of expertise and experience. However, there is not the experience there and I cannot see any way it will be achieved because it will involve redeploying the very people who have not been able to leave because they are not good enough to leave. It will re employ some of the people who are very ordinary clinicians.*

*Ms Anwyl: I come back to your point about the community drug service teams which effectively will replace the one to one case work that the ADA workers have been doing. What will be the level of qualification that the people doing these jobs will have?*

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<sup>46</sup> Evidence to Select Committee by Dr Mark Rooney, 6 April 1998, 10.

*Professor Saunders: For \$30,000 you will get a Salvation Army officer who is well meaning and well intentioned, but not clinically apt and unable to spot depression in a fit. These people are not trained to do that. I am not criticising the Salvation Army – they do an excellent job in some parts of the market. ... The argument is that social workers, clinical psychologists and doctors elsewhere will be mainstreamed and that when these people cannot cope they will refer their clients to these others. These others will not want a bar of it. The reason the ADA was set up in the first place was that, as we all know, and the British experience is exactly the same, the ordinary average person does not want to deal with alcohol and drug problems.”<sup>47</sup>*

Recognition needs to be also given to ensuring that a satisfactory career structure exists within the health sector in relation to health care professionals who work in the alcohol and other drug field, as otherwise it is very difficult to retain or attract skilled and committed professional staff. A witness who appeared at a hearing of the Select Committee, Dr Helen Slattery, a consultant psychiatrist at Sir Charles Gairdner Hospital who also attends a half a day a week at the CDU, made the following observation.

*“One of the historical problems is that when the Alcohol and Drug Authority was set up and when alcohol was the major problem, services separated into people with psychiatric illness and people with alcohol problems. As a result people became quite deskilled in both those areas. Some people treated alcohol problems and some people treated psychiatric illness. Now the range of substances which people abuse is much larger and the incidence of psychiatric comorbidity is quite huge but we have not followed up with a reintegration of services or provided specialists in each area in the different arenas.”<sup>48</sup>*

On its visit to Turning Point Inc in Melbourne the Select Committee received evidence that as a result of contracting out of services in that State there was a subsequent loss of highly skilled people who had worked for a number of years in the alcohol and other drug field. The view was expressed that while some of these individuals returned to work in the field, either as consultants or with a privately run organisation, overall there was a net loss of professional staff in the alcohol and other drug sector.

*“Speaker 1: ... We actually lost a very significant group of staff from the drug and alcohol field and they are no longer working in drug and alcohol.*

*Speaker 2: A certain component come back after setting themselves up as consultants and tendering?*

*Speaker 1: A small number do that. It is really more the senior staff. The nursing staff that used to run units, for example, and ... the ones that had been around and seen it all. ... (M)any of them just got sort of burnt out with the changes and decided to take the package. ... So that was unfortunate from our point of view. We lost a good group of staff.*

*Speaker 2: So, would you say generally that the period of adjustment has not finished yet? Is it ongoing?*

*Speaker 1: It is ongoing. That is just the nature of an environment of competitive tendering which (w)ith every new service that comes along you do not really know where you are going to be until your service has been tendered. So, I think we are now in perpetual change. I think people that are working in the area just got to accept that this is the field, this is the environment and it is not just drug and alcohol (sector) ... it has happened across most health and welfare areas in Victoria.”<sup>49</sup>*

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<sup>47</sup> Evidence to Select Committee by Associate Professor Bill Saunders, 25 September 1997, 15-16.

<sup>48</sup> Evidence to Select Committee by Dr Helen Slattery, 6 April 1998, 8.

<sup>49</sup> Evidence to Select Committee on visit to Turning Point Inc, 19 February 1998, 237.

### 3.3.4. Loss of resources

Of particular concern is the possibility that funds will be redirected to programs in the overall health budget regarded as having a higher priority and being more popular than programs for drug dependents. As since 1994/95 about 11.5 FTEs formerly held by the ADA have been absorbed into the HDWA there are reasonable grounds for concern that a close relationship with the HDWA will result in further scarce resources being shifted to other parts of the health budget.

When the Select Committee met with the four ADA witnesses, Professor Hawks (from the National Centre for Research into the Prevention of Drug Abuse), Dr Alan Quigley (Principal Medical Officer), Mr Chris Baldwin (Director of Treatment Services) and Mr Carlo Calogero (Acting General Manager) it received evidence about the integration of the ADA's function into the Health Department. Professor Hawks, a former CEO of the ADA and a current member of its Board,<sup>50</sup> in response to a question about the shortcomings of the integration, stated the following.

*“At a time when the government rightly has indicated its wish to address the problem, one must ask why a body with expertise in the management of the problem is being rundown. It is clear, as indicated in (its) submission, that over the years in which the problem has got worse, the authority has had fewer resources made available to it. It is a contradiction. Speaking as a member of the ADA Board, unless provision is made in the plan not only to replace the ADA, but also to complement the services previously provided by the organisation, we are in for a tough time.*

*That is not to say that the services provided by the ADA were wholly adequate – we would be the first to acknowledge that, as we have done in the submission. My concern is that the services the authority provided should be replaced with a more comprehensive, accessible and efficient service than that provided in that past.”<sup>51</sup>*

It is understood that the HDWA is developing the concept of a centre of excellence across a number of areas, such as the Mental Health Division, the Public Health Division and also the alcohol and other drugs area. The clinical functions formerly undertaken by the ADA would be organised as one of the proposed centres of excellence.

There is a recognition that whatever division in the Health Department was assigned the responsibility for the Specialist Alcohol and Drug Services, this arrangement would be problematic. This problem was encapsulated in the following response by the General Manager of the ADA.

*“I think the challenge for us, wherever alcohol and drugs was placed, is to make sure that every division of health sees that it has a key responsibility in the area. So, if it had been located in Public Health the danger might have been that Mental Health may not have been involved and the Aboriginal Health may not have been involved. If it had been located in Aboriginal Health the signal might have been that it is just an Aboriginal issue. So, there was a difficulty wherever, there were some challenges wherever it would be placed. The view is that the General Manager of Mental Health will have the capacity with the team that is created in there to ensure that there is good coordination across health across those various areas.”<sup>52</sup>*

### 3.3.5. Reduced access to non clinical services

Incorporation of the remaining ADA services and programs, such as the Central Drug Unit (CDU), William Street Clinic (WSC), professional education and training and information services within the overall structure of the metropolitan health system may result in these services becoming less accessible.

<sup>50</sup> Professor Hawk's term as a Board member expired on 30 September 1997.

<sup>51</sup> Evidence to Select Committee, 25 September 1997, 57-58.

<sup>52</sup> Evidence to Select Committee by Mr Carlo Calogero, 8 April 1998, 28.

There are concerns that if this library is absorbed into the HDWA it will be inaccessible to many of the present users, as it has the State's only collection of specialist materials dealing with all matters concerned with treatment, education, prevention and current research. These materials are widely used by practitioners, students enrolled in university based courses such as nursing, other health care providers, psychologists, social work and drug education, and accessed by those working in the non government service providers.

### 3.3.6. Loss of independence of statutory body

Some concerns were raised by a number of witnesses who gave evidence to the Select Committee concerning the winding up of the ADA and the associated repeal of the *Alcohol and Drug Authority Act 1974*. The Chairperson of Royal Australian and New Zealand College of Psychiatrists made the following observation on this issue:

*"I would not annihilate the ADA. I would maintain a robust Alcohol and Drug Authority and I would not split it into two bits ... I would maintain the administrative integrity of a body committed to providing specialised services to people who have become drug dependent and providing specialised training and specialist teaching."*<sup>53</sup>

The ADA's independence, promoted by the Act, which it has exercised on occasions in the past, has enabled it to engage in public debates which otherwise it would not have been able to do if it was not an independent statutory body. The Select Committee notes the broad ranging functions and powers of the ADA provided for in sections 18 and 19 of the Act and its general contracting out power under section 24.<sup>54</sup> In any event, the Select Committee notes that the ADA is nonetheless subject to broad Ministerial control pursuant to section 17(2) of the Act and notes that in any final analysis, its independence is in reality somewhat limited due to the power of the Minister to give directions on a broad range of matters.

Examples may be given which highlight the advantage of having an independent statutory body. As preventive programs, which reduce the burden on the community from the abuse of licit drugs such as tobacco and alcohol, are likely to involve restrictions on access to and sale of these substances, they will have adverse economic consequences for retailers, hoteliers and other groups. Without the existence of a body able to put the wider interest of the community from a public health perspective, powerful business interests are likely to successfully oppose health campaigns which threaten their economic interest.

There have been a number of occasions in relation to smoking where the ADA and other independent bodies have been a counterbalancing force to strenuous lobbying by tobacco companies and retailers. An example of this scenario has occurred in relation to imposing restrictions on advertising at point of sale, promotion of sporting events by tobacco companies, and restrictions of smoking in public places. A recent example is attempts to reduce the sale of take away alcohol in North West country towns which had been initially opposed by operators of licensed outlets. However, following representation from ADA field workers, in conjunction with community groups, restrictions were imposed.

A truly independent statutory body, with somewhat limited Ministerial control, can play an important role and respond to public concerns which may at times be based on misinformation and misunderstanding about particular issues. For example, this may involve opposition by local residents about the location of a treatment facility in their neighbourhood, or opposition to needle and syringe exchange programs. As programs for those with dependencies on alcohol and other drugs, especially illicit drugs, do not enjoy a high degree of popular support, an independent body can more readily lobby and advocate for resources.

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<sup>53</sup> Evidence to Select Committee by Dr Mark Rooney, 6 April 1998, 11.

<sup>54</sup> A copy of the Alcohol and Drug Authority Act 1972 is contained in Appendix 10.

**Finding 1**

**Several members of the Select Committee expressed some concerns at the demise of the Alcohol and Drug Authority as a dedicated drug agency, of the consequent fragmentation of drug services across a number of government organisations and of the transfer of responsibility for former ADA functions to the Mental Health Services Division.**

**It was also the view of these members that there was a need for a sharply focussed drug agency to effectively lead the fight against illicit drugs in the community. However, the Select Committee is of the view that given these reforms have only occurred at the beginning of the 1997/98 fiscal year it was too soon to come to a view on this issue.**

### 3.3.7. Separate division vs Mental Health Division

The Select Committee received evidence expressing concern about the absorption of the functions of the ADA into the Mental Health Division. While this arrangement may have been the most administratively expedient, it creates the public perception that those who abuse drugs are also suffering from a mental illness. The need to avoid such a stigma was a major factor in the establishment of the ADA in 1974, as a separate body from the Mental Health Services. This issue was considered in the following response from Carlo Calogero, General Manager of the ADA, to a question posed by a member of the Select Committee:

*“Mr McGinty: ... can I suggest to you another downside and that is in terms of people accessing the service, the double stigma of not only having a drug problem but then having to go to psychiatric services for assistance, so I would have thought that was an enormous downside to this arrangement.*

*Mr Calogero: There are some challenges and some difficulties with that and I think you have alerted that before and I agree with you. I mean, we do need to guard against alcohol and drug issues being seen as a specialist psychiatric area and it is not and nor did health see it that way and nor does the General Manager of Health. He will, in the very early stages, pull together a group of people from health that will go across those various divisions. It will go across operations, Aboriginal health and public health and bring them together and say, ‘This is an issue that we all need to deal with, it is not just a psychiatric issue’.”<sup>55</sup>*

An option is to create a separate division in the HDWA, with its own General Manager. Such an arrangement would also contain all the functions at present divided between the WADASO and the HDWA. As the health system is always likely to have a significant capacity to address the health problems due to the abuse of alcohol and other drugs, encompassing preventive and treatment issues, there is a strong argument for the establishment of a unified Division with the HDWA.

Another option is to transfer the functions of the DAPPU to the WADASO. The effect of either option is to avoid the possibilities of duplication and competition that will otherwise tend to arise from the existence of two organisations performing similar responsibilities.

However, as the total devolution of the ADA’s functions is approaching its final stages and is not yet complete, it is premature to comprehensively assess the impact of all changes until a reasonable period of time has elapsed following devolution.

<sup>55</sup> Evidence to Select Committee by Mr Carlo Calogero, 8 April 1998, 30.

**Recommendation 11**

***That a review of the management and general effectiveness in the delivery of alcohol and other drug services within the Mental Health Division of the Health Department of WA be effected in conjunction with the next WA Drug Abuse Strategy Action Plan.***

## **3.4. Administrative issues**

### **3.4.1. Centralisation of services**

The concept of a Specialist Alcohol and Drug Services would be enhanced if all treatment services presently operated by the ADA are centralised on the CDU site. The methadone program at the WSC has limited space and is located on a busy four lane arterial road in Northbridge. Priority should be given to relocating to a purpose built assessment and dispensary facility on the CDU site. As there may be traffic difficulties if the present large number of patients who attend the WSC site were to attend a relocated clinic at the CDU site, it may be feasible to develop two smaller specific purpose public methadone clinics with dispensaries in the metropolitan areas. One of these could be at the CDU site and the other at a location in the southern part of the metropolitan area.

### **3.4.2. Detoxification program**

The CDU is an important and well established detoxification facility. Because of its closeness to the inner city it is able to develop and support close linkages with other health services, such as the Emergency Department and Psychiatric Unit at Royal Perth Hospital. It is to be noted that as the CDU is able to achieve lower bed day costs compared to the major teaching hospitals, it is advantageous to retain its separate identity, even though it is part of the health services and administered by the Metropolitan Health Services Board.

Evidence was received by the Select Committee that detoxification programs operate much better if they were maintained as separate programs than if they were, for example, integrated with a teaching hospital.

*“There are difficulties in dealing with people who have drug problems at, for example, a general hospital and community services and possibly at the approved, authorised hospitals as well. We can deal quite easily with people with alcohol problems and on the whole with people with cannabis problems, but huge difficulties are created when we admit people with illicit substance use to psychiatric units, particularly in general hospitals. Because of the nature of heroin use and illicit substance abuse, people with particular personality profiles are over represented there. People with psychiatric illness are probably the most vulnerable people in the community. So we have quite a lot of trouble admitting people who have only heroin problems and no other problems to a psychiatric ward where we have psychotic people, very depressed people, young people with identity issues and so on. They are very often preyed upon by the people with illicit substance use.”<sup>56</sup>*

### **3.4.3. Turning Point model**

On its visit to Melbourne the Select Committee visited the Turning Point organisation. Turning Point is an incorporated body which is funded by government to undertake a number of activities, such as research, evaluation, training and provide a clinical service. While the Victorian Government appoints the Board of Turning Point, it functions as a separate entity with close relationships with a number of bodies with whom it has developed new programs.

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<sup>56</sup> Evidence to Select Committee by Dr Helen Slattery, 6 April 1998, 8-9.

In the overview of Turning Point later in this chapter, it is apparent that Turning Point performs similar responsibilities to the ADA. It is possible that some of the ADA's responsibilities for and expertise in operation of non clinical services (such as the library, ADIS, training, education and evaluation) could be transferred to a similarly constituted body.

An important feature of such a body would be the development of close relationships with a number of key organisations, including the NCRPDA, the School of Health Studies at Edith Cowan University, Curtin University's Addiction Studies Program, the Institute of Child Health and the School of Public Health at the University of WA.

It is useful to acknowledge the context in which Turning Point was established in May 1995. Unlike this State, there was a lower level of support of NGOs, and accordingly reforms were undertaken to partly redress this concern that resources had been overinvested in expensive institutional programs. As indicated in chapter 2 the ADA had been engaged in ongoing evaluation of its treatment services from the early 1980s, as mandated in its enabling legislation.

Services such as Quo Vadis Hospital had been devolved to NGOs and sobering up centres had been supported to reduce the demand on more expensive residential treatment programs. A policy of shifting an increasing proportion of resources to the NGOs had been implemented some years ago, as indicated in the breakdown of funding in chapter 2.

## 3.5. Commonwealth role

### 3.5.1. Introduction

The National Drug Strategy (NDS) is a cooperative venture between the Commonwealth, State and Territory governments and the non government sector, with the common aim 'to minimise the harmful effects of drugs and drug use in Australian society'.<sup>57</sup> The forerunner to the NDS, the National Campaign Against Drug Abuse (NCADA), was launched in 1985 following a special Premiers' Conference on Drugs and placed under the direction of a Ministerial Council on Drug Strategy (MCDS).

When the NCADA was launched, the then Commonwealth Minister for Health, Dr Neal Blewett, made it clear that the intent was to develop a uniquely Australian strategy. A national approach involving a strong partnership between the Commonwealth, States and Territories was a clear aim. It was also intended to forge a partnership between health and law enforcement, emphasising demand reduction programs which had close interrelationships with control of supply.

The strategy was to be comprehensive, involving an integrated approach to licit and illicit drugs. Perhaps most notably, the new drug strategy was to be based on the principle of harm minimisation. A further principle underlying the new strategy was that 'reliable data, new approaches and evaluation of effort are required'. There were five key elements of the NDS which are listed below.<sup>58</sup>

#### **Harm minimisation**

The object of this approach was to reduce the adverse health, social and economic consequences of misuse of alcohol and other drugs, by minimising or limiting the harms and hazards of drug use for both the community and the individual, without necessarily eliminating use.

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<sup>57</sup> The outline of State-Commonwealth relationships, funding issues and the administrative structure of the NDS is based on information contained in Single E, Rohl T. *The National Drug Strategy: mapping the future. An evaluation of the National Drug Strategy 1993-97*. Canberra, Australian Government Publishing Service, 1997.

<sup>58</sup> Adapted from Drug Treatment Services, Aged, Community and Mental Health Division, Department of Human Services. *Victoria's alcohol and drug treatment services. The framework for service delivery*. Melbourne, Department of Human Services, 1997.

**Drug control**

This involves the adoption of a broad spectrum of control measures, ranging from legislative provisions to controls on the access, availability and use of drugs for certain groups or in certain situations.

**Intersectoral approach**

This element acknowledges that alcohol and other drug problems need to be addressed in an integrated manner across a broad range of sectors.

**International cooperation**

This dimension recognises that as drug abuse involves international concerns, it is important to implement treaties and conventions and implement global action plans to address drug related issues in a focussed and cooperative manner.

**Evaluation and accountability**

This element recognises that it is important to develop needs based planning and evaluation processes to ensure the effectiveness and efficiency of interventions implemented to minimise drug related harm.

### **3.5.2. Evaluation of NDS**

The MCDS commissioned two independent evaluations in 1988 and 1991 to assess progress and make appropriate recommendations regarding the overall direction of Australia's drug effort. After more than a year's deliberation by an eight person task force, the report of the second evaluation, titled *No Quick Fix*, was released in February 1992. Despite the achievements of the NDS, the report expressed a number of concerns about the NCADA which required attention, including:

- a lack of overall strategic goals and direction;
- failure to achieve a harmonious partnership between law enforcement and health;
- impediments to innovation;
- deficiencies in community consultation; and
- the continuing unmet needs of special population groups.

Among its 66 recommendations, it was indicated that the NCADA should be relaunched as the National Drug Strategy based on a new National Drug Strategic Plan; that a special unit should be formed to administer the NDS; that a national clearing house on drugs should be created; and that greater emphasis should be given to law enforcement participation in the Strategy.

Following the recommendations of *No Quick Fix*, the partnership between law enforcement and health was enhanced by two significant funding measures. In June 1992, the MCDS agreed to increase the proportion of NDS cost shared funding for law enforcement initiatives to ten per cent progressively over the next three years. Law enforcement projects were supposed to receive approximately three per cent of cost shared funding in 1992/93, seven per cent in 1993/94 and ten per cent by 1994/95. In addition, the National Drug Crime Prevention Fund was established from Commonwealth funds to support further law enforcement projects.

### **3.5.3. National Drug Strategic Plan**

The recommendations for a strategic plan and for the greater involvement of law enforcement were implemented. Many of the other recommendations were unfortunately not implemented, including that for a national clearing house and for the establishment of a dedicated unit for the NDS.

After extensive consultations and development, the National Drug Strategic Plan 1993 to 1997 was released in 1993. It presented a clear statement of the goals, principles and targets for the

next five years. It represented a significant consensus on the strategic direction for the development of drug strategies in each State and Territory.

The strategic plan set out three major goals in order to achieve its overall mission of minimising the harm caused by drugs:

- to minimise the level of illness, disease, injury and premature death associated with the use of alcohol, tobacco, pharmaceutical and illicit drugs;
- to minimise the level and impact of criminal drug offences and other drug related crime, violence and antisocial behaviour within the community; and
- to minimise the level of personal and social disruption, loss of quality of life, loss of productivity and other economic costs associated with the inappropriate use of alcohol and other drugs.

The strategic plan identified six specific concepts which were to underpin the development and implementation of drug policy:

- harm minimisation;
- social justice;
- maintenance of controls over the supply of drugs;
- an intersectoral approach;
- international cooperation; and
- evaluation and accountability.

A detailed set of performance indicators was set, including sources of data. The key targets of the Strategy were:

- a reduction in injury, violence and loss of productivity associated with excessive drinking or intoxication in hazardous situations, particularly on the roads, in the workplace and in drinking environments;
- a further reduction in the prevalence and uptake of regular smoking, with particular emphasis on socioeconomically disadvantaged groups and young people;
- a reduction in the inappropriate use of alcohol and other drugs by young people;
- a reduction in the inappropriate consumption of commonly misused prescription drugs, with emphasis on at risk groups including older people and polydrug users;
- a reduction in the prevalence of, and crime and social disruption associated with, the trafficking and use of illicit drugs; and
- the prevention of the spread of hepatitis, HIV/AIDS and other infectious diseases associated with unsafe injecting of illicit drugs and unsafe sex associated with intoxication.

The National Drug Strategic Plan 1993 to 97 also proposed a comprehensive range of national initiatives to be developed on a collaborative basis. These included:

- the development of mechanisms for enhancing the partnerships of health, law enforcement and education;
- a review of data collection systems to ensure a capacity to monitor and evaluate the NDS;
- the identification of research needs in key areas of the NDS and improvement of research networks;
- the production of a core set of education resources;
- the collaborative development of media;
- the development and dissemination of drug prevention guidelines appropriate to target groups;
- a national evaluation of Employee Assistance Programs;
- the facilitation of national debate on priority issues;
- the development of a national statement on cannabis;
- the introduction of evaluations on the cost effectiveness of drug abuse programs;
- the development of alcohol and drug crime prevention initiatives;

- the development of effective confiscation of assets legislation and law enforcement strategies targeted at the illicit manufacture, supply and distribution of drugs; and
- the continued contribution to international efforts to minimise the harmful effects of drugs through supply control, demand reduction and problem prevention.

### **3.5.4. Ministerial Council on Drug Strategy**

Overall responsibility for the broad policy direction and operation of the NDS rests with the MCDS, which comprises both health and law enforcement ministers from each State and Territory and the Commonwealth government. The New Zealand Minister for Health has also attended meetings in an observer capacity since 1993. The council meets annually in a different State or Territory and is chaired by the host minister in that State or Territory. Meetings are set in conjunction with the meetings of health ministers.

### **3.5.5. Intergovernmental Committee on Drugs**

The National Drug Strategy Committee (NDSC), which was renamed as the Intergovernmental Committee on Drugs (ICD) following the revamped Commonwealth framework announced in November 1997, plays a key support role with the MCDS. It is mandated to develop proposals for the NDS, implement the NDS, develop policy proposals relating to licit and illicit drugs, and liaise with other governmental agencies on matters relating to the NDS. It consists of one health and one law enforcement representative from each jurisdiction and, more recently, has included representation from the Australian Customs Service and the Commonwealth Law Enforcement Board.

### **3.5.6. Funding arrangements**

In describing the funding arrangements for the NDS, it should be noted at the outset that the NDS does not represent the total response to the problems of substance misuse. The NDS did not replace the existing prevention, treatment and law enforcement programming to deal with drug problems. The funding for NDS programs and activities is intended to be a catalyst for change and represents only a small proportion of the Commonwealth expenditure to deal with drug problems.

The NDS is funded from four sources:

- cost shared funds;
- State and Territory appropriations;
- funds wholly provided by the Commonwealth; and
- special funds.

The largest component of Commonwealth NDS funding is 'cost shared' funds. These funds are provided by the Commonwealth for specific projects and programs and matched by State and Territory governments. Since the fiscal year 1992/93, cost shared funding by the Commonwealth has totalled \$199.7 million. The amount provided to each State and Territory is in proportion to population. The Commonwealth contribution has been indexed to inflation since its inception.

The total contribution of cost shared NDS funds to the States and Territories has increased from \$12.0 million in 1985 to \$20.7 million in 1996/97. In general, the States and Territories have contributed more than the Commonwealth to the cost shared fund. For example, in 1993/94 the Commonwealth allocated \$19.5 million whereas the combined expenditure totalled \$40.2 million.

The NDS cost shared funding supports a diverse range of drug and alcohol services in areas such as treatment, prevention, supply control, education and training. While it is a condition of cost shared funding imposed by the Commonwealth that each jurisdiction provides approved documentation stating the general purposes for which the funds are to be used, the actual details of how and on what the monies are spent rests with each State and Territory.

In addition to the cost shared program, the Commonwealth wholly funds national drug programs such as research centres and specific policy initiatives. Since the fiscal year 1993, the Commonwealth has expended \$66.4 million on drug programs through the Department of Health and Family Services.

Special funding has been provided by the Commonwealth through the Confiscated Assets Trust Fund (CATF) and the Aboriginal Deaths in Custody Fund.<sup>59</sup> Since December 1991, the net proceeds of all recoveries effected under the Commonwealth *Proceeds of Crime Act 1987*, the drug trafficking provisions of the Commonwealth *Customs Act 1901* and the Commonwealth *Crimes Act 1914* have been paid into the CATF. Under the Commonwealth *Proceeds of Crimes Act 1987* these funds were then divided equally between the Commonwealth Health and Attorney General's portfolios to support law enforcement projects and drug rehabilitation and drug education programs.

The CATF provided more than \$7.6 million to the Commonwealth Health Department to support additional NDS projects since 1992/93. However, it was terminated in late 1996 and the Select Committee believes that this fund should be reestablished to provide an identifiable mechanism to fund health and law enforcement activities.

**Recommendation 12**

***That the Commonwealth be requested to consider re-establishing the confiscated Assets Trust Fund.***

In their review of the NDS, Professor Eric Single and Professor Timothy Rohl highlight the difficulty of being able to identify how cost shared funds were spent. There is an apparent difference between the Commonwealth and some of the jurisdictions as to whether these funds were to be used for ongoing services or to develop new programs. It was concluded

*“that a significant proportion of these funds had been utilised to support existing or ongoing services instead of funding new programs. Contrary to Commonwealth understanding of the original intent, the cost shared program has, to a large extent, become a supplementary source of recurrent funding.”<sup>60</sup>*

### **3.5.7. Prevention**

Prevention has a major emphasis within the NDS. It is estimated that approximately one third of projects funded under the NDS cost shared program and one half of the national programs have been focused directly on prevention related activities. A number of notable prevention initiatives have been implemented, including the following:

- Public education and awareness campaigns – ‘Speed Catches up with You’ targeting problems associated with amphetamine use; ‘Alcohol Go Easy’, ‘How Will You Feel Tomorrow’ and ‘Alcohol and Violence Tears You Apart’ campaigns promoting moderation in drinking; and campaigns aimed at reducing youth smoking. Evaluations of these media campaigns indicate positive shifts in awareness of the potential harmful consequences of drug misuse.
- The National Initiatives in Drug Education program. In its first phase the program provided for the ongoing comprehensive training of school teachers to develop skills and knowledge about drug education. The second phase aimed at extending this education to parents, industry and other community groups. An evaluation of the National Initiatives in Drug Education (NIDE) program is scheduled to be commissioned by the Commonwealth Department of Health and Family Services in 1997.

<sup>59</sup> The Aboriginal Deaths in Custody Fund is considered part of the NDS and is funded separately.

<sup>60</sup> Single E, Rohl T. *The National Drug Strategy: mapping the future. An evaluation of the National Drug Strategy 1993-97.* Canberra, Australian Government Publishing Service, 1997, 12.

### **3.5.8. National Drug Strategy**

The current organisational arrangements of the National Drug Strategy (NDS) are outlined below in Figure 3.5. These arrangements outline the key role played by two recently formed committees; the Australian National Council on Drugs (ANCD), which is made up of primarily of representatives of NGOs, community groups and other stakeholders, and the Intergovernmental Committee on Drugs (ICD).

A key supporting role in dealing with specific issues is performed by the five national expert advisory committees which advise the MCDS, the ANCD and the ICD.

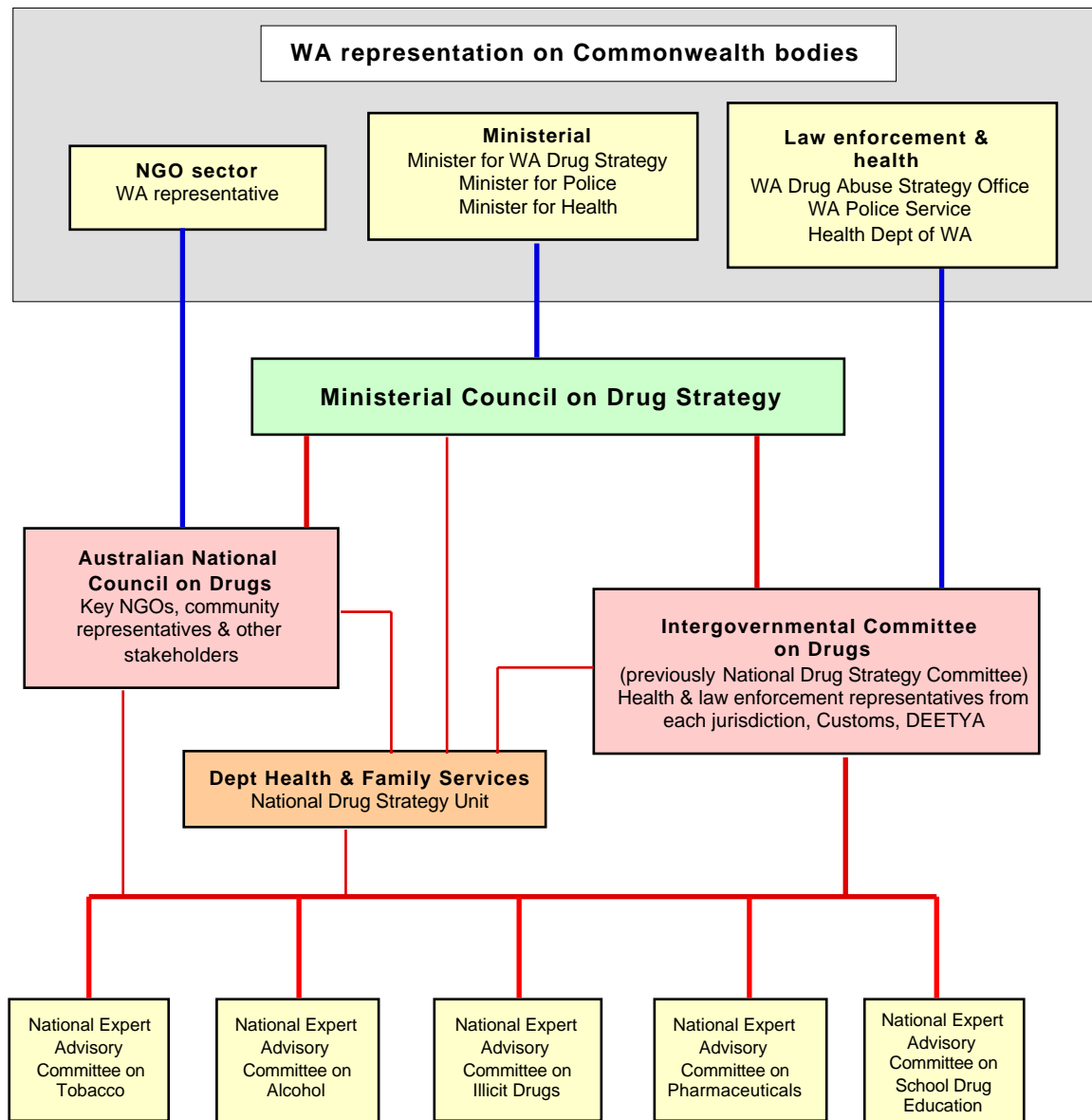
#### **3.5.8.1. Australian National Council on Drugs**

On 16 March 1998 the Prime Minister announced the launch of the Australian National Council on Drugs. The function of the ANCD is to provide input to the Commonwealth Government on assisting those with alcohol and other drug problems, especially with respect to the role of the non government organisations (NGOs). One of the first priorities of the ANCD will be to advise on the development and implementation of the National Drug Strategy and of allocation of funding to NGOs throughout Australia. The membership of the ANCD includes those with experience in community organisations, law enforcement, education, health and other community services.

The membership of the ANCD is as follows:

Major Brian Watters, Director, South East Region Salvation Army (Chairman)  
Mr Mick Palmer, Commissioner, Australian Federal Police (Vice Chairman)  
Professor Wayne Hall, Executive Director, National Drug and Alcohol Research Centre  
Ms Karyn Hart, President, Australian Secondary Principals Association  
Ms Jude Byrne, immediate Past President, Australian Intravenous League  
Professor Ian Webster, President, Alcohol and Other Drugs Council of Australia  
Mr Wesley Noffs, Chief Executive Officer, Ted Noffs Foundation, Sydney  
Mr Arthur Toon, Director, Cyrenian House  
Mr Scott Wilson, Aboriginal Drug and Alcohol Council (SA) Inc

Figure 3.5: Organisational arrangements of the National Drug Strategy at June 1998



### 3.5.8.2. Tough on Drugs

The Select Committee expects this State’s ability to address the growing problem from the abuse of illicit drugs which have a significant addictive potential, especially heroin and amphetamines, to be enhanced with the availability of new Commonwealth funds. The Prime Minister announced that \$87.5 million would become available in November 1997 as part of the NDS (Table 3.1). A further instalment of \$100 million was provided by the Commonwealth in March 1998 (Table 3.2).

**Table 3.1: First instalment NIDS funding, November 1997**

Amount	Target	Purpose
<b>Supply reduction</b> (\$43.8 million over 3 years)		
\$15.5 million	Australian Federal Police	Three strike teams to target drug syndicates
\$7.5 million	Australian Customs Service	Cargo profiling system and examination facilities in Sydney
\$7.3 million	Commonwealth law enforcement agencies	Communication and information technology capabilities
\$6.7 million	Commonwealth law enforcement agencies	Increase coastal surveillance, anti-detection capacity in the Torres Strait
\$3.9 million	Australian Federal Police	National Heroin Signature Program and informant handling and witness protection
\$1.5 million	Australian Transaction Reports and Analysis Centre	Suspicious transactions monitoring
\$1.5 million	Australian Customs Service	Intelligence analysis
<b>Education</b> (\$14 million over 3 years)		
\$7.4 million	Department of Employment, Education, Training and Youth Affairs	Schools drug strategy
\$4.8 million	Community grant program	Local drug prevention and education projects
\$1.8 million	National one-stop shop	Disseminate information to the general community, including parents, schools, universities, health professionals and health care facilities
<b>Rehabilitation and research</b> (\$29.8 million over 3 years)		
\$21.5 million	Non government treatment facilities	New treatment initiatives which fill target group and geographical gaps
\$3 million	Front line professionals	Training
\$4 million	National Health and Medical Research Council	Interdisciplinary research to achieve innovation in the prevention and treatment of illicit drug use
\$1.3 million	Non heroin trials approved by Ministerial Council on Drug Strategy (July 1997)	Evaluation and dissemination of best practice

The following breakdown of the broad funding areas, which form part of the Commonwealth’s “Tough on Drugs” strategy, indicates that in both the first and second instalments just slightly over half of funds will be utilised for supply reduction programs. Out of the \$187.5 million to be made available, \$44.3 million (23.6%) will be used to fund NGO rehabilitation and treatment programs and \$31.8 million (17.0%) will be made available for community awareness and education campaigns and other preventive activities.

The difficulties previously discussed in determining priorities and purpose of cost shared funding are noted. It is important, therefore, to develop a clearer understanding of the application of funds that will be available to the State through allocations from the Commonwealth through Tough on Drugs. The Select Committee is of the view that funding should be available on the basis of need, to augment existing programs and to be utilised for innovative programs.

On the information available to the Select Committee, there is a critical need for the development of a much broader range of programs targeted at managing offenders with drug related problems. There clearly needs to be a much greater investment in both institutional and community based offender management programs.

There is ample information available indicating that many of those in both adult and juvenile institutions frequently commit offences where drug abuse has played a major role. Before realistic programs can be developed for offenders in the State's prisons, it is critical that a comprehensive alcohol and drug assessment screening process be implemented. The assessment process undertaken by the New South Wales Department of Corrective Services is an example that should be adopted in this State. This issue was addressed in the Select Committee's Interim Report, in Recommendation 63.

Assessment enables the identification of prisoners who may be drug dependent at the time of their reception and thus in need of appropriate medical management. Appropriate management of drug dependent prisoners who may be withdrawing from drugs will contribute to reducing the demand for drugs to be smuggled into the prison system. A comprehensive assessment process would also identify those prisoners suitable for induction into a drug free program within the prison, as well as enabling the development of long term treatment plans for those who may require pharmacotherapeutic assistance. There are a range of pharmacotherapies that can be tailored to the individual needs of prisoners, depending on particular medical, psychiatric and psychological factors.

**Table 3.2: Second instalment NIDS funding, March 1998**

Amount	Target	Purpose
<b>Supply reduction</b> (\$51.4 million over 4 years)		
\$11.8 million	Australian Federal Police	Three additional mobile strike force teams
\$21 million	National Crime Authority	Target South East Asian organised crime
\$5.6 million	Asian/Pacific nations	Investigation of drug trafficking
\$6 million	Australian Federal Police	Liaison posts in the East Asian region
\$1 million	Asia/Pacific Group on Money Laundering	Secretariat services, including training, technical assistance, clearing house and development of appropriate legislation and law enforcement measures
\$4.4 million	Australian Customs Service	11 intelligence analysts
\$1.6 million	Australian Institute of Criminology	Participation in International Drug Abuse Monitoring Program
<b>Non government treatment services</b> (\$22.8 million)		
\$20.8 million (over 4 years)	Non government treatment agencies	Expansion of existing treatment services
\$2 million (over 3 years)	Non government treatment agencies	Identification, promotion and dissemination of treatment best practice
<b>Community education and information</b> (\$17.8 million)		
\$17.2 million (over 3 years)		Community education campaign, raising awareness about the dangers of illicit drug use and prevention treatment and rehabilitation
\$.6 million (over 1 year 2001/02)	National one stop shop	Continuation of service which disseminates information to the general community, including parents, schools, universities, health professionals and health care facilities
<b>Monitoring drug use</b> (\$3.5 million)		
\$3.5 million (over 4 years)		Illicit drugs reporting and information database to drug trends
<b>Australian National Council on Drugs</b> (\$3.5 million)		
\$3.5 million	Australian National Council on Drugs	Advise all levels of government on drug issues

## **3.6. Victorian Drug Strategy**

### **3.6.1. 1993 Strategic Plan**

The reform process in Victoria commenced in 1993 following the release of the Victorian Strategic Plan. In 1994 a number of large institutions<sup>61</sup> were closed to bring about a shift in funding of community based services, resulting in the development of drug withdrawal services, counselling and support services and specialist methadone services. The other reform was the establishment of Turning Point, as a focal point to provide leadership in clinical services, research and training.

### **3.6.2. Pennington inquiry**

In December 1995 the Victorian Premier's Drug Advisory Council (PDAC), chaired by Professor Pennington, was established to conduct a detailed public investigation into the trade and use of illicit drugs in Victoria. While the focus of this investigation was illicit drugs, the PDAC identified that

*“(t)here are risks involved with almost all drug use, and serious consequences from their misuse. The level and nature of the risk and the harm done varies with each drug and with the circumstances of use. While the problem is widespread, some groups are particularly vulnerable and require specific assistance.”<sup>62</sup>*

Investigations by the PDAC led to eight major recommendations. These recommendations encompassed a number of areas by additional sub recommendations.<sup>63</sup>

There was a major recommendation that the Government mount a sustained and integrated education program in schools that addressed both licit and illicit drugs. The inquiry also recommended that treatment intervention services be developed which targeted the problem of drug abuse by youth and to assist those with serious drug problems who come into contact with the criminal justice system.

An additional recommendation was concerned with the development of specialist treatment services, including methadone, drug withdrawal programs and to assist problem cannabis users. The inquiry recommended that there was a need to establish an organisation which would provide leadership and coordinate drug activities across all sectors. There was a major recommendation which was concerned with the need to develop local community initiatives and ensure development of statewide structures to monitor drug problems.

With respect to law enforcement issues, the Pennington inquiry recommended that the Police Service adopt harm minimisation strategies at all levels, improve level of training of police officers in relation to this issue and that there be improved coordination of the activities of the Drug Squad with other sections of the Police Service. There was also a series of recommendations concerned with reform of the Victorian *Drugs Poisons and Controlled Substances Act 1981* including removal of some offences concerned with cannabis.

### **3.6.3. Turning the Tide**

In August 1996 the Victorian government announced a comprehensive drug reform strategy for Victoria, *Turning the Tide*. This strategy was the government's response from the Department of Human Services, the Department of Justice and the Department of Education. It is to be noted the Victorian strategy involves a number of principles:

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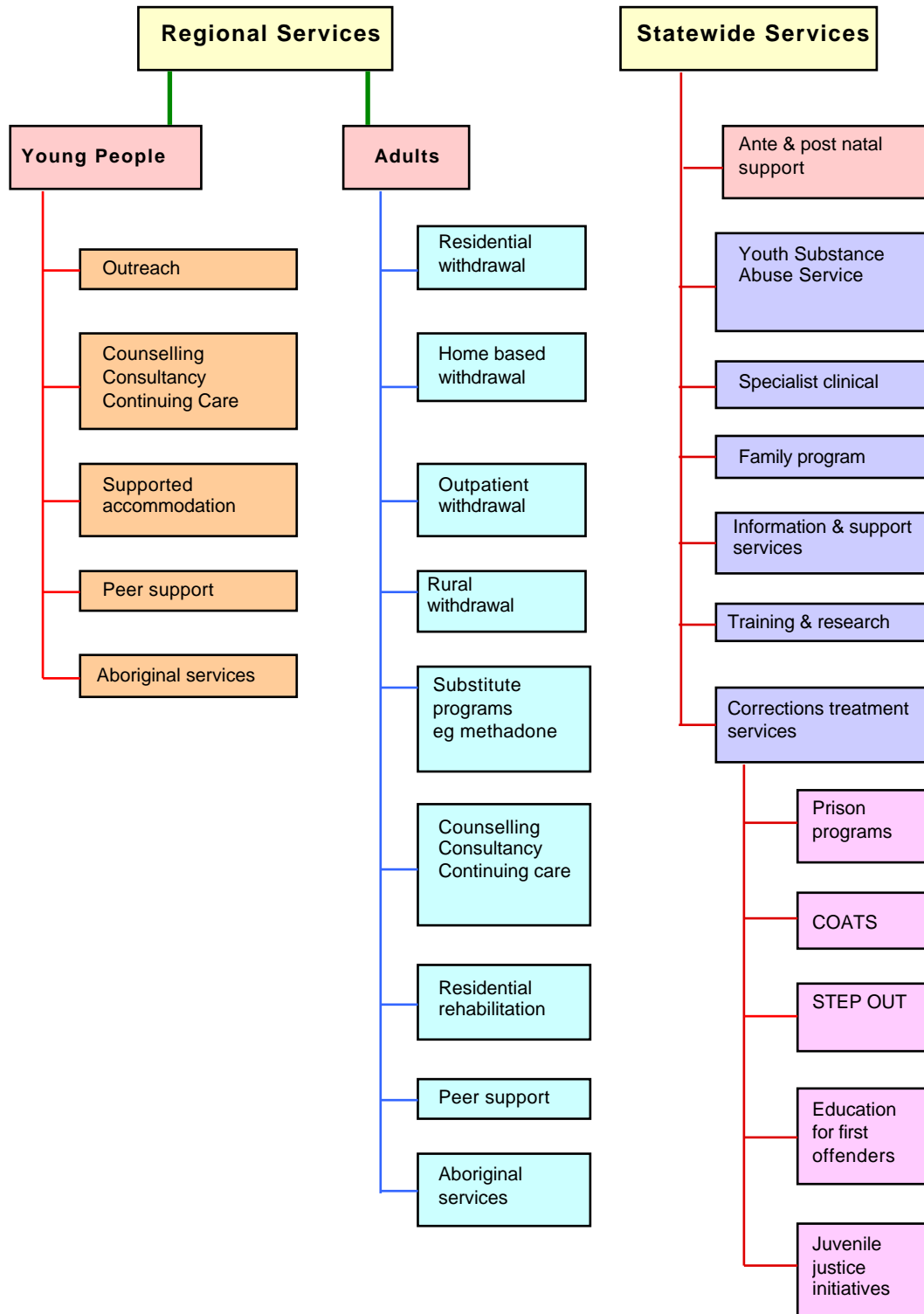
<sup>61</sup> Pleasant View Centre, Smith Street Clinic, Gresswell Rehabilitation Centre, Heatherton Hospital Alcohol and Drug Unit.

<sup>62</sup> Victoria, Premier's Drug Advisory Council. *Drugs and our community*. Melbourne, Victorian Government, 1996, 199.

<sup>63</sup> The full text of these recommendations are contained in Appendix 14.

- the implementation of a harm minimisation philosophy;
- increasing investment in preventative and demand reduction initiatives;
- maintenance of effort and refocussing of law enforcement including legislative reform;
- integrated approach including legal and illegal drugs; and
- whole of government approach.

Figure 3.6: Framework for providing alcohol and other drug services in Victoria



### **3.6.3.1. Overview**

As a result of the reforms that have occurred, alcohol and other drug services are funded on a regional basis, using a population based funding formula, which utilises a combination of population and proxy measures of need. There is an additional component which includes adjustments to account for the additional costs that are associated with providing services in rural areas. As indicated in Figure 3.6, Statewide services are funded separately.

To ensure that regions receive services in accordance with need, they are required to determine the number, type, location and mix of services required to most adequately address the needs of each specific region. This involves the development of a regional service plan, which details how available resources can be utilised to meet needs and outlines how they propose to prioritise these to provide the most cost effective services. Each regional service plan is also required to identify potential gaps in services and indicate how local infrastructures can be utilised.

The regional directors of each health region have a number of key responsibilities to ensure overall functioning of this system, as follows:

- distributing the alcohol and other drug budget equitably throughout the region;
- ensuring the planning and provision of a balanced range of services to meet local needs; and
- negotiating funding and service agreements and monitoring standards of service delivery.

The following material outlines some of the major features of the 129 new or redeveloped services are proposed under *Turning the Tide*. These initiatives, which will cost a total of \$22.6 million, involve a number of areas (Table 3.3).

**Table 3.3: Summary of number services**

	No of providers	Number of beds
Counselling	56	
Youth outreach	27	
Supported accommodation	18	(176 beds in 58 houses)
Withdrawal		
Residential	2	(24 beds)
Home-based	4	
Outpatient	5	
Rural	4	
Residential rehabilitation	4	(58 beds)
Peer support	5	
Rural specialist methadone	1	
YSAS, COATS and Stepout	3	
Withdrawal & specialist methadone	34	
Aboriginal D&A services	19	
<b>Total</b>	<b>182</b>	

#### **Community education**

There have been two major initiatives. The first was a booklet which was circulated to every Victorian household. This was supported by an intensive media campaign and telephone support services with particular attention paid to meeting the needs of the culturally and linguistically diverse community.

The second initiative involved an emphasis on youth, by employing young people to work as peer educators specifically on drug issues. This focussed campaign is supported by a series of cinema, radio and print media advertisements targeted at youth.

**School education**

All State, private and catholic schools in Victoria have been encouraged to develop an individual school drug plan. Additional curriculum resources will be provided, supported by teacher in service training. A key function of school based drug education programs will be to:

- provide parents with information;
- target those from non English speaking backgrounds (NESBs); and
- identify innovative strategies for retaining at risk young people in schools.

**Professional**

Additional funding is to be provided to train a diverse range of professionals, by resourcing university and TAFE courses, to increase their early intervention skills to assist those with alcohol and other drug problems.

**Youth programs**

Another plank of the Victorian strategy is to expand treatment and support services for young people who are involved in using drugs (Table 3.4). The Youth Substance Abuse Service (YSAS) has been funded from resources obtained through redevelopment of State’s alcohol and other drug treatment system.

The target group of the new service will be young people aged 12 to 21 whose use of licit and illicit drugs causes significant physical, psychological and social harm. YSAS will be complemented by 23 new youth alcohol and drug outreach services operating across the state, based in the following regions:

- Bendigo;
- Inner city;
- La Trobe valley;
- Northern suburbs;
- Frankston;
- Springvale/Dandenong; and
- Western suburbs.

These outreach teams will receive funds to purchase a range of services for the young people with whom they are working. YSAS will also manage an eight bed residential service. The service is managed by a consortium involving the Centre for Adolescent Health, St Vincent’s Hospital, Jesuit Social Services and Turning Point Alcohol and Drug Centre. The YSAS will also receive funding to provide specialist training for youth workers.

**Table 3.4: Summary of youth programs**

Type of service	No of services
Outreach	27
Counselling	29
Supported accommodation	13
Withdrawal (outreach and home based)	6
Rural specialist methadone	1
Peer support	4
Youth Substance Abuse Service	1
<b>Total</b>	<b>81</b>

**Community treatment**

A total of 58 new services will be established and integrated into the process of redeveloping alcohol and drug services that has been occurring in Victoria. The new services will include counselling, consultancy and continuing care, supported accommodation, residential, homebased and outpatient withdrawal, residential rehabilitation peer support and youth outreach. The funds

for treatment services are distributed through a formula designed to ensure equitable access across the state.

**Law enforcement**

Additional resources are to be provided under Turning the Tide to provide additional training to Victorian Police to enhance their ability to deal with drugs in a harm minimisation framework.

Police have also undertaken initiatives to reform their approach to overdose events and to pilot a formal warning system for people found to possess small amounts of marijuana. Additional resources have been provided to Victorian Police for the enhancement of data gathering and analysis.

**Local initiatives grants**

The Victorian Government will make available small grants to local organisations to develop community responses. A total of up to \$750,000 per year is to be made available for making these grants.

**Alternative pharmacotherapies**

Turning the Tide includes additional funding of \$3 million to fund research into treatment options involving a range of legal drugs which substitute for heroin and which provide a safe and controlled environment for the user.

**Cannabis and psychosis**

A total of \$795,000 is to be provided for projects to examine the linkage between cannabis use and the experience of psychosis. The funded projects involve the development of information for the community and people working in the field on this issue. The majority of the funds will be invested in three specific research projects dealing with causality and intervention options. The Government will also host an international conference in 1999 to further develop our understanding of this issue.

**Drugs and driving**

Turning the Tide includes support for strategies to reduce the number of road users who use drugs other than alcohol. This part of the package will include legislative changes and research into detection strategies.

## **3.6.4. Offenders**

**Introduction**

Turning the Tide has supported an expansion of programs to reduce the harm associated with drug use caused to offenders, their families and the community, as a result of drug related crime. A total of \$15.7 million has been allocated over three years to fund a range of forensic community treatment initiatives to assist offenders with community based orders by providing targeted treatment options.

These expanded programs attempt to tackle the drug problem from a health perspective and recognise the importance of making public drug treatment services available to community based offenders, rather than further marginalising these clients.

**Community offenders advice and treatment service**

COATS is an independent service which assesses offenders referred by the courts and then purchases necessary services on their behalf. A budget of \$15 million is provided for a new service, which commenced in November 1997. COATS is the largest of these forensic community treatment initiatives and is provided by the Victorian Offenders Support Agency Inc (VOSA).

Referrals will be made from the courts to COATS to undertake assessments and provide an alcohol and drug treatment plan. COATS will purchase any necessary treatment from community based

alcohol and drug treatment agencies for parolees and offenders who receive community based dispositions or the new combined custody and treatment order (CCTO).

In exceptional cases, COATS can undertake pre sentence assessments for the Court, particularly where the Court is considering a CCTO.

***Intensive post prison release drug treatment service***

Stepout is designed to provide structured support to people leaving prisons after relatively short stays. This support is based upon a detailed assessment undertaken while people are in prison and builds on the treatment they receive while in prison.

Stepout was established in October 1997 and is managed by Moreland Hall. The service provides in prison assessment and, where appropriate, intensive counselling and case management to people on release from prison who are high risk or for whom a further period of counselling and support will consolidate the outcomes of treatment received in prison.

***Drug education of first offenders***

This service commenced on 1 April 1998 and will provide drug education sessions for first offenders in possession of a small quantity of illicit drugs (other than cannabis) who receive a bond with an undertaking to attend such education. This service is managed by Moreland Hall.

In addition, the Department of Justice (CORE) funds a range of prison drug services, including drug awareness, drug education, relapse prevention, drug treatment, intensive drug treatment and consultancy, support and liaison.

***Juvenile justice initiatives***

Outdoor education, personal development, counselling and peer education will be established through Turning the Tide, targeted at young people involved in the juvenile justice system.

***Drug detection, deterrence and treatment services***

Prisons both privately provided and in the public sector have expanded their investment in detecting drugs in prisons and have substantially increased the range and availability of treatment services for prisoners. The budget for this initiative is \$5.2 million.

## **3.6.5. Turning Point**

### **3.6.5.1. Introduction**

Turning Point Alcohol & Drug Centre Inc is a non government organisation which receives funds from the Victorian Government's Department of Human Services and from other sources. The budget for Turning Point is as follows. In the 1995/96 fiscal year it was \$3,910,000, in the 1996/97 fiscal year it was \$4,798,000,<sup>64</sup> in 1997/98<sup>65</sup> it was \$4.25 million and in 1998/99 it is expected to be about \$4.5 million.<sup>66</sup>

Turning Point provides a comprehensive and integrated range of research, training and clinical services within one agency and plays a key role to support specialist and generalist health and welfare sectors in Victoria. The model adopted by Turning Point enables the achievement of a number of objectives and is designed to advance alcohol and drug service delivery, knowledge and expertise by the integration of the following three broad areas:

- research services;
- education and training; and
- clinical services and a 24 hour telephone service.

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<sup>64</sup> Turning Point Alcohol & Drug Centre Inc. *Annual Report 1996/97*.

<sup>65</sup> In 1997/98 the State grant was \$3.25 million with an additional \$1.0 million of income from other sources of income, eg Commonwealth research grants, tenders etc.

<sup>66</sup> In 1998/99 the State grant is \$3.0 million, with up to additional \$1.5 million from other sources.

### **3.6.5.2. Research services**

Research services provide high quality research, a statewide supporting body for alcohol and drug research, policy advice and consultation on service system development and analysis and program evaluation services.

Through the integration of research, clinical services and training within one organisation, Turning Point aims to improve intervention technology, quality of care and the cost effectiveness of alcohol and drug services. This combination of services provides an opportunity for the development of a range of innovative research and evaluation projects.

The major research initiatives at Turning Point are in the areas of clinical research, population based research, evaluation research and service development activities.

#### ***Clinical research***

Turning Point's clinical services provide a focus for research that is of relevance to current treatment practices, exploration of new treatment technologies and development of standards of best practice.

A clinical research program currently being conducted at Turning Point is the new pharmacotherapies project. This project is a randomised clinical trial of alternatives to methadone for the treatment of people who are heroin dependent. The feasibility research has developed four main research areas: a LAAM trial, a buprenorphine maintenance trial, a naltrexone treatment outcome study and a buprenorphine heroin withdrawal trial.

Another area of clinical research is a treatment program for dependent cannabis users. This project will investigate the efficacy of two different treatment models for assisting dependent cannabis users to achieve a self defined goal, either abstinence or non dependent use, through significantly reduced consumption.

#### ***Population based research***

This research investigates patterns of alcohol and drug consumption and related harm in the community. The collection and analysis of these data is imperative for the development of needs based planning methodologies and will underpin service system developments.

A major project involves developing indicators of alcohol consumption and related harm at a regional and local level. This involves establishing data sets which include alcohol sales data, population surveys of drinking behaviour, hospital admissions, deaths and road accident data. The collection and analysis of these data will inform policy makers in planning services to deal more effectively with alcohol related health and social problems.

Population based research will be conducted at both a statewide and local community level. For example, Turning Point, in collaboration with the Melbourne Metropolitan Ambulance Service, is establishing a system in which heroin overdoses are recorded. The data will be analysed in order to examine the nature and extent of heroin overdoses across the Melbourne area. The aim is to establish an ongoing system of data collection and analysis which will be of use to relevant agencies.

#### ***Evaluation services***

The evaluation of the feasibility and appropriateness of alcohol and drug services is a primary focus of Turning Point's research activities. Turning Point has also developed methodologies for evaluating a variety of alcohol and drug services. Current evaluation research involves:

- an evaluation of four models of drug withdrawal: community residential withdrawal; outpatient withdrawal, home based withdrawal and rural withdrawal support services;
- evaluation of a community based approach – the Yarra drug and health forum – for dealing with alcohol and drug issues at a local community level; and

- working with local community groups to develop, implement and evaluate local alcohol and drug initiatives.

**Service system development**

Turning Point plays a major role in informing the public of the development of a range of alcohol and drug services in Victoria.

**3.6.5.3. Education and training**

Education and training services seek to improve skills in the detection and management of alcohol and other drug related problems. This is achieved by providing high quality training and support services to a range of health and welfare professionals in Victoria. There are a number of current training initiatives being undertaken by Turning Point.

**Secondary interventions for general health and welfare workers**

This is designed to meet the needs of all health and community service providers, this training provides practitioners with the requisite knowledge and skills to identify and effectively deal with early stage alcohol and drug problems. Core competencies include:

- screening, assessment and referral;
- alcohol and drug interventions/service provision; and
- care coordination and support.

**Specialist alcohol and drug services training**

Through the services support package, Turning Point has made a commitment to new alcohol and drug services across the state of Victoria. Features of the package include:

- service design advice;
- staff orientation programs;
- practice enhancement and dissemination of best practice models; and
- organisational development.

**General practitioner projects**

Turning Point is involved in a number of initiatives aimed at strengthening alcohol and drug competencies among primary health care workers (in particular, general practitioners). Collaborative projects with the Divisions of General Practice, utilising an integrated clinical service and training delivery system, are actively pursued.

**Methadone initiatives**

Turning Point, in collaboration with the Victorian Medical Postgraduate Foundation Inc, provides a methadone program for general practice prescribers, and has developed a proposal for the accreditation of methadone prescribers, which includes training requirements.

Turning Point has also been involved in the recent development of national learning objectives for methadone prescribers.

**3.6.5.4. Clinical services**

Turning Point provides a number of clinical services, as follows:

- direct clinical services to individuals with alcohol and drug problems;
- consultancy services to primary health and welfare, hospital, alcohol and drug workers in Victoria;
- expertise for the development and provision of training services to health and welfare workers;
- an environment for identification of key issues in clinical practice that require further research; and

- research and development of appropriate therapeutic interventions.

**Telephone services**

There are two telephone services which are operated by Turning Point:

- a 24 hour telephone service for the general community providing assessment, counselling, referral and information services; and
- the Drug and Alcohol Clinical Advisory Service, a statewide 24 hour telephone service to provide advice to professionals on the clinical management of alcohol and other drug issues.

**Consultancy services**

Turning Point provides assistance and support to metropolitan and rural health practitioners in the management of individuals with alcohol and drug problems.

**Specialist methadone service**

This service is designed to care for opioid dependent individuals with complex treatment needs that cannot be readily treated as a patient in the community methadone program under the care of a GP.

**Withdrawal services**

This service can be provided directly to clients or in conjunction with a health care provider to undertake a managed outpatient withdrawal or a home based detoxification.

## Chapter 4: Treatment services

### 4.1. Introduction

This chapter provides information about usage of the Central Drug Unit (CDU) and admissions to all programs operated by the Alcohol & Drug Authority (ADA). This information is complemented by details of programs targeted at adults provided by the major NGOs in the metropolitan area: Cyrenian House, Holyoake and Palmerston. There is also discussion of each of the Community Drug Services Teams (CDSTs) which were established at the beginning of 1998 following the devolution of the ADA's regional and community based services. Information about programs operated by the Perth City Mission and Holyoake which are targeted at young people are discussed in chapter 8.

### 4.2. ADA residential detoxification program

#### 4.2.1. Introduction

As noted in chapter 2, there have been a number of changes in the location and operation of the ADA's residential detoxification program. Following the amalgamation of the detoxification programs for licit and illicit drug abusers in June 1991, all detoxification services have been provided at the Central Drug Unit (CDU) in East Perth. The following data suggests this change appeared to have an initial impact on utilisation of this program, as there was a drop in admissions, followed by a relatively static number of admissions until the end of 1994. More recently, there has been an increase in admissions to the CDU. The data in relation to utilisation of the CDU is contained in Tables 14 and 15 (Appendix 13) and in Figures 4.1 to Figure 4.4 within this chapter.

#### 4.2.2. Type of admissions

Over the period of available data, from the June quarter 1988 until the beginning of 1991, the number of *all admissions* to both ADA residential detoxification programs fluctuated between about 160 and 200 admissions per quarter. The number of *all admissions* peaked in the March quarter 1991, when a total of 221 admissions were recorded. There was a drop of 50% in the number of admissions, when a total of 111 admissions were recorded in the June quarter 1991.

The drop in mid 1991 coincides with the amalgamation of the two separate programs at the CDU in East Perth. Over the next three and a half year period, to the end of 1994, the number of admissions to the CDU fluctuated between about 120 and 145 admissions per quarter. There was an increase of 75% in the admissions to the CDU over the 12 month period from the December quarter 1994 (141 admissions) to the December quarter 1995 (226 admissions).

After a drop in admissions, to 169 in the September quarter 1996, there was a period of moderate increase in quarterly admissions to the CDU, reaching 203 admissions in the March quarter 1998. At the June quarter 1998, there had been a small decrease in the number of admissions to the CDU, with 173 admissions recorded for that quarter.

It is to be noted that throughout the period of available data, from the June quarter 1988 to the June quarter 1998, there have been a greater number of admissions of males than females (Figure 4.1). About twice as many males as females were admitted per quarter over the past five years, whereas prior to the amalgamation of programs there was a somewhat higher proportion of males. It is possible that some of the population of alcohol dependent males who formerly had sought inpatient treatment at the ADA have in more recent years attended other organisations, such as programs conducted by the Salvation Army, which focus exclusively on assisting those with alcohol related problems.

Over the first part of the period of available data on the ADA's residential detoxification programs (from the June quarter 1988) there was a greater number of new admissions than readmissions per quarter (Figure 4.2). However, since mid 1991 (when the services were amalgamated) there has been a convergence in the number of new admissions and readmissions per quarter. It is to be noted since the June quarter 1996, when there were a greater number of readmission compared to new admission (118 vs 77), similar numbers of admissions for both groups were recorded (Table 14, Appendix 13).

The growing proportion of readmitted clients being admitted to the ADA residential program may indicate there has been a change in the characteristics of the treatment population, such as being younger and having shorter and less serious dependencies.

### 4.2.3. Gender

Over the 10 year period<sup>67</sup> from the June quarter 1988 to the June quarter 1998 there were a total of 6,926 admissions to the ADA's residential detoxification program, of which 3,980 (57.5%) were new and 2,946 (42.5%) were readmissions.

Of the 6,926 *all admissions*, 4,690 (67.7%) were males and 2,239 (32.3%) were females. Of the 3,980 *new admissions*, 2,658 (66.8%) were males and 1,322 (33.2%) were females. Of the 2,946 *readmissions*, 2,032 (69.0%) were males and 914 (31.0%) were females (Table 14, Appendix 13).

### 4.2.4. Age

Over the period from the June quarter 1988 to mid 1994, the average age of all males admitted to the ADA's residential detoxification program fluctuated between about 35 and 40 years of age. The average age of females was slightly lower, fluctuating between the low 30s and about 40 years of age. More recently both the male and female treatment population has become younger, such that since mid 1997 new male and female admissions had dropped to average age of about 30 years (Figure 4.3; Table 15, Appendix 13).

A breakdown of admissions to the ADA residential detoxification program by age group and principal drug problem indicates that the oldest age group involves those who are alcohol dependent, with about two thirds of admissions in the 30 to 49 age group. In the amphetamine and the illicit opioids group, a majority of users come from the 20 to 29 age group (Table 16, Appendix 13). It is to be noted that the benzodiazepines and licit opioid group typically involve those in the 30 to 39 age group.

### 4.2.5. Type of drug problem

#### **Annual trends**

Over the period 1989 to 1993, there was an average of nearly 95 *illicit opioid* related admissions per year. However, more recently there has been an increase of nearly 300%, from 104 admissions in 1994 to 300 admissions in 1997, for the number of admissions per year with a principal problem due to illicit opioids (Table 16, Appendix 13).

The number of *licit opioid* related admissions has followed a similar pattern as has occurred with illicit opioids with a growing number of admissions over recent years. Since 1995 there has been an average of 85 licit opioid related admissions per year (Table 16, Appendix 13).

The number of admissions related to *amphetamines* increased from 48 in 1988 to 71 in 1990, an increase of nearly 50%. From 1991 to 1995 the number of admissions were relatively stable, with about 50 admissions per year. In 1996 and 1997 the number of amphetamine related admissions declined with only 13 such admissions in 1997 (Table 16, Appendix 13).

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<sup>67</sup> The data collection is available from the June quarter 1988 to the December quarter 1997.

There were very few *cannabis* related admissions to the ADA residential detoxification program up to 1994. However, since 1995 there has been an average of just over 15 admissions per year. There were a greater number of *benzodiazepine* related admissions to ADA residential detoxification programs up to the mid 1990s. In 1996 and 1997 there has been on average of just over 30 benzodiazepine related admissions (Table 16, Appendix 13).

### **Quarterly trends**

A more detailed overview of trends in admissions per quarter covering the period from the June quarter 1988 to the June quarter 1998 for the four major groups of drugs (illicit opioids, amphetamines, benzodiazepines and licit opioids) is presented in Table 22 (Appendix 13) and in Figure 4.4.

The apparent close relationship between an increase in the number of licit and illicit opioid related admissions per quarter that has occurred from the March quarter 1995 requires further investigation. The growth in recent years in prescribing of licit opioids throughout Australia has recently been documented.<sup>68</sup> Some of these individuals may have in the first instance become dependent on heroin and subsequently required detoxification as they had become dependent on licit opioids either obtained directly on prescription or through the black market.

It can be seen that for period up to the September quarter 1993, the number of benzodiazepine related admissions exceeded the number of licit opioid related admissions per quarter. In the March quarter 1994, there were 10 prescribed opioid related admissions. By the March quarter 1998, these had more than doubled to 23 admissions. In relation to amphetamines and illicit opioids, the greatest number of quarterly amphetamine related admissions occurred over the 5 year period from the June quarter 1990 to the June quarter 1995.

There was a greater number of illicit opioid related admissions in the earlier part of the period, from the September quarter 1988 to the March quarter 1991, compared to admissions over the period from mid 1991 to mid 1994. However, there has been a marked growth in illicit opioid related quarterly admissions since the end of 1994, increasing from 24 in the December quarter 1994 to a peak of 91 in the September quarter 1997. In the last 3 quarters of available data, from the December 1997 quarter to the June 1998 quarter, there have been between about 65 to 70 admissions per quarter.

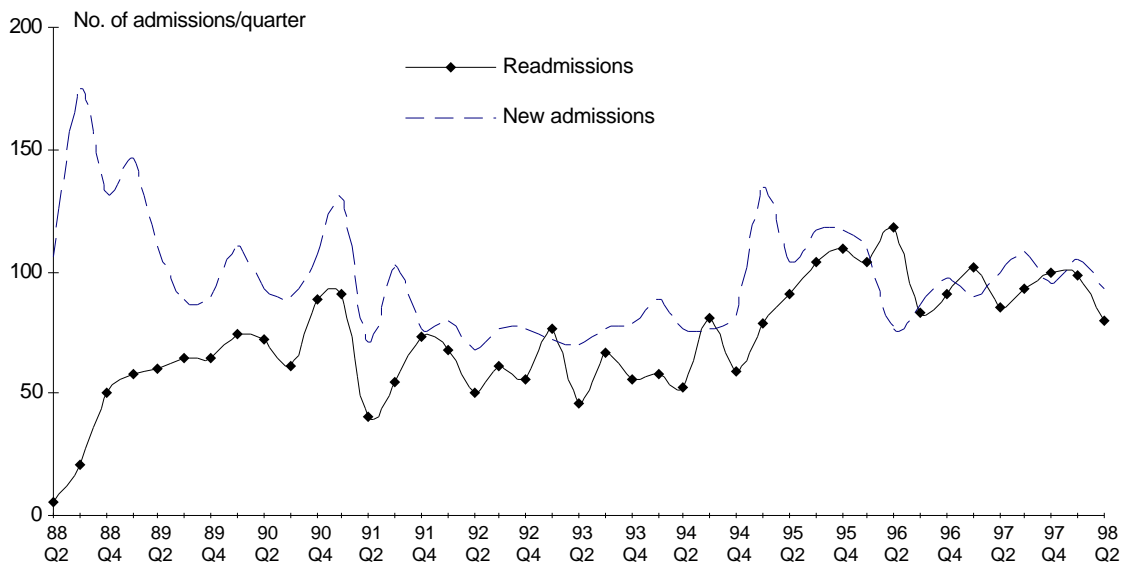
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<sup>68</sup> Bell JR. "Australian trends in opioid prescribing for chronic non-cancer pain, 1986-1996." (1997) 167 *Medical Journal of Australia* 26.

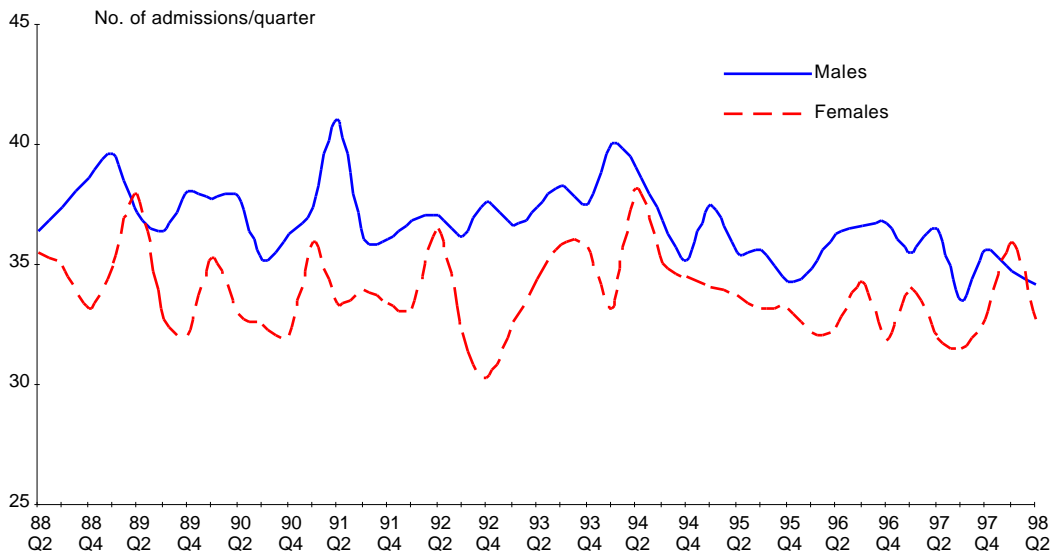
**Figure 4.1: All admissions to ADA residential detoxification programs by quarter and sex, 1988 - 1998**



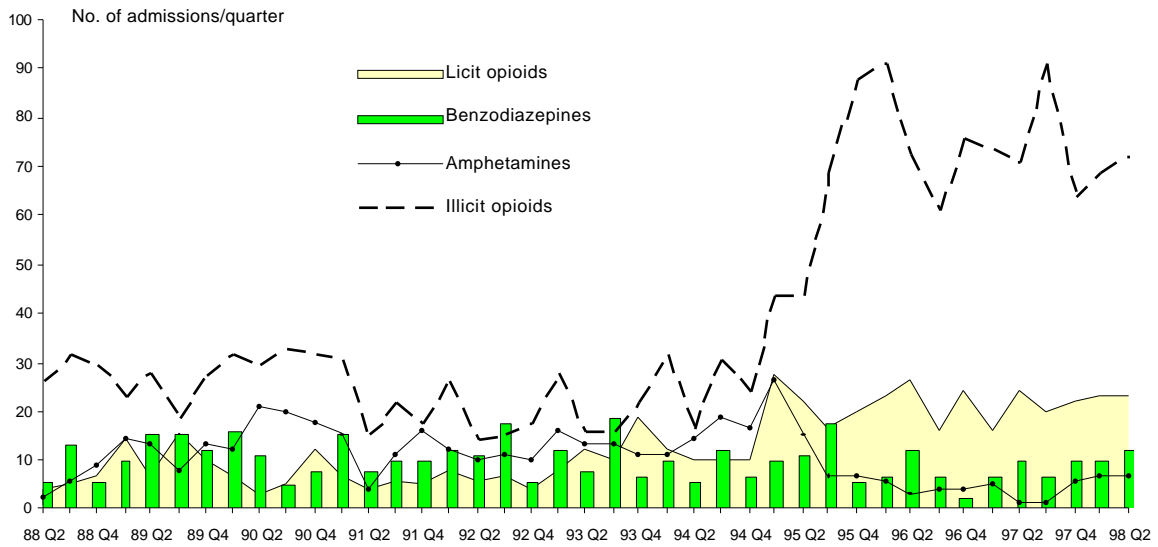
**Figure 4.2: All admissions to ADA residential detoxification programs by quarter and admission status, 1988 - 1998**



**Figure 4.3: Average age of all admissions to ADA residential detoxification programs by quarter and sex, 1988 - 1998**



**Figure 4.4: Admissions to ADA residential detoxification programs by quarter and principal drug problem, 1988 - 1998**



## **4.3. All ADA programs**

### **4.3.1. Type of admissions**

Over the period 1988 to 1997 a total of 14,789 persons were admitted to all ADA treatment programs,<sup>69</sup> of whom 10,302 (69.6%) were males and 4,487 (30.4%) were females.

Overall problems due to alcohol and illicit opioids were the two most frequent problems, responsible for 45.5% and 21.0% of all admissions respectively. The third most frequent group involved amphetamines, with a total of 1,399 (9.4%) of all admissions (Table 4.1).

### **4.3.2. Gender**

There has been a marked shift in the characteristics of the treatment population admitted over the 10 year period. With respect to males, from the 1988 to 1996 there was a greater number of admissions for treatment for alcohol related problems compared to illicit opioids. For the first time in 1997 the number of males seeking treatment for problems due to illicit opioids exceeded those with a principal drug problem that involved alcohol (Table 4.2).

A similar pattern has also evolved over the 10 year period in relation to females. Since 1996 the annual number of females seeking treatment per year for problems due to illicit opioids has exceeded the number of female alcohol related admissions (Table 4.3).

### **4.3.3. Type of drug problem**

The annual number of illicit opioid admissions has increased sharply in recent years, more than trebling from 200 admissions in 1994 to 673 admissions in 1997 (Figure 4.5; Table 17, Appendix 13). The growth in the number of illicit opioid related admissions is partly explained by increased numbers of people being admitted to the ADA's methadone program.<sup>70</sup>

It is noted that the most frequent admissions for the 20 to 29 age group involve those seeking treatment for problems due to illicit opioids. However, in 1997 there was a growth in the number of admissions for the less than 20 age group, indicating that a younger population may be presenting for treatment (Table 17, Appendix 13).

Amphetamine related admissions were clustered over the period 1993 to 1995, with a peak of 320 admission in 1994 (Figure 4.5; Table 17, Appendix 13). The greater number of amphetamine related admissions to all ADA programs may reflect a preference of amphetamine abusers to engage in outpatient programs.

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<sup>69</sup> This refers to first time admissions to the Central Drug Unit, the methadone program and outpatient programs at Carrellis Centre.

<sup>70</sup> The issue of managing opioid dependence is dealt with in Chapter 6.

**Table 4.1: New annual admissions to all ADA programs by principal drug problem, persons, 1988 - 1997**

	Alcohol	Illicit opioids	Prescribed opioids	Barbiturates	Benzo-diazepines	Amphetamines	Cocaine	Cannabis	Other drugs	na	Total
1988	556	247	26	6	45	17	-	25	28	308	1,261
1989	710	169	14	-	41	39	-	38	23	174	1,208
1990	650	148	16	-	37	70	1	23	20	208	1,173
1991	619	163	26	1	49	150	1	70	28	221	1,328
1992	665	158	17	-	30	186	1	122	34	197	1,410
1993	669	210	33	-	22	215	1	76	10	307	1,543
1994	706	200	48	-	30	320	2	115	17	111	1,549
1995	917	498	135	-	61	216	1	127	31	5	1,991
1996	721	639	120	-	42	90	1	148	16	16	1,783
1997	519	673	77	-	28	96	-	123	27	-	1,543
<b>Total</b>	<b>6,732</b>	<b>3,105</b>	<b>512</b>	<b>7</b>	<b>385</b>	<b>1,399</b>	<b>11</b>	<b>867</b>	<b>234</b>	<b>1,537</b>	<b>14,789</b>

Note: na = not available.

**Table 4.2: New annual admissions to all ADA programs by principal drug problem, males, 1988 - 1997**

	Alcohol	Illicit opioids	Prescribed opioids	Barbiturates	Benzo-diazepines	Amphetamines	Cocaine	Cannabis	Other drugs	na	Total
1988	447	165	17	2	12	13	1	17	14	234	922
1989	553	100	8	-	10	25	-	24	7	111	838
1990	528	90	12	-	17	48	1	22	8	136	861
1991	480	102	16	1	24	99	1	59	7	123	912
1992	522	96	10	-	12	134	1	99	24	120	1,018
1993	513	143	16	-	6	149	-	59	7	206	1,099
1994	528	125	34	-	12	226	2	95	12	65	1,099
1995	663	325	64	-	25	136	1	90	20	1	1,325
1996	533	395	64	-	19	63	1	115	7	5	1,202
1997	392	411	42	-	14	66	-	90	11	-	1,026
<b>Total</b>	<b>5,159</b>	<b>1,952</b>	<b>283</b>	<b>3</b>	<b>151</b>	<b>959</b>	<b>8</b>	<b>669</b>	<b>117</b>	<b>1,001</b>	<b>10,302</b>

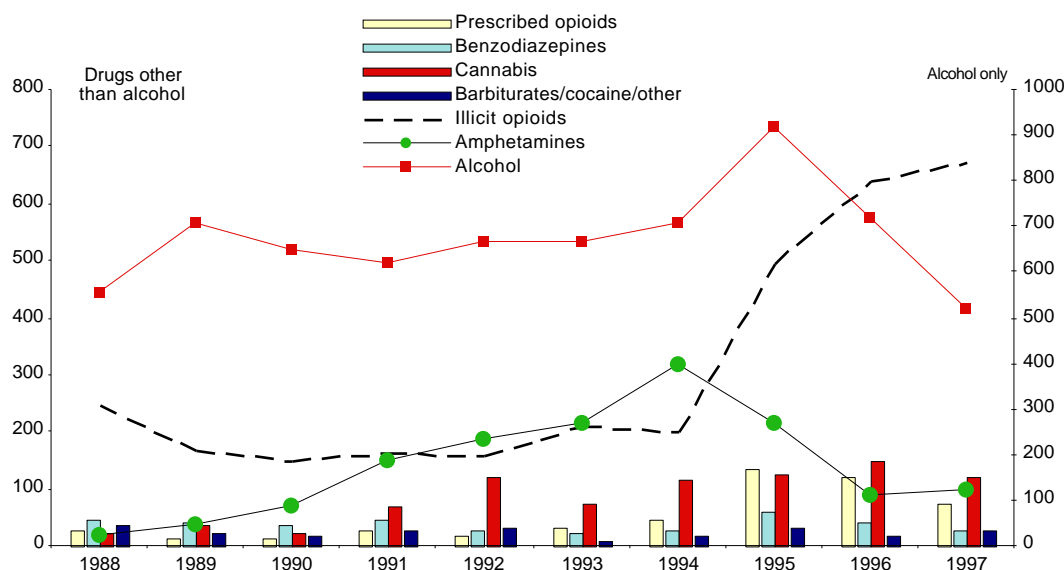
Note: na = not available.

**Table 4.3: New annual admissions to all ADA programs by principal drug problem, females, 1988 - 1997**

	Alcohol	Illicit opioids	Prescribed opioids	Barbiturates	Benzo-diazepines	Amphetamines	Cocaine	Cannabis	Other drugs	na	Total
1988	109	82	9	4	33	4	2	8	14	74	339
1989	157	69	6	-	31	14	-	14	16	63	370
1990	122	58	4	-	20	22	-	2	12	72	312
1991	139	61	10	-	25	51	-	11	21	98	416
1992	143	62	7	-	18	52	-	23	10	77	392
1993	156	67	17	-	16	66	1	17	3	101	444
1994	178	75	14	-	18	94	-	20	5	46	450
1995	254	173	71	-	36	80	-	37	11	4	666
1996	188	244	56	-	23	27	-	33	9	1	581
1997	127	262	35	-	14	30	-	33	16	-	517
<b>Total</b>	<b>1,573</b>	<b>1,153</b>	<b>229</b>	<b>4</b>	<b>234</b>	<b>440</b>	<b>3</b>	<b>198</b>	<b>117</b>	<b>536</b>	<b>4,487</b>

Note: na = not available.

Figure 4.5: New annual admissions to all ADA programs by principal drug problem, 1988 - 1997



## 4.4. Non government organisations

### 4.4.1. Cyrenian House

#### 4.4.1.1. Introduction

Cyrenian House was established in 1981 by Ric Hamersley following the death by overdose of his daughter Julie. In the early days of the Cyrenian House program, abstinence was emphasised. While this is regarded as the preferred outcome of treatment, Cyrenian House has adapted the principles of harm reduction (see objectives below).

It is a general rule of thumb from the accumulated experience of the agency that about one third of drug users get better, a third stay the same and a third get worse. It is considered that overall about half the people who seek treatment get some sort of benefit.

#### 4.4.1.2. Philosophy

As addiction is considered to be a complex problem involving physical, mental and spiritual components, recovery needs to be addressed in a social context. Cyrenian House believes that for those who have experienced sustained dysfunctional drug use, abstinence is the desired goal. However, in the recovery continuum, positive benefits can still be achieved regardless of whether a person attains the goal of abstinence.

The agency draws on a wide range of approaches including 12 step recovery models, family systems theory, cognitive behavioural therapy and social learning theory.

#### 4.4.1.3. Objectives

Cyrenian House embraces a number of principles across its programs. These are to:

- minimise harm caused by drug and alcohol misuse by promoting goals of abstinence, reduction in use, safer using practices and safer sexual practices;

- increase clients' understanding and awareness of the process of addictive and dependent behaviours;
- foster the growth of positive living skills, increase self esteem and widen choice;
- improve communication and relating skills;
- contribute to an improvement in client's health; and
- refer clients to appropriate community based support.

### 4.4.1.4. Funding

The major sources of funding for Cyrenian's programs are from government (50%), through fundraising (approximately 30%) and from fees for services (approximately 20%). For the 1996/97 fiscal year, the total operating cost of all Cyrenian House programs was \$704,376.

### 4.4.1.5. Programs

#### ***Therapeutic community (residential)***

Cyrenian House Residential Program is a therapeutic community for people voluntarily seeking to change their drug/alcohol using patterns. It is located in a semi rural setting in the outer northern suburbs of the Perth metropolitan area. The restoration of physical, mental and spiritual well being is pursued in a balanced program which includes individual counselling, educational and therapeutic groups, social and recreational activities, good nutrition and attendance at 12 step meetings.

The community offers a number of staged modules. The initial eight week 'safety net' phase has been designed to offer a viable treatment option for those persons assessed as not wanting or needing a more intensive program. A 'transition' phase begins after completing six weeks of the safety net program during which clients assess whether they want, or are ready, to continue further with the program. The longer term 'treatment' phase will provide an opportunity to explore identified issues in greater depth and develop strategies for dealing with them on an ongoing basis.

The environment of the therapeutic community provides a safe haven for experimenting with new lifestyles choices and provides support for re entry into the community and setting realistic goals for the future.

#### ***Outpatient program***

The outpatient program is based at 349 Newcastle Street, Northbridge and aims to provide short and intermediate term counselling to people suffering from effects of licit and illicit alcohol and other drug use. The program provides:

- assistance to reduce the abuse of alcohol and other drugs by preventative and early intervention education, information, counselling and supervised withdrawal; and
- a referral and information resource for other health personnel and/or agencies.

Voluntary clients who are experiencing difficulties relating to either past or present addictive behaviours can access this program.

#### ***Conditional program***

The conditional program is based at 349 Newcastle Street, Northbridge and aims to provide an effective educational and therapeutic intervention for individuals obligated to seek treatment. This program is typically of 8 to 12 weeks in duration. The conditional program is an outpatient program. It is designed for people who are motivated to undertake treatment as a result of contact with courts, employees, Ministry of Justice and others.

The program encourages clients to examine their attitudes and behaviour in relation to their drug/alcohol use, with a view to adopting strategies to change their drug/alcohol using behaviour by providing:

- individual counselling;
- group work;
- supervised urinalysis;
- reports written if required with adequate notice; and
- attendance at NA/AA where appropriate.

### **Pre release addiction program**

The outpatient program has been funded on a trial basis by the WADASO. It is based at 349 Newcastle Street, Northbridge and aims to engage clients prior to release from prison and continue treatment after release as condition of parole. If a prisoner becomes involved in the program, this is perceived to maximise his or her chance of early release, as they have agreed to enter into a treatment program.

This program is of 8 weeks in duration following release. The pre release program provides:

- individual counselling;
- group work;
- supervised urinalysis; and
- reports written if required with adequate notice.

### **Family treatment program**

This program is based at 349 Newcastle Street, Northbridge and is a fee for service program. The object of the program is to offer family counselling to couples and families experiencing difficulty with a using member.

In the past, Cyrenian House was able to offer a creche which had a full time staff complement as part of this program. However, a creche is now only offered on a part time basis due to Commonwealth Government cut backs. The program offers:

- information;
- counselling;
- support groups; and
- referral.

## **4.4.2. Holyoake**

### **4.4.2.1. Introduction**

Holyoake was established in the mid 1970s and is the largest NGO in WA providing non residential services to people who are affected by the use of alcohol and other drugs. A total of about 2,500 clients per year receive assistance. It has a primary focus on providing an array of outpatient programs which address a wide spectrum of drug related issues affecting families and young people.

Over a number of years, Holyoake extended its services to populations living outside the Perth metropolitan area by opening regional offices in Port Hedland, Kalgoorlie, Geraldton, Bridgetown and Mandurah. About 100 clients per year were seen at these regional programs. However, by the end of 1997, Holyoake had relinquished all operations except for the Mandurah program, following the devolution of regional services from the ADA and the establishment of CDSTs.

Holyoake was the successful tenderer for the North East Metropolitan CDST. Holyoake receives some government funding from HDWA and had recently participated in the pre parole program (OPERA), a joint initiative with a number of NGOs and Ministry of Justice (MOJ). Overall, about 80% of clients are self referred, with the remaining 20% referred from courts.

Holyoake's specialisation in non residential programs means it is attractive to client groups with established social supports and more likely to be employed. This is reflected in that 60% of clients still have jobs and are in relationships. There have been an increasing number of referrals from the Ministry of Justice. However, it was pointed out to the Select Committee frequently that these clients are not on drug charges, but have charges due to property and other crime that is used to generate an income to sustain a dependency.

The organisation has a staff of 8 FTEs (professional staff) in Perth, and depends on a volunteer staff of approximately 80 to deliver its programs. There is a full time staff training officer who provides training and development for all salaried and volunteer staff.

### 4.4.2.2. Philosophy

The philosophy of Holyoake's programs are to contribute to the well being of the community as a whole by minimising the problems associated with the use of alcohol and other drugs. This represents a shift in philosophy, as Holyoake originally started with an abstinence emphasis, based on the 12 step disease model. This meant that the organisation tended to narrowly focus on people with alcohol problems.

But with the shift to harm reduction as the major philosophy, a broader range of clients receive services to enable them to make choices in their lives in relation to drugs. Alcohol continues to be the primary drug problem most often mentioned by clients presenting at Holyoake, but other drugs also play a significant role depending on the age, gender and economic circumstances of the group of users. Many more people now present as polydrug users.

It was emphasised that with adolescents it is very difficult to promote abstinence as an immediate goal. Accordingly, harm reduction is a good starting point to initially engage young people, as this is often converted into wanting to become abstinent. As young people typically have multiple needs (for example accommodation issues, crisis management, legal and health problems) this supports an approach that places drug problems in a wider context of life issues.

### 4.4.2.3. Funding

For the 1996/97 fiscal year, the total operating cost of all Holyoake programs was \$1.1 million.

### 4.4.2.4. Outpatient treatment and support services

Holyoake's outpatient programs are targeted at a number of broad groups:

- adults with alcohol and other drug related problems;
- juvenile offenders; and
- parents concerned about drug use by their children.

Information about Holyoake programs which are targeted at young people and their families are dealt with in detail in chapter 8.

#### **Adult abstinence programs**

Men and women participating in these programs, in common with other programs, will initially be assessed and then streamed to individual counselling and gender specific programs designed to address the problems associated with a person's use of alcohol and other drugs. There are two programs that are available.

#### **a) Women's program**

Many women who present with alcohol and other drug related problems report past sexual or physical abuse and many have experienced or are currently living in violent relationships. Apart from issues of sexual abuse and domestic violence (DV), other issues that frequently occur include eating and panic disorders, health issues and parenting difficulties. Women with children also report difficulties associated with access to and custody of their children. It is important when

responding to these multiple problems to provide support and be able to make referrals to other professionals and community organisations to adequately deal with specific issues.

**b) Men's program**

Men presenting with alcohol and other drug problems frequently have difficulties related to emotional issues, especially the inappropriate use of anger and difficulties in relationships. An issue of concern is that successful suicides occur in a small number of these clients. It is recognised that as there is a close association between the use of alcohol and other drugs, child abuse and DV, it is important to refer clients to other community organisations able to address these collateral problems.

**Adult harm reduction programs**

The object of these programs is to minimise the harm associated with an individual's drug use by assisting the individual to make informed choices about the use of drugs, by providing information, life skills and support. There are two programs that are available.

**a) Choices program**

Whilst there are many adults who have some issues about their use of alcohol or other drugs, individuals may not identify themselves as having a problematic pattern of use, nor that their drug use warrants abstinence. Examples of people in these situations are those who have been convicted of drink driving offences, or have been excluded from the workplace because they were apparently intoxicated or affected by drugs. The choices program is of 6 weeks duration and focuses on education and awareness of self within the context of appropriate behaviours and self responsibility. This option is also utilised by clients who participate in the prison to parole program.

**b) Prison to parole program**

The prison to parole program (PPP) is targeted at those who are preparing for their release from prison and wish to develop skills, attitudes and resources to better deal with their use of drugs. Clients for the PPP are engaged whilst still in custody and undertake counselling prior to their release. A large number of clients from the PPP will participate in the choices program following their release on parole as part of the process of rehabilitation.

**Family programs**

The purpose of these programs are to assist significant others better deal with the negative consequences they are experiencing as a consequence of another family member's use of alcohol and other drugs.

**a) Focus program**

The focus program (FP) is open to spouses or partners and others who are close to someone with problematic use of alcohol and other drugs. Participants may learn how to better cope with the harmful consequences of another's use of drugs, or to seek support following the breakdown in a relationship. As about nine out of ten of participants in the FP are women, DV is commonly reported as is the need to protect children from abuse by a violent partner or spouse. It is noted that a small number of participants will report the use of alcohol at harmful or hazardous levels. As depression and anxiety is also a common problem, the use of minor tranquillisers and anti depressants can be a problem that requires addressing.

**b) Childhood in perspective program**

This program is targeted at adults who had grown up in a household where a parent had a problematic use of alcohol and/or other drugs. The goal of the program is to assist clients to understand how their family of origin has affected the way they currently feel and behave. Multiple levels of problems may be addressed in this program, such as self management, the individual's use of drugs, and problems in their current role as a parent.

### c) *Young people's program*

Holyoake offers options for young people and their families in relation to four broad areas, which are discussed in greater detail in chapter 8:

- young people's program;
- adolescent program;
- parent talk program; and
- parent drug awareness program.

#### 4.4.2.5. Residential program

At present the organisation's only non metropolitan activity is managing a residential program in Mandurah.<sup>71</sup> This is an 11 bed residential facility that provides a short or long term alcohol free environment for sober adult men who had previously been dependent upon alcohol and is based on the 12 step AA model.

The program also serves an ongoing link with ex residents and with those in the community with alcohol related problems. It is to be noted that residents have often experienced significant losses as a result of their use of alcohol. For these people, the program provides important support and a structured therapeutic environment. A significant number of the residents have physical disabilities which require treatment, or may also experience health problems from their use of alcohol.

#### 4.4.2.6. Statistical overview

The scope of Holyoake's community based and outpatient activities are substantial. For instance, in the 1996/97 fiscal year:

- services were provided to a total of 4,089 clients;
- 296 volunteers were involved in training; and
- 2,167 people attended community and professional education sessions.

In relation to the residential program at Mandurah, in 1996/97 a total of 33 individuals accessed the program, with an average duration of stay of 70 days. For the 1996/97 fiscal year there was a total of 2,699 beddays, with an occupancy rate of 65%.

There are some interesting characteristics of the client group who participate in Holyoake's outpatient program. It can be seen that male clients outnumber females across all age groups. Males are distributed in two broad age groups, the 20 to 24 age group and the 45 to 49 age group. The greatest number of females are from the 20 to 29 age group (Table 4.4; Figure 4.6). Overall the client group who participate in the organisation's outpatient program tend to come from the 20 – 39 age range.

In order to maximise its client focus, in the latter part of 1996 Holyoake undertook a one week sample of 200 clients. As a result of this survey, a number of areas were identified, including:

- ensuring topics are relevant to target groups attending specific programs;
- maintaining the use of groups as the major focus for rehabilitation of clients;
- utilising individual counselling to maintain support for clients in the early stages of attending a group;
- encouraging continuity of counsellor; and
- administration of a consumer survey every 6 months.

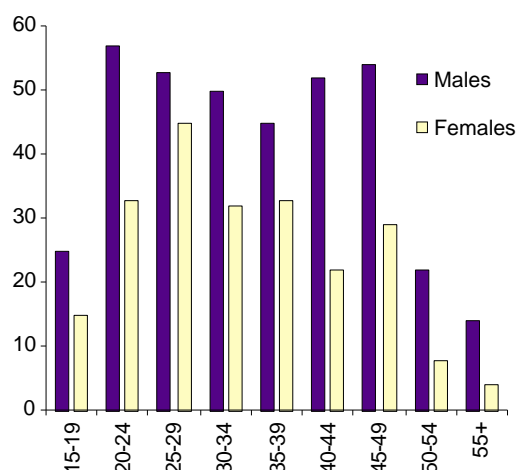
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<sup>71</sup> Alcoholics Recovery and Rehabilitation Foundation of Mandurah Inc

**Table 4.4: Number of clients attending Holyoake outpatient counselling program, 1996/97**

	Males	Females	Persons
15-19	25	15	40
20-24	57	33	90
25-29	53	45	98
30-34	50	32	82
35-39	45	33	78
40-44	52	22	74
45-49	54	29	83
50-54	22	8	30
55+	14	4	18
<b>Total</b>	<b>372</b>	<b>221</b>	<b>593</b>

**Figure 4.6: Age distribution of clients attending Holyoake outpatient counselling program, 1996/97**



#### 4.4.2.7. Issues

At times the agency has had difficulties in getting people admitted to the CDU. It has on occasions resorted to seeking admission to Royal Perth Hospital - this issue arises most often with clients with a dual diagnosis.

It was also pointed out to the Select Committee that it is particularly difficult for young people in regional areas to get admitted to detoxification programs. Another perceived gap in services concerns the lack of facilities for young people who are currently using drugs and require supportive accommodation.

The concept of a sobering up facility was suggested to the committee as the most appropriate model for assisting young people who require temporary care in a safe environment because they are intoxicated. This approach works very well with assisting those affected by alcohol. In the past, such individuals were usually apprehended by the police and kept in a lock up until sober, or dealt with by a court for a minor offence committed while they were intoxicated.

A sobering up shelter targeted specifically at young people would have a number of advantages. These would include providing an option for police to take intoxicated young people to a place

where they could be monitored, assessed and provided with other assistance, if required. Another advantage is that it would assist in correcting a misperception that the specialist alcohol and other drug programs only provide detoxification oriented treatment services.

On the visit by the Select Committee to Holyoake, a number of the professional staff expressed the view that in some instances it would be helpful if there was greater flexibility for young people to be more readily admitted to methadone treatment. A particular issue was that the current criteria of a minimum age of 18 years was too rigid as there had been a number of instances when the agency had contact with a number of young people who had serious heroin dependencies.

These young people, who were in the 16 to 18 age range, were engaged in a range of criminal and high risk behaviours and had a number of failed previous admissions to residential detoxification programs. In these instances the most appropriate short term priority was to stabilise the young person, as a precursor to them being able to develop a drug free life style in the longer term.

### 4.4.3. Palmerston

#### 4.4.3.1. Introduction

Palmerston was established in 1980 as a rehabilitation service for illicit drug users. Up to 1997, the organisation had provided a variety of services from the organisation's administrative base, Palmerston Centre in Northbridge (which specialised in non residential programs) and Palmerston Farm (a longer stay residential drug free therapeutic community (DFTC)). In early 1998 Palmerston expanded its services, following successful tenders for two contracts for Community Drug Service Teams (CDSTs). The expansion of Palmerston's treatment services through the CDSTs will be discussed in the section dealing with CDSTs later in this chapter.

#### 4.4.3.2. Funding

For the 1996/97 fiscal year, the total operating cost of all Palmerston programs was \$763,628.

#### 4.4.3.3. Palmerston Centre

Palmerston Centre provides the following programs:

- an adult program targeted at people 25 years or older who want to change their drug use behaviour;
- as a participating organisation in the Court Diversion Service, which is targeted at people directed by the courts for assessment and counselling;
- a youth program for young people aged 14 to 24 who are experimenting with, or encountering difficulties with, drug use; and
- a parents and friends program for people who are experiencing difficulties because of someone else's drug use.

Participation in programs conducted at Palmerston Centre in Northbridge is summarised in Table 4.5. The organisation has experienced an increase in the number of persons participating in one to one counselling, with about two thirds of attendees being aged less than 27 years of age.

#### 4.4.3.4. Palmerston Farm

Palmerston Farm is a therapeutic rehabilitation community located at Wellard (in the southern metropolitan area) and is targeted at people aged 16 years or older who require medium term treatment and rehabilitation in a secure drug free environment. The farm accepts couples and parents with children.

A commercial market garden and an orchard are attached to the farm, which produces small quantities of organically grown vegetables and fruit for the commercial market. Farm based programs include:

- active participating in day to day activities on the farm;
- farm work;
- individual counselling;
- group therapy;
- wilderness expeditions; and
- art and craft work.

The primary goal of the program is to foster a natural desire for personal growth, self knowledge and self responsibility that will enable residents to make the changes to remain drug free, and face the challenges of effective everyday living.

The length of stay is determined by individual circumstances. The recommended length of stay is a minimum of 3 months. However, the duration of the program for young people is six weeks. Initial assessment is through Palmerston Centre, Palmerston Farm or the CDU. As residents must be drug free, initial detoxification at the CDU may be required prior to admission to the farm program.

Over the 1996 to 1997 period, the number of residents increased nearly four fold, from 56 in the January to June 1996 period to 122 in the July to December 1997 period (Table 4.6).

Palmerston Farm has a high rate of occupancy and though funded for 10 beds, provides up to 15 beds. There is a waiting list of about eight weeks. The estimated total cost of running the two major Palmerston programs is about \$500,000 per annum. Three quarters of funding for Palmerston is provided by the WADASO, the rest is obtained by independent fund raising activities, fee for service and donations.

Statistical data on discharges from the program, set out in Table 4.7, indicates that residents participate in the program on average for about 12 weeks. It can be seen that illicit opioid abusers are the most frequent client group who participate in the farm's rehabilitation program. For instance, in the July to December 1997 period 13 (72.2%) of the 18 residents had a primary illicit opioid drug problem.

**Table 4.5: Activity indicators, Palmerston Centre, 1996 - 1997**

	1996		1997	
	Jan-June	July-Dec	Jan-June	July-Dec
<b>Counselling (one-to-one)</b>				
Number of contacts	1,683	1,729	1,981	2,088
Number of attendees				
Age 25+	94	108	125	78
Age <25	148	185	209	228
Parents	21	22	26	46
Total attendees	263	295	360	352
<b>Groups</b>				
External				
Number of groups	26	52	36	61
Number of attendees	728	2,828	671	2,267
Internal				
Number of groups	38	52	52	60
Number of attendees	641	729	717	531
<b>Community education</b>				
Number of sessions	78	104	88	na
Mean attendees per session	18	34	12	na
Number of attendees				
Significant others	632	575	757	na
Drug users/people with drug use problems	27	18	20	na
Schools	131	2,795	317	na
Professional groups	394	54	47	na
Prisons	57	80	115	na
Other	128	25	-	na
Total number of attendees	1,369	3,547	1,256	na

**Table 4.6: Activity indicators, Palmerston Farm, 1996 - 1997**

	1996		1997	
	Jan-June	July-Dec	Jan-June	July-Dec
<b>Admissions</b>				
Inpatient				
Number of assessments	59	58	54	31
Number of admissions	23	30	25	13
Number of beddays	1,550	1,336	1,823	2,020
Average occupancy rate	100%	75%	100%	100%
Outpatient				
Number of outpatients and significant others	56	108	102	122
<b>Income</b>				
Resident's rents	\$28,263	\$29,934	\$38,834	\$43,202
Farm produce	\$13,507	\$9,821	\$18,328	\$20,556
Sub total income	\$41,770	\$39,755	\$57,162	\$63,758
<b>Expenditure</b>				
Farm and facility maintenance	\$12,359	\$10,893	\$16,443	\$22,298
Household/residents	\$32,663	\$31,014	\$37,538	\$39,205
Sub total expenditure	\$45,022	\$41,907	\$53,981	\$61,503
Mean cost per resident per month (excluding staff costs)	\$642	\$696	\$664	\$594

**Table 4.7: Number of discharges from Palmerston Farm, 1996 - 1997**

	1996		1997	
	Jan-June	July-Dec	Jan-June	July-Dec
<b>Number of discharges</b>				
Male	11	14	10	12
Female	11	7	12	6
All discharges	22	21	22	18
<b>Age</b>				
21+	15	16	17	15
<21	7	5	5	3
Mean age	25	26	27	28
Mean length of stay (weeks)	13	10	8	14
<b>Principal drug of abuse</b>				
Opioids	10	7	15	13
Stimulants	5	4	1	-
Alcohol		4	3	2
Polydrug		3	3	2
Cannabis	2	3	-	1
<b>Reason for discharge</b>				
Completed program	9	10	4	9
Self discharge	3	3	8	6
Disciplinary discharge	10	8	10	3

#### 4.4.3.5. Organisational overview

##### **Source of referral**

About half of all admission to Palmerston programs are self referred, with the remainder of clients being referred through Ministry of Justice programs (such as the CDS or individuals on community based orders). About two thirds of clients who attend are new referrals and one third are readmissions.

##### **Staff**

The organisation has a total of 18 employed staff (equivalent to 16 FTEs), with a variety of experience and qualifications. Palmerston also provides evening services at Palmerston Centre, using volunteers who have been trained through Curtin University's training program.

In the earlier part of its operation, Palmerston favoured the employment of non professional staff (eg recovered drug abusers with prior experience with drug problems). Over recent years, the organisation has employed a greater proportion of professional staff, such as psychologists, social workers, Gestalt trained therapists and people with homoeopathic experience.

The overall approach is to work cooperatively with clients to reduce or give up their use of illicit drugs, based on the premise that the most successful therapeutic success is built on engagement by mutual goal setting. The long term goal is to encourage clients to become abstinent.

##### **Primary drug problem**

In the 1996/97 fiscal year, the primary drug problem of attendances to all programs involved four groups of drugs:

- heroin (55%);
- cannabis (20%);
- amphetamines (14%); and
- alcohol (11%).

### **Patterns in drug use**

Over the past 12 months, there has been a shift to a greater proportion of clients with a primary heroin problem. This is a shift from the previous year, when the majority of drug problems were amphetamine related. Evidence was provided that cocaine use is prevalent among specific sub populations in Perth, such as individuals from higher socio economic backgrounds involved in night entertainment.

Very few solvent abusers are seen at Palmerston. There is some evidence that Rohypnol, a Schedule 4 drug, is abused by the Vietnamese young people. This particular drug is reputed to “cause” shoplifting because it produces disinhibition.

### **Demographics**

It was noted the majority of clients were described as being white middle class population and that the organisation has low representation of ethnic groups in its treatment population.

The typical age profile is:

- 15 to 24 year olds (80%)
- 25 to 34 year olds (15%)
- 35 to 44 year olds (5% usually parents)

## **4.4.4. Parent bereavement support program**

### **4.4.4.1. Program aims**

The aims of this program include the following, to:

- provide a weekly group which is a ‘safe’ place for parents to begin to identify their needs and then to move towards developing ways of managing their grief issues;
- establish a peer support network for parents;
- provide individual grief counselling sessions; and
- provide counselling sessions for couples.

It is to be noted that the counselling component of this program is very important due to the stresses that the loss of a child places on a family and relationships between the parents and other family members. It is estimated that over 70% of relationships break up after the death of a child. Long term monitoring of the couples taking part in the program would be useful in order to determine whether this rate of relationship breakup can be significantly reduced.

### **4.4.4.2. Inclusion criteria**

Criteria for inclusion in the group are:

- Must be a parent or partner of a parent.
- The death must have occurred more than eight weeks previously.
- The death must be drug related. (Note: Any death where the deceased was intoxicated and this contributed to the death would qualify: the group is not limited exclusively to deaths as a result of overdose).

### **4.4.4.3. Structure**

The group meets for 2<sup>1</sup>/<sub>2</sub> hours every week over a 12 week period. It is facilitated by two counsellors, one of whom is a social worker and the other a psychologist.

The first program was purposely arranged to run over the Christmas and New Year period, as parents felt that usual support mechanisms and networks would not be available to them at this time.

At the beginning of the program, none of the deaths had been more than eight months previous. During the first cycle, one parent marked the anniversary of her child's death.

The program offers ongoing support to participants. It provides information about the processes of grief and grief management techniques are identified. Participants are encouraged to feed back their experiences with these techniques.

### **4.4.4.4. Statistics**

As this was a pilot group, it was not advertised. Participants were recruited from bereaved parents known to Palmerston.

#### ***Bereavement group***

- Number of people contacted – 12
- Number completing pre group questionnaires – 9
- Number who commenced program – 9
- Number who will complete program – 8

The one person who withdrew from the group did so after week 6, and requested it be noted that she found the group very valuable. Her withdrawal was due to other life events unrelated to her offspring's death.

#### ***Individual counselling***

- People accessing individual counselling appointments – 6
- People who have had regular/ongoing counselling – 4

The average attendance has been 7 participants, with those who have been absent having been away on holiday at the time.

## **4.4.5. Custodial services adult program**

### **4.4.5.1. Program design**

The prison to parole program has been based on a ten week timetable consisting of up to four individual counselling sessions prior to release and a six week post release program. The objective of the program has been to support individuals in their choice to remain drug free.

The selection criteria for the program include:

- having an ongoing problem with drug use prior to incarceration;
- being eligible for parole within three months;
- a willingness to engage in treatment four weeks prior to release and six weeks post release;
- providing three urine samples per week post release; and
- a commitment to remaining drug free (including alcohol) for the duration of the program.

The pre release counselling sessions aim to assist the client to:

- identify the risks associated with release from prison, drug use and criminal activities;
- plan their release; and
- make positive decisions about lifestyle, particularly in relation to selection of 'friends', appropriate accommodation, recreation and possible employment.

The six week post release program provides the client with:

- support in the form of individual sessions;
- encouragement to achieve goals previously set in prison;

- support in dealing with problems arising since release; and
- requires the client to provide samples for urinalysis three times per week.

#### 4.4.5.2. Referral process

An individual may be referred to the program through any one of the formal prison channels (including SURU) or by self referral. Self referrals are obtained in the form of completed registration of interest forms, which are available to inmates at all prisons. Statistical data on source of referral indicates that the majority of persons accepted to the program are from Canning Vale prison (Table 4.8).

**Table 4.8: Participation in Palmerston pre release program, 1997**

	Referrals							
	Accepted		Not assessed		Not suitable		Counselling	
	Jan-Jun 97	Jul-Dec 97	Jan-Jun 97	Jul-Dec 97	Jan-Jun 97	Jul-Dec 97	Jan-Jun 97	Jul-Dec 97
Canning Vale	15	15	-	2	2	2	20	17
Casuarina	1	8	-	1	1	-	-	7
Wooroloo	8	2	-	-	-	-	3	2
Karnet	1	1	-	1	1	-	-	-
Bandyup*	-	3	-	-	-	-	-	1
Pardelup*	-	1	-	-	-	-	-	1
<b>Total</b>	<b>25</b>	<b>30</b>	<b>-</b>	<b>4</b>	<b>4</b>	<b>2</b>	<b>23</b>	<b>28</b>

\* Bandyup and Pardelup are new inclusions.

In relation to these statistics it is noted that due to the uncertainty of release dates, there is invariably a higher proportion of clients participating in the program while in prison. The statistical summary does not include acknowledgments. These are letters sent to clients who have more than three months still to serve before their earliest release date, to advise them that Palmerston will contact them again within two months of that date.

In addition to the activities included in the table above, the second information group for prisoners, run in conjunction with the intensive SURU course, was held in October. The total number of participants was 18.

**Table 4.9: Participation in Palmerston post release program, 1997**

	No. of clients		Sessions attended <sup>72</sup>		Average no. of sessions		Completed program	
	Jan-Jun 97	Jul-Dec 97	Jan-Jun 97	Jul-Dec 97	Jan-Jun 97	Jul-Dec 97	Jan-Jun 97	Jul-Dec 97
Canning Vale	6	8	15	22	-	2.75	2 (33%)	2 (25%)
Wooroloo	4	1	13	3	-	3	2 (50%)	0 (0%)
Bandyup	-	3	-	-	-	-	-	-
<b>Total</b>	<b>10</b>	<b>12</b>	<b>28</b>	<b>25</b>	<b>-</b>	<b>2.8</b>	<b>4 (40%)</b>	<b>2 (16%)</b>

An overview of participation in the post release program in 1997 is contained in Table 4.9. It has been observed that channels of communication between the prison to parole program and the Ministry have become compromised in the latter half of 1997. This problem arises as the number of clients presenting with the prison to parole program as a condition of their parole is unavailable. It is difficult to interpret outcomes, as a condition of parole is an influential factor in post release attendance in participating in the prison to parole program.

<sup>72</sup> Sessions attended does not include attendance to provide urine samples.

### **4.4.5.3. Problems**

Difficulties have occurred in this program as clients are engaged on the program before release, but are often released without the agency being informed. Another difficulty is due to a lapse in time between a client's release and the allocation of a community corrections officer.

To date the pre release component of the prison to parole program has comprised up to four sessions. In the past, recommendations have been made to change the pre release component of the program from four sessions to two, acknowledging that clients are accessing other means of support and therefore may not require such intensive pre release support from the prison to parole program.

However, it has been found that by restructuring the four sessions – offering one of extensive information delivery and consultation, one of intensive assessment (should the client indicate that careful contemplation has taken place), and two sessions involving reality checking, planning of release, short and long term goal setting and urinalysis information and appointment booking – the benefits in the number of clients adhering to and completing the program may increase. Invariably, this finding has been supported in the latter half of this reporting period by increased post release attendance.

### **4.4.5.4. Comorbidity**

Palmerston has contact with a small number of drug abusers who have underlying psychiatric problems. The organisation has found it difficult to obtain appropriate treatment for such individuals. An example is the difficulty in obtaining after hours referrals to the Psychiatric Emergency Team (PET) and lack of ongoing case management by mental health services.

A helpful service in this regard is Ruah, an accommodation and social support service provided by Marillac Centre<sup>73</sup> for individuals with psychiatric problems. There is a tendency for a significant number of these drug abusers who have concurrent drug related problems.

## **4.5. Community Drug Service Teams**

### **4.5.1. Overview**

The new organisational arrangements for the CDSTs implemented in early 1998 have resulted in the establishment of six regional and four metropolitan CDSTs.

#### **Regional**

- South West CDST, awarded to Centacare, main office in Bunbury with smaller offices in Bridgetown and Busselton;
- Great Southern CDST, awarded to Palmerston Association Inc, main office based in Albany;
- Goldfields CDST, awarded to Centrecare, main office based in Kalgoorlie;
- COMPARI CDST, awarded to Geraldton Health Service and COMPARI Inc, main office in Geraldton with a smaller office in Carnarvon;
- Kimberley CDST, awarded to North West Mental Health Service, main office in Broome with smaller offices in Kununurra and Derby; and
- Pilbara CDST, awarded to East Pilbara Health Service, main office in Port Hedland, with smaller offices in Tom Price, Newman and Karratha.

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<sup>73</sup> Previously known as Daughters of Charity.

**Metropolitan**

- South Metro CDST, awarded to Palmerston Association Inc, main office based in Fremantle;
- South East Metro CDST, awarded to Perth City Mission, main office in Maddington with a smaller office in Armadale;
- North Metro CDST, awarded to St John of God Community Services, main office in Joondalup with a smaller office in Wembley; and
- North East Metro CDST, awarded to Holyoake Institute, based in Midland.

It is to be noted that CDST contracts are for a 3 year period, consisting of a 1 year contract with an option to extend for two further 12 month periods.

## **4.5.2. Function of CDSTs**

CDSTs have both a treatment and prevention focus to:

- provide general alcohol and drug counselling services;
- support to other health and welfare providers to manage alcohol and other drug problems among their clients (through shared case management, consultation and education activities); and
- support to the local community to prevent alcohol and other drug problems.

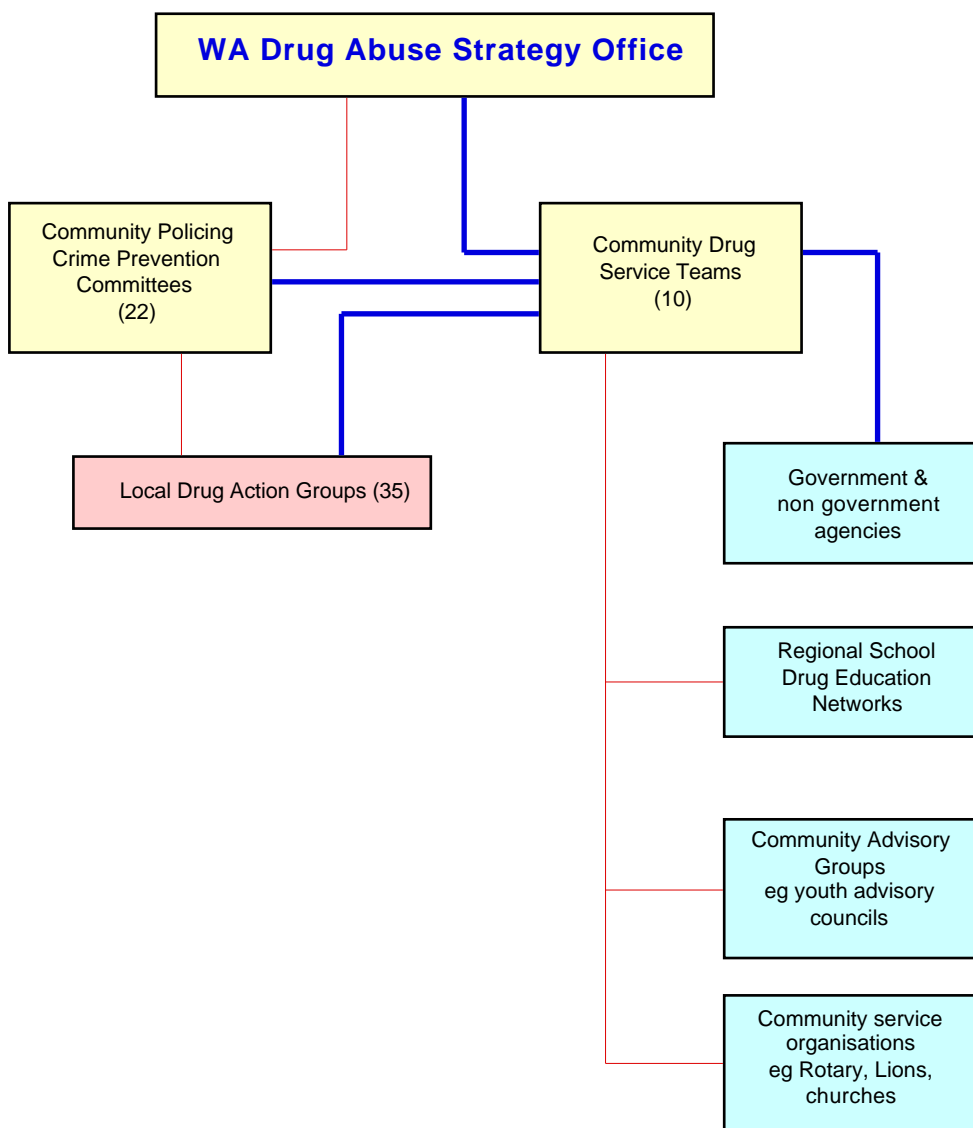
In implementing these services, the CDSTs will particularly emphasise:

- early intervention and family support;
- support for schools dealing with drug abuse incidents;
- outreach counselling for youth;
- attention to specific local problems (such as solvent abuse);
- support for LDAGs; and
- support for regional coordination.

An overview of the regional linkages between CDSTs and service providers, government and non government organisations, local drug action groups and other community based organisations is set out in Figure 4.7.

The development of closer linkages between GPs, pharmacists, professional workers and service providers is designed to maximise community involvement in addressing alcohol and other drug problems at a local and regional level. This approach is regarded as facilitating early intervention for those directly affected by the abuse of alcohol and other drugs and to engage a wider spectrum of groups to undertake a more preventive role with such problems.

Figure 4.7: Linkages between WADASO, CDSTs, regional advisory groups and other organisations



### 4.5.3. ADA regional arrangement

Prior to the devolution of the ADA’s community based services at the end of 1997, it had operated regional offices throughout the State for a number of years. Originally there were seven regional offices located in Albany, Bunbury, Derby, Geraldton, Kalgoorlie, Karratha and Port Hedland. However, more recently only six regional offices provided services after the closure of the Karratha regional office in early 1996.

There were, in addition, two metropolitan offices. The North Metropolitan Team was based in Mount Lawley and the South Metropolitan Team was based in Fremantle, with a total of 10.1 and 10.56 FTEs respectively. There was a mix of professional positions provided in both ADA regional metropolitan offices, as indicated below.

**ADA North Metropolitan office (pre CDST)**

Manager	0.25
Coordinator	1.0
Social Workers (1.0 in ADIS)	4.0
Clinical nurses	2.5
Senior social worker	1.0
Counsellor (in CDU)	1.0
Clinical psychologist	0.45
<b>Total FTEs</b>	<b>10.10</b>

**ADA South Metropolitan office (pre CDST)**

Manager	0.25
Coordinator	1.0
Medical officer	0.8
Social Workers	4.0
Clinical Nurses	2.0
Client services officer	1.0
Clinical Psychologist	0.25
Cleaner	0.16
Courier	0.16
<b>Total FTEs</b>	<b>10.56</b>

Following the establishment of the Community Drug Service Teams (CDSTs) in early 1998, the ADA has continued with community based services at Fremantle.<sup>74</sup> The services provided at the Fremantle Clinic have been refocussed on the following areas:

- specialist methadone assessment of complex and difficult clients;
- management and follow up of methadone clients from William Street Clinic;
- consultation and support to GP prescribers in the southern metropolitan area;
- a home and outpatient withdrawal services;
- assessment and management of complex clients (eg those with dual diagnosis);
- general consultancy and support to health service providers; and
- clinical placement.

As of July 1998 (following the transfer of two FTEs to the Central Drug Unit) the staff establishment at the Fremantle clinic was 5.1 FTEs, as indicated below.

**Fremantle Clinic (post CDST)**

Medical officer (2 part time MOs)	1.0
Social worker	1.0
Clinical nurses (level 2) (1 part time)	1.5
Clinical Psychologist	0.5
Client services officer	1.0
Contract cleaner	0.1
<b>Total FTEs</b>	<b>5.1</b>

As a result of a recent review of the services being provided by the authority, the clinic now functions as an evidence based practice unit which is part of the ADA's Directorate of Policy and Research. The clinic provides three core services.

<sup>74</sup> The ADA continues to provide metropolitan specialist treatment programs at the Central Drug Unit and William Street Clinic.

### **Specialist outpatient methadone services**

This service supports the operation of the community based methadone program and the eight GP methadone prescribers in the Fremantle region. Currently the clinic provides methadone treatment to around 70 patients and accepts (on referral from local GP methadone prescribers) patients with complex clinical needs requiring specialised care.

### **Specialist outpatient alcohol and drug services**

The clinic provides support to the South Metro CDST, local general practitioners and psychiatric services in the south metropolitan region. The clinic also accept referrals for those patients who are assessed by regional health and alcohol and other drug services as requiring specialist management and care.

### **Demonstration projects**

Demonstration projects will be undertaken by the clinic. These will play a major role in developing new and evidence based clinical programs for the whole State, undertaking an important leadership role for the whole alcohol and other drug field. This role will be utilised to complement the work of NGOs.

A number of new pharmacological approaches to treatment, including naltrexone, buprenorphine and LAAM, will be piloted at this clinic. The clinic is also developing a number of programs, including an Antabuse program for people who are HCV positive and on methadone treatment, a cannabis dependency clinic and a parents program.

Experience gained from these demonstration projects will enable the ADA to develop guidelines for clinical practice and will support its wider role related to professional education and the development of practice standards from experience as a provider of alcohol and other drug clinical practice.

## **4.5.4. Concerns about CDST model**

The Select Committee received evidence from a number of witnesses on its visit to both Geraldton and Kalgoorlie, outlining concerns about the short term consequences for non metropolitan based services following the devolution of the ADA. Specific comments about issues pertinent to each region are dealt with later in this chapter, with the examination of specific regional arrangements.

### **4.5.4.1. Transitional arrangements**

In a number of areas, there were delays in setting up the new services following the awarding of the contracts for the CDSTs in late 1997. Overlaps had occurred to enable successful tenderers to establish an office, advertise, interview, select and appoint staff and subsequently train staff to an appropriate level of skills in the alcohol and other drugs field. In some instances, this necessitated continued funding of existing ADA regional staff to provide continuity in service until new CDSTs had become fully operational.

### **4.5.4.2. Administrative costs**

It needs to be emphasised that there are significant costs in establishing new community services, such as a CDST, in remote areas. For instance, there may be a limited stock of office space available for commercial tenure and the costs of operating telephone and other support services can be substantially higher.

It is noted that a number of the tenders in some regional areas were awarded to established health provider organisations. These organisations included the Geraldton Health Service (COMPARI CDST), the Kimberley Northwest Mental Health Service (Kimberley CDST) and the East Pilbara Health Services (Pilbara CDST).

There are a number of advantages in such organisations operating a CDST, including having an established management and administrative infrastructure. An outcome of such arrangements is the CDST has available additional resources for other purposes, such as to pay higher salaries (as in the case of the COMPARI CDST).

### 4.5.4.3. Linkages with established organisations

It was noted that for those CDSTs which had to employ staff who had not previously worked in a particular region, there would need to be a longer period of time to establish close working relationships and linkages with established community organisations and health providers. It is suggested that in a number of instances, the departure of the former ADA regional staff who had worked for a long period of time within particular communities, represented a serious loss of expertise and understanding of local drug problems.

With regard to illicit drugs, this could be a particular problem. For example, in the Goldfields, the use of such drugs tends to occur in particular occupational and age groups. This could mean that alcohol and other drug workers in a recently established CDST would not be able to access such groups.

### 4.5.4.4. Perceptions by local communities

It is the view of some members of the Select Committee that because of affiliations of community service organisations which operate CDSTs with church sponsored welfare programs, this may support a perception in particular communities that a CDST will prefer to provide services for middle class client groups. If this perception does operate, this would mean that some client groups with alcohol and other drug problems will not obtain an appropriate level of service.

On its visit to Kalgoorlie, the Select Committee received evidence that former workers in the ADA regional office had developed close relationships to assist persons with drug problems in the sex industry had established a close working relationship with the Goldfields regional prison.

### 4.5.4.5. Loss of benefits in remote areas

At the time of its visit, the Select Committee received evidence about salary levels that NGOs were offering to staff employed by a number of CDSTs in accordance with the SACS award. As the SACS<sup>75</sup> award rates were in general below those offered through the previous arrangement for ADA staff in regional programs, it was suggested that people would be less attracted to work in the Goldfields and more remote areas of the State, such as in the North West.

In addition to lower salary levels, there were also other impacts, due to the loss of other benefits previously available to former ADA staff employed under public service awards. These additional benefits included low cost housing (ie subsidised under the GEHA scheme) and the use of a motor vehicle.

### 4.5.4.6. Adequacy of remuneration levels

Another concern was that lower salary rates being offered for base level counselling positions were likely to attract new graduates and less experienced staff. A preponderance of such staff would require a considerable investment in training and support in order for them to successfully deliver a high standard of service.

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<sup>75</sup> Social and Community Services Industry, Community Services Workers, WA Award 1996. This was granted under the Workplace Relations Act 1996.

### **4.5.5. SACS award**

The remuneration levels provided by the ADA regional structure were linked to public service rates as base salaries, augmented by the ADA's Enterprise Bargain Agreement (EBA). These salary ranges are listed below.

#### **Public service rate**

- Level 2/3           \$27,784 - \$34,650
- Level 2/4           \$27,784 - \$37,939
- Level 5             \$39,911 - \$44,066

#### **Nursing award**

- Level 2             \$38,911 - \$41,623

There are some differences in remuneration levels provided by the CDST contracts, compared to the levels previously provided to those employed in ADA regional offices.

#### **SACS award**

- Level 7             \$40,947 - \$43,123
- Level 4 or 5        \$29,067 - \$36,594

The introduction of the SACS award on 16 September 1996, which covers workers at non government organisations (NGOs), has resulted in some difficulties for a number of providers. It is to be noted in the short term the increases in salaries has caused budgetary difficulties for a number of agencies, as back payment to the date of the award was required.<sup>76</sup> A number of NGOs received additional funds from WADASO for the 1997/98 year to meet the shortfall.<sup>77</sup>

As the new SACS award has meant increased salaries for employees in NGOs, there are smaller differentials in salaries that were paid to workers formerly employed by the ADA. In the longer term, a greater number of workers could be employed under the SACS award compared to the number that could have previously been employed under a public service award for the equivalent amount of funding.

Table 4.10 below summarises the information that is outlined in more detail for each CDST. A detailed breakdown of the value of the initial contracts, subsequent adjustments and the number of FTEs that are managed by each CDST is also provided.

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<sup>76</sup> Palmerston Annual Report 1996/97.

<sup>77</sup> This involved the following amounts: Palmerston \$55,000, Cyrenian House \$85,000, Hearth House \$10,000, and Serenity Lodge \$20,000.

**Table 4.10: WADASO purchasing for CDSTs, 1997/98 - 1998/99**

Name of CDST	Agency	FTEs	1997/98		1998/99
			Finalised	Pro rata	Recurrent
<b>Metropolitan area</b>					
South Metro	Palmerston Association Inc	6	272,000	160,975	272,000
North Metro	St John of God Community Services	6	272,000	128,912	272,000
South East Metro	Perth City Mission	6	272,000	161,275	272,000
North East Metro	Holyoake Institute	6	272,000	126,423	272,000
<b>Sub total metropolitan</b>		<b>24</b>	<b>1,088,000</b>	<b>577,585</b>	<b>1,088,000</b>
<b>Country regions</b>					
South West	Centacare	3	188,700	94,317	189,300
Great Southern	Palmerston Association Inc	4	168,600	102,302	168,500
Goldfields	Centrecare	4	238,600	102,913	238,600
COMPARI	Geraldton HS & COMPARI	7	287,000	170,590	287,000
Kimberley	Kimberley Northwest Mental HS	4	238,750	130,485	238,700
Pilbara	East Pilbara HS	5	328,707	82,189	328,700
<b>Sub total country</b>		<b>27</b>	<b>1,450,357</b>	<b>682,787</b>	<b>1,450,800</b>
Additional service developments					50,000
<b>Total</b>		<b>51</b>	<b>2,538,357</b>	<b>1,260,372</b>	<b>2,588,800</b>

## 4.5.6. Analysis by Health Zone

### 4.5.6.1. Introduction

An analysis was undertaken to compare different regions of the State by using indices of harm attributable to alcohol and other drugs. This harm is measured by the impact on health services due to the hospitalisation of those with illnesses and conditions caused by drugs.

The unit of regional analysis was each of the State's 10 Health Zones (HZs), which have well defined boundaries and accurate demographic data based on census data.<sup>78</sup> As each HZ consists of a number of Health Services, it provides details of usage of hospitals and other health services, trends and occurrence in illnesses and other health related problems.

As in most instances HZs cover similar geographical areas as each of the non metropolitan CDSTs, it would be advantageous if CDSTs were defined to cover the same area. In the non metropolitan area of the State, this would require the creation of seven CDSTs to coincide with the seven country HZs (Great Southern HZ, Goldfields HZ, Kimberley HZ, Midlands HZ, Midwest HZ, Pilbara HZ and South West HZ). The current four metropolitan CDSTs would require to be redefined to coincide with the three metropolitan HZs (East Metropolitan HZ, North Metropolitan HZ and South Metropolitan HZ).

#### **Recommendation 13**

***That the WA Drug Abuse Strategy Office rearrange the zones for country and metropolitan CDSTs so that they coincide with the same boundaries used for each of the State's Health Zones.***

### 4.5.6.2. WADASO expenditure on treatment programs

An analysis has been made of WADASO expenditure on treatment programs by HZ. This has required an adjustment of expenditure of three CDSTs (North East Metro, North Metro and the Goldfields) to reflect coverage provided by these three CDSTs to the population of the Midlands HZ, which does not have a specifically funded CDST (Table 4.11).

<sup>78</sup> A detailed breakdown of the population for each Health Zone and constituent Health Services is provided in Table 23, Appendix 13.

## Select Committee Into Misuse of Drugs Act 1981

It should be noted this analysis only takes account of expenditure which involved purchasing by WADASO of treatment and support services. These cost a total of \$6,942,249, which represented just over two thirds of the WADASO budget of \$10,207,164 for the 1997/98 fiscal year.

In 1997/98, it was estimated there was a mean expenditure of \$4.00 expenditure per capita by WADASO for the whole State, with a mean per capita expenditure of \$5.63 for non metropolitan areas, compared to a mean of \$3.40 per capita expenditure in the metropolitan area (Table 4.11).

The highest per capita expenditure for any HZ was recorded for the Kimberley HZ, with a mean expenditure of \$39.78 per capita, compared to the lowest, with a mean of \$0.58 per capita for the South West HZ. The high rate of expenditure recorded for the Kimberley HZ reflects the substantial level of funding of sobering up centres in that HZ.

**Table 4.11: Estimated purchasing of treatment services by WADASO by Health Zone, 1997/98**

Health zone	SUCs	NGOs	CDSTs	Total	per capita ()
Non metro HZs					
Great Southern	-	-	102,302	102,302	1.47
Goldfields	413,660	27,245	68,951	509,856	9.13
Kimberley	862,356	-	130,485	992,841	39.78
Midlands	-	-	118,220	118,220	2.21
Midwest	-	27,260	170,590	197,850	3.29
Pilbara	542,200	-	82,180	624,380	14.54
South West	-	-	94,317	94,317	0.58
Sub total non metro	1,818,216	54,505	767,045	2,639,766	5.63
Metro area	193,700	3,665,006	493,327	4,297,528	3.40
Whole of state	4,955	-	-	4,955	-
<b>Total</b>	<b>2,016,871</b>	<b>3,719,511</b>	<b>1,260,372</b>	<b>6,942,249</b>	<b>4.00</b>

Note: Expenditure on 3 CDSTs has been adjusted to reflect services provided to the Midland HZ by a one third pro rata contribution for the North East Metro (\$161,275), North Metro (\$128,912) and Goldfields CDSTs (\$102,913). Adjusted metro total of \$493,327 reflects contribution of \$41,719 (NE Metro CDST) and \$42,540 (North metro CDST) for services provided in Midlands HZ. Estimated contribution of \$33,961 for Goldfields to Midwest CDST.

### 4.5.6.3. Cost of drug related hospitalisation

It is estimated that the cost of drug related illnesses and conditions to the State's health system, as measured by inpatient hospital stays, was just over \$65 million in the year 1995 (Table 4.12). Of this total, \$35,001,120 (53.5%) was due to the cost of treatment for tobacco smoking related illnesses, \$25,799,400 (39.4%) was due to the cost of treating those with illnesses caused by the abuse of alcohol and \$4,644,904 (7.1%) was due to the cost of treating illnesses caused by the abuse of other drugs.<sup>79</sup>

This analysis does not distinguish between licit and illicit drug admissions in the *other drugs* group. There was a total of only 2,315 (10.0%) admissions related to other drugs, of the 23,057 all drug related admissions in 1995 (Table 4.13). It is understood most admissions in the other drugs group involve prescription drug related admissions (eg attempted suicide), and that there were very few admissions involving heroin or other illicit drugs. Of the 23,057 admissions in 1995, 11,746 (50.9%) were tobacco related and 8,996 (39.0%) were alcohol related.

<sup>79</sup> See Tables 24 and 25 Appendix 13 for detailed breakdown by Health Zone of cost of hospitalisation by three major drug groups.

**Table 4.12: Estimated cost of total drug related beddays by Health Zone and major drug group, WA, 1995**

	Tobacco	Alcohol	Other drugs	All drugs
Great Southern	1,338,040	1,083,427	109,472	2,530,939
Goldfields	1,275,560	1,272,333	110,792	2,658,685
Kimberley	673,200	1,077,853	31,680	1,782,733
Midlands	1,595,880	854,333	88,704	2,538,917
Midwest	1,381,600	1,119,067	126,280	2,626,947
Pilbara	576,400	754,893	67,320	1,398,613
South West	3,826,680	2,932,160	315,832	7,074,672
East Metro	9,240,440	6,276,747	1,503,040	17,020,227
North Metro	7,189,160	5,457,320	1,125,696	13,772,176
South Metro	7,904,160	4,971,267	1,166,088	14,041,515
<b>Total</b>	<b>35,001,120</b>	<b>25,799,400</b>	<b>4,644,904</b>	<b>65,445,424</b>

Source: Hospitalisation due to drugs other than tobacco or alcohol in WA, 1991-1995; Smoking-caused deaths and hospitalisation in WA by health services; Alcohol-caused deaths and hospitalisation in WA by health services.

**Table 4.13: Estimated total number of drug related hospital admissions by Health Zone and drug group, WA, 1995**

	Tobacco	Alcohol	Other drugs	Total
Great Southern	536	456	67	1,059
Goldfields	425	552	83	1,060
Kimberley	229	642	24	895
Midlands	490	329	50	869
Midwest	486	511	89	1,086
Pilbara	254	425	48	727
South West	1,327	908	170	2,405
East Metro	2,817	2,045	758	5,620
North Metro	2,417	1,599	492	4,508
South Metro	2,764	1,529	534	4,827
<b>Total</b>	<b>11,746</b>	<b>8,996</b>	<b>2,315</b>	<b>23,057</b>

Source: Hospitalisation due to drugs other than tobacco or alcohol in WA, 1991-1995; Smoking-caused deaths and hospitalisation in WA by health services; Alcohol-caused deaths and hospitalisation in WA by health services.

There were variations between the HZs in the rates of per capita expenditure for drug related hospitalisation in 1995. The cost of hospitalisation for all drug related causes was estimated to have been \$37.80 per head of population in 1995 for the whole State (Table 4.14; Figure 4.8).

There were three HZs which recorded rates above the State average. The Kimberley HZ (\$71.42 per capita) was 1.88 times higher than the State average, with the Goldfields and Midlands HZs 1.25 times higher than the State average. The Great Southern, North Metropolitan and South Metropolitan HZs had below average levels of expenditure on drug related hospitalisation, with rate ratios of 0.96, 0.80 and 0.85 of the State rate, respectively (Table 4.14).

## Select Committee Into Misuse of Drugs Act 1981

**Table 4.14: Estimated cost per capita of drug related hospital admissions by Health Zone and drug group, WA, 1995**

Health zone	1995 population	Alcohol	Tobacco	Other drugs	All drugs	Rate ratio (Health Zone:State)
Great Southern	69,417	\$15.61	\$19.28	\$1.58	\$36.46	0.96
Goldfields	55,828	\$22.79	\$22.85	\$1.98	\$47.62	1.25
Kimberley	24,960	\$43.18	\$26.97	\$1.27	\$71.42	1.88
Midlands	53,476	\$15.98	\$29.84	\$1.66	\$47.48	1.25
Midwest	60,121	\$18.61	\$22.98	\$2.10	\$43.69	1.15
Pilbara	42,946	\$17.58	\$13.42	\$1.57	\$32.57	0.86
South West	162,258	\$18.07	\$23.58	\$1.95	\$43.60	1.15
East Metro	377,815	\$16.61	\$24.46	\$3.98	\$45.05	1.19
North Metro	450,211	\$12.12	\$15.97	\$2.50	\$30.59	0.80
South Metro	434,130	\$11.45	\$18.21	\$2.69	\$32.34	0.85
<b>Total</b>	<b>1,733,787</b>	<b>\$14.90</b>	<b>\$20.22</b>	<b>\$2.68</b>	<b>\$37.80</b>	<b>1.0</b>

Source: Hospitalisation due to drugs other than tobacco or alcohol in WA, 1991-1995; Smoking-caused deaths and hospitalisation in WA by health services; Alcohol-caused deaths and hospitalisation in WA by health services.

**Figure 4.8: Estimated cost per capita of drug related hospital admissions by Health Zone, WA, 1995**



Alcohol related hospitalisation cost \$14.90 per capita for the State. It can be seen that in the Kimberley HZ, the per capita rate was nearly three times higher than the State average, at \$43.18 per capita.

With respect to tobacco, the highest rate was \$29.84 per capita recorded in the Midlands HZ, 1.5 times higher than the State average. It can be seen that the cost attributable to other drug related hospitalisation was substantially lower than was recorded for tobacco or alcohol, costing \$2.68 per capita. The highest rate was recorded for the East Metropolitan HZ of \$3.98, being 1.5 times higher than the State average.

### 4.5.6.4. Comparison of mental health and drug FTEs

The Select Committee received expert evidence concerning a methodology to estimate the number of resources required to adequately address alcohol and drug problems in a community. The view was expressed that on the basis of experience in other countries, the optimal number of

resources is parity between the number of community based mental health FTEs and alcohol and other drug FTEs.

The Select Committee was greatly assisted with information provided from the Health Department which reported the results of the 1996/97 National Survey of Mental Health in Australia, which provided data of the number of mental health FTEs by Health Service throughout WA.

The National Survey identified a total of 2,327 mental health FTEs in this State. However, as the majority of these involve metropolitan hospital based services, such as Graylands Selby Lemnos and Special Care Services, only the non metropolitan data will be referred to. The National Survey indicated a total of 112.7 mental health FTEs existed in the seven non metropolitan HZs. On the basis of incomplete information, the Select Committee has identified 80 alcohol and other drug FTEs in the non metropolitan area; 29 of these are located in CDSTs and 51 in SUCs (Table 4.15).

This information would suggest there could be up to a further 33 alcohol and other drug FTEs in non metropolitan HZs, if it is accepted there should be parity between the number of mental health and alcohol and other drug FTEs. It should be noted that the 43.7 mental health FTEs for the South West HZ is related to the development of mental health services for a catchment area covering a greater regional catchment area.

**Table 4.15: Number of alcohol and other drug FTEs vs mental health FTEs in non metropolitan Health Zones, WA, 1997**

	Alcohol and other drug FTEs				Mental health
	CDST	SUCs	other	All	
Great Southern	4	-	na	na	17.9
Goldfields	3	10	na	na	11.4
Kimberley	4	28	na	na	8.5*
Midlands	3	-	na	na	7.7
Midwest	7	-	2	9	15.0
Pilbara	5	13	na	na	8.5*
South West	3	-	na	na	43.7
<b>Total</b>	<b>29</b>	<b>51</b>	<b>na</b>	<b>na</b>	<b>112.7</b>

Note: \* = split of the 17.0 FTEs in the North West Mental Health Service.

## 4.5.7. COMPARI CDST

### 4.5.7.1. Introduction

The COMPARI CDST is part of the Midwest HZ. In 1995, the total population of the Midwest HZ was estimated to be 60,121. By the year 2001, the population of MWHZ is expected to increase by 8.7%, to a total of 65,438.

It is to be noted in the Midwest HZ that 60% of the population live in the two major towns, with the remaining 40% of the population widely dispersed throughout the region. The Midwest HZ covers the broad area from Leeman to Onslow, with services generally provided in four broad areas: coastal (Leeman - Onslow), the Midwest, the Murchison and the Gascoyne.<sup>80</sup>

<sup>80</sup> Details of the population of the four Health Services that make up this HZ are contained in Table 23, Appendix 13.

### **4.5.7.2. ADA regional arrangement**

In the past, the ADA was the principal provider for alcohol and other drug services in the Midwest, Gascoyne and Murchison region. This was referred to as the Midwest/Gascoyne/Murchison Health Region (MGMHR), which is now part of the Midwest Health Zone (MHZ). This arrangement meant services were primarily available to those who lived in the three largest towns in the region: Geraldton, Carnarvon and Meekatharra.

When the ADA was responsible for alcohol and other drug services, it established a variety of forums, as follows:

- Geraldton - Greenough Alcohol Advisory Group;
- Carnarvon Alcohol and Drug Advisory Group; and
- Meekatharra Health Promotion Team.

In Geraldton and Carnarvon additional specific interest groups operated under the auspices of the ADA.

In Geraldton these included:

- a management of intoxicated persons task group;
- a liquor accord committee;
- a drug education task group;
- a professional counsellors alcohol and drug task group;
- a solvent abuse task group; and
- an illicit drug use task group.

In Carnarvon these included:

- a sobering up shelter task group;
- an alcohol issues task group; and
- a counselling and education task group.

Including the ADA's 2 FTEs, there was a total of 7 alcohol and other drug FTEs in the region, employed in six organisations.

### **4.5.7.3. Drug related hospitalisation**

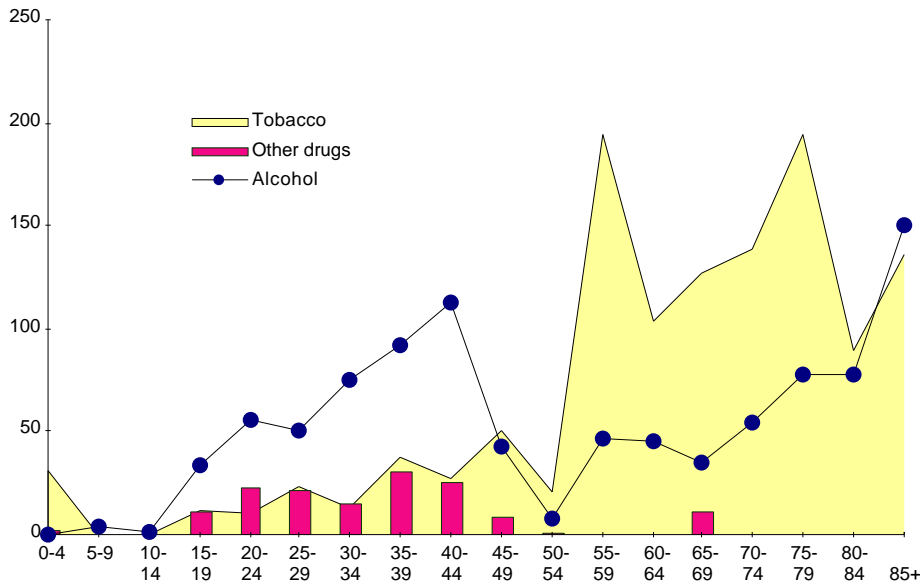
The Health Information Centre assisted the Select Committee with analysis of a number of drug related admissions to the Geraldton Regional Hospital in the 1996/97 by the three major drug groups. There were a total of 476 drug related admissions, resulting in a total of 2,328 beddays, which cost a total of \$1,024,241 (Table 4.16). The age distribution of these admissions by major drug groups highlights that alcohol related admissions mostly involve those aged from 25 to 49 and that other drug related admissions involved an age group mostly aged from 20 to 44 (Figure 4.9).

**Table 4.16: Drug related admissions to Geraldton Regional Hospital by drug group, 1996/97**

Type of drug	Admissions	Beddays	\$
Alcohol	218	966	425,062
Tobacco	202	1,208	531,331
Other drugs	57	154	67,848
<b>All drugs</b>	<b>476</b>	<b>2,328</b>	<b>1,024,241</b>

Source: Epidemiology, Health Department of WA.

**Figure 4.9: Number of admissions by age group and type of drug related hospital admission, Geraldton, 1996/97**



#### 4.5.7.4. Alcohol and other drug resources

Prior to the establishment of the CDST in December 1997 there were:

- 15 FTE mental health positions employed in four organisations;
- 16 FTE public health positions employed in two organisations; and
- 7 FTE D&A positions in six organisations.

In addition to the seven FTEs in the COMPARI CDST, there is a one FTE retained by Rosella House and one FTE retained by the Midwest Life Education Centre (LEC), respectively. This means there is an aggregate total of nine FTEs for responding to alcohol and other drug problems in this HZ. Of the nine positions, eight are based in Geraldton and one is based in Carnarvon.

Rosella House is a residential treatment facility for those recovering from alcohol related dependencies. It receives about \$42,000 per annum from WADASO and raises additional income through fees paid by residents. Difficulties in managing the house over recent years have recently been resolved with the establishment of a new committee of management.

The Midwest LEC is not part of the COMPARI CDST. It receives funding of about \$40,000 per annum from the HDWA, with additional income raised through fees for services. It is also supported by Rotary. The activities of the Midwest LEC are targeted at the primary school level.

#### 4.5.7.5. CDST organisational structure

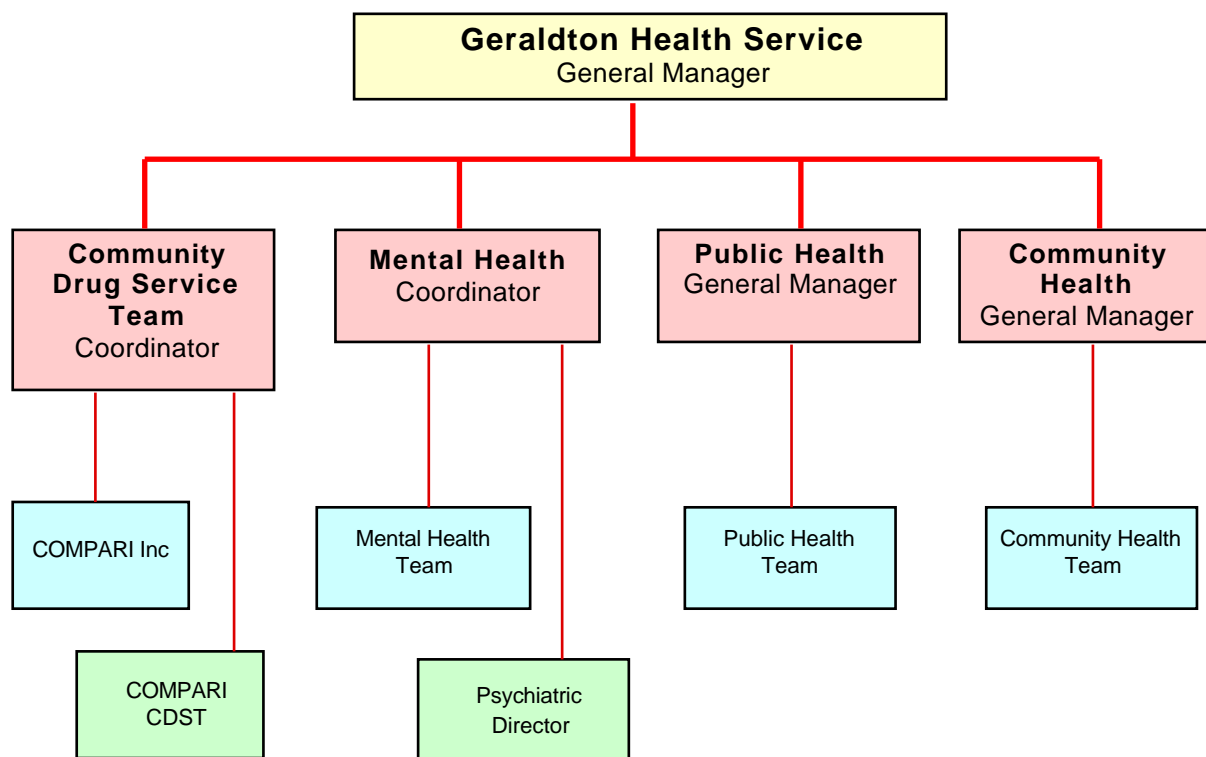
Following the change in funding of regional services through CDSTs, the Geraldton Health Service (GHS) and COMPARI formed a partnership, known as the Gascoyne/Murchison CDST, which successfully tendered for the management and coordination of alcohol and other drug services in this part of the State. The CDST is now called COMPARI CDST.

## Select Committee Into Misuse of Drugs Act 1981

The COMPARI CDST is directed by a regional steering committee, COMPARI Inc.<sup>81</sup> COMPARI Inc has representatives on its committee from each of the region's four Health Services (Geraldton HS, Midwest HS, Murchison HS and Gascoyne HS) together with eight elected community representatives from Rotary, Lions, City of Geraldton, Shire of Greenough, Family and Children's Services and WA Police Service.

The relationship between the CDST, the COMPARI steering committee and the Geraldton Health Service is outlined in Figure 4.10.

**Figure 4.10: Organisational structure of COMPARI CDST**



It is to be noted that the CDST maintains a 50/50 split in responsibilities between treatment and prevention of alcohol and other drug problems. Under the revised structure, which will be a consortium of agencies operating under interagency agreement, COMPARI assumes a key role as a mechanism for community input to initiate, establish and plan services in the region.<sup>82</sup>

### 4.5.7.6. CDST contract

The initial contract for the establishment of the CDST provided funding over a 3 year period. The contract price was \$193,000 pa. The CDST commenced operation in January 1998.

There was an adjustment of \$122,630 to the initial contract price to take account of unanticipated establishment costs of \$28,630 (one off) and for the employment of 2 additional FTEs for \$94,000. For the 1997/98 fiscal year, the pro rata value of the contract was \$170,590.

The initial contract provided for 3 FTEs. Arrangements were finalised in January 1998 for the inclusion of another 4 FTEs<sup>83</sup>, resulting in a total of 7 FTEs included in the CDST.

<sup>81</sup> Previously this was a separately funded NGO

<sup>82</sup> There are 12 members on the COMPARI management committee.

<sup>83</sup> In contracts held by Holyoake, COMPARI, Office of Aboriginal Health and the Gascoyne Health Service.

The 7 positions have been funded as follows:

- 3 FTEs through the tender process funded by WADASO;
- 2 additional FTEs funded by WADASO (1 previously from COMPARI and 1 from Holyoake); and
- 2 FTEs funded by the Health Department of WA (1 from the Gascoyne Health Service and 1 from the Office of Aboriginal Health).

The remuneration levels for the 7 FTEs are as follows:

- Regional Coordinator (1 FTE) HSOA L7;
- Gascoyne Coordination (1 FTE) HSOA L6;
- Project Officers Prevention (2 FTEs) HSOA L4 and L5;
- Project Officers Counselling (2 FTEs) HSOA L4 and L5; and
- Project Officer Youth (1 FTE) HSOA L5.

### 4.5.7.7. Regional initiatives

In 1996 the Regional Coordinator of the CDST, Mr Kevin Boots,<sup>84</sup> was involved in joint research with the NCRPDA into patterns of illicit drug use by workers in the seasonal fishing industries in the Geraldton, Carnarvon and Exmouth region. This was published in May 1997.<sup>85</sup>

It is to be noted that an additional FTE will be in place to undertake alcohol and other drug related law enforcement work as a result of the federally funded pilot project, based on the study by Sutton and James<sup>86</sup> which will be evaluated by the NCRPDA.

### 4.5.7.8. Overview

The new arrangement for the funding of the CDST embodies innovative community based delivery of services to groups throughout the region. It should be noted that in the previous model, local service providers were often administered from Perth, with limited local input. There has apparently been strong local support for the establishment of the CDST, including the transfer of the FTE formerly under the aegis of Holyoake.<sup>87</sup>

The results of the COMPARI project, involving a range of community based education and preventative strategies, have been widely recognised as being very successful. The drug prevention aspect of work in this region is being retained through COMPARI whose funded position has been integrated into the CDST.

It is suggested that the model implemented for the establishment of this CDST has a number of significant advantages in a regional context. These include:

- reduced administrative costs by infrastructure and resource sharing;
- improved relationships with health care providers;
- more scope for providing flexible salary packages;
- development of a mechanism for a mix of preventive and treatment programs;
- less duplication of services; and
- maximisation of community participation in design and planning services.

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<sup>84</sup> Former ADA Regional Coordinator.

<sup>85</sup> Carruthers S, Ewers-Verge J, Boots K, Midford R. *Investigations of alcohol and illicit drug use among a study group of West coast fishing industry workers*. Perth, National Centre for Research Into the Prevention of Drug Abuse, Curtin University of Technology, 1997.

<sup>86</sup> Sutton A, James S. *Evaluation of Australian drug anti trafficking law enforcement*. Payneham, SA, National Police Research Unit, 1996.

<sup>87</sup> "Drug and drink changes." *Geraldton Guardian* 1 December 1997.

## **4.5.8. Goldfields CDST**

### **4.5.8.1. Introduction**

The Goldfields CDST is part of the Goldfields HZ. In 1995, the total population of the Midwest HZ was estimated to be 60,121. In 1995, the total population of the Goldfields Health Zone was estimated to be 55,828. By the year 2001, the population of the Goldfields HZ is expected to increase by 5.4%, to a total of 58,843.<sup>88</sup>

### **4.5.8.2. ADA regional arrangement**

In the past, the ADA was the principal provider for alcohol and other drug services in this region with 2 FTEs based in Kalgoorlie (a Regional Coordinator (Level 5) and a Community Development Officer (Level 2)). The service covered the Kalgoorlie Boulder area, and included a service to Esperance and outlying communities in the Eastern Goldfields.

### **4.5.8.3. Drug related hospitalisation**

The St John Ambulance provided the Select Committee with statistics relating to calls received by it to attend drug overdoses. For the period 1996/97, there were 28 such calls attended by an ambulance in Kalgoorlie, of which it was estimated that less than half of these calls were opioid related. This means that the ambulance service dealt with about one opioid related call per month.<sup>89</sup>

The Health Information Centre assisted the Select Committee with analysis of a number of drug related admissions to the Kalgoorlie Regional Hospital in the 1996/97 by the three major drug groups. There were a total of 705 drug related admissions, which resulted in a total of 3,527 beddays and cost a total of \$1,552,025 (Table 4.17).

The age distribution of these admissions by major drug groups clearly highlights the relatively large number of alcohol related admissions which mostly involved the 20 to 44 age group. It should be noted that there were a significant number of other drug related admissions which involved young adults mostly in the 20 to 34 age group (Figure 4.11).

**Table 4.17: Drug related admissions to Kalgoorlie Regional Hospital by drug group, 1996/97**

Type of drug	Admissions	Beddays	\$
Alcohol	332	1,663	731,830
Tobacco	260	1,465	644,565
Other drugs	113	399	175,630
<b>All drugs</b>	<b>705</b>	<b>3,527</b>	<b>1,552,025</b>

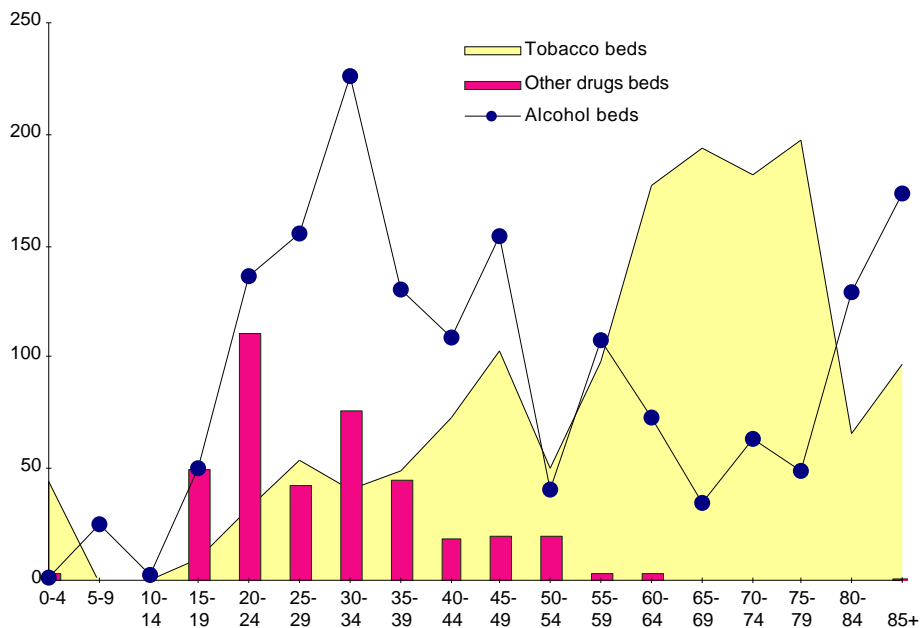
Source: Epidemiology, Health Department of WA.

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<sup>88</sup> Details of the population of the two Health Services that make up this HZ are contained in Table 23, Appendix 13.

<sup>89</sup> Over the 1996/97 a total of 24 drug related calls were received in Bunbury.

**Figure 4.11: Number of admissions by age group and type of drug related hospital admission, Kalgoorlie, 1996/97**



#### 4.5.8.4. Alcohol and other drug resources

In addition to the 4 FTEs in the Goldfields CDST, there is a further 1 FTE retained by Prospect Lodge. This means there is an aggregate total of 5 FTEs for responding to alcohol and other drug problems in this HZ, all of which are based in Kalgoorlie.

Prospect Lodge is a residential treatment facility for those recovering from alcohol related dependencies. It receives about \$27,000 per annum from WADASO and raises additional income through fees paid by residents.

#### 4.5.8.5. CDST contract

The initial contract for the establishment of the CDST was awarded to Centrecare, which is based in Kalgoorlie and is funded for a 3 year period. The contract price was \$183,000 per annum. The CDST commenced operation in February 1998. The initial contract provided for 3 FTEs. Arrangements were finalised in December 1997 for the inclusion of an additional FTE, resulting in a total of 4 FTEs in the CDST.

There was an adjustment of \$55,600 (annual) to the initial contract price, to enable coverage of a service to Esperance for \$9,600 and for the employment of the former Holyoake FTE for \$46,000. For the 1997/98 fiscal year, the pro rata value of the contract was \$102,913.

#### 4.5.8.6. Overview

On its visit to Kalgoorlie, the Select Committee met with a number of representatives of local organisations who were involved in dealing with local drug problems. There was agreement that Kalgoorlie had a serious level of drug related social and health problems, particularly due to the abuse of alcohol, amphetamines, heroin and volatile substances.

It was indicated to the Select Committee that as there was a tolerance in the community towards the excessive use of alcohol, this made it difficult to launch community based interventions about

## **Select Committee Into Misuse of Drugs Act 1981**

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serious problems concerning illicit drugs. In a following section in this chapter, there is a specific recommendation for piloting of a COMPARI style approach to mobilise the Goldfields community.

There are unique local factors which aggravate illicit drug problems in the Goldfields, such as the sex industry and significant numbers of single males attracted to the area because of the relatively high levels of income in the mining industry.

Analysis of the cost from the hospitalisation for all types of drug related admissions in the Goldfields Health Zone was \$47.62 per capita per year, which was 1.25 times higher than the State rate of \$37.80 per capita for drug related hospitalisation. It was estimated in the 1997/98 fiscal year that there was a total WADASO expenditure of \$509,856 for treatment programs in the Goldfields Health Zone. It is to be noted that \$413,660 (81.1%) of this expenditure was for purchasing sobering up services, \$27,425 (5.4%) was a grant to meet some of the recurrent cost of operating a residential facility for recovered alcohol dependents and \$68,951<sup>90</sup> (13.5%) was for the Goldfields CDST.

Based on needle and syringe data for 1997,<sup>91</sup> the Goldfields region had the highest rate of distribution of injecting equipment to IDUs in this State (more than three times higher than the mean State rate). It is believed that this high rate reflects a serious underlying problem of extensive heroin abuse in the region, prompting community concern about the need for additional services which are targeted at illicit drug abusers.<sup>92</sup>

On its visit to Kalgoorlie, the Select Committee met with a local general practitioner who is the only authorised methadone prescriber in the town. Evidence was given about the difficulty in being able to offer an adequate level of service in response to need, as there were few other health care providers who were willing to provide a service to those who abused heroin and other illicit drugs. Management of drug dependent patients was also made difficult given on occasions other practitioners were prepared to prescribe excessive quantities of tranquillisers and other CNS acting drugs, ostensibly for symptomatic relief of those experiencing drug withdrawals.

In the Select Committee's view, there is a strong case for such a service being established in the Kalgoorlie Boulder region, given the extent of the problems related to illicit drugs and of support by health providers for a dedicated residential drug treatment program to detoxify and provide longer term rehabilitation programs.

There is also a need for a peer based outreach service in the region to develop contacts with injecting drug users and provide them with ongoing educational material and support to improve their knowledge of risk behaviours associated with blood borne viruses. The high volume of N&S being distributed suggest that such a service could be developed in conjunction with a needle and syringe exchange program. A NSEP would also be an ideal way for IDUs to develop better relationships with health care providers and to encourage them to participate in treatment programs.

### ***Recommendation 14***

***That the WA Drug Abuse Strategy Office undertake a feasibility study into establishing a range of services targeted at injecting drug users and other groups of illicit drug abusers in the Goldfields, including funding a peer based outreach program, a needle and syringe exchange program and a residential detoxification and rehabilitation facility.***

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<sup>90</sup> This is the adjusted value of the CDST to take account of treatment services provided in the Midwest HZ.

<sup>91</sup> See chapter 8.

<sup>92</sup> Banks A. "Anwyl: need for drug rehab centre." *Kalgoorlie Miner* 2 June 1998.

## **4.5.9. South West CDST**

### **4.5.9.1. Introduction**

Previously the ADA was the principal provider for alcohol and other drug services in this region, with 2 FTEs based in Bunbury (a Regional Coordinator (Level 5) and a Community Development Officer (Level 3)). The Aboriginal CDO position had not been filled after a vacancy since early 1996. The service encompassed the broad area covering Bunbury, Busselton, Narrogin and Collie. A shortcoming of the former service provided by the ADA was that it focussed almost exclusively on Bunbury to the detriment of other centres in the region.

### **4.5.9.2. CDST contract**

The initial contract for the establishment of the CDST was awarded to Centacare, which is based in Bunbury and is funded for a 3 year period. The contract price was \$157,000 per annum. The CDST commenced operation in January 1998. No further adjustments have been made to the 3 FTEs as provided in the initial contract.

There was an adjustment of \$57,804 to the initial contract price, to take account of unanticipated establishment costs of \$26,104 (one off) and for ongoing costs of a vehicle and accommodation of \$31,700. For the 1997/98 fiscal year, the pro rata value of the contract was \$94,317.

## **4.5.10. Great Southern CDST**

### **4.5.10.1. Introduction**

Previously the ADA was the principal provider for alcohol and other drug services in this region, with 2 FTEs based in Albany (a Level 5 Regional Coordinator and a Level 3 Community Development Officer (CDO)). The service covered the broad area from Denmark to Albany and the surrounding rural communities.

### **4.5.10.2. CDST contract**

The initial contract for the establishment of the CDST was awarded to Palmerston Association, which is based in Albany and is funded for a 3 year period. The contract price was \$162,000 per annum. The CDST commenced operation in January 1998. The initial contract for the establishment of the CDST provided for 3 FTEs. There is a further 1 FTE (a CDO) funded by the Office of Aboriginal Health, resulting in a total of 4 FTEs in the CDST.

There was an adjustment of \$36,142 to the initial contract price, to take account of unanticipated establishment costs of \$29,542 (one off) and the \$6,600 annual cost of a vehicle. For the 1997/98 fiscal year, the pro rata value of the contract was \$102,302.

## **4.5.11. Kimberley CDST**

### **4.5.11.1. Introduction**

Previously the ADA was the principal provider for alcohol and other drug services in this region, with 2 FTEs based in Derby (a Regional Coordinator (Level 5) and a Community Development Officer (Level 3)). The service covered the broad area of Derby, Wyndham to Kununurra and outlying communities.

### **4.5.11.2. CDST contract**

The initial contract for the establishment of the CDST was awarded to Kimberley North West Mental Health Services Inc, which is based in Broome and is funded for a 3 year period. The contract price was \$238,750 per annum. The CDST commenced operation in January 1998.

The initial contract for the establishment of the CDST provided for 3 FTEs. There is a further 1 FTE (a CDO) funded by the Office of Aboriginal Health, resulting in a total of 4 FTEs in the CDST. There were no adjustments to the initial contract price. For the 1997/98 fiscal year, the pro rata value of the contract was \$130,485.

### **4.5.12. Pilbara CDST**

#### **4.5.12.1. Introduction**

Previously the ADA was the principal provider for alcohol and other drug services in this region, with 2 FTEs based in Port Hedland (a Regional Coordinator (Level 5) and a Community Development Officer (Level 3)). The service covered the broad area from Exmouth to Port Hedland and outlying communities.

#### **4.5.12.2. CDST contract**

The initial contract for the establishment of the CDST was awarded to East Pilbara Health Services, which is based in Port Hedland and is funded for a 3 year period. The contract price was \$238,750 per annum. The CDST commenced operation in January 1998. The initial contract for the establishment of the CDST provided for 3 FTEs. There are a further 2 FTEs (CDOs) funded by the Office of Aboriginal Health, resulting in a total of 5 FTEs in the CDST.

There was an increase of \$89,957 in the initial contract price to establish additional services in Tom Price, Newman and Karratha. For the 1997/98 fiscal year, the pro rata value of the contract was \$82,180.

### **4.5.13. South Metro CDST**

#### **4.5.13.1. Introduction**

Previously the ADA was the principal provider for alcohol and other drug services in this region, with 10.56 FTEs who operated from the South Metropolitan office. The community based service included a Regional Coordinator (Level 5), and a number of counsellors and professional staff. The service covered the broad area south of the Swan River.

After the transfer of the community based services from the ADA to the CDST at the end of 1997, this office<sup>93</sup> now provides a service only to illicit opioid dependent individuals who are prescribed methadone.

#### **4.5.13.2. CDST contract**

The initial contract for the establishment of the CDST was awarded to Palmerston Association, which is based in Fremantle and is funded for a 3 year period. The contract price was \$272,000 per annum. The CDST commenced operation in late February 1998. The initial contract for the establishment of the CDST provided for 6 FTEs.

There was an adjustment of \$29,542 (one off) to the initial contract price to take account of unanticipated establishment costs. For the 1997/98 fiscal year, the pro rata value of the contract was \$160,975.

### **4.5.14. South East Metro CDST**

#### **4.5.14.1. Introduction**

Previously the ADA was the principal provider for alcohol and other drug services in this area. However, it closed a service in the south east metropolitan area some years ago. The only ADA service south of the river was based in Fremantle.

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<sup>93</sup> Based at 33 Quarry Street, Fremantle.

#### **4.5.14.2. CDST contract**

The initial contract for the establishment of the CDST was awarded to Perth City Mission, which is based in Maddington (with an office also in Armadale) and is funded for a 3 year period. The contract price was \$272,000 per annum. The CDST commenced operation in February 1998. The initial contract for the establishment of the CDST provided for 6 FTEs.

There was an adjustment of \$33,171 (one off) to the initial contract price to take account of unanticipated establishment costs. For the 1997/98 fiscal year, the pro rata value of the contract was \$161,275.

### **4.5.15. North Metro CDST**

#### **4.5.15.1. Introduction**

Previously the ADA was the principal provider for alcohol and other drug services in the broad area north of the Swan River (from Swanbourne to Mundaring) with its North Metropolitan office based at Carrellis Centre in Mount Lawley. The ADA had 10.1 FTEs (a Regional Coordinator (level 7) and a number of counsellors and professional staff). In recent years, a service had not been provided by the ADA to this region.

#### **4.5.15.2. CDST contract**

The initial contract for the establishment of the CDST was awarded to St John of God Community Services, which is based in Joondalup and Wembley and is funded for a 3 year period. The service encompasses the area north from Cottesloe to Yanchep, and east to Alexander Drive.

The contract price was \$272,000 per annum. The CDST commenced operation in January 1998. The initial contract for the establishment of the CDST provided for 6 FTEs. There were no adjustments made to the initial contract price. For the 1997/98 fiscal year, the pro rata value of the contract was \$128,912.

### **4.5.16. North East Metro CDST**

#### **4.5.16.1. Introduction**

Previously the ADA was the principal provider for alcohol and other drug services in the broad area north of the Swan River, with its North Metropolitan office based at Carrellis Centre in Mount Lawley. In recent years, a service had not been provided by the ADA to this region.

#### **4.5.16.2. CDST contract**

The initial contract for the establishment of the CDST was awarded to Holyoake, which is based in Midland and is funded for a 3 year period. The service encompasses the area east from Alexander Drive to the outskirts of the metropolitan region north of the Swan River.

The contract price was \$272,000 per annum. The CDST commenced operation in February 1998. The initial contract for the establishment of the CDST provided for 6 FTEs. There were no adjustments made to the initial contract price. For the 1997/98 fiscal year, the pro rata value of the contract was \$126,423.

## **4.6. Local Drug Action Groups**

LDAGs comprise members of the community who combine to take action voluntarily to address drug related problems in their local areas. The success of a LDAG will ultimately depend on the breadth of community support for activities that are developed. It is expected that a wide range of

projects will be undertaken by LDAGs, such as recreational activities for young people and support for parents.

In October 1997, the WA Government announced the availability of \$200,000 to fund projects by LDAGs in 1997/98. Grants of up to \$4,000 will be available for LDAGs and all funding will be managed by the WADASO. At 30 June 1998, a total of \$85,337 had been made available on grants for LDAGs. This consisted of \$58,836 for joint WANADA/Lotteries Commission grants that were administered by the WADASO, with \$26,500 provided by the WADASO. Criteria for the selection of grants are:

- community support for the project;
- local focus of the project; and
- potential to reduce or prevent drug abuse.

## 4.7. Community based interventions

### 4.7.1. Introduction

The analysis earlier in this chapter identified disparities between different regions in the State with respect to health related consequences from the use of alcohol and other drugs. In some instances these disparities are substantial. The regional variations in the nature of drug related problems across the State underpins the need for a commitment to community based interventions which engage a wide spectrum of health care providers and alcohol and other drug providers to target specific drug issues.

There is a substantial impact in financial terms from these differentials on local hospitals and other health care providers. There is also clearly a significant human cost through preventable injury and illness, borne by individuals themselves affected by the use of drugs and their families. It has also been recognised that the impact in the workplace from the abuse of licit and illicit drugs imposes a significant cost on industry.

A key problem in many regional areas is the excessive use of alcohol. This issue has been identified from numerous surveys of high levels of alcohol consumption associated with alcohol related illness, injury and premature death. High levels of alcohol use by young adults is a major cause of social harm, such as motor vehicle accidents, assaults, domestic violence and other public order offences. The COMPARI model was an example of how a community is able to address both licit and illicit drug abuse in a coordinated and consistent fashion.

Community tolerance of alcohol related intoxication is a signal to young people that other types of drug induced intoxication is permissible. Exposure to the serious consequences from alcohol related abuse in families and in the community may also justify for some young people their use of other drugs, such as cannabis and ecstasy, as these drugs do not necessarily produce the same scale of health and social harm as occurs with alcohol abuse.

The experience from the COMPARI project is a good example of how communities need to be mobilised to address the harmful and hazardous use of alcohol as a precursor to other drug problems. COMPARI exemplifies an approach of how to develop a framework to change community tolerance of the excessive use of alcohol. This framework can then be utilised to address other problems.

It should be noted there is significant resistance by communities to addressing alcohol related issues. A quote from the progress report at the end of the first year of COMPARI reflects the issue of community resistance.

*“It is no doubt easier and safer for people to ignore their own use and focus on illicit drugs or drug use among disenfranchised groups. In Geraldton, community members perceived marijuana use as a major problem. When alcohol was mentioned, people usually said that*

*something should be done about Aboriginal drinking. From the beginning it was difficult to get the community to examine its own drinking habits and the amount of alcohol related harm. However, alcohol is associated with virtually all aspects of life in this city and leads to a variety of social and health problems.*

*It was very difficult to obtain any unpaid media support for alcohol initiatives. The editor of the main newspaper in the town was involved with the establishment of the 'Keep off the grass' campaign and viewed alcohol prevention as a waste of government funds. In an editorial he stated: 'Once the department recognises the damage that marijuana causes to young brains and bodies, perhaps our government can prise some of the money out of the anti AIDS and anti alcohol coffers to address a problem of far greater significance to a far greater number of ordinary young West Australians'."*<sup>94</sup>

## **4.7.2. Strengthening community responses to drug problems**

The Select Committee was unable to obtain sufficient information (with the exception of data provided by the WADASO) of expenditure by the major agencies, to enable it to develop a complete understanding of the relationship between regional patterns in alcohol and other drug related problems and the level of available resources.

The most comprehensive information was inpatient hospitalisation data, which indicated regional disparities in indices of harm attributable to alcohol. This information confirms results of a number of studies of spending on and consumption of alcohol. With respect to illicit drugs, it is suggested very few of those experiencing problems attend health services, unless they have developed serious medical or psychiatric problems.

In addition, it appears that many illicit drug abusers (especially in non metropolitan areas) may be excluded from the mainstream health services, because of historical familiarity with alcohol dependents and other factors. For instance, in Geraldton the Select Committee was informed on its visit to the Aboriginal Medical Service that it was providing assistance to a number of young non Aboriginal people who were experiencing problems due to their abuse of heroin. These young people were reportedly experiencing difficulty in accessing mainstream health services in the town.

There are likely serious public health implications if a significant proportion of the illicit drug population in any community perceive mainstream health providers are reluctant or disinterested in assisting them or that health care providers are considered to hold negative attitudes towards illicit drug users. Without ready access to mainstream health services, illicit drug abusers and the wider community face increased risks associated with illicit drug use, including the transmission of blood borne viruses and other health problems.

Without access to appropriate treatment, drug abusers are also likely to engage in crime to generate income, causing an additional costs to businesses and the community. On its visit to Geraldton, the Select Committee received evidence from local law enforcement officers that drug related crime had become an issue of increasing concern in their region. The Select Committee was impressed with these officers' support and commitment to evaluating a National Community Based Approach to Drug law Enforcement (NCBADLE) project in Geraldton. This initiative will provide a model for other communities with drug related problems to develop mechanisms to coordinate the activities of law enforcement, health providers and community based organisations. A discussion of the aims of the WA NCBADLE projects is contained in chapter 2.

The Select Committee believes that support should be provided for innovative preventive campaigns in non metropolitan areas with high levels of problems due to the abuse of licit and

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<sup>94</sup> James R, Harrison D, Laughlin D. *Community mobilisation for the prevention of alcohol related injury. Progress report year 1: problems with parachuting in Perth*, National Centre for Research Into the Prevention of Drug Abuse, Curtin University of Technology, 1993, 36.

## **Select Committee Into Misuse of Drugs Act 1981**

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illicit drugs. The Goldfields is an example of a region which has apparently high levels of problems due to the abuse of both alcohol and illicit drugs, which need to be addressed in a comprehensive fashion.

The Select Committee received evidence from a number of witnesses on its visit to Kalgoorlie, including workers in statutory agencies dealing with offenders, the mental health service, medical and health workers, the magistracy, law enforcement officers and alcohol and other drug workers.

A common theme in this evidence was community tolerance for the excessive use of alcohol, which it was suggested facilitated the abuse of illicit drugs by recognisable populations in the community. The abuse of volatile substances are responsible for a considerable amount of crime and social breakdown in some Aboriginal communities. In the city, young people also engage in the abuse of amphetamines and heroin.

Local health services and alcohol and other drug workers reported that heroin abuse was a problem which had developed more recently, supplanting to an extent amphetamines. Management of those who were dependent on or had serious problems with heroin was aggravated by there being one medical practitioner who had been prepared to prescribe methadone.

Given the success of the COMPARI model, it is the view of the Select Committee that a similar approach should be considered in the first instance in the Goldfields. In the future, further pilot projects should be considered for a number of other regions which have high levels of alcohol and illicit drug related problems. The strength of the COMPARI model is it's time limited project which sets out to achieve certain outcomes within a particular time frame, achieved by maximising community participation.

The involvement of a research oriented, university sponsored research team, in conjunction with other personnel who had expertise in mounting health campaigns and being able to develop educational and resource materials, was also an important aspect of the project.

It is acknowledged that a role of the CDSTs is to develop some capacity to undertake preventive activities to address underlying social, environmental, cultural and other factors which contribute to drug problems in a community. It is expected that as CDSTs will need to devote a significant proportion of their limited resources to providing and developing clinical programs, they are unlikely to be able to support large scale community level campaigns.

In the longer term, it would be desirable for CDSTs to broaden their approach to dealing with drug problems. However, given the magnitude of the effort required to mount a COMPARI type effort, in the short term CDSTs should focus on the main business of providing direct services to client groups, and to consolidate by developing good working relationships with other organisations and community groups.

### ***Finding 2***

***That the COMPARI model is an excellent organisational framework for linking and coordinating the provision of drug treatment and counselling services and engaging community based organisations. The Select Committee commends in the highest possible terms all those who have played a role in the establishment, expansion and continued operation of COMPARI in the Mid West Health Zone.***

**Recommendation 15**

*Subject to an appropriate review by WADASO of the provision of drug and alcohol services in the Goldfields, that a COMPARI style organisational model be considered to implement a project to mobilise the community in the Goldfields to address the abuse of alcohol and other drugs and be evaluated through a partnership with a university based consortium.*

### **4.7.3. Past interventions by HPS**

#### **4.7.3.1. Speed Catches Up With You**

In 1993, the Illicit Drugs Education Program conducted the WA component of the Commonwealth Drug Offensive campaign aimed at reducing harm associated with amphetamine use by 15 to 25 year olds, 'Speed Catches Up With You'.

The campaign utilised strategies including:

- youth cinema, television, magazine and radio ads;
- busback and billboard posters;
- an information magazine distributed at late night venues (with the cooperation of the WA Cabaret Owners' Association);
- a dance party and a competition to win a private dance party; and
- release of a CD by leading dance music performers;
- information for children (distributed through schools) and parents (distributed through agencies).

#### **4.7.3.2. Drug Aware (phase I)**

In 1995, the Western Australian Task Force on Drug Abuse recognised the need for ongoing public education focusing on illicit drug use as part of a comprehensive approach to reducing illicit drug abuse. In 1996, the Task Force provided funding for a public education campaign. The campaign, which targeted parents, provided information about the health and social effects of illicit drug use and encouraged communication about illicit drug use between parents and adolescents.

Many of the publications utilised by the campaign were produced by Health Promotion Services. These resources included:

- the Drug Aware - It's Time to Talk Straight parent booklet (also available on Internet);
- press ads encouraging effective parent child communication;
- drug information phone lines and distribution of print information pertaining to specific drugs;
- support for activities conducted by Local Drug Action Groups, the WA Lions Drug Education Foundation, and health and education professionals;
- the Wellington St megasite billboard; posters, fridge magnets and memo pads;
- Drug Aware Business stickers; and
- Illicit Drug Fact Sheets for People Working in the Alcohol and Other Drugs Field.

#### **4.7.3.3. Heroin Overdose Prevention Project**

In consultation with injecting drug users and the ADA, a pair of characters named Horse and Hammer (street terminology for heroin) were developed to promote effective responses to opioid overdose. The resultant resources, two postcards and a poster, were distributed to heroin users via dedicated services such as needle and syringe exchanges, the Opiate Overdose Prevention Project, the Western Australian Substance Users' Association and treatment services.

#### **4.7.3.4. Parent Drug Information Service**

Health Promotion Services have recently assisted in the publication of 80,000 brochures and 5,000 posters promoting the PDIS service, which has proved a valuable supporting campaign for the Drug Aware campaign. These resources will be distributed statewide.

#### **4.7.4. Current and ongoing interventions by HPS**

##### **4.7.4.1. Drug Aware phase II**

Liaison with the WA Drug Abuse Strategy Office will continue into 1998, with the development of the two strands comprising the Drug Aware campaign's second phase.

The parent press advertisement campaign promoting more effective parent child communication about drugs, and encouraging parents to inform themselves about specific drugs, has been expanded into the second phase. The current advertisements were launched by the Minister Responsible for the WA Drug Abuse Strategy on 3 September 1997.

In addition, the Minister launched a series of youth press and radio advertisements aimed at preventing the uptake of heroin amongst young people aged 16 to 24 years who use other illicit drugs.

##### **4.7.4.2. Late night venue resources**

The Illicit Drugs Education Program has been charged with developing resources for young people who attend late night entertainment venues such as hotels, nightclubs, concerts, dance parties and raves. A series of postcards providing information of ways to reduce potential harms associated with alcohol and other drug use and late night travel are currently in development.

These resources are being tested for effectiveness with their target group, and have been predicated on young peoples' need for credible, non judgmental information in their own terminology. The launch is planned for the beginning of the 1998 summer party season.

##### **4.7.4.3. Information provision**

Student and other public inquiries regarding illicit drug use result in phone and/or print information provision. Current publications include pamphlets entitled Heroin, Ecstasy, Amphetamines, Cannabis, Drugs and Pregnancy, and Common Myths About Drugs (produced by the Centre for Education and Information about Drug Abuse). Health Promotion Services is the primary source of printed information about alcohol and illicit drugs for the public, students and alcohol and other drug professionals.

##### **4.7.4.4. Drugs in perspective course**

Drugs in Perspective (DIP) is a drug education course for parents, specifically designed to assist parents to become better informed about drug issues so they feel more comfortable discussing these issues with their children. Health Promotion Services runs train the trainer courses to train health and education professionals, community police officers and interested parents to conduct DIP courses in their communities. Additionally, a number of major non government agencies will provide drug education courses for parents in a range of formats.

##### **4.7.4.5. Health in schools magazine**

Three issues of the Health in Schools magazine are produced each year and are distributed to all schools, community nurses working in schools, Public Health Units and other relevant health and education professionals. This magazine is the primary source of information about best practice and health issues in school health promotion.

## 4.8. Utilisation of services

### 4.8.1. COTSA survey

#### 4.8.1.1. Introduction

One of the best sources of data to estimate the characteristics of treatment populations attending all alcohol and other drug treatment programs in this State is the national survey of treatment populations, the Client of Treatment Service Agencies (COTSA) survey. The first national census was held in March 1990<sup>95</sup> and the second census followed two years later, in March 1992.<sup>96</sup> The most recent COTSA survey, the third national census, was held in June 1995. Subsequent surveys are planned on a triennial basis. The National Drug and Alcohol Research Centre (NDARC) is responsible for the two most recent COTSA surveys.

#### 4.8.1.2. Results 1995 survey

##### **Introduction**

A limitation of the COTSA survey is that it only sampled identified, established and recognised alcohol and other drug programs. This means the COTSA data under represents those socio-economic groups who seek assistance through private hospitals and fee for service providers, such as doctors, psychiatrists, psychologists, social workers and other counsellors.

The COTSA survey also does not encompass attendances at self help groups (such as Alcoholics Anonymous and Narcotics Anonymous) stays at sobering up shelters or people participating in smoking cessation programs. The survey also underestimates the total population of persons in outpatient treatment at the agencies surveyed because it does not include those currently in treatment but who did not attend on the day of the survey.

##### **Overview**

In WA, there were a total of 355 persons attending alcohol and other drug treatment programs on the census day: 260 (73.2%) were males and 95 (26.8%) were females (Table 4.18). It is noted that males were slightly older than females, with a mean age of 33.6 years and 32.6 years respectively (Table 4.19). Overall, 198 (55.8%) of all clients sought treatment in relation to alcohol, followed by 68 (19.1%) amphetamine related admissions and 35 (9.8%) opioid related admissions (Table 4.20).

##### **Type of service**

The survey covered all major agencies providing a range of services, such as non residential assessment and referral programs, outpatient counselling, methadone with counselling, outpatient detoxification, inpatient detoxification, inpatient rehabilitation, drug free therapeutic community (DFTC), and other types of residential or non residential assistance.

##### **Age and drug group**

The mean age of males attending treatment programs with a principal problem related to alcohol was 38.2 years, compared to females who had an average age of 35.1 years. There was a marked difference in the average age of males and females attending with a principal drug problem related to amphetamines; the average age of males was 18.9 years, compared to an average of 27.4 years for females (Table 4.19).

The mean age of males attending treatment programs with a principal problem related to illicit opioids was 30.7 years, compared to females who had an average age of 31.8 years. Of the 355 clients who sought treatment on the census day, 16 (4.5%) had a principal problem related to

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<sup>95</sup> Webster P, Mattick RP, Baillie A. *Clients of treatment service agencies March 1990, census findings*. Canberra, Department of Health, Housing and Community Services, 1991.

<sup>96</sup> Chen R, Mattick RP, Baillie A. *Clients of treatment service agencies March 1992 census findings*. Canberra, Department of Health, Housing, Local Government and Community Services, 1994.

cannabis. The mean age of males from this group was 20.2 years compared to a mean age of 31.3 years for females.

***Injecting drug use***

The 1995 survey (as with its predecessor) included a question in relation to whether respondents had injected any drugs in the preceding 12 months, and if so, which type of drug(s) were injected. Of the clients identified as having injected at least one drug within the past 12 months, by type of drug (Table 4.21):

- 78 (22.0%) had injected opioids; and
- 68 (19.2%) had injected amphetamines.

***Attendances at all treatment programs***

An adjustment is necessary to the COTSA data to include those persons who received only a methadone dose on the day of the COTSA survey. This shortcoming arises as the COTSA survey defined contact on the day of the census as including counselling. On the census day, there were a total of 735 persons who attended the methadone program (Table 4.22). These clients have been combined with the COTSA data to provide a complete profile of the client population attending treatment programs in WA.

It is estimated that there were 1,071 persons who participated in treatment in alcohol and other drug programs in this State in June 1995, of whom 677 (63.2%) were males and 394 (36.8%) were females (Table 4.23). With this adjustment, it can be seen that there are two major groups of clients who utilise treatment services.

Just over two thirds of the population with alcohol and other drug related problems are engaged in the methadone program and just under one fifth sought treatment in relation to alcohol abuse. It is to be noted that there are relatively few individuals with illicit opioid related problems who seek other forms of treatment, as only 49 (4.6%) of the 1,071 clients were engaged in drug free and other forms of treatment such as detoxification.

The majority of the treatment population engage in non residential forms of treatment. Overall, a total of 900 (84.0%) individuals participated in either assessment, counselling, methadone treatment or outpatient detoxification programs (Table 4.24). It was found that only 171 (about one in seven) clients participate in residential programs.

Of the 171 clients engaged in residential treatment programs, 35 (20.5%) were in a detoxification program, 131 (76.6%) were in a rehabilitation program and 5 (2.9%) were in a therapeutic community.

**Table 4.18: COTSA survey, primary drug problem by age group and sex, WA, June 1995**

Age group	Alcohol	Opioids	Amphetamines	Other	Total
<b>Males</b>					
10-19	5	1	9	10	25
20-29	29	14	7	12	62
30-39	45	17	6	8	76
40-49	42	4	-	3	49
50-59	20	1	-	1	22
60+	11	-	-	1	12
Missing age	6	1	6	1	14
<b>All males</b>	<b>158</b>	<b>38</b>	<b>28</b>	<b>36</b>	<b>260</b>
<b>Females</b>					
10-19	2	-	-	3	5
20-29	7	11	6	7	31
30-39	18	17	1	4	40
40-49	10	2	-	3	15
50-59	3	-	-	1	4
60+	-	-	-	-	-
Missing age	-	-	-	-	-
<b>All females</b>	<b>40</b>	<b>30</b>	<b>7</b>	<b>18</b>	<b>95</b>
<b>Persons</b>					
10-19	7	1	9	13	30
20-29	36	25	13	19	93
30-39	63	34	7	12	116
40-49	52	6	-	6	64
50-59	23	1	-	2	26
60+	11	-	-	1	12
Missing age	6	1	6	1	14
<b>All persons</b>	<b>198</b>	<b>68</b>	<b>35</b>	<b>54</b>	<b>355</b>

Note: Based on 1995 COTSA survey data.

**Table 4.19: COTSA survey, primary drug problem by average age and sex, WA, June 1995**

	Males		Females		Persons	
	n	Average age	n	Average age	n	Average age
Alcohol	158	38.2	40	35.1	198	37.6
Amphetamines	28	18.9	7	27.4	35	20.6
Barbiturates	1	43.0	-	-	1	43.0
Benzodiazepines	3	31.7	6	37.5	9	35.6
Other tranquillisers	-	-	2	42.5	2	42.5
Cannabis	11	20.2	3	31.3	16	22.6
Hallucinogens	2	15.0	1	15.0	3	15.0
Opioids	38	30.7	30	31.8	68	31.2
Polydrugs (excluding opioids)	3	34.3	-	-	3	34.3
Polydrugs (including opioids)	7	29.0	4	24.3	11	27.3
Tobacco	7	37.3	1	20.0	9	35.1
Volatile substances	2	16.0	1	12.0	3	14.7
<b>Total</b>	<b>260</b>	<b>33.6</b>	<b>95</b>	<b>32.6</b>	<b>355</b>	<b>33.3</b>

Note: Based on 1995 COTSA survey data.

## Select Committee Into Misuse of Drugs Act 1981

**Table 4.20: COTSA survey, type of treatment by primary drug problem, WA, June 1995**

Type of treatment	Alcohol	Opioids	Amphetamines	Other drugs	All drugs
<b>Non residential</b>					
Assessment and referral non residential	11	7	5	6	29
Counselling non residential	48	24	30	25	127
Methadone non residential	-	-	19	-	19
Detoxification non residential	-	-	-	3	3
Other non residential	-	1	5	-	6
<b>Inpatient</b>					
Detoxification inpatient	25	-	7	3	35
Rehabilitation inpatient	114	2	-	15	131
Therapeutic community inpatient	-	1	2	2	5
Other inpatient	-	-	-	-	-
<b>Total</b>	<b>198</b>	<b>35</b>	<b>68</b>	<b>54</b>	<b>355</b>

Note: Based on 1995 COTSA survey data.

**Table 4.21: COTSA survey, average age of injecting drug use in past 12 months, WA, June 1995**

	Males		Females		Total	
	n	Average age	n	Average age	n	Average age
Opioids	47	30.8	31	31.6	78	31.2
Amphetamines	50	26.7	18	27.8	68	27.0
Cocaine	3	29.7	-	-	3	29.7
Barbiturates	2	23.0	-	47.0	2	31.0
Benzodiazepines	4	19.5	2	34.0	6	24.3
Other tranquillisers	-	-	1	30.0	1	30.0
Other drugs	1	37.0	-	-	1	37.0

Note: Based on 1995 COTSA survey data.

**Table 4.22: ADA methadone population by age group and sex, June 1995**

	Males		Females		Total	
	n	%	n	%	n	%
15-19	2	0.5	2	0.7	4	0.5
20-24	19	4.4	24	7.8	43	5.9
25-29	46	10.7	52	16.9	98	13.3
30-34	126	29.4	89	29.0	215	29.3
35-39	137	32.0	97	31.6	234	31.8
40+	98	22.9	43	14.0	141	19.2
<b>Total</b>	<b>428</b>	<b>100.0</b>	<b>307</b>	<b>100.0</b>	<b>735</b>	<b>100.0</b>

**Table 4.23: Total treatment population, primary drug problem by sex WA, June 1995**

Primary drug problem	Males		Females		Persons	
	n	%	n	%	n	%
Alcohol	158	23.3	40	10.2	198	18.5
Amphetamines	28	4.1	7	1.8	35	3.3
Barbiturates	1	0.1	-	0.0	1	0.1
Benzodiazepines	3	0.4	6	1.5	9	0.8
Other tranquillisers	-	0.0	2	0.5	2	0.2
Cannabis	11	1.6	3	0.8	14	1.3
Hallucinogens	2	0.3	1	0.3	3	0.3
Opioids (methadone)	428	63.2	307	77.9	735	68.6
Opioids (not methadone)	27	4.0	22	5.6	49	4.6
Polydrug (excluding opioids)	3	0.4	-	0.0	3	0.3
Polydrug (including opioids)	7	1.0	4	1.0	11	1.0
Tobacco	7	1.0	1	0.3	8	0.7
Volatile substances	2	0.3	1	0.3	3	0.3
<b>Total</b>	<b>677</b>	<b>100.0</b>	<b>394</b>	<b>100.0</b>	<b>1,071</b>	<b>100.0</b>

Note: Based on adjusted 1995 COTSA survey data.

#### ***Residence of treatment population by postcode***

Postcode data of place of usual residence was obtained by the COTSA survey and similar information was provided by the ADA for the methadone treatment population. A breakdown by postcode areas indicates that 85% of all clients in treatment programs in June 1995 lived in the metropolitan area (Table 4.25).

With respect to the 906 persons living in the metropolitan area, 101 (11.1%) lived in the postcode areas 6059 to 6069, broadly covering the area from Dianella to Upper Swan and 162 (17.9%) lived in the postcode areas 6156 to 6163, broadly covering the area from Melville to Spearwood.

A relatively small number of clients, 75 (8.3%), lived in the Perth inner city area. Smaller numbers lived in the Victoria Park-Cannington, Kwinana-Port Kennedy and City Beach-Stirling areas.

## Select Committee Into Misuse of Drugs Act 1981

**Table 4.24: Total treatment population by sex and type of treatment, WA, June 1995**

Type of treatment	Males		Females		Persons	
	n	%	n	%	n	%
<b>Non residential</b>						
Assessment and referral	22	3.2	7	1.8	29	2.7
Counselling	84	12.4	43	10.9	127	11.9
Methadone	428	63.2	307	77.9	735	68.6
Detoxification	3	0.4	-	-	3	0.3
Other	5	0.7	1	0.2	6	0.6
Sub total	542	80.1	358	90.9	900	84.0
<b>Inpatient</b>						
Detoxification	25	3.7	10	2.5	35	3.3
Rehabilitation	106	15.7	25	6.3	131	12.2
Therapeutic community	4	0.6	1	0.2	5	0.5
Other	-	-	-	-	-	-
Sub total	135	19.9	36	9.1	171	16.0
<b>Total all types of treatment</b>	<b>677</b>	<b>100.0</b>	<b>394</b>	<b>100.0</b>	<b>1,071</b>	<b>100.0</b>

Note: Based on adjusted 1995 COTSA survey data.

**Table 4.25: Total treatment population by postcode, WA, June 1995**

Locality	Postcode areas	Opioids			Non opioids			All drugs
		Methadone	Not methadone	All	Alcohol	Amphetamines	Other	
<b>Perth Statistical Division</b>								
Perth inner city	6000-6005	47	4	51	12	4	8	75
Victoria Park-Cannington	6100-6107	47	4	51	9	3	4	67
Thornlie-Armadale	6108-6113	31	1	32	39	1	1	73
Dianella-Upper Swan	6059-6069, 6090	87	3	90	5	4	2	101
Melville-Spearwood	6156-6163	142	9	151	7	1	3	162
Mt Lawley	6050	11	1	12	14	-	7	33
Hamersley-Two Rocks	6022-6037	29	2	31	3	3	5	42
South of river	6147-6155	35	3	38	5	2	5	49
Kwinana-Port Kennedy	6164-6176	50	4	54	7	1	3	65
City Beach-Stirling	6015, 6017-6021	61	3	64	3	1	1	69
Maylands-Bayswater	6051-6053	44	3	47	4	-	3	54
Daglish-Mosman Park	6008-6012	31	1	32	4	-	2	38
Wembley-North Perth	6006-6007, 6014, 6016	39	2	41	4	-	1	46
Hills	6070-6084	8	1	9	2	-	-	11
Bassendean-Midland	6054-6058	16	-	16	3	1	-	20
Byford-Serpentine	6201-6205	-	-	-	-	1	-	1
Sub total		678	41	719	120	22	45	906
Total non metro		49	2	51	41	4	3	99
Missing postcode		8	6	14	36	9	6	65
<b>Total state</b>		<b>735</b>	<b>49</b>	<b>784</b>	<b>198</b>	<b>35</b>	<b>54</b>	<b>1,071</b>

Note: Based on adjusted 1995 COTSA survey data.

## 4.8.2. WANADA survey of NGOs, 1997

### 4.8.2.1. Introduction

The WA Network of Drug Agencies kindly surveyed the major NGO alcohol and other drug provider organisations in Perth as to the number of clients seen in the year 1997 with a major problem attributable to the use of heroin and other illicit drugs.

The effort by the 12 participating organisations (Palmerston, Holyoake, Cyrenian, Yirra, Bridge House, Perth Women's Centre, Hearth, Thamkrabok, Teen Challenge, St Patricks, the Hepatitis C Council and the WA Substance Users Association) in supplying information is gratefully acknowledged.

Detoxification and sobering up program data will be referred to, even though it is likely a number of these include admissions of those with primary drug problems due to drugs other than heroin or other illicit, in order to highlight the significant role of these programs.

In some instances, agencies are involved in an extensive range of treatment, outreach and prevention activities. There is also considerable variation in the mode of provision of counselling services, with a number of agencies offering low intensity programs of short duration involving a group format, with more traditional (and expensive) one to one counselling targeted at those with more serious and complex drug problems. In the latter case, the agency may perform a role of a case manager, to ensure the individual can access specific services from a number of agencies and service providers.

#### **4.8.2.2. Special issues**

Compared to a number of years ago, a growing number of clients now abuse a range of drugs such as alcohol, cannabis, opioids, psychostimulants, sedatives and benzodiazepines and may become dependent on one or more of these at different times. Accordingly, this may mean there is a significant number of clients with histories of illicit drug related problems who may be counted as having a primary problem due to the abuse of alcohol.

It is believed that over recent years there has been a growing proportion of clients with dual diagnoses, ie a psychiatric problem and a drug related problem. These clients can present difficult management problems, with a number of agencies accepting such individuals into their residential programs.

#### **4.8.2.3. Overview**

WANADA collated the results and provided summary tables, on the proviso that individual agencies were not identified. The WANADA data have been grouped into a number of tables (Table 4.26). The major findings of this survey of attendances at alcohol and other drug treatment agencies in 1997 are as follows. There was a total of:

- 574 clients who attended residential drug free programs;
- 3,822 clients who attended outpatient programs; and
- 13,409 contacts for community education programs.

In addition to the more traditional services such as counselling and rehabilitation that are provided by most agencies, an agency had developed a wilderness adventure program targeted at young people. Another agency had developed expertise in providing a telephone help service.

#### **4.8.2.4. Limitations**

A number of shortcomings of these data may tend to over enumerate the utilisation of services for the 12 month period. These limitations include:

- over a period of time the same individuals may present at a number of different agencies;
- the number of admissions do not differentiate between new admissions and readmissions;
- admissions for the calendar year 1997 have been calculated, as a number of agencies provided data over different time period;
- as a number of agencies only provided the number of group sessions, this has been adjusted on the assumption that a mean of 10 persons were present at each session; and

## Select Committee Into Misuse of Drugs Act 1981

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- in a number of instances, it is believed agencies provided data that included admissions for alcohol, other licit and illicit drug related admissions.

However, it is suggested this data emphasises that many of the NGOs surveyed were involved in providing a wide range of services. With respect to the treatment aspect of service, as expected the greatest number of services involved outpatient counselling and support, with a total of 3,822 clients having received a service. It is to be noted that this figure does not represent unique individuals. The total of nearly 13,500 community education contacts is distorted by a high number of talks delivered by one agency to large groups of school students in class room situations.

**Table 4.26: Utilisation of NGO services, WA, 1997**

Provider	Outpatient programs (contacts)	Drug free programs (admissions)	Community education (contacts)	Other programs (contacts)
Agency 1	537	72		25
Agency 2	860	226	415	
Agency 3	506	35	3,498	
Agency 4	576			
Agency 5	100			
Agency 6	796		980	
Agency 7	200	50	8,000	
Agency 8	16		48	
Agency 9	206	191	206	
Agency 10	25			
Agency 11			262	
Agency 12				1,350
<b>Totals</b>	<b>3,822</b>	<b>574</b>	<b>13,409</b>	<b>1,375</b>

## Chapter 5: Responding to opioids

### 5.1. Introduction

As heroin is not legally available in Australia, users obtain supplies of the drug via the black market. This results in a dose containing an uncertain amount and contaminated by a variety of diluents of varying quality and safety, with resultant risks to users, such as overdose and infections.

Most users inject their dose using a number of solvents for the powder they purchase. Acidifying agents are used to facilitate dissolving the drug and these in their own right may produce complications (for instance, fungal contamination of lemon juice). Users inject intermittently and may pass from occasional use (for instance, once a week or less) to a major “habit” where the drug may be used 3 or 4 times per day.

The context of heroin use, involving the establishment of a black market and the adoption of unhygienic injection practices, means that a combination of demand and supply reduction measures need to be developed to avoid the serious costs borne by individuals and the community. The Select Committee has in the course of its investigation considered a range of information about treatments and preventative strategies and notes over the last 18 months there has been debate in the community about options to deal with the growing problem of heroin abuse.

As outlined in this chapter, one of the most significant and well established treatments is the provision of methadone, which has been prescribed in Australia for nearly 30 years. This treatment continues to attract large numbers of heroin dependents and the Select Committee is pleased to note that access to this treatment has expanded following the introduction of the community based methadone program in June 1997.

There are other forms of treatment besides methadone, such as short stay detoxification programs and longer term drug free therapeutic communities which attract smaller numbers of clients who obtain benefits from abstinence oriented treatment. More recently, alternative pharmacotherapies such as buprenorphine and naltrexone have been discussed and trials are under way in a number of states to determine the effectiveness of these treatments.

In July 1997, a medical practitioner in Perth commenced prescribing naltrexone to assist in the detoxification of heroin dependents.<sup>97</sup> This approach avoids many of the risks associated with the highly publicised ultra rapid opioid detoxification process developed in 1993 in Israel by the Centre for the Investigation and Treatment of Addiction (CITA), which has now been franchised in a number of countries.

Each treatment has potential to assist particular groups of heroin dependents. The Select Committee believes that, in the longer term, a broader range of pharmacotherapies and drug free regimes is desirable and will become available. The concept that treatment consists of graded stages to achieving eventual abstinence and social rehabilitation was recognised more than two decades ago.<sup>98</sup>

This process has been described as sequential treatment employing pharmacologic supports (STEPS) and involves providing more prolonged and stable pharmacological supports over a period of time. The first step would involve daily oral methadone, followed by three times a week oral levo alpha acetylmethadol (LAAM), followed by three times a week oral naltrexone (an opiate antagonist), abstinence without pharmacological support and with counselling and finally abstinence without support.

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<sup>97</sup> Hulse G. “Naltrexone – defining a framework for use.” *APSAD Newsletter*, Summer 1998.

<sup>98</sup> Goldstein A, “Heroin addiction – sequential treatment employing pharmacologic supports.” (1976) 33 *Archives of General Psychiatry* 353-358.

## 5.2. Trends in heroin use

### 5.2.1. Pre 1960s

The first attempt by the Federal Government to regulate the importation of opiates was by the use of the Commonwealth *Customs Act 1901*, when it issued an order, the *Opium Proclamation 1905*, to prohibit the importation of opium suitable for smoking. A further order, the *Opium Proclamation 1914*, permitted the importation of heroin and a number of drugs only for medicinal purposes.

By 1920, the Federal Government had issued a series of proclamations and orders which attempted to regulate the use of heroin and other opiates, by placing limits on the quantities of opiates that could be distributed by importers based on a formula of the amount of heroin the average pharmacist or medical practitioner should use in a year.

It is known from annual returns of licit heroin consumption submitted to the Permanent Opium Control Board (in compliance with international treaty obligations) that Australia had a relatively high annual rate of *per capita* licit heroin consumption from the 1900s to the 1950s. For instance, an article in the Australasian Journal of Pharmacy in March 1936 contained figures that indicated that in the 1930s, Australians consumed three times the *per capita* amount of heroin as in Britain, and *per capita* consumed over 50 times the US consumption.<sup>99</sup>

A report in 1936 by the League of Nations indicated that Australia had the highest *per capita* consumption of heroin and cocaine in the world. A further report in 1953 by a United Nations body, the Permanent Central Opium Board, indicated that the annual *per capita* consumption of heroin (in kilograms per million inhabitants) in Australia increased from 2.42 kilograms per million persons in 1946 to 5.25 kilograms per million persons in 1951.<sup>100</sup>

These reports precipitated a change in Australian domestic policy, with the Federal Government banning the importation of heroin in July 1953. One commentator described the findings of this report in the following terms.

*“Australia’s heroin use had doubled in the seven years from 1946 to 1951 ... Australia was once again at the top of the list on a per capita basis of the world’s heroin consuming countries. ... The 1951 figure of 11.35 lb per million people was more than seventy per cent higher than the comparable figure for 1935.”*<sup>101</sup>

### 5.2.2. 1960s-1970s

There is a belief that Australia’s contemporary heroin problem had its origins in the social milieu of Sydney and Melbourne in the 1960s, it being

*“concentrated almost exclusively in the major urban vice districts, Melbourne’s St Kilda and Sydney’s Kings Cross, experimentation with cannabis and heroin began in the mid 1960s and within a few years had become an habitual pastime among the prostitutes and strongmen there.”*<sup>102</sup>

The next stage in the history of heroin in Australia has been linked to the presence from 1966 of large numbers of American servicemen on “R & R” from the Vietnam war. The majority of these servicemen spent their time, it has been claimed, in the red light districts of Kings Cross in

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<sup>99</sup> Manderson D. *Proscription and prescription*. Canberra, Australian Government Publishing Service, 1987, 28.

<sup>100</sup> “Legal trade in narcotics.” (1953) 5 (2) *Bulletin on Narcotics*, 48, 49.

<sup>101</sup> Davies S. *Shooting up heroin - Australia*. Sydney, Hale & Iremonger, 1986, 40.

<sup>102</sup> McCoy AW. *Drug traffic narcotics and organised crime in Australia*. Artarmon, NSW, Harper & Row, 1980, 258.

Sydney, and St Kilda in Melbourne, such that “over a period of several years, more than a quarter of a million servicemen spent eighty million dollars - primarily in the Kings Cross district.”<sup>103</sup>

The growth in the availability of heroin in Australia stemmed, it is believed, from the activities of established criminal groups in Sydney in the early 1970s, who organised large scale importing of heroin from South East Asia. By the mid 1970s, these syndicates had expanded into well established interstate operations dealing with heroin and other illicit drugs, especially cannabis.

*“At every stage in the growth of Australia’s illicit drug trade during the decade of the 1970s organised crime was heavily involved. To the extent that any small group can be responsible for any major social change, it is accurate to say that organised crime created Australia’s illicit drug traffic.”*<sup>104</sup>

### 5.2.3. 1980s-1990s

Research indicates that heroin use is statistically rare in Australia, with prevalence believed to have remained relatively static from the mid 1970s until the early 1990s. There is growing evidence since the early 1990s of increased quantities of high quality heroin being available in Australia, which has triggered off a new epidemic. Prior to the recent heroin epidemic it was believed that relatively few young people used and became dependent on heroin. The typical heroin dependent was someone in their early thirties.

The most rigorous research has been conducted in conjunction with the National Drug Strategy evaluation studies, and indicates that heroin use is most frequent amongst young males whose usage peaks in their late 20s.<sup>105</sup> It has been concluded that

*“across the population as a whole, slightly less than 2% of individuals report ever having used the drug. However, the results show that use is strongly concentrated in specific age and gender groups. Use of the drug peaks among males in their late 20s, 9% of whom in the survey reported having used heroin. By comparison, only 3% of females in the same age group reported having used it. Among those aged in their 30s or over, heroin use is virtually non-existent.”*<sup>106</sup>

## 5.3. Prevalence in WA

In the Statistical Supplement to the report on the evaluation of the NDS, the following observations were made about trends in heroin use in Australia.

*“Prevalence of heroin consumption remained at relatively low rates between 1988 and 1995. Less than 0.5% of the Australian population have used heroin in the past 12 months. Males were more likely than females to have used heroin, and consumption was concentrated in persons aged less than 30 years. While prevalence rates are low in comparison with other illicit drugs, the trend for the younger age groups appears to be towards more, rather than fewer, persons using heroin.”*<sup>107</sup>

The few surveys of heroin use in WA have involved highly selective populations. For instance, a survey in 1987 of 926 Western Australian prisoners’ drug use found that 19.7% of respondents

<sup>103</sup> Davies S. *Shooting up heroin - Australia*. Sydney, Hale & Iremonger, 1986, 47.

<sup>104</sup> McCoy AW. *Drug traffic narcotics and organised crime in Australia*. Artarmon, NSW, Harper & Row, 1980, 257.

<sup>105</sup> McAllister I, Moore R. *Drugs and public opinion the sociology of drug use in Australia*. Canberra, Department of Community Services and Health, 1988; Plant A, Macaskill P, Lo SK, Pierce J. *Report of the evaluation of the anti-heroin campaign*. Sydney, Department of Public Health, University of Sydney, 1988.

<sup>106</sup> McAllister I, Moore R. *Drugs and public opinion the sociology of drug use in Australia*. Canberra, Department of Community Services and Health, 1988.

<sup>107</sup> Williams P. *Progress of the National Drug Strategy: key national indicators. Evaluation of the National Drug Strategy 1993-1997, statistical supplement*. Canberra, Department of Health & Family Services, 1997, 58.

self reported previous heroin use, even though only 1.7% of those surveyed were imprisoned because of a heroin related offence.<sup>108</sup>

The 1996 ASSAD survey of 12 to 17 year old West Australian secondary school students was conducted by Health Promotion Services in metropolitan and rural schools. Given the small percentages and comparatively large confidence intervals, extreme caution is advised when making conclusions about prevalence. Comparison with other, earlier studies of young people's illicit drug use is problematic due to small sample sizes and different research methodology.<sup>109</sup>

The 1996 ASSAD survey found that 2.2% of 12 to 17 year olds had used heroin in the past year, and 0.8% had done so in the last month. In the 16 to 17 year old age group, 1.9% and 2.7% of males and females respectively had used heroin in the last year, and 0.6% of males and 1.1% of females had used in the last month. Among younger students (12 to 15 years), 2.2% of males and 2.7% of females had used in the last year, and 1.1% of males and 0.5% of females had done so in the last month.

A survey of illicit drug use by Western Australians aged 18 years and over was conducted by Health Promotion Services in 1997.<sup>110</sup> Comparison with previous national figures is problematic due to the small WA sample sizes in the national surveys, and is compounded by the small numbers of people using these illicit drugs.

The 1997 survey found that 1.7% of 18 to 24 year olds had used heroin in the last year, and 0.8% of 18 to 24 year olds had done so in the last month. In comparison, 1.7% of 25 to 34 year olds had also used heroin in the last year, and 0.9% had done so in the last month. Among the adult population aged 18 years and over, 0.6% had used heroin in the last year and 0.4% had used in the last month.

## 5.4. Indicators of abuse

### 5.4.1. ADIS telephone calls

Over the period from the June quarter 1986 to the June quarter 1998, a total of 14,111 illicit opioid related telephone calls were dealt with by ADIS; this was 11.7% of the total of 120,243 drug related calls received in this State (Table 13, Appendix 13).

From 1986 to the end of 1993, the number of opioid related calls received per quarter remained relatively constant, with approximately between 175 and 200 calls per quarter. However, over the four year period from the March quarter 1994, when 208 calls were recorded, to the March quarter 1998, when 632 calls were received, the number of illicit opioid related calls more than trebled. It is to be noted the number of illicit opioid calls over the last three quarters decreased by 15.8%, from 703 calls in the September quarter 1997 to 592 calls in the June quarter 1998 (Table 5.1; Figure 5.1).

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<sup>108</sup> Indermaur D, Upton, K. "Alcohol and drug use patterns of prisoners in Perth." (1988) 21 *Australian and New Zealand Journal of Sociology* 144.

<sup>109</sup> Blaze-Temple D, Lo SK. "Stages of drug use: a community survey of Perth teenagers." (1992) 87 *British Journal of Addiction* 215-225; Odgers P, Houghton S, Douglas G. *Reputation enhancement theory and adolescent substance use* (unpublished).

<sup>110</sup> Health Department of WA. *1997 tobacco, alcohol and illicit drug consumption survey results for licit and illicit drug usage (adults 18+)* (unpublished)

Figure 5.1: Quarterly opioid related calls to ADIS, 1986 - 1998

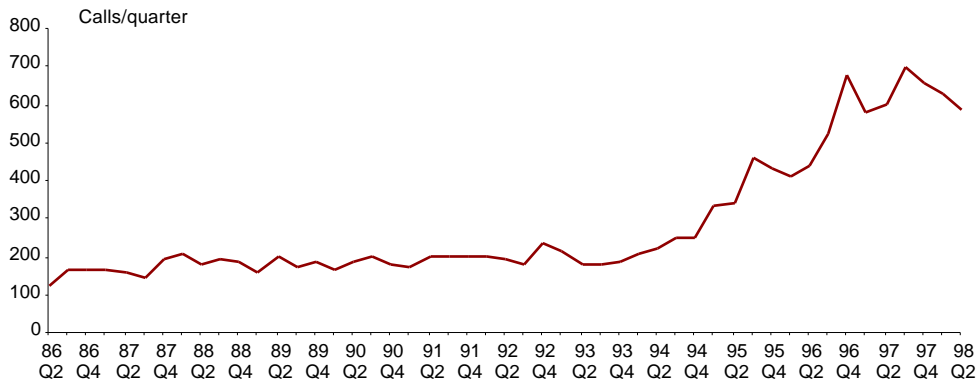


Table 5.1: Quarterly ADIS illicit opioid related telephone calls, 1986 - 1998

Year	Quarter	n	Year	Quarter	n
1986	January-March		1992	January-March	202
	April-June	124		April-June	193
	July-September	166		July-September	183
	October-December	169		October-December	239
	<b>Total</b>	<b>459</b>		<b>Total</b>	<b>817</b>
1987	January-March	166	1993	January-March	215
	April-June	163		April-June	179
	July-September	147		July-September	183
	October-December	196		October-December	191
	<b>Total</b>	<b>672</b>		<b>Total</b>	<b>768</b>
1988	January-March	214	1994	January-March	208
	April-June	185		April-June	223
	July-September	196		July-September	254
	October-December	186		October-December	252
	<b>Total</b>	<b>781</b>		<b>Total</b>	<b>937</b>
1989	January-March	162	1995	January-March	335
	April-June	201		April-June	346
	July-September	178		July-September	462
	October-December	190		October-December	437
	<b>Total</b>	<b>731</b>		<b>Total</b>	<b>1,580</b>
1990	January-March	169	1996	January-March	416
	April-June	190		April-June	440
	July-September	207		July-September	528
	October-December	181		October-December	678
	<b>Total</b>	<b>747</b>		<b>Total</b>	<b>2,062</b>
1991	January-March	177	1997	January-March	580
	April-June	201		April-June	604
	July-September	202		July-September	703
	October-December	203		October-December	663
	<b>Total</b>	<b>783</b>		<b>Total</b>	<b>2,550</b>
			1998	January-March	632
				April-June	592

Source: Alcohol and Drug Information Service.

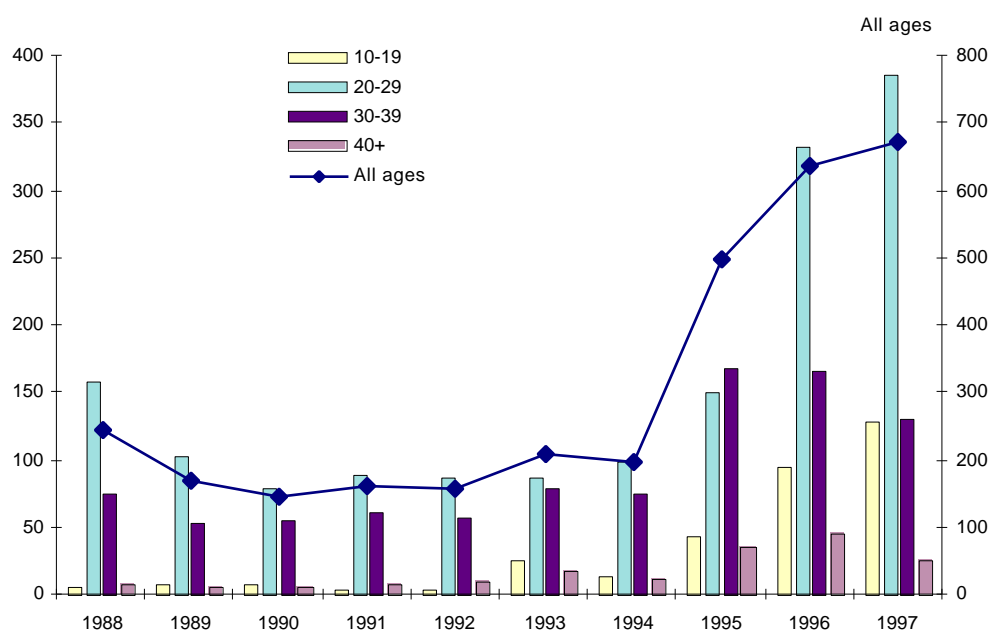
## 5.4.2. Admissions to ADA programs

### 5.4.2.1. Admissions to all programs

Over the period 1988<sup>111</sup> to 1997, there were a total of 3,617 new admissions to all ADA programs for which opioid dependence was the principal problem, of which 3,105 (85.8%) involved *illicit* opioids and 512 (14.2%) involved *licit* opioids.<sup>112</sup> Persons seeking treatment for problems due to licit opioids tended to be mostly in 30 to 39 age group, whereas those seeking treatment for problems due to illicit opioids tended to be a younger population, with the most frequent admissions from the 20 to 29 age group (Table 17, Appendix 13).

The number of new illicit opioid admissions to all ADA programs fluctuated at around 150 per year from 1989<sup>113</sup> to 1992. In 1993 and 1994, there were about 200 admissions per year. Since 1994, the number of new admissions has more than trebled, to 673 in 1997 (Figure 5.2). It can be seen that in 1997, three quarters of all new admissions involved persons aged less than 30 years, whereas in 1994 just over half of all admissions involved those aged less than 30 years of age (Table 17, Appendix 13).

**Figure 5.2: New admissions to all ADA programs by age group – illicit opioids 1988 - 1997**



<sup>111</sup> As the ADA's computerised patient data system was established in March 1988, data for the year 1988 contains refers to the period for the June, September and December quarters of 1988.

<sup>112</sup> Persons dependent on licit opioids are sometimes referred to as having an iatrogenic dependence. Such individuals have become dependent on opioid drugs (such as morphine, pethidine, dextromoramide, oxycodone, codeine and pentazocine) that have been prescribed to them over a period by a GP for the treatment of a pain condition. These individuals usually administer these drugs intramuscularly. However, intravenous drug use may also occur.

<sup>113</sup> The first full year of data is for 1989.

### 5.4.2.2. Admissions to residential detoxification programs

#### **Annual trends**

Over the period 1988 to 1997, there was a total of 1,987 opioid related admissions to ADA residential detoxification programs, of which 484 (24.4%) involved *licit opioids* and 1,503 (75.6%) involved *illicit opioids* (Table 16, Appendix 13). There was a three fold increase in annual admissions due to illicit opioids over the nine year period, from 97 admissions in 1989 to 300 admissions in 1997. The number of *licit opioid* related admissions has followed a similar pattern as has occurred with *illicit opioids* with a growing number of admissions over recent years. Since 1995, there has been an average of 85 licit opioid related admissions per year (Table 16, Appendix 13).

#### **Quarterly trends**

A more detailed overview of trends in admissions per quarter covering the period from the June quarter 1988 to the June quarter 1998 for opioid related admissions is contained elsewhere in this report (Table 22, Appendix 13) and in Figure 5.3.

There have been corresponding increases in the number of licit and illicit opioid related quarterly admissions since the March quarter 1995. This pattern requires further investigation as it may indicate that a small number of GPs are prescribing opioids to illicit opioid abusers and that such drugs are finding their way into the black market. There is support for this proposition, for as was noted earlier in this report, there has been a growth in recent years in prescribing of licit opioids throughout Australia.<sup>114</sup>

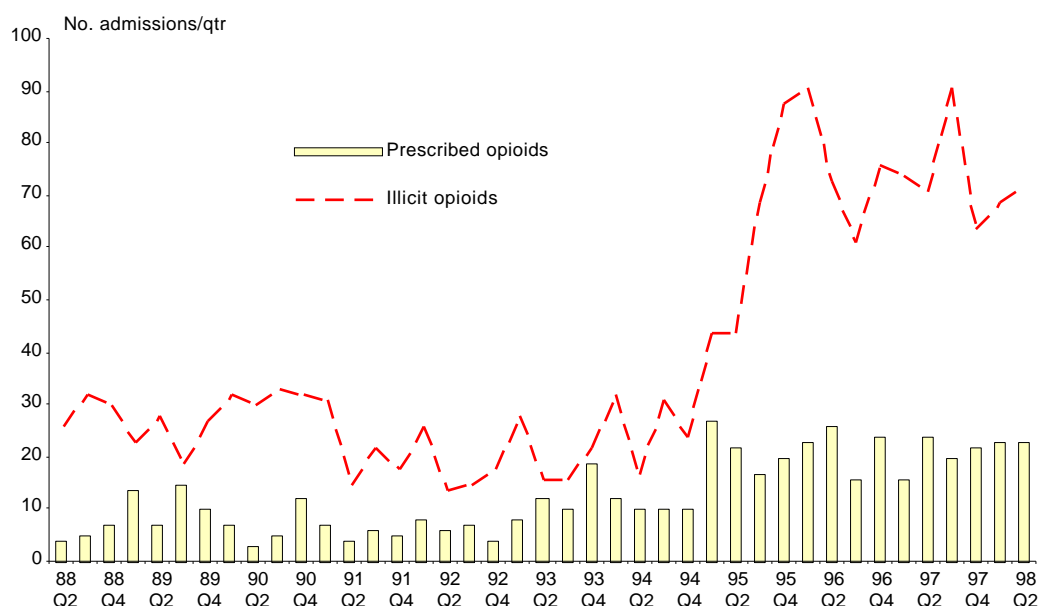
In the March quarter 1994, there were 10 prescribed opioid related admissions. By the March quarter 1998, these had more than doubled to 23 admissions. There was a greater number of illicit opioid related admissions in the earlier part of the period, from the September quarter 1988 to the March quarter 1991, compared to admissions over the period from mid 1991 to mid 1994.

However, there has been a marked growth in illicit opioid related admissions per quarter since the end of 1994, increasing from 24 in the December quarter 1994 to a peak of 91 in the September quarter 1997. In the last 3 quarters, from the December 1997 quarter to the June 1998 quarter, there have been between approximately 65 and 70 admissions per quarter.

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<sup>114</sup> Bell JR. "Australian trends in opioid prescribing for chronic non-cancer pain, 1986-1996." (1997) 167 *Medical Journal of Australia* 26.

**Figure 5.3: Admissions to ADA residential detoxification programs by quarter for licit and illicit opioids, 1988 - 1998**



**Age**

There was a slightly older age group admitted to the CDU in 1997 compared to those admitted to all ADA programs, with just under two thirds of all admissions involving those aged less than 30 years of age. It is to be noted that about a quarter of all patients admitted to the CDU were from the licit opioid group.

**5.4.3. Admissions to hospitals**

Over the period 1982 to 1992 there was a total of 3,883 opioid related hospital admissions, of which 1,448 (37.3%) were males and 2,435 (62.7 %) were females. Opioids accounted for 18.9% of the total of 20,528 inpatient admissions to hospitals due to drugs other than alcohol in WA over this period (Table 5.2).

**Table 5.2: Opioid related hospital admissions by sex, WA, 1982 - 1992**

	Males		Females		Persons	
	n	%	n	%	n	%
Opioids	1,448	16.7	2,435	20.5	3,883	18.9
<b>All drugs (other than alcohol)</b>	<b>8,677</b>	<b>100.0</b>	<b>11,851</b>	<b>100.0</b>	<b>20,528</b>	<b>100.0</b>

**Poisoning**

Over the period 1982 to 1992, there was a total of 3,526 hospital admissions due to poisoning by opioids, of which 1,238 (35.1%) were males and 2,288 (64.9%) were females (Table 5.3). Opioids accounted for 22.2% of the total of 15,891 inpatient admissions to hospitals due to poisoning caused by drugs other than alcohol over this period.

**Table 5.3: Opioid related hospitalisation due to poisoning, WA, 1982 - 1992**

	Males		Females		Persons	
	n	%	n	%	n	%
Opioids	1,238	18.9	2,288	21.9	3,526	22.2
All drugs (other than alcohol)	6,261	100.0	8,580	100.0	15,891	100.0

**Trends**

The male age standardised rate (ASR) of hospitalisation for poisoning due to opioids fluctuated between about 12 and 15 per 100,000 over the period 1982 to 1992, compared to the female rate which fluctuated between about 20 and 35 per 100,000 (Table 5.4). The female rate increased from 30 per 100,000 in 1990 to 35 per 100,000 in 1992. The higher female rate, typically twice the male rate over the latter part of the period, is attributable to a higher rate of attempted suicide by females which results in inpatient hospital treatment.<sup>115</sup>

**Table 5.4: Age standardised rate of opioid related hospitalisation due to poisoning, WA, 1982 - 1992**

	Males	Females
1982	13.4	27.9
1983	15.4	24.5
1984	14.5	24.4
1985	13.7	24.5
1986	11.9	29.8
1987	13.2	21.6
1988	12.5	25.0
1989	12.8	26.6
1990	14.9	29.5
1991	15.3	35.1
1992	14.0	34.9

**5.4.4. Admissions to psychiatric hospitals and units**

**Overview**

It is estimated it cost the mental health system a total of \$25 million to treat those admitted for the first time from 1988 to 1997 to inpatient psychiatric units and hospitals in this State, of which opioid related mental disorders cost a total of \$891,360 (Table 5.5).

Over the period 1988 to 1997, there was a total of 630 admissions directly caused by opioids, which resulted in 3,045 beddays of inpatient stays in psychiatric hospitals and units in this State. This represented a mean of 63 first time admissions per year to inpatient psychiatric facilities in this State over the 10 year period (Table 5.5).

Non dependent abuse of opioids was responsible for 118 (18.7%) of the total 630 admissions and for 478 beddays (15.7%) of the total 3,045 beddays. In relation to all types of drug caused mental disorders over this 10 year period, opioids were responsible for 5.4% of the 11,639 admissions and 6.6% of the 46,071 beddays due to the abuse of drugs other than alcohol.

<sup>115</sup> The male rate for attempted suicide is lower than the female rate, as females typically use less lethal methods of suicide than males. Females more frequently use drugs to attempt suicide, which tend to be less successful, compared to males who use guns, hanging and other more violent methods of suicide, which more often succeed.

## Select Committee Into Misuse of Drugs Act 1981

**Table 5.5: First ever admissions to psychiatric hospitals and units due to opioid abuse, WA, 1988 - 1997**

	Opioid dependence			Non dependent abuse			Dependence and non dependent abuse combined		
	Beddays	\$	Admissions	Beddays	\$	Admissions	Beddays	\$	Admissions
1988	57	15,042	14	48	12,667	3	105	27,710	17
1989	58	16,936	10	-	-	-	58	16,936	10
1990	25	7,765	4	2	621	2	27	8,386	2
1991	62	19,437	9	10	3,135	1	72	22,572	10
1992	85	26,648	10	11	3,449	4	96	30,096	14
1993	104	33,592	17	34	10,982	9	137	44,251	26
1994	404	136,108	49	123	41,439	25	527	177,546	74
1995	486	171,558	126	54	19,062	11	540	190,620	137
1996	825	296,010	178	78	27,986	26	903	323,996	204
1997	461	168,265	95	118	43,070	37	579	211,335	132
<b>Total</b>	<b>2567</b>	<b>891,360</b>	<b>512</b>	<b>478</b>	<b>162,411</b>	<b>118</b>	<b>3044</b>	<b>1,053,448</b>	<b>626</b>

Note: Opioid dependence includes opioid combination.

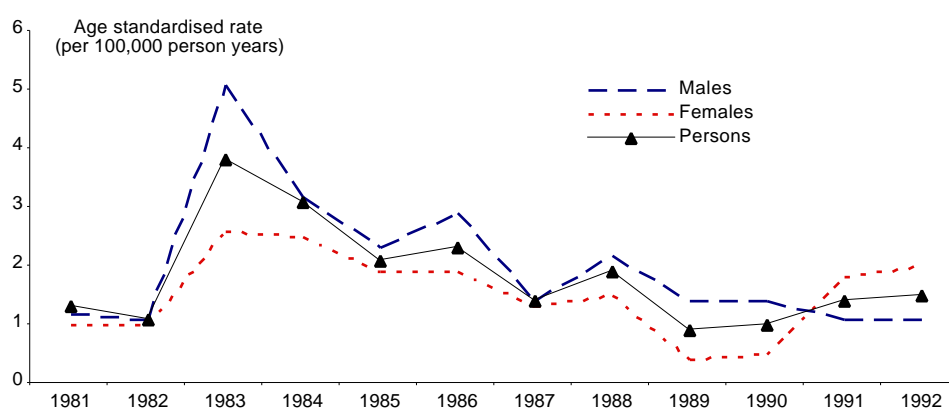
### Trends

There were a number of trends in the age standardised rate (ASR) of hospitalisation for opioid dependence in WA over the period 1981 to 1992. In the early part of the period, from 1981 to 1983, the rate more than trebled, peaking at 3.8 per 100,000 in 1983. However, for the remainder of the period the rate decreased (Table 5.6; Figure 5.4).

The male ASR has decreased from a peak of 5.1 per 100,000 in 1983 to a rate of 1.1 in 1992. However, the female ASR, which had declined to a rate of below 1 per 100,000 by the late 1980s, has increased since 1990, and by 1992 exceeded the male rate (Table 5.6).

The marked reduction in the rate of admissions due to opioid dependence since 1983 is believed to be due to increased access to drug treatment services, particularly methadone treatment.

**Figure 5.4: Age standardised rates of hospitalisation due to opioid dependence, WA, 1981 - 1992**



**Table 5.6: Age standardised rates of hospitalisation due to opioid dependence, WA, 1981 - 1992**

	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
Males	1.2	1.1	5.1	3.2	2.3	2.9	1.4	2.2	1.4	1.4	1.1	1.1
Females	1.0	1.0	2.6	2.5	1.9	1.9	1.3	1.5	0.4	0.5	1.8	2.0
Persons	1.3	1.1	3.8	3.1	2.1	2.3	1.4	1.9	0.9	1.0	1.4	1.5

Note: Age standardised rate per 100,000 person years.

## 5.4.5. Mortality

### 5.4.5.1. Overview - Australia

In drawing conclusions on trends in mortality between jurisdictions, it is important to note that with respect to the less populous jurisdictions (such as the Australian Capital Territory, the Northern Territory and Tasmania) small annual changes in the *number* of fatal deaths can produce apparently large fluctuations in the *rate* of fatal overdose.

Over the period 1988 to 1996, the number of opioid related deaths in Australia increased by 58.7%, from 351 in 1988 to 557 in 1996 (Table 5.7). This was an increase of 42.6% in the standardised mortality rate over this nine year period, from a rate of 36.6 per million population to a rate of 52.2 per million population. To provide a perspective on opioid related mortality in the context of all causes of mortality, the following observation was made in a recent discussion of these data.

*“In 1996 approximately 6.5% of all deaths among people aged 15 to 24 years were due to opioid overdose and approximately 10% of all deaths among those aged 25 to 34 were attributed to this cause. During the interval from 1988 to 1996 the proportion of deaths attributed to opioid overdose increased. Among individuals aged 25 to 34 years, the proportion of deaths attributed to opioid overdose was approximately half that attributed to suicide.”<sup>116</sup>*

There was a small decrease (of 25 deaths) in the total number of fatal opioid deaths from 1995 to 1996. (As will be indicated below, the number of deaths in this State, increased from 1996 to 1997.)

There are a number of observations that can be made about jurisdictional trends over the period. Overall, of the total of 3,503 deaths that occurred from 1988 to 1996, just over three quarters came from the two most populous jurisdictions, with a total of 1,816 (51.7%) deaths from NSW and 888 (25.3%) deaths from Victoria. Just over 20% of the remaining deaths occurred in three jurisdictions: 281 deaths (8.0%) were from WA, 225 deaths (6.4%) were from South Australia and 204 deaths (5.8%) were from Queensland.

Trends in the standardised mortality rate for South Australia, WA and the whole of Australia over the nine year period are presented in Figure 5.4. It can be seen that in the early part of the period (from 1988 to 1991) the WA rate declined by nearly one third, from 19.6 in 1988 to 13.4 in 1991. However, for the remainder of the period the WA mortality steadily increased and reached 61.1 in 1996, an increase of 356% from the rate of 13.4 in 1991. In 1996, the WA rate of 61.1 was 1.17 times higher than the national rate of 52.2.

Of interest, from 1990 to 1994 the South Australian mortality rate exceeded the rate for WA (Table 5.7). However, after peaking with a rate of 45.1 in 1995, the South Australian rate recorded a small decrease in 1996. The recent reduction in deaths in South Australia could be

<sup>116</sup> Lynskey M, Hall W. *Jurisdictional trends in opioid overdose deaths, 1988-1996*. Sydney, National Drug & Alcohol Research Centre, University of NSW, 1988, 4.

## Select Committee Into Misuse of Drugs Act 1981

attributed to the impact of a recently comprehensive heroin overdose prevention campaign in 1996 in that State, under the auspices of the Drug and Alcohol Services Council.

This campaign involved dissemination of education material to heroin abusers, training of peer educators and the development of partnerships between police, user groups, ambulance services and accident and emergency services. The project has resulted in improved protocols for attendances by emergency services at overdose events and respondents have reported a greater understanding of knowledge about overdose and effects of heroin and combinations of other drugs.<sup>117</sup>

It is to be noted that the South Australian rate of 37.9 in 1996 was 154.4% higher than the rate of 14.9 recorded in 1988. As noted above, the rate for WA has increased since the early 1990s, and by 1995 exceeded the South Australian rate.

An examination of the trends in the rate of mortality for New South Wales, Victoria, Queensland and the ACT shows that from 1988 to 1996 all jurisdictions recorded increases in opioid related mortality, as follows (Table 5.7):

- Queensland increased by 60.4%, from 10.1 to 16.2;
- NSW increased by 16.3%, from 62.5 to 72.7; and
- Victoria increased by 37.3%, from 39.9 to 54.8.

It can be observed that over the nine year period from 1988 to 1996, Queensland had a rate that was generally lower than the other three jurisdictions, the Victorian rate was close to or just below the national average and the NSW rate was above the national average (Figure 5.5).

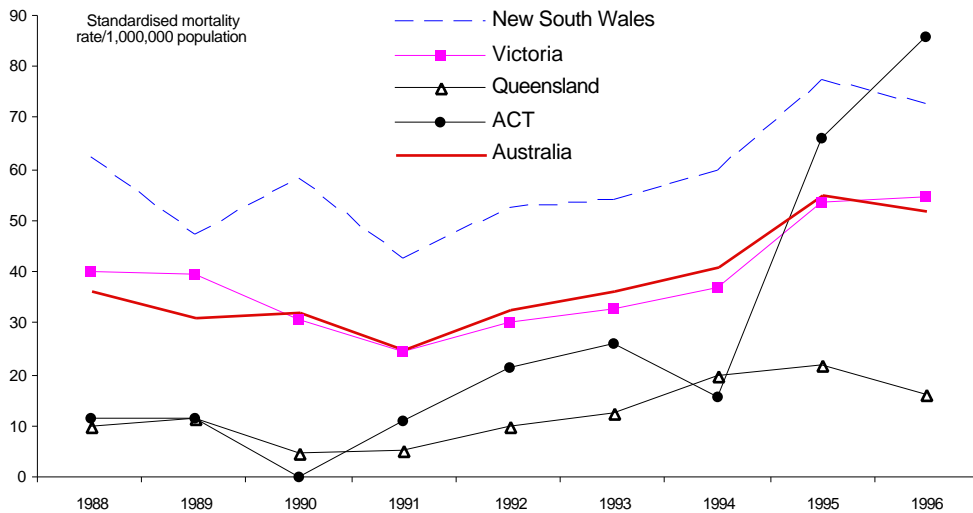
**Table 5.7: Trends in opioid related mortality by jurisdiction persons aged 15 to 54, 1988 - 1996**

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
<b>Number of deaths</b>									
1988	204	99	16	12	18	-	-	2	351
1989	158	99	19	8	18	1	2	2	307
1990	196	79	8	19	14	5	-	-	321
1991	146	64	9	13	13	3	-	2	250
1992	182	79	18	30	22	-	1	4	336
1993	188	86	23	41	24	5	2	5	374
1994	209	97	37	32	38	4	5	3	425
1995	273	140	42	38	70	6	-	13	582
1996	260	145	32	32	64	5	2	17	557
<b>1988-1996</b>	<b>1,816</b>	<b>888</b>	<b>204</b>	<b>225</b>	<b>281</b>	<b>29</b>	<b>12</b>	<b>48</b>	<b>3,503</b>
<b>Standardised mortality rate (per 1,000,000 population)</b>									
1988	62.5	39.9	10.1	14.9	19.6	-	-	11.4	36.6
1989	47.5	39.3	11.6	9.8	19.2	3.9	19.2	11.4	31.3
1990	58.2	30.8	4.7	23.1	14.6	19.1	-	-	32.2
1991	42.8	24.7	5.2	15.7	13.4	11.4	-	10.8	24.8
1992	52.8	30.3	10.1	35.9	22.4	-	9.2	21.1	32.9
1993	54.3	33	12.6	48.9	24.1	18.8	18.3	25.9	36.3
1994	59.9	37.1	19.7	38.1	37.7	15	45.5	15.4	40.9
1995	77.4	53.4	21.8	45.1	68.1	22.5	-	66.2	55.2
1996	72.7	54.8	16.2	37.9	61.1	18.7	17.7	85.6	52.2

Source: Lynskey M, Hall W. Jurisdictional trends in opioid overdose deaths, 1996.

<sup>117</sup> Wood C. "Overcome overdose." *Connexions*, December 1997/January 1998, 12.

**Figure 5.5: Trends in opioid related mortality, NSW, Victoria, Queensland, ACT and Australia, persons aged 15-54, 1988-1996**



#### 5.4.5.2. Overview – Western Australia

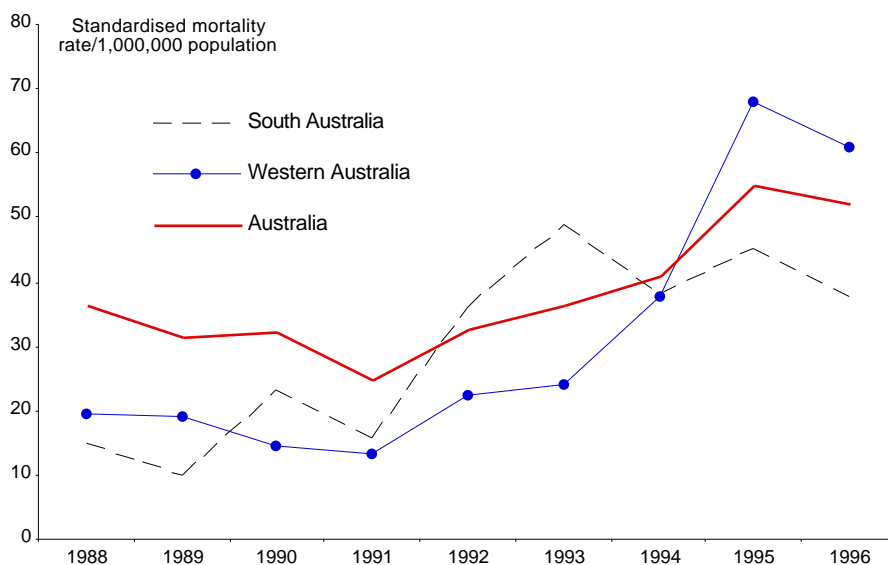
Over the 14 year period from 1984 to 1997, there were an estimated 502 deaths caused by opioid drugs in this State. These 502 deaths, involving both licit and illicit opioids, were due to a number of identified drug related causes (dependence, non dependent abuse, accidental poisoning, suicide or undetermined cause and assault by poisoning<sup>118</sup>).

Over the period 1984 to 1991, the number of opioid deaths in WA fluctuated between 16 and 27 deaths per year. However, over the six year period since 1991, the annual number of opioid deaths has increased, reaching a total of 90 in 1997 (Figure 5.6).<sup>119</sup>

<sup>118</sup> Referred to as ICD9 cause of death codes as set out in: World Health Organisation. *Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death. Ninth Revision.* Geneva, World Health Organisation, 1977.

<sup>119</sup> It is to be noted that the definitive number of deaths for 1997 attributed to opioids was still to be confirmed at the time of writing this report.

Figure 5.6: Trends in opioid related mortality, Western Australia, South Australia and Australia, persons aged 15 to 54, 1988 - 1996



Since 1995, it has been possible to obtain a greater level of detail about the specific opioid drugs involved in opioid deaths in this State, with the establishment of the Coronial Database (under the auspices of the WADASO in collaboration with the Coroner's Court). In the three year period 1995 to 1997, there were a total of 235 deaths caused by opioids, nearly 9 out of 10 of which were due to illicit opioids (Table 5.8):

- 191 (81.3%) were illicit opioid deaths which involved heroin/morphine;
- 14 (5.9%) were illicit opioid deaths which involved the illicit use of opioids other than heroin/morphine; and
- 30 (12.8%) were licit opioid deaths.

Heroin/morphine deaths are those cases where heroin was confirmed by toxicological analysis of blood specimens obtained at post mortem with positive count of the presence of either metabolite diacetylmorphine (uncommon) or monoacetylmorphine (present in almost all cases). In a small number of cases, only morphine was detected. In these instances, this was confirmed as being illicit in origin, being metabolised heroin or morphine, with additional forensic information, such as evidence of injection sites, testimony in witness statements that the deceased had used heroin and evidence of injection paraphernalia at the scene.

In addition to heroin/morphine deaths, there were an additional number of deaths which were classified as other illicit opioid deaths. These deaths involved cases where it was confirmed by toxicological analysis and (where possible) coronial finding that death was due to an opioid other than heroin/morphine, taking into account laboratory findings as to levels of toxicity (ie therapeutic or higher levels) of all drugs detected.

Additional information was gleaned from coronial records to confirm the presence of paraphernalia at the scene, stigmata of injecting drug use, a previous history of the abuse of heroin and other illicit drugs, a history of treatment and the source of the opioid to confirm that death arose from non prescribed abuse.

Quarterly trends in heroin/morphine related mortality are contained in Figure 5.8. It is likely that a number of the deaths in the March quarter 1998, at present recorded as licit, may be due to illicit abuse, depending on confirmation by coronial finding.

Licit opioid deaths involved cases where the individual had been under the management of a medical practitioner, usually for an iatrogenic condition or an illness which required pain management, and that during the course of treatment the individual had overdosed intentionally or accidentally. There was no information to suggest injecting drug use by these individuals. In these cases, it was apparent that a number of the cases involved those with incurable terminal medical conditions who had taken their lives.

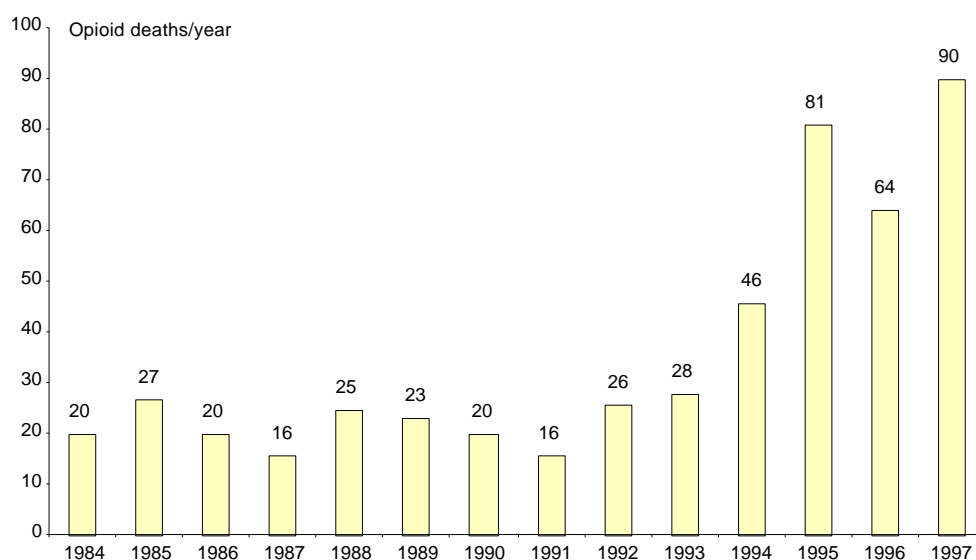
It is suggested that a more accurate picture of opioid abuse in the community is obtained by inclusion of those cases involving heroin/morphine and other cases involving the illicit abuse of opioids of pharmaceutical origin. It was noted that a number of these cases involving illicit abuse of opioids other than heroin/morphine had a history of heroin dependence, who were (at the time of their death) under the care of a medical practitioner authorised to prescribe them a Schedule 8 drug. These patients had ostensibly been prescribed a licit opioid for the management of a pain condition (eg a long standing injury from a motor vehicle or workplace accident) even though they had injected this medication.

By this analysis in WA from 1995 to 1997 there were a total of 71 illicit opioid deaths in 1995, 52 illicit opioid deaths in 1996 and 82 illicit opioid deaths in 1997 (Table 5.8; Figure 5.7). Of these 205 deaths, there was a total of 14 (6.8%) which involved other illicit opioids.

A more detailed consideration of the circumstances of the 14 other illicit opioid deaths for the period 1995 to 1997 is beyond the scope of this report.<sup>120</sup> In summary:

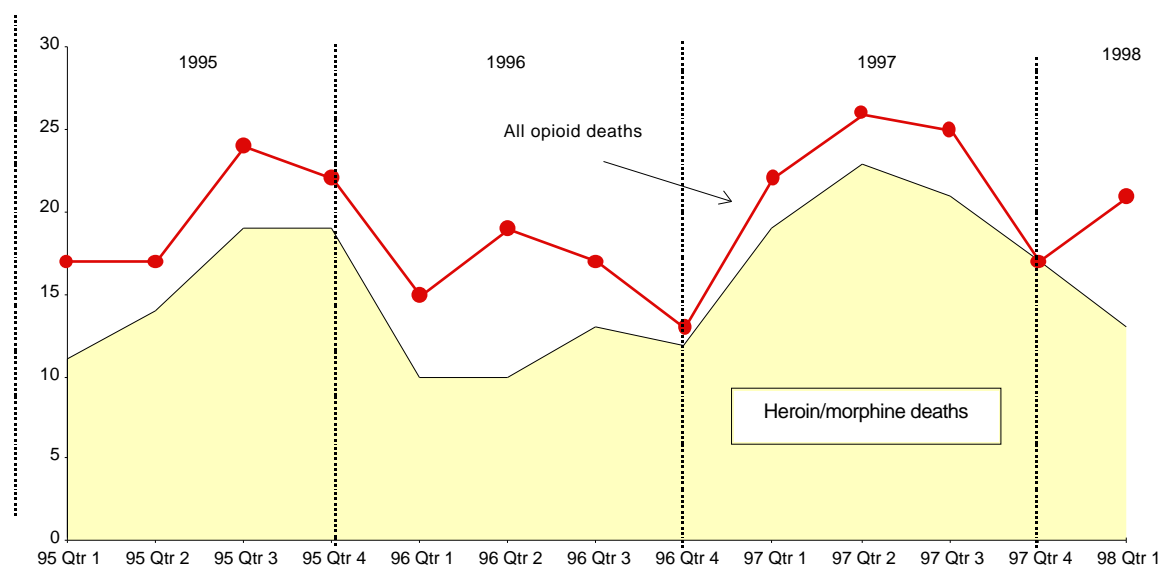
- of the five deaths in 1995, two were due to methadone, two were due to dextromoramide and one was due to oxycodone;
- of the seven deaths in 1996, one was due to methadone, two were due to oxycodone, two were due to dextromoramide, one was due to propoxyphene and one was due to a combination of opioids; and
- two deaths in 1997 were due to methadone.

**Figure 5.7: Annual deaths due to licit and illicit opioid drugs, WA, 1984 - 1997**



<sup>120</sup> A discussion will be contained in a forthcoming Statistical Bulletin to be published by the WADASO.

**Figure 5.8: Quarterly opioid related deaths due to heroin/morphine and all opioids, WA, 1995 - 1998**



**Table 5.8: Quarterly opioid related deaths due to heroin/morphine and all opioids, WA, 1995 - 1998**

	Illicit opioids		Total	Licit opioids	All opioids
	Heroin/morphine	Other			
<b>1995</b>					
Qtr 1	12	2	14	3	17
Qtr 2	14	1	15	2	17
Qtr 3	22	1	23	3	26
Qtr 4	18	1	19	2	21
Total 1995	66	5	71	10	81
<b>1996</b>					
Qtr 1	10	3	13	2	15
Qtr 2	10	3	13	6	19
Qtr 3	13	1	14	3	17
Qtr 4	12	-	12	1	13
Total 1996	45	7	52	12	64
<b>1997</b>					
Qtr 1	19	-	19	3	22
Qtr 2	23	-	23	3	26
Qtr 3	21	2	23	2	25
Qtr 4	17	-	17	-	17
Total 1997	80	2	82	8	90
<b>1998</b>					
Qtr 1	13	1	14	7	21

## 5.5. Pharmacology of opioids

Heroin (diacetylmorphine) is a semi synthetic opiate derived from morphine which is produced in minimal amounts legally. Street heroin is produced in illicit laboratories and imported into Australia, where it is diluted with adulterants before it reaches end users. The chemical is a white crystalline powder, soluble in water. Coloured preparations reflect different contaminants present.

The drug is most commonly administered intravenously (IV) or intra muscularly (IM), but it is also active if smoked or used orally. It is most often used IV because this is a far more cost effective means of achieving the desired psychoactive effects.

The onset of action is rapid and the duration of action is approximately 3-4 hours. The impact effect or “rush” after an IV dose is related to the high fat solubility of the drug and thus its rapid entry into the brain.

## **5.6. Risks**

Apart from the risk of overdose which is a direct CNS effect of the drug, most complications of heroin use relate to the injection of contaminated material, or the use of non sterile injecting equipment. These may include acute heroin reaction, a syndrome with acute onset and signs of cardiovascular collapse, which may prove fatal and septic complications, often resulting from the use of non sterile injecting equipment. There are a number of septic complications including:

- septicemia;
- bacterial endocarditis;
- skin abscesses;
- infective emboli;
- ophthalmitis (a fungal infection); and
- viral infections such as Hepatitis B (HBV), Hepatitis C (HCV), HIV;

In addition to septic complications, heroin use can be associated with neurological complications, infections, embolic lesions, trauma to nerves from direct injection and the sexual transmission of HIV and HBV.

## **5.7. Withdrawal**

Dependence, both physical and psychological, results from regular use of the drug and withdrawal will develop within 12 hours of ceasing regular usage. Maximal withdrawal symptoms are experienced between 36 and 72 hours and symptoms consist of:

- chills and shivering;
- excessive sweating;
- prominent gooseflesh (‘cold turkey’);
- irritability;
- insomnia;
- loss of appetite;
- rhinorrhoea and lacrimation;
- muscle aches and cramps, restlessness;
- diarrhoea; and/or
- yawning.

## **5.8. Treatment of opioid dependency**

There are three main approaches to the treatment of heroin dependence. These are detoxification, relapse prevention and substitution pharmacotherapy.<sup>121</sup>

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<sup>121</sup> Some of the information contained in this section is based on a paper prepared at the request of the Committee by Dr Allan Quigley, Medical Officer in Charge, WA Alcohol and Drug Authority.

### **5.8.1. Relapse prevention**

Relapse prevention is primarily concerned with psychological approaches towards maintaining abstinence including counselling, therapeutic communities and self help programs. Naltrexone is an alternative pharmacological approach to relapse prevention.

### **5.8.2. Substitution pharmacotherapy**

Drugs used in treating opioid dependence may be grouped into two distinct categories, according to the way they function:

- agonists, which act at opiate receptor sites in the brain to induce a change in body function; and
- antagonists, which prevent access of neurotransmitters to opiate receptor sites in the brain, thereby displacing any opioids, reducing craving for and blocking the euphoric effects of opiates.

Substitution pharmacotherapy (maintenance treatment) is concerned with substituting heroin with a legal, synthetic opiate such as methadone. Treatment can vary from six months to several years. There is considerable evidence that if individuals can be maintained on a substitution drug, they are less likely to use heroin, are less likely to engage in criminal activity and to experience improved health and psychosocial functioning. In WA, methadone is the only currently available substitution drug. Alternative pharmacotherapies include buprenorphine and LAAM. For an overview of the major effects and functions of antagonist and agonist drugs used to treat opioid dependence see, Table 5.9.

#### **5.8.2.1. Methadone**

Methadone, a synthetic opiate, replaces heroin and in doing so decreases the need for heroin dependent individuals to regularly use the intravenous opiate. As methadone has a longer life in the body than heroin, clients participating in a methadone maintenance program receive a single prescribed dose of methadone every day. The dose is determined according to the characteristics of the individual. The amount of methadone prescribed is enough to eliminate withdrawal symptoms for 24-36 hours, while still allowing the individual to undertake normal activities and functions.

Patients must take the prescribed dose every day to ensure a stable level of methadone in the bloodstream and control any physical effects which may be experienced. The effects of the drug will vary from person to person. While some individuals will not experience any adverse effects, the strength of effects and their duration may depend upon the size of the dose and the frequency of administration.

#### **Short term effects**

The short term effects of methadone may include:

- sweating and increased body odour;
- analgesia;
- euphoria;
- miosis;
- problems with sexual functioning;
- nausea and vomiting;
- depressed respiration;
- intense constipation;
- below normal drop in body temperature;
- slow pulse, heart palpitations, low blood pressure; and/or
- poor blood circulation.

**Table 5.9: Pharmacology of drugs used to treat opioid dependence**

Drug name	Brand name	Pharmacology	Treatment
Methadone	Physeptone (methadone hydrochloride) Methadone syrup (methadone hydrochloride)	Synthetic opioid analgesic used to relieve severe pain and is a prescribed substitute for heroin for opiate dependent people.  A full opioid agonist.  Reduces the awareness of pain, prevents opioid withdrawal, reduces cravings and blocks the effects of heroin use when given in adequate doses.	In a treatment program, methadone is provided daily in syrup form to be taken orally, with the effects lasting an average of 24 hours.  Methadone treatment assists people to break the routines and habits associated with heroin use and is cleaner and safer than injecting heroin.
LAAM (levo-alpha-acetylmethadol)	Not registered in Australia	Synthetic opioid analgesic.  Full opioid agonist with slow onset and long duration of action.  LAAM prevents opioid withdrawal symptoms.	Alternative to methadone as it is just as effective but lasts an average of 48 hours and can be ingested orally.  Provides greater flexibility for the client and there is less opportunity for illicit diversion.
Heroin (diacetylmorphine)	Illegal in Australia	Opioid analgesic.  Full opioid agonist with fast onset and short half life.  Produces feelings of euphoria, dulls the awareness of pain, blocks the cough reflex, depresses breathing and dampens bowel activity.	Alternative to methadone maintenance treatment as an intermediate goal in treatment and for those not interested in entering methadone maintenance.  The effectiveness of heroin as a treatment for opioid dependency is still under review.
Buprenorphine	Subutex	Synthetic opioid analgesic, as effective as morphine.  Partial opioid agonist with slow onset and long duration of action.  Invokes morphine-like subjective effects.	Available in tablet form for analgesia, rather than for opioid dependence.  For many people, high doses allow for dosing every two to three days.
Naltrexone	Not registered in Australia	Opioid antagonist.	Taken orally and is long acting (up to 72 hours, depending on the dose).  Blocks the effects of heroin or other opiate use.  Has a potential role as a maintenance medication, with selected and highly motivated patients, but the target population is small.  Sometimes used in accelerated or rapid opiate detoxification.
Naloxone	Narcan or Naloxone Hydrochloride Injection	Opioid antagonist. Naloxone vigorously displaces opiates at receptor sites.	Used to reverse the effects of opioid agonists, like heroin, in cases of overdose. It is not used for the treatment of heroin dependence.  It is very costly to use. It can take oral doses as high as 2-3mg to provide a 24 hour blockade.
Clonidine	Catapress	Clonidine is a non opiate (alpha adrenergic blocking agent) that has mainly been used in the treatment of hypertension.	Clonidine is used in a limited fashion to treat opiate withdrawal during the initial phase of detoxification.  Clonidine may be used in combination with an antagonist, such as naltrexone, to minimise precipitated withdrawal symptoms in opioid dependent people.

**Long term effects**

Methadone, when administered in pure and regular doses as part of a treatment program, should not have any severe long term effects on an individual’s health. A number of possible long term effects include:

- weight increase, usually due to fluid retention or change in diet;
- tooth decay, due to reduction in amount of saliva produced (this problem is often present prior to participation in methadone program);
- may lead to impotence or delayed ejaculation in some men;

- loss of libido has been reported by some women;
- amenorrhoea;
- disrupted menstrual cycles; and/or
- reduced fertility.

### **5.8.2.2. Buprenorphine**

Buprenorphine is a long acting mixed opioid agonist-antagonist. It is a strong analgesic but does not produce a heroin like rush when injected. It is poorly absorbed when swallowed and is produced as a tablet that is dissolved under the tongue.

Buprenorphine has the potential to be used as a treatment for opiate withdrawal or as a maintenance treatment. Research in the USA suggests that buprenorphine and methadone have similar effects when used as maintenance treatments. A potential advantage of buprenorphine over methadone is that patients may only need to take the drug every second day. Another advantage is that the withdrawal symptoms that occur when buprenorphine is stopped are less than those associated with methadone.

A clinical trial comparing buprenorphine to methadone is currently being conducted in New South Wales and South Australia. Clinical research using buprenorphine was conducted by the Alcohol and Drug Authority in the mid 1980s. Buprenorphine was shown to be a useful detoxification treatment and an effective alternative to methadone. However, Reckitt & Colman (the parent drug company) were not then interested in seeking TGA approval for use of the drug in the treatment of drug addiction.

Currently, buprenorphine is available in Australia as a 0.2mg tablet for the treatment of pain. At this stage it is unclear whether, even if the more recent trial results are favourable, Reckitt & Colman will seek TGA approval to market a suitable preparation of the drug (an 8mg tablet) in Australia.

### **5.8.2.3. LAAM**

Levo alpha acetylmethadol (LAAM) is an opiate agonist similar to methadone with a duration of action of 48 to 72 hours and is used as a maintenance treatment. The long duration of action allows dosing to be reduced to three times per week and reduces the need for take away doses and the risk of dose diversion. LAAM has been shown to reduce heroin use, reduce involvement in criminal activities and increase emotional and physical wellbeing for those individuals participating in treatment.

The safety and efficacy of LAAM has been demonstrated by international research. LAAM is not registered with the TGA in Australia but has been approved by the FDA in America. Currently, a clinical trial of LAAM is planned in South Australia and an implementation trial is planned in Victoria.

### **5.8.2.4. Heroin prescribing**

In a historical perspective, heroin (diacetylmorphine) and morphine have been prescribed at different periods of time in a number of countries over the past 80 years as a treatment of opioid dependence. For instance, in the United States between 1919 and 1923 more than 40 government clinics prescribed injectable morphine.<sup>122</sup> The so called 'British system' is the best known example of a system for the medical management of those dependent on heroin. In the United

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<sup>122</sup> These were subsequently closed in 1924 following amendments to the Harrison Act. Cf Brecher EM and Editors of Consumer Reports. *Licit and illicit drugs*. Boston, Little Brown, 1972; Musto DF "Opium, cocaine and marijuana in American history." (1991) 265 *Scientific American* 20-27.

Kingdom, prescribing of heroin to treat heroin dependent individuals was instituted following the 1926 Rolleston Committee.<sup>123</sup>

The concept of providing sufficient heroin to an opioid dependent individual to maintain them for as long as they wish is commonly referred to as ‘heroin maintenance.’ This approach to treatment differs from the approach of reducing the dose to eventually detoxify such individuals off the drug completely.

The British approach to treatment operated without much apparent difficulty until the late 1960s, when the demographic profile of the population of opioid dependents changed with growing numbers of younger adults who had become dependent on black market heroin.<sup>124</sup> Drug dependency clinics were established in England in 1968 to better manage prescribing of heroin and other substitute drugs to:

- provide medical care to dependent users;
- provide controlled withdrawal for dependent users; and
- control the spread of heroin use.

Over recent years, the model of drug dependency clinics staffed with psychiatrists and specialist health workers have been supplanted by a growing number of general practitioners prescribing methadone. Consistent with this trend has been a reduction in the number of patients prescribed heroin, with the majority of patients in the UK now receiving methadone.

In the UK in 1993 less than 400 users were prescribed diacetylmorphine, most being in the Merseyside area. In comparison 10,000 were being prescribed methadone. The number being prescribed diacetylmorphine has now fallen further, to 150. A licence is not required if diacetylmorphine is being prescribed for the treatment of organic disease or injury. Although the practice of prescribing heroin to addicts has received significant international attention over the past decade, a recent estimate has put the number of dependent heroin users being prescribed diamorphine as only 336 people for the whole of England.<sup>125</sup>

As noted, in the UK the current approach is to use methadone to treat opioid dependence, which can be prescribed by all registered general practitioners. Only three controlled drugs are not generally permitted to be prescribed in the treatment of drug addiction, for which permission must be obtained from the Home Office.<sup>126</sup> These drugs are diacetylmorphine, cocaine or dipipanone and are generally only granted to consultant psychiatrists working in the National Health Service drug treatment clinics.

*“The rationale for evaluation of medical prescription of heroin is based mainly on the need for dramatically improved treatment outcomes. The results of the recently completed heroin trial in Switzerland showed impressive health, social and economic gains, although the lack of a control arm inevitably limits any conclusions ... Retention on heroin prescription was considerably better than contemporary national retention rates for oral methadone treatment*

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<sup>123</sup> Berridge V. “War conditions and narcotics control: the passing of the Defence of the Realm Act Regulation 40B.” (1978) 7 *Journal of Social Policy* 285-304; Berridge V. “Drugs and social policy: the establishment of drug control in Britain 1900-1930.” (1984) 79 *British Journal of Addiction* 17-29; Spear HB. “Heroin and the British system.” In Bammer G (ed.) *International perspectives on the prescription of heroin to dependent users: a collection of papers from the United Kingdom, Switzerland, the Netherlands and Australia. Stage 2 working papers. Feasibility research into the controlled availability of opioids.* Canberra, National Centre for Epidemiology and Population Health, Australian National University and Australian Institute of Criminology, 1994.

<sup>124</sup> Edwards G. “British policies on opiate addiction: ten years working of the revised response and options for the future.” (1979) 134 *British Journal of Psychiatry* 1-13.

<sup>125</sup> Fleming PM. “Prescription heroin as treatment for dependence – current UK situation.” Paper presented at the 7<sup>th</sup> *International Conference on the Reduction of Drug Related Harm*, Hobart, 3-7 March 1996, 8.

<sup>126</sup> Edwards P. *They don’t become angels. A study of some alternative heroin treatment programs in England from a law enforcement perspective and the relevance to a heroin trial proposed for Australia.* Hobart, Tasmania Police, 1997.

## Select Committee Into Misuse of Drugs Act 1981

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*(although better staffing of the experimental program makes such comparisons problematic). After the Swiss heroin trial, 71% of voters in a national referendum supported continuation of this treatment, with majorities in all 26 cantons.*"<sup>127</sup>

At its meeting on 31 July 1997, the Ministerial Council on Drug Strategy endorsed a heroin trial in the Australian Capital Territory.<sup>128</sup> This trial, if it had proceeded, would have involved 40 people, with the possibility of an additional trial in Sydney.<sup>129</sup> However, on 19 August 1997 the Federal Cabinet withheld approval of the necessary import licences for the trial to proceed. Further to this, there has been some doubt expressed about whether the Commonwealth needed to pass special enabling legislation for the importation of heroin for the trial. The Prime Minister also claimed in an article published in *The Australian*, that a rigorous trial of medically prescribed heroin was tantamount to legalisation and would "send the wrong message".<sup>130</sup>

There has been a range of opinion about the consequences of the refusal of the Federal Government to implement the legislative measures to support the trial. For instance, it has been suggested that this refusal sent wrong messages, one being that

*"this problem will continue to be dealt with predominantly by law enforcement, an approach now widely recognised to be prohibitively costly and hopelessly impractical."*<sup>131</sup>

There has been a growing international interest in prescribing heroin as a treatment of heroin dependent individuals. For example, in June 1998 the New York Academy of Medicine hosted the first international scientific meeting on prescribing heroin. A heroin trial is due to be held in the Netherlands this year, with additional trials under consideration in the UK, Germany, Spain, Austria and Canada.<sup>132</sup>

The Swiss heroin trial, which commenced in January 1994,<sup>133</sup> has generated a range of views amongst professional practitioners and stimulated intense debate in the wider community as to the pros and cons of providing heroin on prescription as a treatment. At the time of writing this report, a number of the evaluations of the Swiss heroin trial have become available, which have generally presented favourable outcomes of the trial.<sup>134</sup>

*"Health outcomes of this trial were extremely impressive. Among 1,146 subjects treated for 18 months, there were no overdose deaths, only three new HIV infections, four new hepatitis B infections and five new hepatitis C infections. Reported income from illicit and semi legal activities decreased from 69% to 10%, the number of offences dropped by 60%, court convictions declined significantly, employment increased from 14% to 32%, and there were net savings of approximately \$A45 per patient per day."*<sup>135</sup>

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<sup>127</sup> Wodak A. "Prescribing heroin: nothing to fear but fear itself?" (1998) 168 *Medical Journal of Australia* 590, 591.

<sup>128</sup> Bammer G et al. *Feasibility research into the controlled availability of opioids. Vol 1: Report and recommendations*. Canberra, National Centre for Epidemiology and Population Health, Australian National University, 1991; Bammer G et al. *Feasibility research into the controlled availability of opioids. Vol 2: Background papers*. Canberra, National Centre for Epidemiology and Population Health, Australian National University, 1991.

<sup>129</sup> National Drug Subcommittee on the Controlled Availability of Opioids. *Controlled availability of diacetylmorphine for the treatment of dependence: the national implications*. Information paper prepared for the Ministerial Council on the Drug Strategy. May 1997.

<sup>130</sup> Cited in Wodak AD. "Public health and politics: the demise of the ACT heroin trial." (1997) 167 *Medical Journal of Australia*, 348.

<sup>131</sup> Ibid.

<sup>132</sup> Nadelmann E "Commonsense drug policy." (1998) *Foreign Affairs* Jan/Feb 111-126 cited in Wodak A "Prescribing heroin: nothing to fear but fear itself?" (1998) 168 *Medical Journal of Australia* 590-591.

<sup>133</sup> Nadelmann EA. "Switzerland's heroin experiment." *National Review* 10 July 1995, 46-47.

<sup>134</sup> Perneger TV, Giner F, Del Rio M, Mino A. "Randomised trial of heroin maintenance program for addicts who fail in conventional drug treatments." (1998) 317 *British Medical Journal* 13-18.

<sup>135</sup> Wodak AD. "Public health and politics: the demise of the ACT heroin trial." (1997) 167 *Medical Journal of Australia*, 348.

The Select Committee received a number of written submissions presenting points of view both for and against consideration of a heroin trial in this State. The Select Committee accepts that there would need to be a period of intense and careful consideration before a heroin trial could be implemented in this State. Clearly any such development would need to involve a national approach to avoid ‘honey pot’ effects<sup>136</sup> and would need to be fully supported by the Federal Government.

**Finding 3**

*Despite divergent views on the issue, and while accepting there will and needs to be a fully informed ongoing community debate on possible ways for dealing with the heroin problem, it was noted that current Federal Government policy would not allow a free heroin treatment program or trial. Accordingly the majority of the Select Committee is of the view that any recommendation on this issue would be pointless.*

**5.8.2.5. Other drugs**

In Australia there has also been interest in clinical trials of injectable heroin and slow release oral morphine as detailed above. The heroin trial that was being planned in the ACT has failed to gain the necessary Federal Government support. A trial of oral morphine as an alternative to methadone is being considered in Victoria.

**Recommendation 16**

*That the Health Department of WA monitor and report on the alternative pharmacotherapies as they become available in the treatment of illicit drug abuse.*

**5.8.3. Detoxification**

Detoxification is primarily concerned with the safe and comfortable physiological withdrawal from opioids, and usually involves medication and supportive counselling. The usual length of heroin withdrawal is 5 to 7 days. Drug withdrawal in itself does not produce behaviour change resulting in long term abstinence, it is only the first step.

In WA, residential and outpatient detoxification is provided at the Central Drug Unit and home based detoxification is primarily provided by general practitioners. The medications most commonly prescribed are doloxene, clonidine, diazepam and temazepam. Alternative pharmacotherapies for opioid withdrawal include buprenorphine and (for rapid detoxification) combinations of clonidine, diazepam, naloxone and naltrexone.

**5.8.3.1. Ultra rapid opiate detoxification**

Ultra Rapid Opiate Detoxification (UROD) has recently been promoted in Australia by Dr Andre Weissman as a treatment for opiate dependence, which it is claimed achieves a very high rate of abstinence after 12 months. The treatment being provided at Dr Weissman’s Institute in Tel Aviv involves a medically induced detoxification followed by up to one year’s maintenance on naltrexone.

Detoxification is achieved within 1-2 days by administering naloxone and naltrexone under general anaesthesia in an intensive care unit. Naloxone and naltrexone are opiate antagonists that displace heroin from the opioid receptors in the brain. In UROD, naloxone and naltrexone are

<sup>136</sup> Bammer G, Tunnicliff D, Chadwick-Masters J. *How could an influx of users be prevented if Canberra introduces a trial of controlled availability of heroin? Stage 2 working papers. Feasibility research into the controlled availability of opioids.* Canberra, National Centre for Epidemiology and Population Health, Australian National University and Australian Institute of Criminology, 1994.

administered under anaesthesia so that patients do not experience the distressing symptoms of opiate withdrawal.

This controversial deep sedation phase of the treatment is not an essential component because naltrexone assisted detoxification can also be accomplished in a conscious patient using other drugs such as clonidine and benzodiazepines to treat the withdrawal symptoms. This less aggressive approach to detoxification is referred to as rapid opiate detoxification (ROD).

There has been considerable concern expressed by experienced alcohol and drug clinicians and researchers in Australia about the treatment provided by Dr Waissman, the claims for 100% success that have been made and the media promotion of UROD. Painful and important lessons have been learnt in Australia from the Chelmsford Private Hospital experience with deep sleep therapy. These clinicians and researchers recommend that UROD should only be introduced to Australia after very careful research and evaluation.

More recently, disquiet has been raised concerning the overpromotion of UROD as a comprehensive treatment for heroin dependence. The confusion over this issue has arisen because of the promotion of UROD as an accelerated detoxification procedure, a relatively intense process extending over 24 to 48 hours, to be followed by a period of extended maintenance on naltrexone as a treatment for heroin dependence.

It has been suggested that the perception that naltrexone is a treatment for heroin dependence entails some significant risks. One such risk is that if treated users drop out of naltrexone treatment and resume heroin use, they face a much greater risk of fatal overdose than would otherwise be the case, as they would have zero tolerance to heroin. In an interview in October 1997 Professor Wayne Hall, Director of the National Drug and Alcohol Research Centre, made the following observation.

*“... there was a lot of enthusiasm for naltrexone in the mid to late 1970s and quite a lot of work was done on it. It was a very attractive drug ... because it does not have any effect in itself, except to block heroin... it was trialed against methadone and against placebo. The results were quite disappointing largely because people tended to discontinue taking it. That’s true of a lot of drugs, but it was particularly true of naltrexone”.*<sup>137</sup>

Other criticisms have included that UROD, given it offers the possibility to a heroin dependent individual to be quickly and apparently painlessly detoxified, will be construed by some as removing a barrier that would have otherwise constrained their use of heroin. In effect, the prospect of an easy cure may encourage, it is suggested, an attitude of more reckless and unfettered use in the heroin using community.

A recent criticism of the UROD approach appeared in the June 1998 issue of Time magazine. The article outlined the operation of CITA in the USA, where it has opened a number of franchised clinics which charges \$6,800 per treatment.<sup>138</sup> Similar clinics have been opened in a number of other countries.

*“Of greater concern, a report released two years ago by the National Institute on Drug Abuse warned that the technique involves an ‘unacceptable’ risk of death, and a review article in the Journal of the American Medical Association last January concluded that existing data do not support the safety of the process.”*<sup>139</sup>

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<sup>137</sup> Ultra rapid opiate detoxification (Transcript). *Health Report, Radio National*. Radio Transcripts, Australian Broadcasting Commission. [<http://www.abc.net.au/rn/talks/8.30/helthrpt/stories/s318.htm>]

<sup>138</sup> For ethical concerns about the franchising of CITA’s method of rapid opioid withdrawal under anaesthesia see Brewer C, Williams J, Renduels EC, Garcia JB. “Unethical promotion of rapid opiate detoxification under anaesthesia (RODA).” (1998) 351 *Lancet* 218.

<sup>139</sup> Jaroff L. “How good is ER’s R?” *Time* 1 June 1998, 51.

A recently released paper dealt with the results of a study of a cohort of 81 opioid dependent patients treated with naltrexone, compared with those who received either an intensive psychosocial protocol or a standard community treatment. It was found that 13 subjects had overdosed within a 12 month period, four of which were fatal. These overdose rates are much higher than patients on methadone treatment and are similar to mortality rates of untreated heroin dependence.<sup>140</sup>

A comprehensive discussion of the advantages and risks of naltrexone treatment are beyond the scope of this report, as the research in this field is voluminous.<sup>141</sup> It is expected that with the completion over the next two years of a number of trials in a number of Australian jurisdictions and other countries, it will be possible to more clearly identify outcomes.

### 5.8.3.2. Naltrexone

#### **Introduction**

Naltrexone is an opioid antagonist that binds to the opioid receptors in the body and blocks the effect of heroin and other opioids. Once inducted on naltrexone, patients cease craving and using opiates. It does not produce euphoria, is not addictive, and patients do not abuse it. For most people, its side effect are minimal.

Naltrexone has been demonstrated to reduce relapse rates and improve psychosocial functioning in patients who have completed an opiate withdrawal. However, its place in the long term treatment of opioid addicts is limited by the high failure rates of opioid detoxification (a necessary first step to naltrexone treatment) and low patient acceptance. Certain subgroups of patients, such as recovering health professionals and paroled prisoners, do better than street addicts.<sup>142</sup>

#### **Clinical pharmacology**

Naltrexone hydrochloride, a thebaine derivative, is a synthetic congener of oxymorphone. It is a white crystalline compound that is soluble in water.

Naltrexone is a pure opioid antagonist that blocks, by competitive binding at opioid receptors, the pharmacological effects of intravenously administered opioids. Tolerance does not develop to its opioid antagonist effect. It has few intrinsic actions other than producing some pupillary constriction. In heroin dependent individuals it will induce withdrawal.

Naltrexone is quickly absorbed after oral administration. Its effects are long lasting. A dose of 50mg of naltrexone will block the effects of 25mg of IV heroin for up to 24 hours. Following oral administration, naltrexone is subject to extensive “first pass” hepatic metabolism. The major metabolite, 6-b-naltrexol, is also believed to be a pure opiate antagonist. Naltrexone and its metabolites are excreted primarily by the liver.

Naltrexone has the capacity to cause dose related hepatocellular injury, with the margin of separation between the apparently safe and the hepatotoxic dose being five fold or less. Naltrexone is contraindicated in opioid dependent patients (detoxification is necessary) and patients with acute hepatitis or liver failure.

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<sup>140</sup> Miotto K, McCann MJ, Rawson RA, Frosch D, Ling W. “Overdose, suicide attempts and death among a cohort of naltrexone treated opioid addicts.” (1997) 45 *Drug and Alcohol Dependence* 131-134.

<sup>141</sup> Mattick RP, Bell J, Daws LC, White JM, O’Brien S, Harris SJ. *Review of the evidence on the effectiveness of antagonists in managing opioid dependence*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1998.

<sup>142</sup> Mattick RP, Bell J, Daws LC, White JM, O’Brien S, Harris SJ. *Review of the evidence on the effectiveness of antagonists in managing opioid dependence*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1998.

## **Select Committee Into Misuse of Drugs Act 1981**

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### **Australian situation**

Naltrexone is not registered with the Australian Therapeutic Goods Administration (TGA) and prescribers must either obtain authorisation under section 19(5) of the Commonwealth *Therapeutic Goods Act 1989* or advise of an exemption in life threatening cases under section 12(A) of the Act. Clinical trials must also be approved by the TGA.

In America, naltrexone was approved by the Food and Drug Administration (FDA) for general use in 1984. Naltrexone is available as a 50mg tablet manufactured in the USA by Du Pont Pharmaceuticals and 'distributed' in Australia by The Boots Company (Australia) Pty Ltd.

At the Ministerial Council on Drug Strategy (MCDS) meeting of 31 July 1997, Ministers endorsed a concerted national effort to develop a broad range of effective and evidence based treatment options for people who are opioid dependent. A number of jurisdictions have indicated their intention to trial a range of alternative treatment modalities, including:

- trials of buprenorphine and naltrexone for heroin withdrawal and of naltrexone for accelerated detoxification from methadone (ACT);
- a trial of rapid opiate detoxification at the Royal Brisbane Hospital and a trial of naltrexone as a relapse prevention agent (Qld);
- trials of rapid opiate detoxification, with and without anaesthesia, and a two stage trial at Sydney Hospital of rapid opiate detoxification under sedation (NSW); and
- a trial to be undertaken by the Drug and Alcohol Services Council, in collaboration with the Royal Adelaide Hospital and the University of Adelaide, which will consist of 50 people being treated by accelerated detoxification under anaesthetic, followed by a daily dose of naltrexone for 12 months (SA).

As part of the National Illicit Drugs Strategy, \$1.3 million over 3 years has been allocated for evaluation, monitoring and subsequent dissemination of the outcomes of such trials. At its meeting of 4 May 1998, MCDS noted that as a matter of urgency the Commonwealth will let a contract to finalise a nationally consistent framework for evaluation and monitoring of trials of alternative pharmacotherapies for opioid dependence across the nation.

The Commonwealth has begun discussions with the National Drug and Alcohol Research Centre (NDARC) on the details of this contract. NDARC will work in close collaboration with all States and Territories undertaking or planning to undertake trials of alternative pharmacotherapies.

In preliminary discussions with Professor Wayne Hall, Director of NDARC, it has been identified that the role of NDARC will be to:

- develop best practice protocols and build infrastructure and expertise in Australia to undertake controlled evaluations of new treatments for drug and alcohol dependence;
- ensure that the trials provide as authoritative as possible assessments of the safety, efficacy and cost effectiveness of these treatments;
- develop standardised treatment protocols and treatment record forms that will maximise the comparability of data and allow results from trials to be pooled; and
- develop economic methods of evaluation that may permit estimates to be made of the cost effectiveness of the treatments by comparison with existing treatments, such as methadone.

In early February 1998 the NSW Government announced a \$600,000 trial of naltrexone with 110 patients at two Sydney hospitals. Westmead Hospital will be one site for the trial, while it is understood the other is Sydney Hospital in the city centre. Stage one of the trial will be completed by 30 June 1998, and will be followed by a full, randomised clinical trial. The Westmead trial will test the rapid opioid detoxification process on 80 patients both with and without anaesthesia.

The naltrexone trial at the Westmead Hospital involves a process of naltrexone administration called Rapid Induction of Opioid Receptor Blockade (RIORB), which blocks the receptor for up to three days. This means that if heroin is used over this period, there is no effect. The trial was

divided into 2 programs targeted at two different populations of opioid dependence: heroin users and methadone users. The heroin program is divided into three sample groups, each consisting of 80 people. The first group undertakes conventional detox with subsequent opioid receptor blockade. Both the second and third group use the RIORB method, except the second group uses it under anaesthetic while the third group uses it under sedation. All the groups receive 12 months support and counselling.

Dr Jon Currie, a member of the medical team conducting this trial, has warned

*“that if a person on naltrexone administers an opioid at pretreatment levels there is a danger of an opioid overdose. This is because naltrexone has blocked the receptors and in doing so, has reduced all tolerance levels to opioids. Patients need to be told of this at the beginning to avoid the potential for overdoses.”*<sup>143</sup>

Other concerns about the aspects of this trial have been raised by Dr Alex Wodak, who has stated *“there has been no call for submissions, no independent scientific reviewing panel and no criteria for judging and that’s not the way to get maximum bang for scientific dollars which are very scarce”*. Professor Ian Webster, Professor of Public Health at the University of NSW, also indicated concern of this trial when he stated that *“any innovation has to go through the proper trials and ethical and scientific reviews”*.<sup>144</sup>

### **Therapeutic Goods Administration**

The fundamental basis of supply of therapeutic goods in Australia is their inclusion in the Australian Register of Therapeutic Goods (ARTG). Presently, there are no naltrexone products registered in the ARTG; therefore, they cannot be marketed in this country and are referred to as “unregistered”. The decision to pursue registration of a drug product is a matter for sponsors (usually drug companies) and such decisions are usually made on commercial grounds.

If a sponsor wished to register a product containing naltrexone, it would be necessary to submit a registration application to the TGA. The TGA evaluates registration applications to ensure the drug is safe and effective for its intended use before it is approved (registered) for marketing in this country.

The Commonwealth *Therapeutic Goods Act 1989* contains provisions which allow fees associated with registration to be waived or reduced in certain circumstances (for example, when supply of the drug is in the public interest and registration of the product would not otherwise be commercially viable for the drug company).

Importation of naltrexone is controlled under the Commonwealth *Customs (Prohibited Imports) Regulations 1956*. The TGA is responsible for issuing import permission and would, in general, only give permission where it had been confirmed that the proposed use of the drug would be lawful under the Commonwealth *Therapeutic Goods Act 1989* (for example, use under one of the above mechanisms).

### **Supply as an unregistered drug product**

Unregistered therapeutic goods can be legally supplied only if they are the subject of a specific exemption or approval provided for under the Commonwealth *Therapeutic Goods Act 1989* (the Act).

Naltrexone has been supplied under these special provisions of the Act for some years and has been subject to the same approval requirements for importation and use as any other unregistered drug of its type. The mechanisms via which it may be supplied currently are:

- under the Special Access Scheme (SAS);
- by an authorised prescriber under section 19(5); and

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<sup>143</sup> CEIDA update.

<sup>144</sup> ADCA News of the Day [update@adca.org.au].

## **Select Committee Into Misuse of Drugs Act 1981**

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- for use in a clinical trial notified under the Clinical Trial Notification (CTN) Scheme.

The Australian company currently holding the licence for naltrexone may provide supply of an unregistered naltrexone product via these mechanisms.

The TGA is unable to give any assurances regarding the quality, safety and efficacy of an unregistered drug product and use of unregistered drug preparations must be regarded both medico legally and ethically as experimental.

### **Special access scheme**

Section 19(1) of the Commonwealth *Therapeutic Goods Act 1989* provides for an approval to supply an unregistered drug product via the SAS to an individual patient. An exception to this process exists where supply of an unregistered drug is required for the treatment of a patient who is terminally ill or seriously ill with a life threatening condition. Such supply is classed as Special Access Scheme Category A and is not subject to case by case approval by the TGA – only notification to the TGA is required. SAS Category A is provided for under section 18 of the Act.

Requests from medical practitioners for approval to use naltrexone in individual patients are considered by the TGA on a case by case basis in line with usual SAS procedures. As part of the approval process, the TGA seeks reasonable assurance that the practitioner has appropriate qualifications and experience, that the drug will be used under adequate medical supervision, and that use of an unregistered drug is justified for the proposed indication.

Section 19(1) is intended to apply on an individual case basis and where the number of patients treated by an individual practitioner is expected to be very small. An appropriate mechanism for supply of an unregistered drug product for use in larger numbers of patients would be for the prescriber to seek authorisation to prescribe the drug under section 19(5) of the Commonwealth *Therapeutic Goods Act 1989*.

### **Authorisation under section 19(5)**

Medical practitioners may request approval from the TGA for authorisation to supply an unregistered drug under section 19(5) of the Commonwealth *Therapeutic Goods Act 1989*. As part of the application process, a practitioner would provide a justification for use of the drug and seek the endorsement for the proposed use of the drug from an institutional ethics committee or relevant specialist medical college or society as appropriate to the practitioner's medical practice. Doctors authorised by the TGA under section 19(5) may supply a specified unregistered drug to patients in their immediate care without seeking approval from the administration on an individual patient basis.

### **Clinical trial notification scheme**

The majority of clinical trials undertaken in Australia are conducted under the Clinical Trial Notification (CTN) Scheme. Under this scheme, the Commonwealth is not directly involved in approving trials – that responsibility rests with Institutional Ethics Committees. Where approval to conduct a clinical trial involving an unregistered drug has been obtained from a properly constituted ethics committee, only notification to the Therapeutic Goods Administration of intention to conduct the trial is required.

### **Permission given to a therapeutic body**

It is also believed that the Royal Australian College of General Practitioners has received approval from the TGA for selected and trained GPs to prescribe naltrexone. Arrangements for this method of providing greater access to naltrexone through GPs in this State has not been finalised at this stage.

### **Standard for the uniform scheduling of drugs and poisons**

The Standard for the uniform scheduling of drugs and poisons (SUSDP) is the recommendation of the National Drugs and Poisons Schedule Committee regarding classification of drugs and poisons

into schedules for inclusion in the relevant legislation of the States and Territories. One of the intentions of the SUSDP is to promote uniform scheduling of substances throughout Australia.

At its November 1997 meeting, the Select Committee recommended that naltrexone be entered into Schedule 4 (S4) of the SUSDP.<sup>145</sup> This recommendation follows the increasing use of naltrexone under the various provisions for importation and supply of unregistered drugs in Australia. In view of the special precautions, warnings and contraindications which need to be considered with naltrexone, the drug should only be used under appropriate medical supervision. In addition, similar substances, such as naloxone, are included in Schedule 4 of the SUSDP.

The TGA anticipates that where the S4 recommendation for naltrexone is adopted into State/Territory legislation, the change will come into effect on 19 June 1998.

The scheduling of a substance in the SUSDP is very different from the registration of a product on the ARTG for marketing. The SUSDP includes substances that are contained in registered and unregistered goods.

Entry of naltrexone in S4 of the SUSDP does not:

- alter the current status of naltrexone as unregistered;
- alter the mechanisms or approval processes via which naltrexone may be supplied as an unregistered product under the Commonwealth Therapeutic Goods Act; and
- remove the need to have a valid approval or exemption for use of an unregistered naltrexone product.

One of the conditions of supply of an unregistered drug is that its use must comply with any State or Territory requirements. If adopted as S4 under State/Territory legislation, naltrexone would be prescription only (that is, it could only be supplied on the prescription of a medical practitioner). Consultation with a medical practitioner would therefore be required to legally obtain supply of this drug.

### **Local situation**

In June 1997 Dr George O'Neil, an obstetrician in private practice in Subiaco with an interest in treating patients with drug related problems, started prescribing naltrexone. Working under the umbrella of the Australian Medical Procedures Research Foundation (a Christian mission and charitable organisation), he has developed a treatment program that involves rapid outpatient opiate detoxification, naltrexone and an active social and rehabilitation program.<sup>146</sup> A preliminary report on the first 100 patients treated by Dr O'Neil was published earlier this year, which provides an overview of the approach followed, including the emphasis of daily supervision of naltrexone administration.<sup>147</sup>

Following release of this initial report there was some criticism of aspects of these results, concerning the issue of whether naltrexone patients may face higher risk from overdose if they cease treatment.<sup>148</sup> In an article in *The West Australian* which reported on Dr Byrne's criticisms, it was stated that Dr O'Neil believed that a 90% retention rate was a very good outcome compared to overseas naltrexone trials.<sup>149</sup>

*"It should be noted that mortality (from all causes) in patients in methadone treatment is approximately 0.25 – 0.5% per annum. The two deaths in 4 months in 100 cases represents a*

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<sup>145</sup> Schedule 4 deals with poisons that should, in the public interest, be restricted to medical, dental or veterinary prescription or supply, together with substances or preparations intended for therapeutic use, the safety or efficacy of which requires further evaluation.

<sup>146</sup> As at May 1998 it is believed that about 700 patients had participated in the AMPRF naltrexone program.

<sup>147</sup> Hulse G. "Naltrexone – defining a framework for use." *APSAD Newsletter* Summer 1998.

<sup>148</sup> <sup>148</sup> Byrne A. "Comments on APSAD Newsletter report on naltrexone trial." [ajbyrne@ozemail.com.au].

<sup>149</sup> Pryer W. "Expert attacks heroin hope." *The West Australian* 30 March 1998, 11.

*raw figure of 6% ... These results are broadly consistent with overseas experience where poor retention rates and deaths have been reported.*<sup>150</sup>

There is active consideration for the ADA to be involved in a collaborative study in the use of naltrexone with Turning Point. The details of the arrangements have not been finalised at this stage. The HDWA entered into a contract for \$60,000 with Dr O'Neil earlier in 1998, for him to develop an infrastructure and establish the capability to collect data and to monitor participation of patients in his program. This funding is intended to enable the development of a computerised patient record system – it is not related to an evaluation of the treatment program.

An evaluation of Dr O'Neill's naltrexone program has been funded by the HDWA for \$20,000 and is to be conducted by Dr Gary Hulse from the University Department of Psychiatry. This evaluation covers the period September 1997 to April 1998, and at this stage, only an interim report has been published.

## 5.9. Methadone treatment

### 5.9.1. Introduction

#### 5.9.1.1. National perspective

Methadone is a synthetic opioid which was developed in Germany in 1941 for the relief of pain. It was first used as a treatment for heroin dependence in New York in 1964 and was subsequently introduced in 1969 into Australia for the same purpose. From 1969 and up to the early 1980s, methadone treatment was gradually expanded in Australia, to reach a national treatment population of about 3,000.

In the early 1980s there was a widespread community and professional concern about the increasing amount of mortality, illnesses and crime associated with heroin use, particularly in New South Wales. There was a realisation by all governments that increased resources and expanded treatment and preventive options, including methadone treatment, needed to be implemented because of serious concerns, especially regarding the public health consequences of a growing number of injecting drug users.

The Special Premiers' Conference was held in April 1985 and provided a consensus on a national approach, the National Campaign Against Drug Abuse (NCADA), to deal with the growing health and social problems from the abuse of heroin and other drugs in Australian society. At the launch of NCADA, methadone treatment was endorsed as an appropriate and useful modality for treating those who were heroin dependent. An important outcome of the Special Premier's Conference was a greater understanding of the need to incorporate public health principles into the response to drug problems and that it *“accepted harm minimisation as the principal aim of national drug policies”*.<sup>151</sup>

Following the Special Premier's Conference, there was a growing appreciation of the serious risks posed from HIV being spread due to the high risk practices of injecting drug users (IDUs), particularly due to the reuse of non sterile injection equipment. There was considerable concern that the spread of HIV posed an enormous threat to IDUs themselves and the wider community, as HIV was readily transmitted by heterosexual contact to those who did not use heroin. Experience from the United States had also identified that limited access to treatment was responsible for significant numbers of heroin dependent women becoming infected and giving birth to HIV positive babies who developed AIDS. The burden on the health and welfare systems from this problem was substantial.

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<sup>150</sup> Byrne A. Comments on APSAD Newsletter report on naltrexone trial. [ajbyrne@ozemail.com.au].

<sup>151</sup> Australia, Department of Health and Family Services. *National policy of methadone treatment*. Canberra, Australian Government Publishing Service, 1997, 4.

These public health concerns meant that by the late 1980s methadone programs had expanded in most jurisdictions, as a policy instrument to implement public health measures to reduce the risks of HIV and to promote social and rehabilitative goals to assist those dependent on heroin. In the early 1990s, the public health advantages of methadone were realised following growing evidence of very high rates of hepatitis C (HCV) infection in the population of IDUs in all jurisdictions. It has been estimated that in Australia between 50 and 70% of IDUs have been infected with HCV.<sup>152</sup> A more detailed discussion of HCV is provided in chapter 8.

A key advantage of methadone programs is that which they are able to attract large numbers of heroin dependent individuals for treatment, contributes to the net reduction in demand for heroin in the community. This means that the impact of treatment needs to be considered in a wider context, as part of the mix of demand and supply reduction strategies.

There is limited information about the size of the population of untreated individuals at any point in time who either regularly use heroin or who are dependent. A study of the number of regular or dependent heroin users over the period 1988 to 1993 found that approximately 30% of the estimated 50,000 regular or dependent heroin users in Australia were enrolled in methadone treatment in 1994, compared to approximately 17% of users who were enrolled in 1987. It was concluded that

*“although the proportion of regular heroin users enrolled in methadone maintenance treatment has substantially increased over the past five years or so, less than half of regular heroin users have been enrolled. The fact that there has been no sign of a slackening in demand for methadone treatment suggests that demand has not been fully met even if a majority of heroin users are not interested in enrolling in methadone treatment”.*<sup>153</sup>

### 5.9.1.2. West Australian perspective

The first reference to the development of a methadone treatment program in WA was made in a report by the Director of the Mental Health Services, who between July and November 1971 visited nine countries, inspected treatment facilities, and consulted with a wide range of authorities about alcohol and other drug use problems. At this time he also visited Dr Stella Dalton’s Wisteria House program in Sydney and reported favourably on her program.<sup>154</sup>

The Williams Honorary Royal Commission was established in May 1972 and conducted hearings during 1972 and 1973 into alcohol and other drug problems in WA. There was little discussion of the issue of heroin dependence, though a detoxification centre in Perth was recommended for ‘hard’ drug users. Methadone treatment was not mentioned, even though it had been promoted and positively perceived at this time in the US as an effective method of breaking the linkage between crime and opioid dependency.

This shortcoming probably reflects a limited knowledge at that time of international and interstate trends in heroin abuse and of the need for a range of treatment options. The issue of heroin use was largely understood as being an external problem and associated with socially marginalised groups (as in the United States). In the report, reservations were expressed that if a treatment centre was established it would be costly and *“probably intensify the local problem by attracting interstate and overseas drug users”.*<sup>155</sup>

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<sup>152</sup> Crofts N et al “Hepatitis C infection among a cohort of Victorian injecting drug users.” (1993) *159 Medical Journal of Australia* 237-241; Bell J et al “Hepatitis C virus in intravenous drug users.” (1990) *153 Medical Journal of Australia* 274-276.

<sup>153</sup> Hall W. *The demand for methadone maintenance treatment in Australia*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1995.

<sup>154</sup> Ellis AS. *Investigation into drugs and alcohol 1971*. Perth, Mental Health Services, 1971.

<sup>155</sup> Western Australia, Parliament. *Report of Honorary Royal Commission to Inquire Into and Report Upon the Treatment of Alcohol and Drug Dependents*. Perth, WA Government Printer, 1973, 22.

## **5.9.2. National Drug Strategy**

### **5.9.2.1. National perspective**

The launch of the NCADA in April 1985 was a catalyst for the development of a set of common principles and practice guidelines, the National Methadone Guidelines (NMG). The NMG have been regularly updated and the most recent version, now referred as the National Policy on Methadone Treatment (NPMT), was released in 1997.<sup>156</sup> The principles and guidelines contained in the NPMT are a comprehensive set of minimum standards which are followed in all Australian jurisdictions for the assessment, ongoing care and other medical considerations in the treatment of heroin dependents.

Since the late 1980s throughout Australia there has been a steady increase of about 15% per annum in the number of clients in methadone treatment. At June 1996 there were approximately 15,000 patients in methadone treatment programs, of whom about 3,700 were in Victoria.

The 1995 Commonwealth review of methadone treatment in Australia identified rapid growth in the number of clients seeking methadone treatment and consequent increased funding demands on Medicare. Consequently, the Commonwealth Department of Health and Family Services is implementing around Australia a number of trials of alternative funding arrangements for private methadone services. The development of these trials was foreshadowed in the Commonwealth Government's 1997 budget.

The trials will evaluate the funding of private methadone services as part of the Public Health Program, instead of through Medicare. Under this arrangement, grants in lieu of fee for service payments for private methadone clients will be paid through Specific Purpose Payments to the States.

At this stage only two states, Western Australia and South Australia, will be participating in the trials. The Commonwealth has proposed to pay participating prescribers an annual fee of \$700 per client, which will cover the estimated cost of assessment, stabilisation and monitoring of methadone clients and will include the provision of urinalysis. A further \$50 per capita will be paid to participating GPs, for the additional costs incurred as a result of trial participation. An additional \$100 per capita will be available for fundholding and evaluation costs.

South Australia will undertake a trial of a cooperative funding model between the Drug and Alcohol Services Council (DASC) and a Division of General Practice (the Southern Division), whereby funding will be received by DASC and disbursed to the Division on the basis of a negotiated contract. The Division will subcontract individual general practitioners to provide methadone related services. Under the contract the Divisions, in association with the general practitioners, may also provide associated services such as counselling.

### **5.9.2.2. West Australian perspective**

Western Australia is proposing to undertake a comparative trial of two differing funding models in both rural and urban locations.

There will be a state based central fundholding, where funds will be received by the Western Australian Alcohol and Drug Authority and disbursed to subcontracted GPs based on the number of enrolled clients.

There will also be a Division of General Practice fundholding, where funds will be received by the WMDA and disbursed to the Osborne and Bunbury Division of General Practice on the basis of a negotiated contract. The Divisions will subcontract individual GPs to provide methadone related services (including assessment, stabilisation, ongoing treatment and urinalysis to patients). Under

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<sup>156</sup> Australia, Commonwealth Department of Health & Family Services. *National policy on methadone treatment*. Canberra, Australian Government Publishing Service, 1997.

the contract, the Division, in association with its general practitioners, may also provide associated services such as counselling.

In line with treatment best practice outlined for the Community Based Methadone Program, the provision of private methadone treatment in WA requires GPs to spend considerably more time engaged in client related consultations than that used to determine indicative costings and the subsequent per capita annual fee for service payment. In WA, the proposed \$700 annual payment will cover the estimated cost of assessment, stabilisation and monitoring of methadone clients and will include the provision of urinalysis. However, in maintaining current quality of service provision, additional services such as counselling and client management services cannot be provided under the existing per annum payment.

The provision of these services is vital for the continued success and maintenance of the quality of service in the Community Based Methadone Program. Costs of these services per annum have been estimated at \$300 per client. It is proposed that an additional \$200 per capita payment is made to the fundholding bodies per annum, to enable the purchase of additional services through the use of pooled funds. A number of different services have been suggested including:

- client support services (eg specialist counselling services, specialist case management and crisis intervention services);
- continuing education (eg facilitation of ongoing education for participating GPs in rural locations; client resource materials); and
- Divisional Methadone Review Seminars (eg case management seminars involving GPs and pharmacists).

The evaluation strategy for the WA trial will link closely with the current evaluation of the Community Based Methadone Program. As this program has only been operational for just over 12 months it is critical that this trial does not adversely affect the continued success of private methadone prescribing in this State.

Therefore the evaluation will focus on:

- maintaining the quality of methadone services currently provided through the Community Based Methadone Program;
- the potential to attract general practitioners into the Community Based Methadone Program and barriers to realising this potential;
- barriers to the smooth operation of the funding arrangements, via both fundholding mechanisms; and
- the ability of Divisions to add value to the provision of methadone related services to its members and their clients.

It is proposed the trial be conducted over a 12 month period, with completion of data collection at least 3 months prior to the implementation of the new funding arrangements. Three months is considered an appropriate time period for the analysis and reporting of trial outcomes and to enable outcomes to inform discussion related to the move to Public Health Agreement funding.

### 5.9.3. 1969 to mid 1970s

#### 5.9.3.1. National perspective

A historical review of the NSW methadone program provides a useful overview of the history of methadone treatment in Australia.<sup>157</sup> New South Wales was the first state in which methadone was prescribed to heroin dependents and historically has had the largest methadone treatment population with the most comprehensive system of metropolitan, regional and prison based programs.

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<sup>157</sup> Reilly D. "Methadone: a perspective on methadone services in NSW." (1988) *Connexions* May/June.

## Select Committee Into Misuse of Drugs Act 1981

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The first documented use of methadone in Australia as a treatment for heroin users was by Dr Stella Dalton, a private psychiatrist, in Sydney in 1969.<sup>158</sup> She prescribed pharmaceutical heroin in the United Kingdom, and after her return to Australia in 1969, established the Wayback Committee, an organisation concerned with treatment for people with problems from the use of alcohol and other drugs. A hallmark of Dr Dalton's program at Wisteria House, a ward of the Parramatta Psychiatric Centre, was (and still is) high daily doses of methadone, a so called "blockade" regime, for long term maintenance treatment of heroin users.<sup>159</sup>

There was little regulation of these programs and they used high daily "blockade" doses of methadone along the lines recommended by Dole and Nyswander.<sup>160</sup> In the early 1970s methadone treatment expanded rapidly and by the end of 1976 about 1,980 persons had participated in public and private methadone programs in NSW. Methadone was subsequently introduced in the early 1970s in Victoria, Queensland, South Australia and Western Australia.

There were a variety of responses at this time in Australia, from:

- refusing to permit doctors to prescribe methadone (the approach adopted by Tasmania and the Northern Territory);
- establishing fully State run methadone program (an approach adopted in WA after 1977); or
- a mixture of public and privately run programs (the approach adopted in New South Wales, Victoria and Queensland).

By 1976 favourable evaluations of methadone treatment had been reported.<sup>161</sup> A two year follow up study by the New South Wales Health Commission indicated favourable improvements in the health and social function of 116 former heroin users in a New South Wales program. However, in spite of these benefits, the authors of this research cautioned that

*"in terms of the achievement of total abstinence there is a low success rate in the short term; but enough long term studies have been carried out to make conclusive statements about outcome in terms of the eventual achievement of abstinence. However, methadone has helped to make addicts more socially productive, stable and healthy (for example, increased employment rates, reduced crime rates, reduced mortality rates)."*<sup>162</sup>

Another follow up study, of the first 50 participants in the Wisteria House program, indicated marked improvements in social functioning had also occurred.

*"Results show that ... 88% had no new criminal convictions and 75% remained drug free, apart from taking methadone during the follow up period (mean, 12.5 months). Five of the 36 patients were free of all drug dependencies, including methadone"*.<sup>163</sup>

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<sup>158</sup> Wodak A. "The treatment of heroin dependence - an overview." (1985) 65 *Proceedings of Australian Institute of Criminology* 27-44.

<sup>159</sup> "Methadone: through a glass darkly." (1989) *Connexions* September/October 11-24; November/December 2-9.

<sup>160</sup> Dole VP, Nyswander ME. "A medical treatment for diacetylmorphine (heroin) addiction. A clinical trial with methadone hydrochloride." (1965) 193 *Journal of American Medical Association* 80-84; Dole VP, Nyswander ME. "Heroin addiction - a metabolic disease." (1967) 120 *Archives of Internal Medicine* 19-24; Dole VP, Nyswander ME, Warner A. "Successful treatment of 750 criminal addicts." (1968) 206 *Journal of American Medical Association* 2708-2711.

<sup>161</sup> Dalton MS, Duncan D, Taylor N. "Methadone blockade in the treatment of opiate addiction: a follow up study." (1976) 1 *Medical Journal of Australia* 755-756; Reynolds L, Magro D. "The use of methadone as a treatment tool for opiate addicts: a two year follow up study." (1976) 2 *Medical Journal of Australia* 560-562; Reynolds I, Di Giusto J, McCulloch R. *A review of the New South Wales Health Commission treatment services for narcotic dependent persons*. Sydney, Division of Health Services Research, NSW Health Commission, 1976.

<sup>162</sup> Reynolds L, Magro D. "The use of methadone as a treatment tool for opiate addicts: a two year follow up study." (1976) 2 *Medical Journal of Australia* 562

<sup>163</sup> Dalton MS, Duncan D, Taylor N. "Methadone blockade in the treatment of opiate addiction: a follow up study." (1976) 1 *Medical Journal of Australia* 755.

### 5.9.3.2. West Australian perspective

Methadone was first prescribed in the latter part of 1973 in WA in psychiatric inpatient settings to aid the detoxification of dependent heroin users. Soon afterwards, it was used by a small number of private psychiatrists and medical practitioners as an outpatient treatment. In November 1974, the ADA was established as a statutory organisation directly responsible to the Minister for Health, following the passing of the *Alcohol and Drug Authority Act 1974*. It was established as a body separate from the HDWA, the Mental Health Services and other health services and hospitals.

It is to be noted that in the 12 months prior to the ADA's establishment, methadone had already been prescribed by private prescribers to about 30 individuals in Perth. As there were minimal controls over the use of methadone and other Schedule 8 drugs at this time an individual could attend any medical practitioner who could at his/her discretion prescribe any Schedule 8 drug. A doctor could prescribe methadone to medically manage opioid related withdrawal sickness, as a substitute for illicit heroin use, or in conjunction with a therapeutic program (eg acupuncture or psychotherapy).

Attendance at private practitioners did not require clients to bear the cost of the consultation if the doctor bulk billed. It is believed that private prescribers routinely bulk billed methadone consultations. Privately prescribed methadone was dispensed at retail pharmacies, and this meant that patients obtained large quantities of methadone (such as a week's supply) in tablet form at one time.

From November 1974, an outpatient clinic operated by the ADA started to provide methadone to heroin dependents.<sup>164</sup> Many of the medical and nursing staff of the ADA had transferred from the MHS, including the inaugural Medical Director, Dr John Pougher. As some Commonwealth funding for capital works had been obtained through the Community Health Program, it is possible that there was an expectation that a community based psychiatric service would be developed by the ADA, although information is not available on this matter.<sup>165</sup>

The ADA provided methadone without cost but required more frequent attendance than private prescribers and dispensed smaller quantities of take away doses of methadone.<sup>166</sup> This dual system of private and public prescribers apparently functioned without difficulty until August 1976, until a new Medical Director of the ADA, Dr J Scott, was appointed. He too had previously worked as a psychiatrist with the MHS and before 1975 worked in the United Kingdom.

The first newspaper report of methadone treatment in WA was in May 1975, in a Sunday Times article and detailed the range of alcohol and drug problems that had been seen at Carrellis Centre since it had opened. The photo that accompanied the article was a side view of a well built tattooed male swallowing a dose of methadone with a caption that referred to him being 'watched' by a nurse. The article also made reference to 'four young long haired men' waiting for their dose of methadone at the dispensary at Carrellis Centre.

In a newspaper interview in December 1975 to coincide with the ADA's first anniversary, Dr Pougher reflected on the ADA's methadone program.

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<sup>164</sup> It is to be noted that from November 1974 to June 1976 the ADA prescribed methadone and other oral and injectable opioid drugs (eg morphine and pethidine) for the treatment of heroin addicts.

<sup>165</sup> Coghlan AJ, Pixley L, Zimmerman RS. "Community health concepts and methadone maintenance. Are they compatible?" (1974) 10 *Community Mental Health Journal* 426-433 had outlined a case for the integration of methadone and community mental health clinics (CMHCs), because while many methadone clients "have severe emotional problems that have been masked by their use of heroin", the location of methadone programs in CMHCs would support the proposition that "heroin addiction will be seen as primarily a breakdown in human relationships".

<sup>166</sup> The term 'take away' refers to the practice of an individual obtaining multiple doses on a single day, ie tomorrow's dose(s) today.

## Select Committee Into Misuse of Drugs Act 1981

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*“(It) had been started for those who could not be weaned off their craving for drugs ... The methadone regime was strict and dependents had to attend daily in the first three or four weeks. The quantity of methadone allowed was gradually reduced. When the methadone program was started a year ago, nearly all the people on it were unemployed ... Now so many had jobs they came for it in the evening”.*<sup>167</sup>

Up to the end of 1975, newspaper reports about methadone treatment did not acknowledge that private medical practitioners had treated heroin dependents since 1973. The press at the time also developed a theme of the ADA having an adversarial relationship with its target treatment population. This was a battle that also reflected the ADA’s relationship with the general community. For instance, in May 1976 a group of West Perth residents were reported as having petitioned the Perth City Council to not approve the conversion of a building in West Perth to a detoxification hospital for alcohol and illicit drug users.<sup>168</sup>

In August 1976 the ADA changed its methadone policy. This was to prove to be a short sighted, if not cavalier approach to policy making. Over the next six to nine months, a considerable amount of effort was needed to defend it, until final abandonment in May 1977. As a consequence of the policy, the ADA became peripherally involved in the management of heroin users and prescribed very little methadone. Clientele excluded from the ADA program attended private GPs and as they applied few (if any) restrictions, within a short time there was a boom in the supply of methadone to opioid dependents in Perth by private prescribers.

The lack of agreement on policy between the private medical profession, the ADA and the HDWA meant that private prescribers became responsible for running the State’s methadone program. As a result of this approach to the use of methadone, over a period of time a large quantity of methadone was diverted into the illicit drug market in Perth, which increased the quantity of illicit opioids in Perth and contributed to the increase in opioid dependence.

Another outcome of the growth in black market methadone tablets was the increase in the number of deaths due to methadone, with a peak of 7 methadone deaths in 1977.<sup>169</sup> On reflection, the implementation of a restrictive policy which contained a mixture of rehabilitative and coercive elements proved difficult to defend, even though it appeared to enjoy community support.

The conflict over the ADA’s treatment policy continued to be frequently and prominently reported in the local press. In spite of a HDWA inquiry in September 1976 that recommended administrative changes, criticisms by MPs and mass staff resignations continued throughout 1976.<sup>170</sup>

In late January 1977 Dr Gerald Tewfik, a private psychiatrist, stated that he believed that more than 300 heroin dependents were being treated by private doctors. He also made the observation that the ADA’s conservative policy had only shifted the problem from the public health system to private medical practitioners. Dr Tewfik reflected that helping heroin dependents was a positive and valuable activity.

*“They have a low morale and feel they are the scum of the earth,” he said. ‘They have been unemployed for a long time. People should know they are not just louts. They are nice intelligent boys. It could be your son involved. If somebody doesn’t look after them the situation will become dangerous indeed’.*<sup>171</sup>

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<sup>167</sup> Martin C. “Drug recovery centre planned.” *West Australian* 1 December 1975.

<sup>168</sup> “Anger at planned alcoholics hospital.” *Sunday Times* 23 May 1976.

<sup>169</sup> Swensen G. “Opioid deaths in Western Australia, 1974-1984.” (1988) *7 Australian Drug & Alcohol Review* 181-185.

<sup>170</sup> Cyle K. “Alcohol Drug Authority staffing is serious.” *Daily News* 13 October 1976; Mayman J. “Patients back ADA staff.” *Sunday Independent* 19 September 1976; Roberts P. “No breach over addicts say ADA.” *Weekend News* 22 November 1976; Williams G. “Staff quit, condemn drug centre’s policy.” *Daily News* 18 November 1976.

<sup>171</sup> “GPs treat most drug addicts – doctor.” *West Australian* 18 January 1977.

Any change that restricted private prescribing meant that the ADA needed further resources to treat the large number of clients who had been under the care of private prescribers. As at that time all the ADA's outpatient programs operated at its one site in West Perth, it needed to establish a number of clinics in the metropolitan area to match the access to treatment that private prescribers had provided previously. This concern was addressed by Dr Tewfik:

*"I can understand the authorities saying that methadone should only be issued at one centre and the addict must take it on the spot, to avoid trafficking in the drug ... (But) It is impracticable to the chap on methadone, who has a job and is trying to break the habit, to travel to the West Perth centre, say from Fremantle, to get his daily dose. He soon becomes unemployed, stops at home watching TV, has no girlfriend, and gets lonely. There is not much chance of him breaking the habit".<sup>172</sup>*

In summary, at this time methadone treatment in this State involved:

- no maximum daily dosage;
- minimal admission criteria, on basis of individual medical practitioner's judgment as to whether an individual had a preexisting opioid dependence;
- unsupervised consumption of daily doses (ie dependents able to collect daily doses of methadone for an extended period known as 'take away' doses, with attendant likelihood of injection and/or sale and supply to other opioid users);
- multiple dispensing locations, enabling use by dependents of aliases to collect multiple doses;
- multiple prescribers, facilitating dependent selectivity of prescriber to avoid sanctions and also use of multiple aliases; and
- methadone dispensed in tablet form.

### 5.9.4. Mid 1970s to early 1980s

#### 5.9.4.1. National perspective

In the mid 1970s, the NSW Government introduced controls over the activities of private prescribers and restricted public methadone programs. There was also a sharp reduction in funding for methadone treatment and a shift to the funding of drug free rehabilitation programs run by non government organisations (NGOs).

In spite of the favourable results of research, there was disquiet about a treatment which did not have abstinence as the primary measure of effectiveness. By the mid 1970s, there was a growing perception by policy makers that methadone was not regarded by its target population as a "treatment" but as an avenue to obtain alternative licit opioids. The capability of methadone programs to readily attract large numbers of heroin users, compared to detoxification and drug free programs, was not interpreted as a positive outcome. On the contrary, increased enrolments in methadone alarmed policy makers who blamed doctors for too readily prescribing to heroin users.

In an editorial in the Medical Journal of Australia in 1976, Dr Gerald Milner, a psychiatrist with the Victorian Alcohol and Drug Dependent's Persons Service, maintained that the growth in the number of people receiving methadone was caused by over prescribing.

*"(C)urrent prescribing trends of methadone in Australia are disturbing in that they indicate possibly casual and certainly much inadequately supervised treatment of narcotic users (consumption rates for methadone are climbing in most States in a fashion disproportionate to any possible increase in the numbers of 'therapeutic addicts' ... so there must be much prescribing of narcotics for narcotic dependent persons by family doctors)".<sup>173</sup>*

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<sup>172</sup> Martin C. "Perth's heroin addicts." *West Australian* 21 January 1977.

<sup>173</sup> Milner G. "Guest editorial: methadone." (1976) 2 *Medical Journal of Australia* 551-553.

## Select Committee Into Misuse of Drugs Act 1981

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A 1976 review by the New South Wales Health Commission urged restrictions on methadone treatment because of concerns about the administration of programs and that methadone treatment was perceived to undermine alternative drug free programs.

*“There is an obvious need to reduce the numbers of clients entering the methadone program ... This reduction in methadone clients would necessarily imply the diversion of some clients into alternative programs (which) could be partly achieved by more critical assessment of clients before they are prescribed methadone (so that) only clients who are physically dependent on opioids are prescribed methadone. A further reduction in numbers could be achieved by adherence to the additional requirements that alternative forms of therapy must have been shown to have failed”.*<sup>174</sup>

The report from the Joint Committee of the New South Wales Parliament, which investigated drug use and treatment approaches in that State, was especially scathing of methadone treatment. The Committee claimed methadone had

*“become an alternative means of drug dependence to many, it has lent itself to abuse by both users and prescribers, it has not been matched by backup vocational rehabilitation programs and it has stifled initiative in exploring alternative means of treatment to meet the needs of the individual. The Committee would like to see its use phased out altogether. ... The Committee cannot endorse a health policy which seeks almost entirely to replace one form of drug dependence with another”.*<sup>175</sup>

In 1979, favourable results of an eight year follow up of the first 50 persons in Australia treated with methadone were reported. Conclusions from this study, which contrast with the views of the Joint Select Committee, bear repeating in part here.

*“We would like to state our belief that a patient who is a success should be one who cooperates to a reasonable extent with the treatment program, who remains in fair physical and psychiatric health with no, or only sporadic, drug usage, and who may or may not be receiving methadone from authorised sources. ... According to these, very free, criteria, success was achieved by 31 of 43 patients (72%)”.*<sup>176</sup>

From 1976 to the early 1980s, methadone treatment was severely restricted by the Wran Labor Government,<sup>177</sup> which instead funded detoxification facilities, drug free rehabilitation programs and abstinence oriented self help groups - treatment modalities that were philosophically opposed to methadone treatment.<sup>178</sup>

There was little support for methadone treatment outside of New South Wales. Given other States appeared to have a smaller heroin problem, there was a limited opportunity for a national approach. Other States adopted measures that deliberately restricted the growth in methadone programs. At this time, methadone was begrudgingly tolerated as legitimate treatment.

There is a possibility that some of the other States' programs came under pressure from heroin users displaced from NSW methadone programs. A similar phenomenon apparently occurred in the 1970s, when large numbers of heroin users fled from New Zealand to Australia after a policy of compulsory treatment and vigorous law enforcement was instituted, as

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<sup>174</sup> Reynolds I, Di Giusto J, McCulloch R. *A review of the New South Wales Health Commission treatment services for narcotic dependent persons.* Sydney, Division of Health Services Research, NSW Health Commission, 1976, 6.

<sup>175</sup> New South Wales, Parliament, Joint Committee Upon Drugs. *Progress report and minutes of proceedings 1976-78.* Sydney, Government Printer, 1978, 102.

<sup>176</sup> Dalton MS, Duncan DW. “Fifty opiate addicts treated with methadone blockade - eight year follow up.” (1979) *1 Medical Journal of Australia* 153, 154.

<sup>177</sup> In 1982 there were only 601 people in methadone treatment in New South Wales, of whom 427 (71%) participated in Dr Stella Dalton's methadone program (Rankin et al 1981). Between 1981 and 1984 there were between 600 and 700 people in methadone programs in New South Wales.

<sup>178</sup> Reilly D. “Methadone: a perspective on methadone services in NSW.” *Connexions*

*“(d)rug addicts are possibly the most mobile of all population groups in Australia, moving freely from city to city evading law enforcement”*.<sup>179</sup>

### 5.9.4.2. West Australian perspective

In July 1977, there were 16 participants in the ADA methadone program, which increased to 141 in August 1977. By December 1977, there were 206 persons in treatment. Growth in numbers continued rapidly, and by August 1978 a total of 305 persons were in treatment.

The more restrictive policy of the use of identification photos, controls over admissions and removal of tablets meant that the HDWA could withdraw authorisations from private prescribers. Though most of the private prescribers accepted the HDWA’s apparent legal authority to confine methadone treatment to the ADA, a small number increased their prescription of tablets of another Schedule 8 drug, Palfium (dextromoramide), a short acting synthetic opioid.

In late August 1978, after the passage of the amendments to the *Poisons Act 1964*, an express power was given to the Commissioner for Public Health to regulate the prescribing and dispensing of drugs of dependence. With clarification of the power of the HDWA to regulate Schedule 8 drugs, private practitioners largely ceased to prescribe Schedule 8 drugs as an ongoing treatment to opioid dependents in this State.

The ADA was vested with the responsibility of methadone prescription for the treatment of registered drug dependents. During this phase, the ADA adopted key principles from the NHMRC’s *National policy on methadone*, such as that daily doses should be in the range of 100-120 mgs.

*“The goals are to reduce mortality, to reduce ill health, to reduce crime, to reduce the contagion of illegal drug use, to increase productivity, and to assist the individual addicted person in coping. The goal of a drug free existence is, at least temporarily, deferred. Methadone maintenance appears to be effective because it keeps the addicted person in contact with the treatment agency; it partially satisfies the needs of the addicted person and at the same time reduces the effects obtainable from the use of other opioids; it removes the need for the addicted person to be preoccupied with obtaining and using illegal drugs; it allows the addicted person to get on with the job of organising and living his (sic) life”*.<sup>180</sup>

Over the period September 1978 to June 1979, the ADA implemented a restrictive methadone policy, including use of Naloxone (opioid antagonist) testing as a precondition to admission. All doses had to be swallowed on a daily basis, under supervision, at ADA premises. Refusal by patients to consume doses under supervised conditions involved punitive sanctions, by withholding alternate daily doses.

Between July 1979 and October 1980, the ADA methadone program operated according to a mixture of strict and relaxed controls within the same policy. For instance, the use of both objective (ie Narcan) and subjective measurement of a degree of physical opioid dependence and dispensing was relaxed in that it did not require supervised daily consumption at ADA premises after the first two weeks of treatment. Because of a narrow interpretation of admission criteria, the number of persons in treatment declined from 232 in July 1979 to 176 in October 1980.

Compared to the practice that had operated from September 1978 to June 1979, no punitive sanctions were applied if after the two week period any patient refused to consume methadone under supervision. The assumption was that diversion was less likely to occur after a period of supervised consumption as patients would have become physically dependent on methadone.

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<sup>179</sup> Bell DS. “Australia and New Zealand.” In Einstein S (ed). *The community’s response to drug use*. NY, Pergamon, 1986, 36.

<sup>180</sup> National Health and Medical Research Council. *National policy on methadone*. Canberra, National Health and Medical Research Council, 1977, section 3.1.2.

## **5.9.5. Early 1980s to early 1985**

### **5.9.5.1. National perspective**

Pressure on governments from heroin dependents unable to get admitted to methadone programs, their families, from health providers, and other groups resulted in a liberalisation of admission policies. These changes included the adoption of non punitive methods to deal with clientele whose performance in treatment did not conform to expectations. The growing community concern about rises in crime rates believed to be caused by an increasing level of heroin abuse and dependence also forced governments to permit limited growth in methadone programs.

However, the reluctance of some State governments (NSW in particular) to expand methadone treatment meant that by the early 1980s there was mounting concern about the failure of abstinence oriented drug free programs to have made other than a minor impact on heroin use. This was in spite of the widespread application of quasi compulsory treatment approaches through court diversionary schemes.<sup>181</sup> Support for the expansion of methadone treatment as a measure to reduce crime caused by heroin use was supported from two strands of investigation. An inquiry chaired by Dr James Rankin, in 1981 recommended prescribing heroin as a treatment.<sup>182</sup> Other research undertaken by the NSW Bureau of Crime Statistics and Research confirmed an association between heroin and other drug abuse and property crime.<sup>183</sup>

It was apparent by the mid 1980s that the rehabilitative oriented programs had been largely unsuccessful in containing the heroin problem and that demand for methadone treatment greatly exceeded supply. However, as this strategy would involve direct Federal funding (particularly in NSW) there was the need for a comprehensive and coordinated national approach to the heroin problem.

*“Drug problems are a national issue. Patterns vary with location but events in one location influence those in others. Resources and ideas need to be shared ... In the overall context of drug abuse, attempts to restrict supply will not be successful on their own, though considerable resources have already been and will continue to be applied in attempts to limit supply. It is time for a more concerted effort at reducing demand”.*<sup>184</sup>

### **5.9.5.2. Western Australian perspective**

In WA there had been concern in the late 1970s, as in other jurisdictions, about crime and the rate of imprisonment. This led to an inquiry in 1981 by a retired Chief Crown Prosecutor Owen Dixon. In his report Mr Dixon stated *“if one could reduce the dependence on alcohol and drugs there would be a truly dramatic decline in the rate of imprisonment”.*<sup>185</sup>

However, compared to the Rankin inquiries in NSW, the WA inquiry arrived at a different view about the use of methadone to reduce the rate of heroin related crime. Mr Dixon supported

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<sup>181</sup> Kerr CB, Challenor W, Morey S, Sergeant T, Whitlam F. *Final report of committee of review into drug and alcohol services in NSW*. Sydney, NSW Department of Health, 1985.

<sup>182</sup> Rankin J. *The use of methadone in New South Wales for the management of opiate dependent individuals: a review and recommendations for change*. Sydney, Health Commission of NSW, 1981; Rankin J, Holst V, McKnight J, Moait S, Rae A. *Report of the New South Wales Committee of Inquiry Into the Legal Provision of Heroin and Other Possible Methods of Diminishing Crime Associated With the Supply and Use of Heroin*. Sydney, NSW Health Commission, 1981.

<sup>183</sup> Dobinson I, Ward P. *Drugs and crime. A survey of NSW prison property offenders 1984*. Sydney, NSW Bureau of Crime Statistics and Research, 1985.

<sup>184</sup> Commonwealth Department of Health. *National Campaign Against Drug Abuse. Campaign document issued following the Special Premier's Conference, Canberra, 2 April 1985*. Canberra, Australian Government Publishing Service, 1985.

<sup>185</sup> Western Australia, Committee of Inquiry Into the Rate of Imprisonment. *Report*. Perth, Government Printer, 1981, 130.

critical comments about methadone treatment from ‘one of the professional staff of the WA Alcohol and Drug Authority’ and from the testimony of

*“two very intelligent young people who were both in prison and quite independently each expressed grave doubts not only as to the efficiency of the methadone treatment but also the wisdom of using it at all”.*<sup>186</sup>

In August 1980 a large number of amendments, which included the use of methadone as a treatment of dependents and machinery provisions for the authorisation of prescriptions, were made to the *Poisons Act Regulations 1965*. These were gazetted in late October 1980. The strict supervision of methadone consumption prevailed throughout the early 1980s in this State.

In March 1983, it was reported that a group of 80 drug dependents had sent a petition to the Minister for Health requesting reviews of the methadone program. The petition also contained specific complaints about the methadone program, in particular that daily attendance imposed very high social costs and that the conditions of very strict surveillance were demeaning.

*“(D)oses of methadone had to be drunk in front of staff at the clinic. And that has angered the addicts, who say the ADA’s refusal to distribute take home doses disrupts their home lives and gives the ADA too much power over them”.*<sup>187</sup>

The Minister for Health announced in June 1983 that methadone patients would be able to obtain methadone from metropolitan hospitals, so that they would not be required to attend the ADA’s only facility at William Street Clinic. However, “*Mr Hodge (the then Minister for Health) has told them he will not grant their request for take home methadone doses for weekends and holidays because current procedure conforms to national drugs policy*”.<sup>188</sup>

The ADA did establish small dispensing units at Fremantle and Osborne Park Hospitals which were not resourced by either hospital. However these were expensive to run and, as they only operated for three hours per day Monday to Friday, were not popular with clientele.

In late 1983 a new opioid substitute drug, Temgesic (buprenorphine) which was in ampoule form, was reported as having been overprescribed by private GPs to opioid dependent persons in Perth. One practitioner who had been using this drug since about May 1983 was interviewed about this new pharmacotherapy.

*“Dr Patrick Cranley who says he has prescribed the drug for about 80 patients, believes restricting the drug will drive addicts to get it by alternative and illegal means. ... ‘I’m treating up to 40 young addicts a day at my surgery, and they all say they will never go to the ADA. They say they are treated like criminals rather than as patients,’ he said. ... It was proving a better method of curing heroin addiction than the methadone treatment organised by the ADA, that required addicts to take the treatment over a longer period, Dr Cranley said”.*<sup>189</sup>

During 1984, there were a number of newspaper reports about the use of Temgesic that favourably compared it to methadone treatment.<sup>190</sup> By the time the HDWA prohibited the prescription of Temgesic to opioid dependents in April 1984, it was reported that Dr Cranley had prescribed the drug to 600 dependents.<sup>191</sup>

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<sup>186</sup> Id 132.

<sup>187</sup> Sinclair-Jones M. “Addicts call for better deal.” *Western Mail* 19 March 1983.

<sup>188</sup> Sinclair-Jones M. “Relief for addicts to become easier.” *Western Mail* 11 June 1983.

<sup>189</sup> “Doctor protests at drug curb.” *West Australian* 28 December 1983.

<sup>190</sup> Abbott S. “The drug you don’t get hooked on.” *Daily News* 6 January 1984; Mills M. “Addicts try to kick the habit.” *Sunday Independent* 8 January 1984.

<sup>191</sup> Murray K. “Doctor supplied 24,000 shots.” *Daily News* 10 May 1984.

## Select Committee Into Misuse of Drugs Act 1981

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In 1984, there were a number of overdose deaths that were attributed to the restrictions being placed on Temgesic.<sup>192</sup> In a number of these articles, criticisms were also made about the ADA methadone program. For instance, in May 1984 Dr Cranley had made a submission to the Select Committee on Alcohol and Drugs, in which he was reported as having stated “*Addicts could buy heroin from cars parked outside the ADA clinic in William Street*”.<sup>193</sup>

Over the period November 1980 to March 1985, the ADA enforced a policy of strict daily supervision of methadone with denial of methadone for non compliance by implementing an automatic detoxification regime of 5 mg per day. It also implemented a delayed assessment process, which included written reports to a separate Decision Making Panel.

### 5.9.6. Early 1985 to present

#### 5.9.6.1. National perspective

In April 1985, the Federal Government (through the NCADA) undertook direct funding of State drug treatment programs. By 1990 methadone, treatment programs were expanded in most jurisdictions, particularly in NSW and Victoria. Over this time there was a growing realisation that methadone treatment was one of the most effective policy options to reduce the spread of blood borne viruses (BBVs), such as HIV and more recently HCV, which are readily transmitted from infected IDUs by sharing of non sterile injection paraphernalia.

The change in emphasis can be understood as a shift from the rehabilitative emphasis to a public health focus. The shift occurred because of the realisation there was an appreciable risk of BBVs being spread to the wider community through unsafe sexual practices between untreated IDUs infected with HIV and HCV and their non drug using sexual partners.<sup>194</sup>

In overview, there are three main strands to the methadone policy since 1985, as follows:

- the development of a national approach to Australia’s heroin problem;
- the use of Federal funds to expand treatment programs, develop preventive programs and provide training to health and welfare workers; and
- a public health concern about the spread of BBVs in Australia by IDUs.

The third strand emphasises the importance of the medical profession, who have become dominant players in the national strategy to deal with Australia’s heroin problem. Methadone policy has been the exclusive domain of practitioners, leading to the criticism that policy making only serves professional rather than community interests. In a 1989 discussion paper from the Commonwealth Department of Community Services and Health, it was stated that

*“clinicians working in these services became the most influential local experts in methadone programs, set the local service standards and have largely influenced the subsequent development of Australian methadone treatment policy. In this there may have been some conflict between their roles as expert advisers to government and as service providers dependent on government funding. In short, methadone treatment practice has been more provider than public policy driven, and it has had no direct client input”*.<sup>195</sup>

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<sup>192</sup> Matheson A. “Addicts die after drug clampdown.” *Weekend News* 2-3 June 1984; Murray “Drugs kill Perth beauty queen.” *Daily News* 10 May 1984; Murray K. “Tragic story of double suicide.” *Daily News* 15 June 1984.

<sup>193</sup> “Police to probe heroin availability.” *West Australian* 10 May 1984.

<sup>194</sup> Burrows D, Dickie M, Langenberg J, Wodak A. *AIDS and intravenous drug use - overcoming the obstacles to change. Proceedings of national workshop, Canberra May 1989*. Canberra, Australian Government Publishing Service, 1990; Commonwealth Department of Community Services & Health. *National HIV/AIDS strategy. A policy information paper*. Canberra, Australian Government Publishing Service, 1989; Western Australia, Parliament, Legislative Assembly. *Report of Select Committee Appointed into the National HIV/AIDS Strategy White Paper*. Perth, Government Printer, 1990.

<sup>195</sup> McKay & Associates. *Review of funding of methadone programs in Australia*. Canberra, Department of Community Services & Health, 1989, 7.

### 5.9.6.2. West Australian perspective

Since 1985, there has been a reduced emphasis on the need for daily supervised oral consumption of all doses. By the late 1980s, the ADA encouraged patients to receive methadone from community pharmacies after a period of stable daily attendance at the William Street Clinic. There was a shift in the admission criteria, in line with changes in the NMTP, being based on consideration of medical and social factors, evidence of injecting drug use, verification of opioid use by physical examination (eg stigmata of injecting drug use) and a drug use history.

There was also a preferential admission of IDUs infected with HIV, those who were infected with HBV or HCV and had a carrier status, those who were pregnant or those who had other serious medical conditions.

#### **Community based methadone program**

A fundamental change in the approach to methadone treatment in this State occurred with the establishment of the community based methadone program (CBMP). Previously, from 1978 until the program was implemented in June 1997, GPs had been prevented under the *Poisons Act Regulations 1965* from prescribing methadone as a treatment of heroin dependence.

The need to expand methadone treatment was triggered by increasingly long waiting lists (of more than 3 months) of those wanting to be admitted to the ADA program. This problem had occurred as the ADA program was unable to adequately meet demand, given it had very limited facilities and space at its central dispensary and clinic at William Street Clinic. Any further expansion of the public methadone program would have required a substantial investment to establish new facilities in a number of strategic locations in northern, eastern and southern parts of the metropolitan region, to take the pressure off the central clinic.

Instead of expanding the public methadone treatment system, it was decided to implement a community based program which relied on GPs. A similar approach to expansion of methadone had been followed in other jurisdictions, such as Victoria and NSW where the majority of patients were treated by private practitioners.<sup>196</sup> There were a number of advantages with developing the CBMP in conjunction with the ADA methadone program, including that:

- patients could be admitted to methadone without being placed on a waiting list;
- treatment could be provided in non metropolitan regions of the State which previously had been unable to provide a service;
- it was consistent with the practice in a number of other jurisdictions of private prescribers having a major role in providing treatment;
- the treatment of heroin dependents was developed within mainstream health services, thus avoiding some of the possible negative stigma associated with a specialist service; and
- it built on the network of community pharmacies for them to be responsible for the day to day management of dispensing and dosing.

Compared to the experience that occurred in WA in the late 1970s, where large numbers of untrained GPs prescribed methadone, the CBMP has been carefully implemented. The scheme that has evolved since mid 1997 relies on a pool of trained GPs who have small caseloads, with a maximum of 50 patients per prescriber. A key aspect of the CBMP is that prescribers have access to the Clinical Advisory Service, a specialist service based at the ADA to assist in management of difficult cases.

The model adopted in this State resembles that developed elsewhere based on the concept of 'shared care', enabling close consultation between a specialist drug service and GPs. The critical role for a specialist service has been recognised in the UK, where GPs have a major role in the care of drug dependents.

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<sup>196</sup> Lintzeris N, Koutroulis G, Odgers P, Ezard N, Lanagan A, Muhleisin P, Stowe A. *Report on the evaluation of the community methadone services in Victoria*. Melbourne, Turning Point, 1996.

*“The international experience in countries that have developed community models of methadone services has highlighted the necessity of specialist services. In particular, the British literature has emphasises the importance of specialist clinical and consultancy services providing support for general practitioners engaged in methadone prescribing. In relation to policy developments in the UK, one author concluded: ‘the policy makers may have underestimated the reluctance of general practitioners to take on the treatment of the opiate addict in a general practice setting – especially when this relates to the management of addicts in the long term with ready support from a specialist unit’.”<sup>197</sup>*

### **5.9.7. Treatment needs of women**

There was some recognition in Australian methadone programs of the treatment needs of pregnant heroin users when a methadone program was specifically established in 1979 for women heroin dependents at the former Crown Street Women’s Hospital in Sydney. This program was transferred to the King George Hospital in 1982 and by 1986 had 150 women enrolled in it.<sup>198</sup>

The increasing proportion of women in methadone treatment populations who were formerly heroin dependent may be because females are more disposed to participate in methadone programs, that programs discriminate in their favour, or that there has been an increase in the number of female heroin users. There has been a marked increase in the proportion of females in the WA methadone program, increasing from 29% of the treatment population in January 1978 to 42% in December 1997 (Tables 5.14 and 5.15; Figure 5.10).<sup>199</sup>

In methadone programs, women’s obstetric and gynaecological needs are usually a low priority compared to concerns about rates of offending and non prescribed drug use. A recent Australian review of the problems faced by female heroin users stated

*“...it was becoming increasingly evident to workers in the field that the problems and difficulties faced by (pregnant) women far exceeded the problems for medical management presented by the effects of narcotic use on the foetus, yet both Australian and American research was restricted almost exclusively to the medical. Where research ventured into more sociological areas, it often perpetrated a judgmental and even hostile attitude towards this group of women.”<sup>200</sup>*

There had been some discussion in this State about the needs of women in methadone treatment by the 1990 Ministerial Task Force to Review Obstetric, Neonatal and Gynaecological Services. This resulted in the establishment of a specialist service at King Edward Memorial Hospital for Women.

### **5.9.8. Overview**

The philosophies from the mid 1970s to the mid 1980s were predicated on rehabilitative intervention and abstinence, if necessary by court ordered mandated conditions of heroin users who had appeared before the courts where their offending was apparently drug related. However, a weakness in the rehabilitative approach emphasises up to mid 1980s was that it ignored the high

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<sup>197</sup> Kutin JJ, Lintzeris N, Ezard N, Muhleisen P. *Evaluation of the specialist methadone service at Turning Point Alcohol & Drug Centre and Western Hospital Footscray*. Melbourne, Turning Point, 1997, 2.

<sup>198</sup> Waldby C. *Mothering and addiction. Women with children in methadone programs*. Canberra, Australian Government Publishing Service, 1988.

<sup>199</sup> Cf Swensen G. *Indicators of illicit drug use in Western Australia 1981-1989*. Perth, Epidemiology & Research Branch, Health Department of WA, 1991; Swensen G. *Indicators of drug use in Western Australia 1982-1992*. Perth, Epidemiology Branch, Health Department of WA, 1995.

<sup>200</sup> Waldby C. *Mothering and addiction. Women with children in methadone programs*. Canberra, Australian Government Publishing Service, 1988, 1

levels of morbidity associated with heroin use (such as BBVs)<sup>201</sup> and discriminated against heroin dependents with special needs, such as users who were parents, who were mostly females.<sup>202</sup>

Since the late 1980s there appears to have been a change in the demographic profile of the treatment populations, who compared to heroin users from the 1970s and early 1980s, appear to be less involved in crime, come from a middle class background and are better educated. There has also been a greater proportion of females with dependent children compared to the earlier population.

There was also an important shift in the public perception of heroin dependence over the 1980s as a problem affecting the middle class, following the revelation by the Prime Minister of the time, Hon R J Hawke, that his oldest daughter was heroin dependent. Methadone treatment populations now

*“tend to be older with a higher ratio of women to men, more likely to have children and to have come from higher socioeconomic backgrounds ... (Accordingly) Programs need to focus more on resolving family, emotional, legal, social and health problems rather than worrying about the odd dirty urine.”<sup>203</sup>*

### 5.9.9. Benefits

There are numerous studies which confirm the social and health benefits of methadone treatment, such as reduced rates of offending by those in treatment compared to those not in treatment, including increased levels of employment, lowered risk of mortality<sup>204</sup> and a number of other health measures.<sup>205</sup> A number of studies have indicated there are also much better outcomes for those who participate in treatment over an extended period of time (such as methadone treatment) compared to those who attempt short term treatments.<sup>206</sup>

A potential benefit of methadone treatment is that it is likely to reduce use of inpatient hospital resources of heroin dependent individuals. For instance, the most recent average bed day cost of inpatient stay at a hospital, which includes the Central Drug Unit, in WA is \$440 per day.

As methadone is a very cost effective outpatient treatment, any reductions in the level of usage of inpatient facilities attributable to people being admitted to methadone represents a net gain to the community if they had otherwise required inpatient treatment.

A representation of trends in hospitalisation for opioid dependence over the period 1981 to 1992 compared with trends in the number of admissions to the ADA methadone program is indicated in

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<sup>201</sup> Ostor AG. “The medical complications of narcotic addiction.” (1977) *Medical Journal of Australia* 410-415, 448-451, 497-499.

<sup>202</sup> Cf Submission of the Obstetric Social Workers Group in the Inner Metropolitan Area to New South Wales, Parliament, Joint Committee Upon Drugs. *Progress report and minutes of proceedings 1976-78*. Sydney, Government Printer, 1978, Annexure E.

<sup>203</sup> Reilly D. “Methadone: a perspective on methadone services in NSW.” (1988) *Connexions* 25

<sup>204</sup> It has been estimated that the relative risk of death during methadone maintenance is one quarter of the rate for heroin users not in methadone maintenance. White J. “Does increasing the availability of methadone reduce heroin deaths?” In Lenton S, Stockwell T, Ali R (eds). *Proceedings of a national workshop on the prevention of heroin overdose, Sydney, August 1997*. Perth, National Centre for Research Into the Prevention of Drug Abuse, Curtin University, 1997.

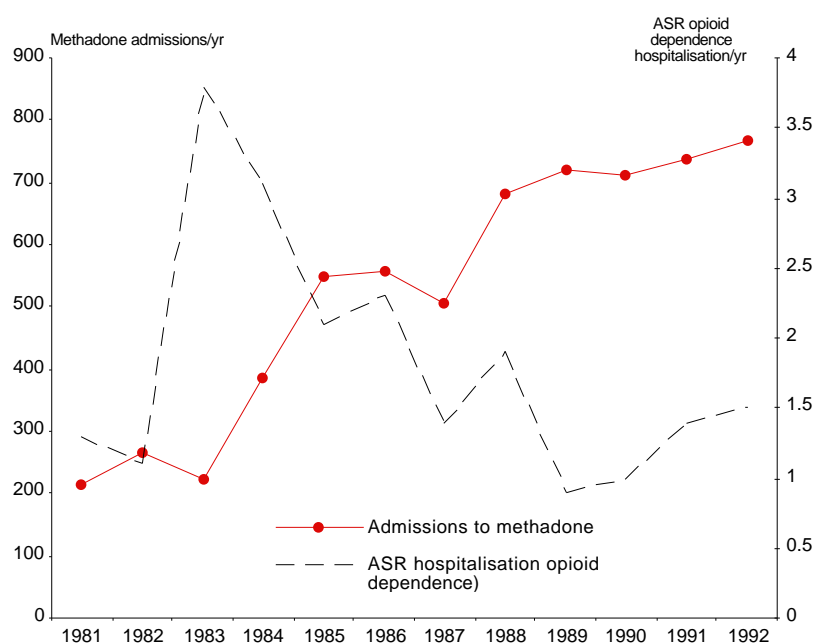
<sup>205</sup> Mattick RP, Hall W. *A treatment outline for approaches to opioid dependence. Quality assurance in the treatment of drug dependence project*. Canberra, Australian Government Publishing Services, 1993; Ward J, Mattick R, Hall W. *Key issues in methadone maintenance treatment*. Sydney, University of NSW Press, 1992; Rankin J, Mattick RP. *Review of the effectiveness of methadone treatment and analysis of St Mary’s Clinic, Sydney*. Sydney, National Drug and Alcohol Research Centre, 1997.

<sup>206</sup> Cooper JR, Altman F, Brown BS, Czechowicz, D. *Research on the treatment of narcotic addiction. State of the art*. Rockville, MD, National Institute on Drug Abuse, 1983; McCaffrey BR. *Treatment protocol effectiveness study*. Washington, DC, Office of National Drug Control Policy, 1996; Chemical Dependency Research Working Group. *Methadone treatment works: a compendium for methadone maintenance treatment*. NY, State Office of Alcoholism and Substance Abuse Services, 1996.

Figure 5.8. This data shows that the age standardised rate of hospitalisation for opioid dependence peaked in 1983 when there were a rate of hospitalisation of 3.8 persons per 100,000. After 1983, the rate has more than halved and since 1987 has fluctuated at a rate of about 1.5 persons per 100,000 (Figure 5.9).

While it requires confirmation, it is suggested the drop in hospitalisation can be attributed to the expansion of methadone treatment. This would suggest that the liberalisation of the ADA's admission criteria, which had started to occur by the time NCADA occurred in April 1985, meant that those who previously could have only have detoxified through much more expensive inpatient treatment, could participate in much lower cost methadone treatment.

**Figure 5.9: Annual trends in hospitalisation for opioid dependence and admissions to methadone treatment, WA, 1982 – 1992**



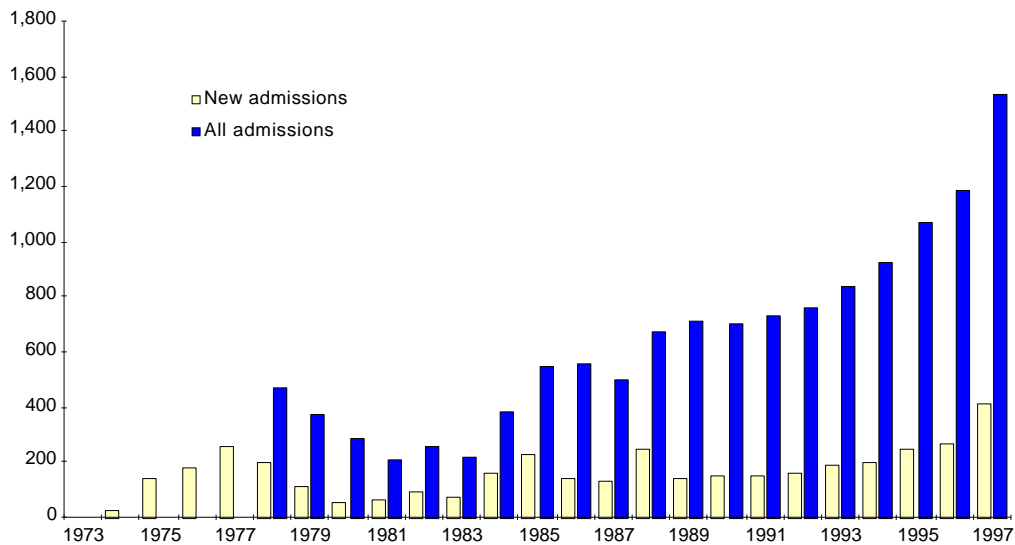
## 5.9.10. Statistical overview

### 5.9.10.1. Number of patients

Over the 25 year period from 1973 to 1997, a total of 4,133 distinct individuals who were heroin dependent were treated with methadone in this State. The size of the annual treatment population has continually increased since the early 1980s, reaching a total of 1,537 unique individuals in 1997. From 1983 to 1997, the number of patients treated per year increased nearly seven fold, from 225 individuals in 1983 to 1,537 individuals in 1997 (Table 5.10; Figure 5.10).

At 30 June 1998, there was a total of 1,703 patients, of whom 984 (57.8%) participated in the ADA program and 719 (42.2%) participated in the community based methadone program. Based on the most recently available detailed information about the WA methadone treatment population (at 31 March 1998) 58.3% were males and 41.7% were females (Table 5.11).

Figure 5.10: Annual admissions to WA methadone program, 1973 - 1997



### 5.9.10.2. New admissions

Over the period from 1978 to 1997, the composition of the treatment population has changed, with a reduced proportion of new admissions in more recent years. From 1978 to 1985, about 40% of the treatment population each year were new admissions. However, since 1986 between 20% and 25% of the treatment population each year has been new admissions (Table 5.10; Figure 5.9). The decrease in the proportion of new admissions may indicate that the relaxed admission criteria encouraged those who had relapsed to re present for treatment.

Over the period 1982 to 1992, the number of *new* admissions fluctuated between 20 and 40 per quarter. Since 1993 until mid 1996, there has been about 50 new admissions per quarter. Since mid 1996 to the end of 1997, the number of quarterly admissions increased by 76%, from 67 in the September quarter 1996 to 118 in the December quarter 1997. It is to be noted in 1998 the number of new admissions has dropped, with 24 new admissions being recorded in the June quarter 1998 (Tables 18 and 19, Appendix 13).

### 5.9.10.3. All admissions

Over the period 1982 to 1998, there has been a marked increase in the number of persons per quarter who have participated in the ADA methadone program. In the March quarter 1982, there was a total of 118 persons. By the March quarter 1998, there was a total of 1,050 persons, a nine fold increase over the 17 year period (Figure 5.11). It is to be noted that admissions peaked in the last quarter of 1997, when there were 1,114 admissions (Tables 18 and 19, Appendix 13).

### 5.9.10.4. Gender

The expansion of methadone treatment has been accompanied by a growth in the number of females who have participated in the methadone treatment (Figure 5.11). Females have constituted about 42% of all admissions since 1989 (Tables 18 and 19, Appendix 13). In the March 1978 quarter,<sup>207</sup> females made up about 30% of the treatment population, reaching a peak of 45% of all admissions in the March 1986 quarter.

<sup>207</sup> Swensen G. *Indicators of illicit drug use in Western Australia 1981-1989*. Perth, Epidemiology and Research Branch, Health Department of WA, February 1991.

### 5.9.10.5. Age related trends

Age related trends in the ADA methadone program over the period 1990 to 1997 for males (Figure 5.12) and females (Figure 5.13) indicate that growth in the methadone program has mostly involved those in the 30 to 39 and 40 year and over age groups. Over the period, the number of persons aged 20 to 29 remained relatively static, with increases occurring for both males and females in this age group since mid 1996.

The mean age of males has been about 35. Females had an average age of about 32. Small decreases in mean age were recorded for both males and females in 1997. The overall mean age of the ADA methadone treatment population has increased from 29.1 years in the March quarter 1986 to 33.4 in the December quarter 1997 (Table 20, Appendix 13).

There were a total of 1,114 people in methadone treatment, of whom 21 (1.9%) were in the 15 to 19 age group, 314 (28.2%) were in the 20 to 29 age group, 535 (48.0%) were in the 30 to 39 age group and 244 (21.9%) were in the 40 years and over age group (Table 20, Appendix 13).

**Table 5.10: Annual admissions to WA methadone program, 1973 - 1997**

Year	Unique individuals	New	% new	Cumulative new
1973	na	2	-	2
1974	na	31	-	33
1975	na	142	-	175
1976	na	188	-	363
1977	na	266	-	629
1978	479	205	42.8	834
1979	382	118	30.9	952
1980	288	59	20.5	1,011
1981	214	68	31.8	1,079
1982	264	100	37.9	1,179
1983	225	77	34.2	1,256
1984	387	163	42.1	1,419
1985	547	230	42.0	1,649
1986	557	150	26.9	1,799
1987	506	134	26.5	1,933
1988	680	247	36.3	2,180
1989	720	144	20.0	2,324
1990	710	153	21.5	2,477
1991	739	153	20.7	2,630
1992	766	163	21.3	2,793
1993	841	197	23.4	2,990
1994	930	202	21.7	3,192
1995	1,072	251	23.4	3,443
1996	1,190	272	22.9	3,715
1997	1,537	418	27.2	4,133

Source: Alcohol and Drug Authority.  
 Note: Size of annual treatment population not available for period 1973-1977.

**Table 5.11: Number of males and females participating in all methadone programs by quarter, WA, 1997 - 1998**

Year	Quarter	ADA		Community		All programs		
		M	F	M	F	M	F	Total
1997	January-March	573	424	-	-	573	424	997
	April-June	600	448	-	-	600	448	1,048
	July-September	629	455	141	96	770	551	1,321
	October-December	638	476	216	141	854	617	1,471
1998	January-March	606	444	356	244	962	688	1,650
	April-June	561	423	na	na	na	na	1,703

Source: Alcohol and Drug Authority, Pharmaceutical Services, HDWA.

**Figure 5.11: Number of males and females participating in ADA methadone program by quarter, 1978 - 1998**

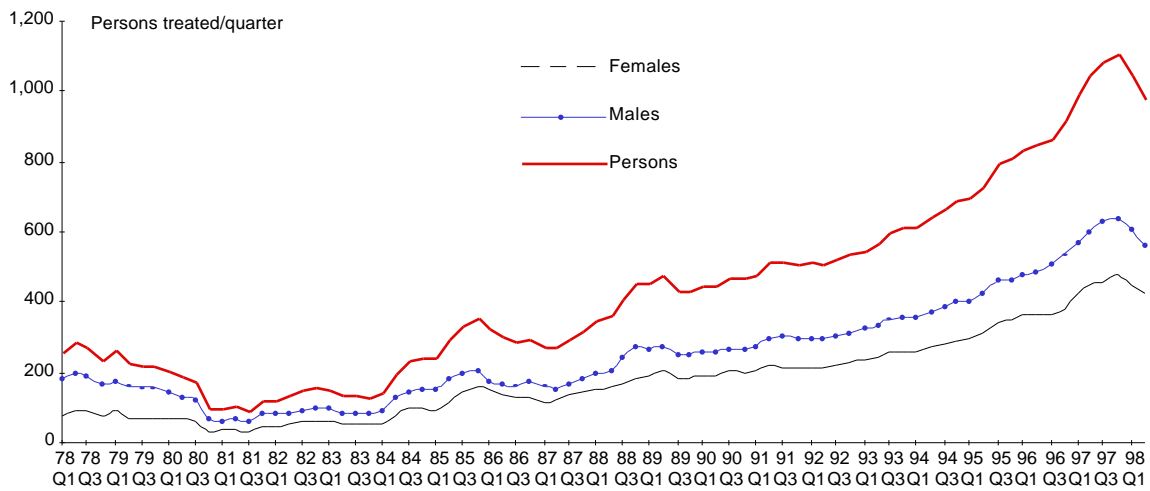


Figure 5.12: Number of males participating in ADA methadone program by age group and quarter, 1990 - 1998

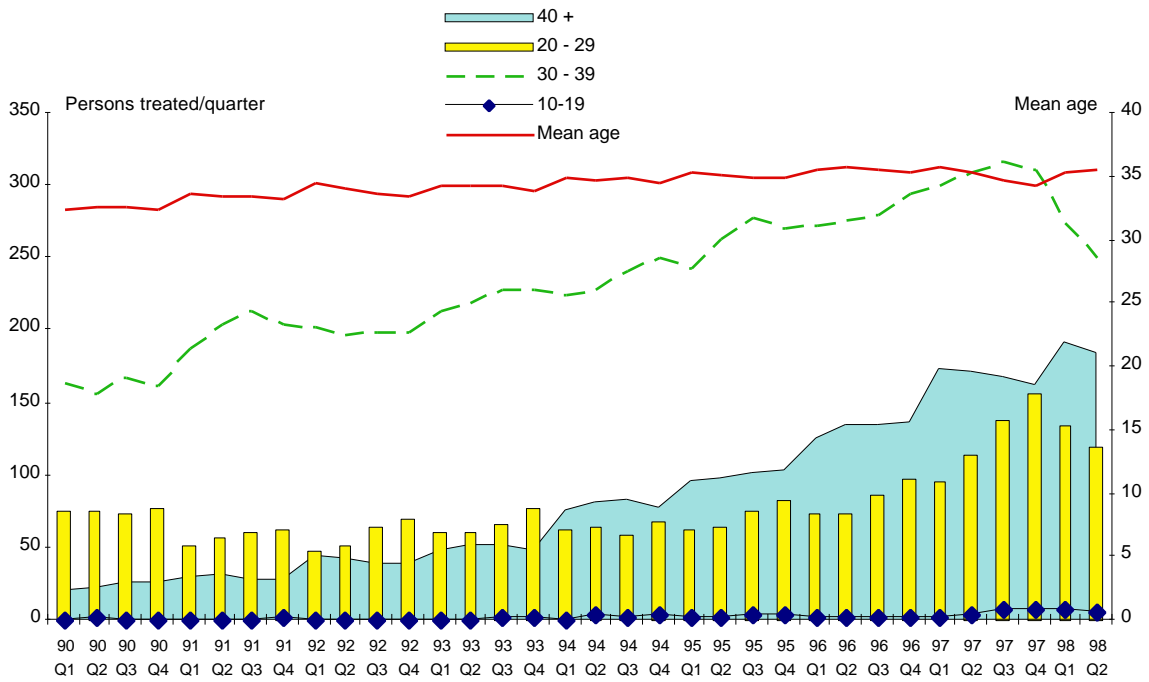
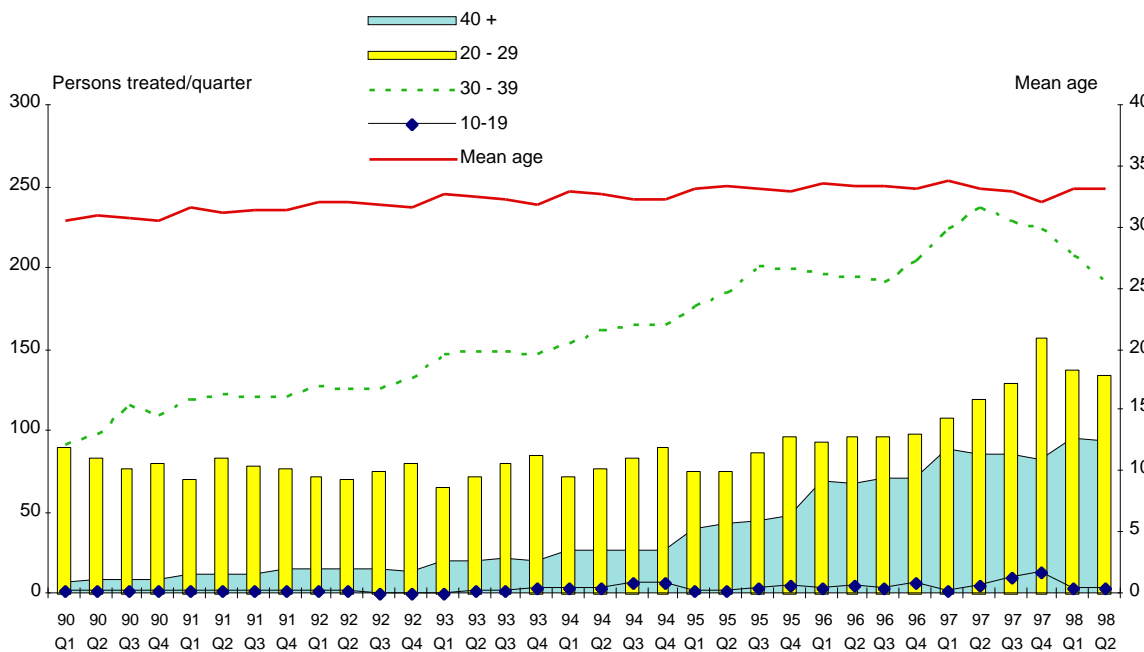


Figure 5.13: Number of females participating in ADA methadone program by age group and quarter, 1990 - 1998



### 5.9.10.6. Length of stay – ongoing treatment group

An important indicator of treatment outcome for methadone programs is the length of stay, with longer lengths of stay indicative of much better treatment outcomes. Over the 12 years from 1986 to 1997, the length of stay of the ADA treatment population nearly doubled, from a mean of 15.3 months in the March quarter 1986 to a mean of 31.0 months in the December quarter 1997 (Table 21, Appendix 13; Figure 5.14). This achievement is believed to be due to a number of factors, especially a policy of increased dosage levels to provide better management of withdrawal discomfort.

### 5.9.10.7. Length of stay – ceased treatment group

The mean length of stay of those who have ceased methadone treatment increased from a mean of about 6 months in 1986 to a mean of about 16 months in 1997 (Figure 5.15). The fluctuations in the mean length of stay may be due to a combination of program factors, such as changes in staff, dosage policies, opening hours or external factors, such as changes in the availability of drugs or law enforcement activities.

### 5.9.10.8. Cost of treatment

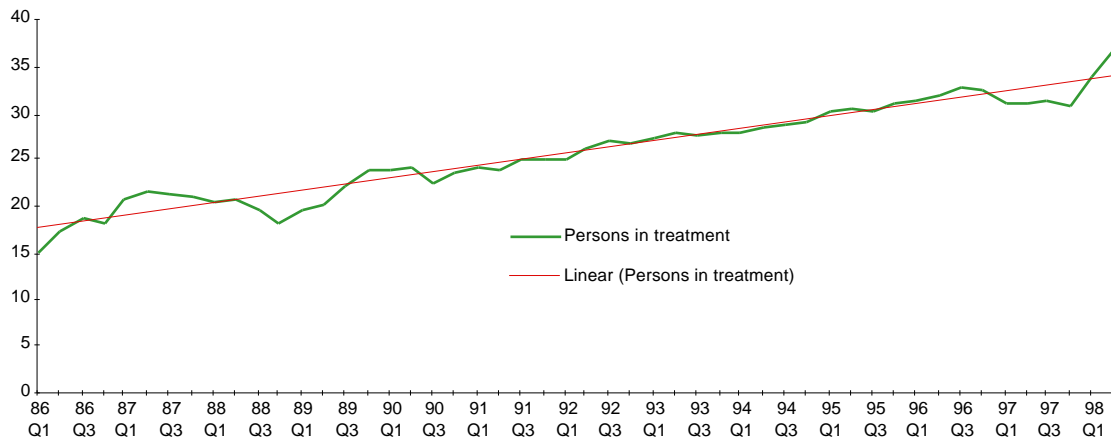
The total recurrent cost of the ADA methadone program has risen by 47.6% from \$947,321 in 1990/91 to \$1,398,546 in 1996/97 (Table 5.12). Over this time, the number of persons in treatment has increased by 91.4%, from 514 patients in the June quarter 1991 to 984 patients in the June quarter 1998 (Table 19, Appendix 13).

**Table 5.12: Annual direct costs ADA methadone program, 1990/91 - 1996/97**

Year	Total FTEs	Salaries (\$)			Other costs (\$)	Total (\$)
		Medical	Nursing	Other		
1990/91	25.1	357,802	118,877	470,642	*	947,321
1991/92	24.5	354,154	120,418	463,618	*	938,190
1992/93	24.5	368,350	110,545	483,662	*	962,557
1993/94	24.7	339,419	173,608	474,420	*	987,447
1994/95	23.7	216,466	130,542	593,166	144,456	1,084,630
1995/96	22.6	317,866	142,023	618,158	143,702	1,221,749
1996/97	24.0	441,569	184,737	611,015	161,225	1,398,546

Note: Actual costs were available only for salaries from 1990 to 1994, since the actual costs for other expenses were archived and thus difficult to obtain.  
\* not separately tabulated.

**Figure 5.14: Mean length of stay (months) of persons participating in ADA methadone program by quarter, 1986 - 1998**



**Figure 5.15: Mean length of stay (months) of persons who ceased participation in ADA methadone program by quarter, 1986 - 1998**



### 5.9.10.9. Daily doses dispensed

The number of daily doses dispensed by the ADA has increased. This is consistent with the marked growth in the size of the treatment population that has occurred since the mid 1980s (Table 5.13). The total number of daily doses per quarter has increased by 122%, from a total of 44,972 daily doses in the March 1993 quarter to a total of 99,888 daily doses in the December 1997 quarter.

Since the September quarter 1997, the total number of daily doses per quarter of ADA patients attending chemists has exceeded the total number of doses dispensed at William Street Clinic. By the June quarter 1998, nearly three times as many doses were dispensed at chemists as were dispensed at William Street Clinic. This change in policy was introduced by the ADA in mid 1997 to relieve overcrowding at William Street Clinic.

The new policy permits new patients to receive methadone doses at William Street Clinic for only the first six weeks of their treatment and thereafter they are expected to make arrangements to continue to receive doses from a community pharmacy. The ADA does not charge a daily dispensing fee for the methadone it provides to its patients, whereas all patients who attend community pharmacies pay a daily fee. This is presently \$4 per day.

**Table 5.13: Quarterly totals of ADA methadone daily doses by dispensing outlet, 1993 - 1998**

Year	Quarter	WSC	Chemist	Elsewhere	Take aways	Total
1993	January-March	25,978	16,484	2,490	20	44,972
	April-June	27,924	17,652	3,251	28	48,855
	July-September	28,150	19,186	3,398	29	50,763
	October-December	29,111	18,537	3,624	39	51,311
1994	January-March	29,445	18,789	4,076	53	52,363
	April-June	31,585	19,426	4,371	69	55,451
	July-September	30,803	20,777	5,530	46	57,156
	October-December	32,718	21,737	5,592	54	60,101
1995	January-March	32,068	21,924	5,440	108	59,540
	April-June	32,592	24,134	5,429	120	62,275
	July-September	35,468	26,408	6,082	162	68,120
	October-December	35,290	27,762	6,039	295	69,386
1996	January-March	36,553	29,279	6,884	224	72,940
	April-June	38,017	28,432	7,532	316	74,297
	July-September	38,817	28,450	7,366	250	74,883
	October-December	39,966	27,358	8,692	315	76,331
1997	January-March	39,347	28,209	9,197	299	77,052
	April-June	39,699	39,201	10,371	27	89,298
	July-September	37,566	47,452	10,596	5	95,619
	October-December	36,849	52,857	10,179	3	99,888
1998	January-March	28,545	58,161	8,233	3	94,942
	April-June	21,701	61,447	8,096	21	91,265

Note: WSC - William Street Clinic

### 5.9.10.10. Community based methadone program

Data for the community based methadone program, which is only available from the September quarter 1997, indicates very similar mean ages as reported for the ADA methadone program. The number of patients in this program has trebled from 237 in treatment at 30 September 1997 to a total of 719 in treatment at 30 June 1998 (Table 5.14).

## Select Committee Into Misuse of Drugs Act 1981

At 30 June 1998, a total of 50 prescribers had been approved to prescribe methadone in this State, of whom 34 (68%) were based in the metropolitan area, with the remaining 16 (32%) prescribers being based in non metropolitan areas. The 16 non metropolitan prescribers were based in: Albany (2), Bunbury (1), Collie (1), Denmark (2), Carnarvon (1), Dunsborough (2), Mandurah (1), Margaret River (1), Kalgoorlie (1), Geraldton (2), Kalbarri (1) and South Hedland (1).

**Table 5.14: Number of persons participating in community based methadone program by quarter, WA, 1997 - 1998**

Year	Quarter	Persons					Mean age
		15-19	20-29	30-39	40+	All ages	
1997	July-September	10	81	112	34	237	32.1
	October-December	15	128	154	60	357	32.2
1998	January-March	38	222	257	83	600	31.7
	April-June	na	na	na	na	719	na

Source: Pharmaceutical Services, Environmental Health Branch, Health Department of WA.

## 5.10. Notifications of drug addiction, 1982 - 1997

### 5.10.1. Overview

The HDWA has for a number of years maintained a register of 'notified addicts', as required under the *Health Act 1911*. The register provides a count of the number of persons who have come to the attention of a medical practitioner who, in the opinion of the doctor, satisfy any of the three criteria for dependence provided under the *Health Act 1911*.

There were 4,618 notifications in the period 1982 to 1997, of which 2,819 (61.0%) involved males and 1,799 (39.0%) involved females. These notifications involved mostly those in the age range 20 to 39, with 2,593 notifications (56.1%) of those aged 20 to 29 and 1,411 notifications (30.6%) of those aged 30 to 39 (Table 5.15).

There have been a number of peaks in notifications, due to increased notifications in 1984 and 1988, as a consequence of overprescribing by GPs of Temgesic (buprenorphine) and tranquillisers (especially ampoules of benzodiazepines), respectively. The increase in notifications that has occurred in 1996 and 1997 is attributable to the expansion in methadone treatment in this State.

For all age groups, except the 10 to 19 age group, there is a higher proportion of male (Table 5.16; Figure 5.16) compared to female (Table 5.17; Figure 5.17) notifications. It is noted that female:male ratio decreases with age: 1:0.76 (10 to 19 age group), 1:1.45 (20 to 29 age group), 1:1.93 (30 to 39 age group) and 1:2.42 (40 years and older age group).

It is possible that females present sooner for treatment in their drug using careers than males, and that with age they cease drug use at higher rate compared to males.

A large proportion of the notifications involve people who are admitted to the methadone treatment program, suggesting few IDUs are notified by GPs.

**Table 5.15: Annual notifications of drug addiction by age group, persons, WA, 1982 - 1997**

Year	10-19	20-29	30-39	40+	Age Missing	All ages
1982	18	117	30	9	14	188
1983	12	140	28	8	5	193
1984	21	215	57	8	1	302
1985	17	162	64	13	-	256
1986	4	153	49	6	2	214
1987	9	134	49	6	4	202
1988	15	240	114	15	2	386
1989	15	166	86	18	1	286
1990	9	126	61	4	1	201
1991	9	91	72	4	-	176
1992	3	85	58	8	-	154
1993	7	89	89	15	1	201
1994	16	107	71	21	2	217
1995	19	141	112	28	2	302
1996	36	226	201	55	6	524
1997	74	401	270	70	1	816
<b>1982-1997</b>	<b>284</b>	<b>2,593</b>	<b>1,411</b>	<b>288</b>	<b>42</b>	<b>4,618</b>

Source: Health Department of WA.

**Table 5.16: Annual notifications of drug addiction by age group, males, WA, 1982-1997**

Year	10-19	20-29	30-39	40+	Age Missing	All ages
1982	8	75	22	7	11	123
1983	6	94	18	5	3	126
1984	9	134	33	5	1	182
1985	8	87	46	9	-	150
1986	2	86	32	5	1	126
1987	6	82	34	5	3	130
1988	9	153	80	8	1	251
1989	7	100	56	10	-	173
1990	5	81	41	3	-	130
1991	4	61	55	3	-	123
1992	2	51	32	4	-	89
1993	4	42	59	10	1	116
1994	2	56	49	17	1	125
1995	7	87	72	17	1	184
1996	17	119	124	41	3	304
1997	27	227	177	55	1	487
<b>1982-1997</b>	<b>123</b>	<b>1,535</b>	<b>930</b>	<b>204</b>	<b>27</b>	<b>2,819</b>

Source: Health Department of WA.

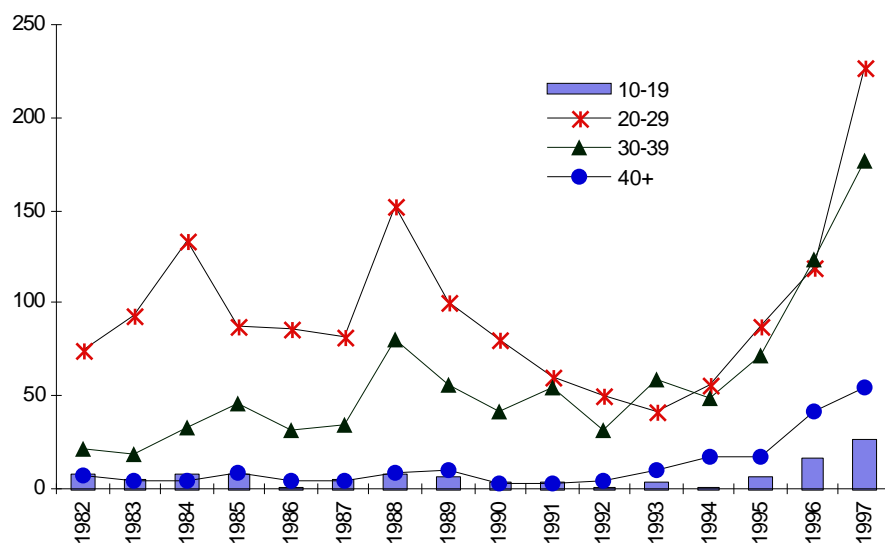
## Select Committee Into Misuse of Drugs Act 1981

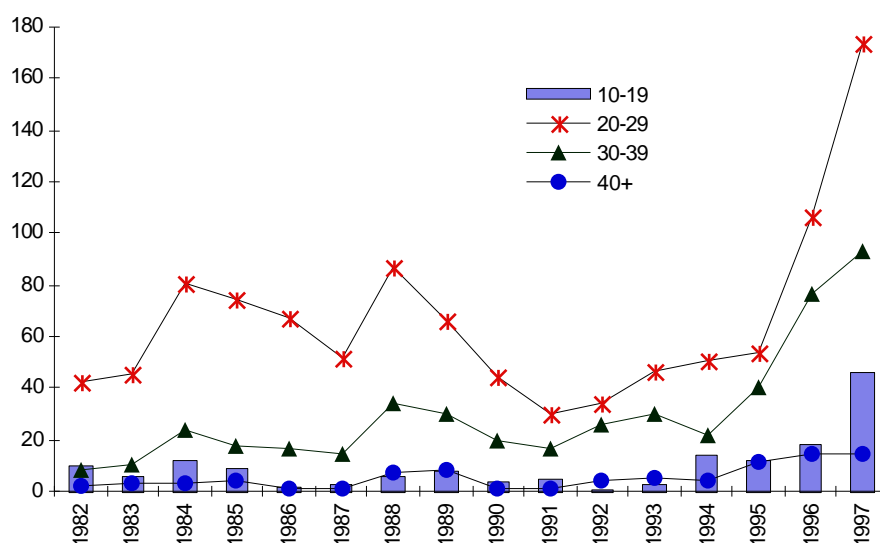
**Table 5.17: Annual notifications of drug addiction by age group, females, WA, 1982-1997**

Year	10-19	20-29	30-39	40+	Age Missing	All ages
1982	10	42	8	2	3	65
1983	6	46	10	3	2	67
1984	12	81	24	3	-	120
1985	9	75	18	4	-	106
1986	2	67	17	1	1	88
1987	3	52	15	1	1	72
1988	6	87	34	7	1	135
1989	8	66	30	8	1	113
1990	4	45	20	1	1	71
1991	5	30	17	1	-	53
1992	1	34	26	4	-	65
1993	3	47	30	5	-	85
1994	14	51	22	4	1	92
1995	12	54	40	11	1	118
1996	19	107	77	14	3	220
1997	47	174	93	15	-	329
<b>1982-1997</b>	<b>161</b>	<b>1,058</b>	<b>481</b>	<b>84</b>	<b>15</b>	<b>1,799</b>

Source: Health Department of WA.

**Figure 5.16: Annual notifications of drug addiction by age group, males, WA, 1982-1997**



**Figure 5.17: Annual notifications of drug addiction by age group, females, WA, 1982-1997**

Until recently, it has been difficult to obtain more detailed information about patterns of drug abuse of those who have been notified. The data available for the years 1995 to 1997 highlights the magnitude of the public health problems that are associated with drug abuse, in that for about nine out of every 10 notifications injecting drug use was recorded at the primary mode of use (Table 5.18).

Over the three year period 1995 to 1997, a total of 11 notifications recorded smoking, a method with a lower risk of BBV compared to injecting, as the primary mode of use. As these notifications refer to heroin dependent individuals, an increase in this mode could reflect a shift by the heroin using population to a lower risk method of use. There have been accounts in a number of overseas countries of shifts towards smoking in preference to injecting.

The mean age for each mode of use are set out in Table 5.19. These data confirm that generally the injecting group is slightly younger than the three other groups, with the anal (ie suppository) group being the oldest.

**Table 5.18: Annual notifications of drug addiction by mode of drug use, WA, 1995 - 1997**

Year	Sex	Anally	Intravenous	Orally	Smoking	Total
1995	M	-	159	22	2	183
	F	1	104	11	1	117
	<b>All</b>	<b>1</b>	<b>265</b>	<b>33</b>	<b>3</b>	<b>302</b>
1996	M	3	271	25	2	301
	F	-	204	11	1	217
	<b>All</b>	<b>3</b>	<b>480</b>	<b>37</b>	<b>3</b>	<b>524</b>
1997	M	3	441	40	2	486
	F	1	296	29	3	329
	<b>All</b>	<b>4</b>	<b>738</b>	<b>69</b>	<b>5</b>	<b>816</b>

Source: Health Department of WA.

**Table 5.19: Average age of notifications of drug addiction by mode of drug use, WA, 1995-1997**

Year	Sex	Anally	Intravenous	Orally	Smoking	Total
1995	M	-	30.0	32.6	32.5	30.4
	F	34.2	29.1	31.1	31.9	29.3
	<b>All</b>	<b>34.2</b>	<b>29.9</b>	<b>32.1</b>	<b>32.3</b>	<b>30.2</b>
1996	M	32.6	31.4	32.8	21.2	31.4
	F	-	28.8	32.0	27.6	29.0
	<b>All</b>	<b>32.6</b>	<b>30.2</b>	<b>32.8</b>	<b>23.3</b>	<b>30.3</b>
1997	M	35.2	30.0	32.4	29.9	30.2
	F	27.3	27.0	29.3	31.6	27.2
	<b>All</b>	<b>33.3</b>	<b>28.8</b>	<b>31.1</b>	<b>30.9</b>	<b>29.0</b>

Source: Health Department of WA.

## 5.11. Psychiatric comorbidity

As heroin abusers may be unable to obtain regular doses of heroin every day, they may substitute heroin with other central nervous system (CNS) depressants, typically benzodiazepines such as diazepam, oxazepam and temazepam which are available on prescription. As diazepam is available in an injectable form as ampoules, it is particularly attractive to IDUs. In common with other benzodiazepines, diazepam may produce serious secondary dependencies, in addition to the principal dependence on heroin.

Specific concern about benzodiazepines and a close association between their use and fatal heroin overdoses has been documented in both New South Wales and WA. It has been found that about one in four heroin abusers who report benzodiazepine use have some clinically demonstrable level of benzodiazepine dependence.<sup>208</sup> In addition to the management difficulties associated with the benzodiazepine dependence, there are other complex problems, as there is a

*“strong association between opioid use and psychopathology ... with higher rates of anxiety and depression being noted amongst those opioid users who use benzodiazepines. Heroin users who use benzodiazepines have been found to have higher levels of depression, anxiety and global psychopathology than other heroin users”.*<sup>209</sup>

Historically, services to assist those who have both drug related problems and serious mental illness have been organised and delivered as parallel systems. This results in programs for alcohol and other drug problems being unconnected with the services provided by the mental health treatment system.<sup>210</sup>

There is a substantial body of experience which indicates that the established methods for assisting those with drug dependencies are ineffective and inappropriate for treating those with mental illnesses. This has meant the demonstrated limited success in treating those with coexisting mental illnesses and drug dependencies has mitigated against an integrated approach being developed.<sup>211</sup> There is a need for additional resources and the development of a specialised service, as on the basis of research there is

<sup>208</sup> Ross J, Darke S. *Benzodiazepine dependence and psychopathology among heroin users in Sydney*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1997.

<sup>209</sup> Ross J, Darke S. “Benzodiazepine dependence and psychopathology among heroin users.” In Dillon P, Topp L, Swift W. (eds) *Illicit drugs: current issues and responses. Proceedings from the eleventh NDARC annual research symposium, November 1997*. Sydney, National Drug and Alcohol Research Centre, 1998.

<sup>210</sup> McKey J. “Dual diagnosis: joining forces.” (1998) 18(4) *Connexions* 4-11.

<sup>211</sup> Teesson, M, Gallagher J, Ozols S. *The Gemini Project: an evaluation of a treatment program for persons with serious mental illness and substance misuse*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1998.

*“a strong association between injecting drug use and psychopathology. Studies consistently show in excess of (half) of IDU qualify for at least one psychiatric diagnosis other than drug dependence, of which the most commonly diagnosed Axis I disorders are anxiety and depression”.*<sup>212</sup>

Evidence from a number of witnesses dealt with the issue of mental illness and the abuse of illicit drugs. It was pointed out there is a tendency to focus on mental disorders involving psychotic episodes (which for instance can be induced by amphetamine abuse) whereas this form of mental illness represents a small proportion of all psychiatric illness.

This evidence supports research from other jurisdictions, namely, that mental illness was an under recognised health issue amongst the population who have problematic drug use, with about one third of this population having psychiatric disorders at some time. Concern was also expressed about the parallel development of the mental health system and the alcohol and other drug treatment system in this State.

Originally the ADA was expected to deal with the large population of persons with alcohol problems. However, over time there has been changes in the types of drugs abused which has meant that there is a need for integrated services in some areas.

*“One of the historical problems is that when the Alcohol and Drug Authority was set up and when alcohol was the major problem, services separated into people with psychiatric illness and people with alcohol problems. As a result people became quite deskilled in both these areas. Some people treated alcohol problems and some people treated psychiatric illness. Now the range of substances which people abuse is much larger and the incidence of psychiatric comorbidity is quite huge, but we have not followed up with a reintegration of services or developed specialists in each area in the different arenas”.*<sup>213</sup>

It was also indicated that a significant proportion (one estimate being about 40%) of patients admitted for inpatient psychiatric treatment also have coexisting alcohol or other drug problems. The Select Committee understands the ADA has had a part time psychiatrist attending the CDU to assess and assist in the management of patients with dual diagnoses of mental illness and alcohol and other drug problems.

The Select Committee believes there is a need for additional resources provided to enable the employment of health care providers with mental health training in both outpatient and inpatient programs, to assist both young people and adults with problems involving comorbidity. An option that should be considered is to support a project, such as the Gemini Project in Sydney, to develop closer working relationships between providers working in both sectors.

Such a commitment would need to be substantial to ensure that the project includes a component for training and for sufficient resources to develop services in non metropolitan areas such as the Goldfields, which have high levels of abuse of illicit drugs.

***Recommendation 17***

***That the WA Drug Abuse Strategy Office develop a pilot project in metropolitan and regional centres with the object of examining ways to improve the skills and knowledge of health providers in treating opioid dependents with dual diagnoses.***

<sup>212</sup> Darke S, Ross J. “Polydrug dependence and psychiatric comorbidity among heroin injectors.” (1997) 48 *Drug & Alcohol Dependence* 135-141, 136.

<sup>213</sup> Evidence from Dr Helen Slattery, Consultant Psychiatrist, Sir Charles Gairdner Hospital.

## **5.12. Heroin overdoses**

### **5.12.1. Introduction**

There is between approximately 80 to 90 ambulance trips per month due to illicit drug overdoses in WA, almost all of which occur in the metropolitan area. The average cost of an ambulance trip is about \$300. This means on an annual basis between approximately \$290,000 and \$320,000 is incurred by St John's Ambulance Service to transport people to hospital who have overdosed on illicit drugs.

As the cost of an ambulance trip is normally billed, there is some concern that this has sometimes deterred people from using the service because of an inability to pay. It is believed there have been discussions between WA Substance Users' Association (WASUA) and the St John Ambulance Service to negotiate a group rate on behalf of members of the association. WASUA (to its credit) has been actively encouraging its members to take out membership for St John Ambulance Medical Fund, which is now administered by the Hospital Benefit Fund of WA.

In addition to the obvious concern about cost to the health system from usage of ambulance services to assist those who have overdosed on heroin, there are some specific concerns in relation to young people and the use of ambulance services.

The Select Committee notes that the problem of heroin overdose is not confined to WA. Over recent years, a number of interstate and overseas jurisdictions have reported significant increases in heroin related fatal and non fatal overdoses.<sup>214</sup> In an attempt to grapple with this serious problem, a range of strategies have been implemented in a number of jurisdictions.<sup>215</sup> This has included better protocols between the police and ambulance services,<sup>216</sup> development of peer based education, outreach work, access to Narcan (opiate antagonist) and teaching of resuscitation skills.

### **5.12.2. Opiate overdose prevention strategy**

The Opiate Overdose Prevention Strategy (OOPS) was initiated in WA in 1997 as part of a national response to the growing number of heroin related overdoses. The OOPS project involves two aspects, firstly a peer education project and secondly an emergency department project. OOPS involves a number of measures to reduce both overdoses and HRDs by:

- distributing resources to increase the knowledge and skills of IDUs in overdose situations;
- supporting peer education strategies;
- establishing networks between users, police, ambulances, drug and alcohol agencies and relevant others to address heroin overdose issues;
- informing service providers of the needs of IDUs in relation to heroin overdose; and
- informing the wider community about heroin overdose from a harm minimisation perspective.

#### **5.12.2.1. Management**

The achievement of the goals of the project will be maintained through three groups to provide forums for discussion relating to direction, knowledge and resources. Additionally, the opiate overdose review group would provide a wider forum for exchange of information. This group

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<sup>214</sup> Hall W (ed). *Proceedings of an international opioid overdose symposium, Sydney, 14-15 August 1997*. Sydney, National Drug and Alcohol Research Centre, 1998.

<sup>215</sup> McGregor C, Darke S, Ali R, Christie P. "Experience of non-fatal overdose among heroin users in Adelaide, Australia: circumstances and risk perceptions." (1998) 93 *Addiction* 701-711; Gore C. *Report of the pilot heroin overdose peer education project March 1997*. Rozelle, NSW, Centre for Education and Information on Drugs and Alcohol, 1997.

<sup>216</sup> So that police should not attend overdose situations unless someone has died. See Appendix 3 for copies of guidelines.

consists of members from the Australian Medical Association, St John's Ambulance Service, WASUA, community based methadone program, Health Promotion Service, WADASO, the Pharmacy Guild and others.

#### 5.12.2.2. OOPS reference group

The membership of the OOPS reference group consists of WADASO, WASUA, staff of the OOPS project and the ADA's Director of Education. It will provide a forum for information exchange relevant to the project as well as providing ideas for future direction.

#### 5.12.2.3. IDU initiatives group

The IDU initiatives group provides a forum where information gained from the project could be exchanged amongst agencies working in the IDU area. It will also provide an avenue to distribute OOPS resources.

#### 5.12.2.4. OOPS resource group

The OOPS reference group is a forum where ideas for resources could be discussed and designed. Members of this group would consist of staff from the Health Promotions Service, a member of WASUA, members of the OOPS team, the ADA's Director of Education, the IDU coordinator of the WA AIDS Council and selected individuals with expertise in various media as required.

### 5.12.3. Peer education project

The WA Substance Users Association Inc (WASUA) was funded by the HDWA (for a trial commencing in November 1997) to provide a peer based education, referral and outreach service for IDUs. The project incorporates a fixed site needle and syringe exchange and disposal service in inner city Perth, with the aim of assisting with the reduction of transmission of BBVs. A report in July 1998 which dealt with the service's application to the local authority for permission to continue on a permanent basis, indicates favourable support for the service after initial opposition by local residents and businesses.

*"The Town of Vincent has received good reports about the 440 William Street drug users' centre and is expected to approve it this month. 'Our rangers say they've been picking up 75 per cent fewer needles in parks and laneways since it opened,' Deputy Mayor John Hyde said."*<sup>217</sup>

The Select Committee is aware that during the course of the BBV project, WASUA is also regularly approached for advice about overdoses and other issues concerned with illicit drug use. As indicated earlier, the cost of ambulance services is substantial and thus preventative activities which reduce usage of the St John's Ambulance Service would be potentially highly cost effective.

Accordingly, a modest investment in the funding of community based organisations such as WASUA can produce a substantial gain to the community as a whole, in addition to the issue of improving the health of IDUs. It is desirable that WASUA be encouraged to have a broader focus than just on the issue of prevention of BBVs.

#### **Recommendation 18**

***That there be increased funding and support for the OOPS Project and the Emergency Department Project, and consideration of additional funding of peer education and innovative outreach programs as part of a comprehensive strategy to reduce the number of heroin overdoses in metropolitan and country areas, and to reduce the transmission of BBVs.***

<sup>217</sup> Magnus J. "Needle exchange certain to remain." *Guardian Express* 14-20 July 1998.

Strategies have been identified in other similar projects to develop effective peer based programs are listed below.<sup>218</sup>

- Identify established peer networks of IDUs who may be at risk of heroin overdose and establish peer education strategies in the prevention of opiate overdose.
- Identify key individuals in established networks who would disseminate resources and information within their networks. These key individuals would be trained with 'train the trainer' skills to further increase penetration of information into established networks.
- Provide a range of creative and flexible projects which target particular groups or subcultures within the IDU community (eg prisoners, Aboriginal communities, homeless youth, etc). These groups are then assisted to develop, produce and disseminate their own culturally appropriate resources with relevant information for that target group.
- Develop and distribute appropriate resource materials to drug users not identified as a culture or group.
- Provide key service providers with resources and support to enable them to deliver appropriate services to injecting drug users with regards to overdose.
- Provide education and training to increase the knowledge, confidence and competence of workers.

### 5.12.4. Emergency department (ED) project

#### 5.12.4.1. Background

The ED project is a part of the successful opiate overdose prevention strategy which was developed by the ADA (in association with the WASUA) to find ways to access and educate opiate users in regards to safer heroin use and prevention of overdose.

Various strategies were developed, such as rock concerts, liaison with both police and ambulance services, postcards, a drop in centre where users were taught EAR and workshops to community groups. The response from users has been substantial, with call rates to ambulances decreasing and general knowledge surrounding the issue increasing.

It is believed that most opiate users have little access to mainstream health services. For those clients who are taken to hospital, they are often wary of hospital staff and leave the ED as soon as they are physically able. This makes intervention difficult, yet this may be a time when users are most accessible for education.

The ED project has been designed as a peer support, brief intervention and education service for post overdose patients. OOPS has been given funding to set up and administer this project. Initially a pilot study of three months will take place staffed by project officers. This will be on a Monday to Friday (8.30 am to 5.00 pm) basis. In this time protocols will be developed, data collected and training of volunteers will take place. After that, a 24 hour service staffed by professionally trained volunteers will be provided.

#### 5.12.4.2. Aims

- Educate opiate users about the issues surrounding heroin use.
- Encourage peer support following an overdose.
- Establish and encourage peer education networks on the issue of overdose.

It is envisioned that these strategies will:

- Reduce the prevalence of opiate overdose.
- Reduce the occurrence of re presentation of opiate overdose.

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<sup>218</sup> An exemplar of this approach is outlined in Gore C. *Report of the pilot heroin overdose peer education project March 1997*. Rozelle, Centre for Education & Information on Drugs and Alcohol, 1997.

### 5.12.4.3. Procedures

The process will involve the following procedures.

A business card with project phone number and information will be given to either the patient or their support person and they will be encouraged to phone the project themselves. If the patient is alone and agrees to meet someone from the project, the duty doctor will phone and a volunteer or project officer will attend.

The project worker will meet the patient on discharge and at that time both patient and project worker will move away from the ED.

The project worker will offer any immediate support needed (eg pre printed taxi vouchers, referral to crisis accommodation, etc) and will offer to meet at a later time to discuss overdose prevention with the client and their peers. This may range from teaching EAR, how to recognise OD, to treatment options. If the presenting patient will not stay in ED, then a business size card with project information and a phone number will be offered by ED staff. Intervention would end at that point.

### 5.12.4.4. Data

The collection of appropriate data will take place. This will include age, gender, postcode, brief history of drug use and other non identifying information that may be useful to hospitals and other agencies.

## 5.12.5. Relations with health care providers

The Select Committee received evidence from expert witnesses, as well as a number of those who attended the users' forum, indicating that many drug users report poor relations with staff working at hospital emergency departments. Without evidence on specific issues, it is difficult to determine whether the causes of such complaints lie with one side or the other. However, it is apparent that these problems have existed for a number of years and consequentially are a major barrier in illicit drug users attending hospitals as inpatients or outpatients.

For these reasons, the Select Committee has strongly supported the development of peer outreach initiatives, such as that being undertaken with the Emergency Department project. This type of service development should be beneficial to staff working in emergency departments, who are at times placed in difficult, confrontational situations with drug users who are withdrawing and angry, and who perceive that they do not receive sympathetic treatment. There should also be advantages to drug abusers who may feel that outreach workers are more able to understand their distress and frustration.

It is possible that a drug abuser may be notified as a 'drug addict,' as under the Commonwealth *Drugs of Addiction Notification Regulations 1965* there is a duty by law for doctors to notify those they suspect or know are drug dependent.<sup>219</sup> This and other reasons are likely to contribute to a perception of a climate of mistrust and hostility between hospitals and those who have been notified or are likely to be notified as drug dependent.

If the drug user is a young person, there are additional factors which create barriers to treatment, as it is likely his or her parents and other authority figures may be notified. This is a particular issue with respect to those aged below 16 years of age. There is also a view widely shared by drug abusers who have young dependent children that they may lose care of their children if Family and Children's Services (FCS) are notified by a health provider who perceives a child in their care may be at a risk of neglect.

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<sup>219</sup> This power is derived from the *Health Act 1911* s 289B.

### **5.12.6. Young injecting drug users**

The Select Committee commends the research undertaken by Dr Wendy Loxley and Mr Peter Davidson from the National Centre for Research Into the Prevention of Drug Abuse which was published in February 1998.<sup>220</sup> This research, which was funded by WADASO, involved qualitative research with 40 young people aged between 14 and 21 years of age, most of whom had injected heroin in the previous 6 months.

It should be noted that while relatively few young people die prematurely from heroin overdose, the number of deaths of those aged less than 25 age group have increased over the past two years. This research project was undertaken to obtain better information about young IDUs so as to develop effective educational campaigns and to implement preventive strategies targeted at this group.

This research contains a detailed examination of a sample of young people's knowledge about drug overdose and their knowledge of health and other related information. As those surveyed tended to be reluctant users of mainstream health services, the report contains suggestions for health providers to be sensitised to the needs of young people who attend hospitals or use ambulance services.

There are particular difficulties posed for health providers when young people who are aged less than 16 present at an emergency department. In these situations, it is likely that the young person's parent or guardian will be contacted. As this outcome is likely to deter some young people from utilising services, the under 16 age group faces particular risks from the use of heroin.

There is a greater flexibility in the management of young people who are aged between 16 and 18 years attending hospitals and other health service because of drug overdose. Some young people in this age range may be regarded as having sufficient maturity to be able to make competent decisions as to treatment. For instance, young people who live independently away from home may be able to insist that other members of their family are not contacted by the hospital.

An issue that is raised in the *Forgetting to breathe* study concerns billing by the ambulance service for transporting a young person to a hospital following an overdose. As parents are likely to be billed for the ambulance trip, this raises issues about confidentiality when a young person is transported to hospital. As a number of the young people in the study were aware that they or their families may be billed in some situations, this deters the use of health services.

The context in which young people's heroin use occurs is of particular importance, as this may involve the purchase and use of heroin in street contexts. Injecting drug use in this situation is particularly fraught with risk. Such risks include, for instance, less chance to use partial doses, lower rates of new needle use and less opportunity to be in the presence of others who can monitor for overdose.

There are 21 recommendations contained in this report, which are listed below. It is understood these recommendations have been adopted and steps being taken to involve relevant agencies as necessary. As can be seen, some of these recommendations are far reaching with both short and long term consequences, involving support for community based organisations and outreach programs, involvement by key health provider groups and preventive and educational material targeted at young people.

#### **Recommendation 1**

Every attempt should be made to encourage young drug users to make contact with health or welfare agencies who can offer support and advice. Those agencies that are being accessed by young people, such as general practitioners and community pharmacies, should be encouraged to

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<sup>220</sup> Loxley W, Davidson P. *Forgetting to breathe: opioid overdose and young injecting drug users in Perth*. Perth, National Centre for Research Into the Prevention of Drug Abuse, Curtin University of Technology, 1998.

support young drug users and offer information and referral sources which can facilitate a more healthy lifestyle.

**Recommendation 2**

Young people who experience dependence on heroin should be encouraged to seek professional help, where their suitability for methadone and/or other programs can be assessed.

**Recommendation 3**

Education about the causes and mechanisms of overdose is vital if it is to be prevented. All drug users must be taught about the risks of mixing CNS depressants and that this is the primary cause of overdose; the length of time that should elapse between using different drugs; the approximate period it takes to establish and lose tolerance and the fact that the majority of overdoses are not instantaneous but occur gradually over some hours.

**Recommendation 4**

The ready availability of benzodiazepines and oral morphine in pharmaceutical preparations should be investigated and monitored by the appropriate authorities. Doctors should be encouraged not to prescribe these preparations to drug seeking young people, but to make appropriate referrals to drug treatment agencies.

**Recommendation 5**

Street injecting by younger drug users, and the risk of overdosing when in a place where help cannot easily be sought is a major, and possible growing concern. A variety of strategies should be undertaken to address this, from encouraging young people to wait to inject until they get home or to a safe place; suggesting to parents who know that their teenagers use drugs that injecting at home and under supervision is safer than doing so in the street, and encouraging staff of pubs and cafes to call for ambulances for drug users 'on the nod', rather than to evict them.

**Recommendation 6**

A campaign to encourage smoking or inhaling heroin as an alternative to injecting should be undertaken. This should be accompanied by accurate and simple information on how to smoke or inhale heroin, and might best be undertaken by the WA Substance Users' Association with appropriate funding.

**Recommendation 7**

While using drugs alone does not appear to be a particular risk in this age group, materials should continue to emphasise the dangers of solitary use and the value of using in a group and monitoring friends' conditions.

**Recommendation 8**

First aid training for drug users is of benefit if it is appropriately directed. Subsidised first aid courses for drug users should be widely available and general first aid for the community should include training in how to respond to a suspected drug overdose.

**Recommendation 9**

While messages about the need to call ambulances to suspected overdoses have clearly had an effect, they need to be maintained, and it needs to be stressed that calling an ambulance should be the *first*, not the *last* response. Young people's concerns about the cost of calling ambulances need to be addressed.

**Recommendation 10**

The message that police will not attend with ambulances is known and believed by some young users, but not by all. Continued effort to spread this message is needed. Police should be encouraged to respect the ambulance protocol and their responses should be monitored.

**Recommendation 11**

The single biggest reason why young people do not utilise emergency services is fear of unwanted intervention by police, parents and/or welfare. Because of this, on site treatment is preferred by most users, and ambulance staff should be encouraged to consider whether treatment can be appropriately delivered at the site without recourse to hospital.

**Recommendation 12**

Drug users repeatedly complain about poor treatment at the hands of hospital staff, and it should be clear that users have the same rights to humane and ethical treatment as anyone else. Where users are underage there is a particular problem in terms of the hospital's duty of care. While it might be appropriate to notify the parents of juveniles with suspected overdoses, it would be helpful to discuss such notification with the young person, particularly if they are aged between 16 and 18. If parents are to be called in, the young person should be informed of this as a matter of course.

**Recommendation 13**

If parents are called in, particularly when they have no prior knowledge of the young person's drug use, they should be provided with some information and support so that they can be helped to react in an appropriate and informed manner.

**Recommendation 14**

Welfare services in hospitals should be made aware that harassment of juveniles by them reduces the likelihood that the young person will call an ambulance on future emergency occasions.

**Recommendation 15**

A variety of education strategies are needed, including materials such as posters and pamphlets, peer education and train the trainer courses for youth workers and treatment agencies. Innovative ways to make contact with young people, such as many of those in this study who were not in touch with standard agencies, should be developed.

**Recommendation 16**

There is a need for a range of educational materials from the simple one liner, for example, "Using pills and heroin within 12 hours of each other is the single largest cause of fatal overdose", through to information intensive leaflets or booklets, for example, covering symptoms of overdose, what to tell the 000 and the ambulance operators, overdose specific resuscitation in detailed steps, etc.

**Recommendation 17**

Materials should reflect local terminology. Direct adoption of materials developed interstate or overseas may be inappropriate and unnecessarily confusing.

**Recommendation 18**

It is important that young people are made aware that they *can* prevent overdoses by not mixing drugs. All education/prevention materials that make any mention of the reasons heroin is dangerous must also mention the role of polydrug use.

**Recommendation 19**

Polydrug pharmacology is poorly understood. Detailed information about clearance times and other relevant factors should be made available to peer educators, WASUA and others working with drug users.

**Recommendation 20**

Education materials should be developed to address the issue of tolerance and loss of tolerance. These should be widely available particularly in youth detention centres, prisons, detoxification and rehabilitation centres; ie. anywhere where drug users are concentrated and (however temporarily) separated from drugs.

### Recommendation 21

Risk reduction techniques should be couched in positive terms. ‘Use half and wait’ is less appealing to a young person than ‘leave some for when you’re coming down’ which suggests improved technique and may prove a more fruitful approach.

## 5.13. Indo Chinese community

### 5.13.1. Introduction

The Select Committee believes it is important to introduce measures to avoid the scale of problems involving Vietnamese young people using heroin, as can be witnessed in Sydney and Melbourne. On its interstate visit, the Select Committee observed at first hand extensive and visible street level heroin dealing by young Indo Chinese and Vietnamese people in Cabramatta. Evidence was given which confirmed similar markets operated in particular suburbs in Melbourne.

These markets involved many small and medium scale operators who had access to significant quantities of high grade heroin. Transactions occurred in a number of forms, such as groups of individuals selling \$30 caps<sup>221</sup> on the street during the day time and buyers in cars cruising built up areas at night time. The scale of this market was such that it also operated during the day time in the main business and shopping area, with street level sales of heroin occurring in visible selling areas.

Information provided to the Select Committee from Victorian and New South Wales police indicated that while it was possible to mount intensive police campaigns to apprehend dealers, such measures were regarded as being effective only in the short term. For instance, intense police activity in one area had the effect of displacing the heroin market to an adjoining suburb and is likely to produce unintended public health risks.<sup>222</sup> It was emphasised that in the longer term police needed to liaise closely with the local community and to ensure law enforcement activities were complemented by a network of outreach workers and other health and welfare workers.

The Select Committee was impressed with a recent detailed analysis of the operation of the heroin market in Cabramatta. This information is derived from an ethnographic study which was undertaken to overcome the shortcomings of information from more conventional sources about prevalence. While this type of qualitative research is relatively expensive, it can be an invaluable means of developing an understanding of problems in accessible and socially marginalised groups. The *Forgetting to breathe* research project is a good example of the application of this process to obtain detailed knowledge of attitudes towards, practices in and trends in drug taking in hard to reach groups, and to utilise such information to improve services.

Given the interest at a local level in this issue, the following description is presented to illustrate the complex criminal, health and social issues involved. This account reproduces some of the text of research undertaken into the operation of the selling market and of the interaction between law enforcement and community based health and other services.<sup>223</sup> A discussion of the need for additional programs to prevent similar problems occurring in this State is dealt with in chapter 8 of this report.

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<sup>221</sup> Heroin marketed in this form involved small sealed water balloons which were carried in a person’s mouth. Police could rarely obtain evidence of those selling in this form, as the cap was usually swallowed if the young person was apprehended.

<sup>222</sup> Maher L, Dixon D, Lynskey M, Hall W. *Running the risks. Heroin, health and harm in South West Sydney*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1998.

<sup>223</sup> The description of heroin use and dealing that follows is from Hando J, O’Brien S, Darke S, Maher L, Hall W. *The illicit drug reporting system (IDRS) trial: final report*. Sydney, NDARC, University of NSW, 1997, 21-26.

## **5.13.2. Case study - Cabramatta**

Most recent heroin purchases in Cabramatta (70%) were of small units packaged for individual sale as “caps”. These were typically wrapped in a small piece of foil, often taken from the inside lining of a cigarette packet, and sealed in small plastic water balloons. The remaining 30% of purchases involved “half weights”.

### **5.13.2.1. Drug distribution and sales activities**

Contrary to media reports, street level heroin distribution in Cabramatta is a freelance market dominated by Indo Chinese user sellers. Fieldwork suggests that it is not “controlled” or monopolised by the 5T, or anyone else. Heroin is primarily distributed under a freelance model by individuals and multiple units of small entrepreneurs (mostly user dealers) rather than by mega organisations or businesses. Entrepreneurial participation is relatively easy to accomplish, but often sporadic and short lived. While the market primarily operates as a freelance system, the domination by Asians structures the participation of non Asian sellers.

Interviews and observations to date suggest that involvement in drug distribution and sales activity enables some Indo Chinese young people, and young Indo Chinese women in particular, to avoid involvement in income generating crime such as robberies and burglaries.

Subjects were also asked where the dealer had retrieved the heroin from on the last purchase. The majority reported that the dealer had retrieved the heroin from his or her mouth (58%), or from his or her nose (10%). Most dealers therefore were storing heroin in body cavities, increasing the risk of transmitting tuberculosis as well as blood borne viruses if the buyer then places the purchase in his or her own mouth. The remainder (32%) reported that dealers retrieved heroin from other places including pockets (17%) and inside buildings, underneath tables, packages or wrappers on the ground, underclothes, tracksuit linings and mobile phones (15%).

### **5.13.2.2. The emergence of street based injecting**

The emergence of a street based injecting culture in Cabramatta is evidenced by discarded syringes, spoons and other injection paraphernalia littering streets, alleyways and stairwells. This culture has emerged for a number of reasons including homelessness, the need to conceal drug use from other household members, individual need or craving for drugs and the fear of arrest.<sup>224, 225, 226</sup> The relatively young age of new injectors means that many conceal their drug use from parents and caretakers. More significantly the large open air drug market and street scene provides a focal point for young people to meet. Few have enough income (legal or illegal) to purchase desired quantities of heroin, and collaborative criminal activity frequently results in collective drug purchasing and collective injecting. Street based injecting has also been encouraged by fear of overdose and the inability to self administer.

### **5.13.2.3. Drug acquisition routines**

Crime was the most common means of acquiring funds or goods with which to purchase heroin. Most subjects engaged in income generating crime, principally high frequency low volume shoplifting, other commercial thefts (eg “run outs” and “searches”), domestic burglaries, and drug distribution and sales activities. The high level of demand for stolen goods in Cabramatta (especially brand name sportswear, gold, mobile phones) made it possible for street level users to support their heroin use by direct exchanges.

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<sup>224</sup> Ouellet LJ, Jimenez AD, Johnson WA, Wiebel WW. “Shooting galleries and HIV disease: variations in places for injecting illicit drugs.” (1991) 37 *Crime and Delinquency* 64-85.

<sup>225</sup> Koester S. “Waters, cookers and cottons: additional risks for intravenous drug users.” In National Institute on Drug Abuse. *Epidemiologic trends in drug abuse. Proceedings of the Community Epidemiology Working Group*. Rockville, MD, National Institute on Drug Abuse, 1989.

<sup>226</sup> Klee H, Morris J. “Factors that characterise street injectors.” (1995) 90 *Addiction* 837-841.

#### 5.13.2.4. Collective injecting episodes

Almost all injectors in this study reported using a syringe after someone else, most often during their initial period of injecting drug use. During this period, user's perceptions of risk appear to be conditioned by perceptions of their own good health and that of their peers. Most perceived that it was "OK" to share injecting equipment with their (regular) sexual partners: "Well, we sleep together so if I'm going to get something, I've already got it." (Kylie, 17 year old Anglo Australian female).

The likelihood of sharing a syringe was also affected by the reluctance of many users to carry syringes, their difficulty in accessing clean syringes, and their need or desire for heroin. Many users were unaware that the possession of needles and syringes is not a crime in New South Wales. Many feared coming to police attention because they were carrying a syringe, and then being taken into custody after checks for outstanding warrants. For many young injectors, the fear of detection extended to parents, while for young Indo Chinese injectors, there was the additional fear of detection by their peers.<sup>227</sup>

The availability of clean injecting equipment in Cabramatta was largely restricted to business hours. During business hours, sterile injecting equipment could be obtained at varying cost from one of four chemists, or free of charge from one of two local agencies which provide needle and syringe exchange. There was also an outreach bus service in Cabramatta on Friday and Saturday evenings. During the week, between the hours of 9.00 pm and 9.00 am, users in Cabramatta were at risk of sharing or reusing previously used injecting equipment.

Many young people reported that they simply could not afford to purchase a clean syringe. The influence of economic factors and drug dependence on risk behaviours was most apparent when users were "hanging out" (withdrawing from heroin). Then users often saw themselves as having little or no choice when faced with an opportunity to use heroin.

Collective injecting more often involved sharing filters, spoons and rinse/mix water than the direct sharing, or the transfer of the contents, of syringes.<sup>228</sup> On occasions, there was also syringe mediated drug sharing which involved sharing drug solution that has been in direct contact with injecting equipment (ie "backloading").

Collective injecting episodes also involved simultaneous administration. In this scenario, two or more individuals simultaneously drew up heroin solution from a spoon with their syringes in what one user described as "pigs in a trough".<sup>229</sup> The fear of being interrupted or "busted" by the police also encouraged collective injecting practices. Other factors influencing collective preparation, distribution and administration of heroin solutions included a lack of injecting experience and the fear of overdose. The data suggest that young women were less willing or able to self administer and more reluctant to "go first". Young injectors who were aware that they had been infected with a blood borne virus (typically HCV) were reluctant to disclose their health status to other users.

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<sup>227</sup> Maher L. *Age, culture, environment and risk: contextualising high risk practices among new injectors in South West Sydney. Paper presented at the VII International Conference on the Reduction of Drug Related Harm. Tasmania, March 1996.*

<sup>228</sup> Koester S. "Waters, cookers and cottons: additional risks for intravenous drug users." In National Institute on Drug Abuse. *Epidemiologic trends in drug abuse. Proceedings of the Community Epidemiology Working Group.* Rockville, MD, National Institute on Drug Abuse, 1989; Koester S, Hoffer L. "Indirect sharing: additional HIV risks associated with drug injection." (1994) 9 *AIDS Public Policy Journal* 100-105; Needle R, Cesari H, Koester S. "Multi person use of drug injection equipment: HIV transmission risks associated with drug preparation and injection practices." Paper presented at the *10th International Conference on AIDS.* Yokohama, Japan, August 1996.

<sup>229</sup> Maher L. "Age, culture, environment and risk: contextualising high risk practices among new injectors in South West Sydney." Paper presented at the *VII International Conference on the Reduction of Drug Related Harm.* Tasmania, March 3-7 1996.

### **5.13.2.5. Use settings**

Heroin users in Cabramatta injected in a variety of private, semi private and public settings. Private settings include residential addresses and motel rooms. Semi private settings include motor vehicles and abandoned houses. Public settings include the walkways, stairwells and gardens of local flats, public toilets, trains, bus shelters and outdoor locations such as parks, underpasses and car parks.

Collective injecting was more likely to occur in public settings. Most of these were well known to IDUs, local residents and the police, and so provided little, if any, privacy. Conditions were unsanitary and poorly lit and ventilated. With the exception of public toilets, they had no running water, and they were littered with injecting paraphernalia, including discarded syringes. Many of these can be characterised as “free” shooting galleries in that they provided a “space where IDUs regularly gather to inject drugs but where there is no admission fee”.<sup>230</sup> While the vigorous policing of such locations may have reduced the number of users who used these public settings, it may also promote the use of less desirable and possibly more “hidden” settings.

There was also at least one “taste gallery” operating in an abandoned house in Cabramatta. Conditions in Cabramatta appear conducive to the development of commercially oriented galleries where people provide places for others to inject for a fee (either in drugs or money). The presence of abandoned/condemned houses meant that there was no shortage of suitable premises. While the establishment of commercial galleries may provide gatekeepers, and the potential for safe using norms and safe disposal, research in the United States indicates that some types of shooting galleries can serve as vectors for the transmission of HIV and other blood borne viruses.<sup>231</sup>

### **5.13.2.6. Law enforcement practices**

During the study period Cabramatta was the site of high profile, intensive and sustained street level policing. It is important to note that some types of policing may have the potential to do more, rather than less, harm.<sup>232</sup> While the presence of uniformed beat police, mobile patrols, officers on horseback and dog teams appears to have had little impact on the drug market, it has contributed to a number of undesirable public health outcomes.

Firstly, it encouraged both the oral and intranasal storage and transfer of heroin. Second, it may have increased the incidence of high risk injecting since injectors who used public settings were fearful of being interrupted by police either during preparation or actual administration. They were anxious to “get on” and get away as soon as possible, a situation that did not encourage safer injecting practices or safe disposal of equipment. Such street based injectors were also less likely to carry injecting equipment, less likely to use tourniquets and less likely to swab before and after injecting. They were also more likely to engage in collective injecting episodes, unsafe drug

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<sup>230</sup> Ouellet LJ, Jimenez AD, Johnson WA, Wiebel WW. “Shooting galleries and HIV disease: variations in places for injecting illicit drugs.” (1991) 37 *Crime and Delinquency* 64-85.

<sup>231</sup> Des Jarlais D, Friedman SR, Strug D. “AIDS among intravenous drug users: a sociocultural perspective.” In Feldman D, Johnson T (eds.). *The social dimensions of AIDS: Methods and theory*. New York, Praeger, 1986; Marmour M, Des Jarlais DC, Cohen H, Friedman SR, Beatrice ST, Dubin N, El-Sadr W, Midvan D, Yancovitz S, Mathur U, Holzman R. “Risk factors for infection with human immunodeficiency virus among intravenous drug abusers in New York City.” (1987) 1 *AIDS* 39-44; Des Jarlais DC, Friedman SR. “Shooting galleries and AIDS: infection probabilities and ‘tough’ policies.” (1990) 80 *American Journal of Public Health* 142-144; Ouellet LJ, Jimenez AD, Johnson WA, Wiebel WW. “Shooting galleries and HIV disease: variations in places for injecting illicit drugs.” (1991) 37 *Crime and Delinquency* 64-85.

<sup>232</sup> Weatherburn D, Lind B. *Drug law enforcement policy and its impact on the heroin market*. Sydney, New South Wales Bureau of Crime Statistics and Research, 1995; Moore MH. “Supply reduction and drug law enforcement.” In Tonry M, Wilson JQ (eds). *Drugs and crime*. Chicago, University of Chicago Press, 1990; Dorn N, Murji K, South N. *Traffickers: drug markets and law enforcement*. London, Routledge, 1992; Collison M. *Police, drugs and community*. London, Free Association Press, 1995; Manning PK. *The narc’s game: organisational and informational limits on drug law enforcement*. Cambridge, Mass, MIT Press, 1980.

preparation and backloading, and more likely to share needles, use discarded needles and to leave paraphernalia behind.<sup>233</sup>

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<sup>233</sup> Maher L. "Age, culture, environment and risk: contextualising high risk practices among new injectors in South West Sydney." Paper presented at the *VII International Conference on the Reduction of Drug Related Harm*. Tasmania, 3-7 March 1996.



## Chapter 6: Responding to cannabis

### 6.1. Introduction

This chapter deals with the use of cannabis, which remains the most widely used illicit drug in most Western economies. Data from a number of West Australian and national surveys of both young people and adults are summarised to provide an understanding of prevalence and trends in usage since the mid 1980s. A discussion of the issue of cannabis use in relation to young people is provided, as the prevalence data confirms that cannabis use in WA (as in all other Australian jurisdictions) is particularly prevalent among young people.<sup>234</sup>

Prior to the 1960s, cannabis use was confined to a narrow spectrum of society. Over the past three decades, it has become increasingly popular and (as will be discussed below) is now used by a wide cross section of the community. The term “cannabis” is used to identify the psychotropic product derived from the plant *cannabis sativa*. The pharmacologically active compounds in cannabis are termed cannabinoids. The major active isolate in cannabis has been identified as delta-9 tetrahydrocannabinol (THC). As it is lipid soluble, it may remain in the body tissues for many days after a single dose.

### 6.2. WA prevalence data

#### 6.2.1. 1994 survey of metropolitan high school students

This survey was undertaken by a research group headed by Professor Stephen Houghton from the Graduate School of Education of the University of WA, which involved a sample of 1,394 high school students in years 8 to 12 from six separate high schools in Perth.<sup>235</sup> The survey found that three groups of drugs accounted for much of the *current* drug use by metropolitan secondary school students: 39% used alcohol, 24% used cannabis and 20% used tobacco (Table 12, Appendix 13).<sup>236</sup>

Results confirmed that higher rates of *current* use of cannabis by males compared to females (25% of males vs 22% of females) and that 59% of *current* users used frequently. With respect to gender, two thirds of current male users reporting *frequent*<sup>237</sup> use compared to frequent use by half of current female users.

Cannabis had been *ever* used by 14% of year 8 students, this rate doubling to 27% of year 9 students, and to 43% of year 10 students. In higher secondary school students, prevalence levelled off, with 46% of the year 11/12 group reporting ever use. Current use of cannabis increased across all levels of schooling, increasing from 10% of year 8 students to 37% of year 11/12 students. These age related trends are presented in Figure 6.1.<sup>238</sup>

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<sup>234</sup> Makkai T, McAllister I. *Marijuana in Australia: patterns and attitudes*. Canberra, Australian Government Publishing Service, 1997.

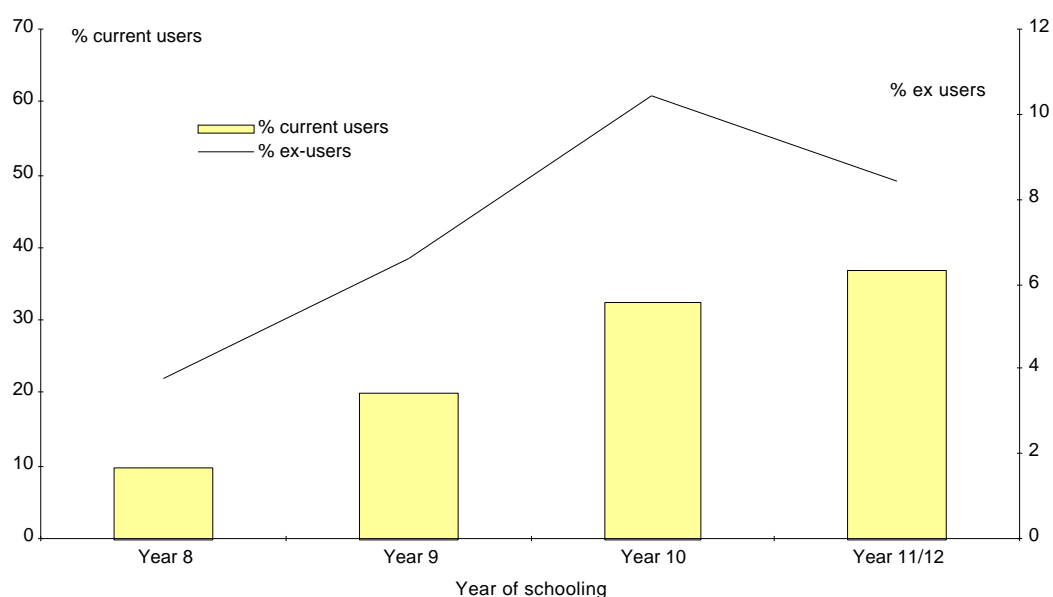
<sup>235</sup> Odgers P, Houghton S, Douglas G. *Prevalence and frequency of drug use among Western Australian metropolitan high school students* (Addictive Behaviours in press). The results from this survey with respect to other drugs are contained in Table 12, Appendix 13.

<sup>236</sup> Cf Western Australia. Task Force on Drug Abuse. *Protecting the community: the report of the Task Force on Drug Abuse*. Vol. 2. Perth, Ministry of Premier & Cabinet, 1995, 164-173.

<sup>237</sup> Frequent use defined in the survey as used daily and up to 20 times per week.

<sup>238</sup> For details of related research of drug use by young people see Houghton S, Carroll A, Odgers P. *Young children's and adolescents' knowledge and awareness of alcohol and alcohol related issues, and the significance of reputation in orientation to alcohol*. Final report. Perth, Graduate School of Education, University of WA, 1997; “Research may reduce crime.” *Healthway Newsletter of the WA Health Promotion Foundation*, December 1994, Issue 12.

**Figure 6.1: Percentage of current and ex users of cannabis by year of schooling, WA metropolitan high school students, 1994**



## 6.2.2. 1993 WA Child Health Survey

The WA Child Health Survey (WACHS) was undertaken by a research team in 1993 from the TVW Telethon Institute for Child Health Research, which is based at Princess Margaret Hospital.<sup>239</sup> This research indicated that one third of 15 to 16 year olds had tried cannabis at some time, and that 18 per cent reported regular use.<sup>240</sup> Although a sizeable proportion (18%) of adolescents stated that they had tried cannabis, the frequency of use was generally low. Among the estimated 14,200 older adolescents who had used cannabis, just over one third (34%) had not done so within the last year while 13 per cent had used it less than monthly. Just over one quarter reported either monthly use (27%) or weekly or daily use (26%).

The WACHS further found that adolescents' use of cannabis rose steadily with age, increasing from around 7% at 13 years of age to 34% by 16 years of age (Table 6.1). A greater percentage of 15 to 16 year old males (34.5%) had ever used cannabis compared to females (32.0%). In the 15 to 16 year old age group, males were more likely than females to be *regular*<sup>241</sup> users (21.0% vs 14.1%), whereas females were more likely than males to be *infrequent*<sup>242</sup> users (18.0% vs 12.7%) (see Table 6.1).

<sup>239</sup> For a description of the survey see Zubrick S, Silburn S, Garton A, Burton P, Dalby R, Carlton J, Shepherd C, Lawrence D. *Western Australian Child Health Survey: Developing health and well-being in the nineties*. Perth, Australian Bureau of Statistics and Institute for Child Health Research, 1995; Zubrick S, Silburn S, Garton A, Gurrin L, Burton P, Dalby R, Carlton J, Shepherd C, Lawrence D. *Western Australian Child Health Survey: Family and community health*. Perth, Australian Bureau of Statistics and Institute for Child Health Research, 1996; Zubrick S, Silburn S, Gurrin L, Teoh H, Shepherd C, Carlton J, Lawrence D. *Western Australian Child Health Survey: Education, health and competence*. Perth, Australian Bureau of Statistics and Institute for Child Health Research, 1997.

<sup>240</sup> Information in this section is based on a submission provided by Mr Sven Silburn and Dr Stephen Zubrick, from the Division for Psychological Research at the TVW Telethon Institute for Child Health Research.

<sup>241</sup> Regular use defined in the survey as monthly, weekly or daily use.

<sup>242</sup> Infrequent use defined in the survey as less than monthly use.

**Table 6.1: Prevalence (%) of WA adolescent cannabis use by age group and sex, 1993**

	Age group		
	12-14	15-16	12-16
<b>Males</b>			
Ever used	9.4	34.5	18.5
Frequency of use			
Used infrequently	7.4	12.7	9.3
Used regularly	2.0	21.8	9.2
<b>Females</b>			
Ever used	5.8	32.0	16.6
Frequency of use			
Used infrequently	2.9	18.0	9.1
Used regularly	2.9	14.1	7.5

Source: WA Child Health Survey

Note: Infrequent use = less than monthly; regular use = monthly; weekly or daily

### 6.2.3. 1996 ASSAD survey

A survey was conducted by Health Promotion Services in metropolitan and rural schools in 1996, which included items on illicit drugs.<sup>243</sup> This survey found 36.2% of 12 to 17 year old secondary school students had used cannabis in the last year, 23.8% had done so in the last month and 15.8% in the last week (Table 6.2).

In the 16 to 17 age group, 59.5% of males and 57.2% of females had used cannabis in the last year, 40.8% of males and 34.9% of females had used in the last month, and 30.8% of males and 21.5% of females had used in the last week.

In the 12 to 15 age group, 33.5% of males and 26.4% of females had used cannabis in the last year, 23.6% of males and 16.0% of females had used in the last month, and 16.3% of males and 9.4% of females had used in the last week.

**Table 6.2: Prevalence (%) of cannabis use by WA school students, by age group and sex, 1996**

	12-15 years		16-17 years		12-17 years		All
	Males	Females	Males	Females	Males	Females	
Used in last 12 mths	<b>33.5</b> (30.7-36.3)	<b>28.4</b> (25.9-30.9)	<b>59.5</b> (54.7-64.3)	<b>57.2</b> (52.8-61.6)	<b>38.9</b> (36.5-41.3)	<b>33.5</b> (31.3-35.7)	<b>36.2</b> (34.6-37.8)
Used in last month	<b>23.6</b> (21.1-26.1)	<b>16.0</b> (14.0-18.0)	<b>40.8</b> (36.0-45.6)	<b>34.9</b> (30.7-39.1)	<b>27.2</b> (25.0-29.4)	<b>20.4</b> (18.5-22.3)	<b>23.8</b> (22.4-25.2)
Used in last week	<b>16.3</b> (14.1-18.5)	<b>9.4</b> (7.8-11.0)	<b>30.8</b> (26.3-35.3)	<b>21.5</b> (17.9-25.1)	<b>19.3</b> (17.3-21.3)	<b>12.1</b> (10.6-13.6)	<b>15.8</b> (14.6-17.0)

Source: Health Promotion Services, HDWA. 1996 ASSAD survey of licit and illicit drug consumption by WA school students, 1996.

Note: All data are weighted. Figures in brackets represent the 95% confidence limits for the prevalence estimates.

### 6.2.4. 1997 survey of WA adults

This survey of the use of alcohol, tobacco and a number of illicit drugs was conducted by Health Promotion Services in 1997.<sup>244</sup> Among the adult population aged 18 years and over, 15.1% had

<sup>243</sup> Cf Tables 10 and 11, Appendix 13 in this report.

<sup>244</sup> Cf Table 1, Appendix 13 in this report.

## Select Committee Into Misuse of Drugs Act 1981

used cannabis in the last year, 10.0% had used in the last month and 5.8% in the last week (Table 6.3).

Cannabis use was higher among males than females, with 19.5% of adult males reporting use in the last year compared to 10.7% of females. Similarly, 9.0% of adult males reported using cannabis in the last week, compared to 2.6% of females. Prevalence of use dropped considerably among people aged 35 years and over.

In the 18 to 24 year age group, 46.9% of West Australians had used cannabis in the last year, 32.8% had done so in the last month and 20.1% had used in the last week.

In the 25 to 34 age group, 21.4% had used cannabis in the last year, 13.4% had done so in the last month and 8% in the last week.

These results are consistent with other Australian data which found the prevalence of cannabis use is higher among men than women, and decreases with age, especially among those over the age of 40 years, after peaking in the late teens and early twenties. Most cannabis use is infrequent and intermittent, with about three quarters of adult women and two thirds of adult men having discontinued their use, or continued to use less often than weekly. Rates of weekly use are highest among those aged 20 to 24 years, and decline markedly with increasing age.<sup>245</sup>

**Table 6.3: Prevalence (%) of WA adult cannabis use by age group and sex, 1997**

	18–24	25–34	35–44	45+	18–34	Males	Females	18+ total
Used in last 12 mths	<b>46.9</b> (41.7-52.1)	<b>21.4</b> (18.1-24.7)	<b>13.8</b> (11.1-16.5)	<b>1.7</b> (1.0-2.4)	<b>31.5</b> (28.7-34.5)	<b>19.5</b> (17.4-21.8)	<b>10.7</b> (9.2-12.2)	<b>15.1</b> (13.8-16.4)
Used in last month	<b>32.8</b> (28.0-37.6)	<b>13.4</b> (10.7-16.1)	<b>9.1</b> (6.8-11.4)	<b>0.9</b> (0.3-1.3)	<b>21.2</b> (18.6-23.8)	<b>14.1</b> (12.2-16.0)	<b>5.9</b> (4.7-7.1)	<b>10.0</b> (8.9-11.1)
Used in last week	<b>20.1</b> (16.0-24.2)	<b>8.0</b> (5.8-10.2)	<b>4.5</b> (2.9-6.1)	<b>0.4</b> (0.1-0.9)	<b>12.8</b> (10.7-14.9)	<b>9.0</b> (7.6-10.6)	<b>2.6</b> (1.8-3.4)	<b>5.8</b> (4.9-6.7)

Source: Health Promotion Services, HDWA. 1997 survey of tobacco, alcohol and illicit drug consumption by WA adults, 1997.  
Note: All data are weighted. Figures in brackets represent the 95% confidence limits for the prevalence estimates.

## 6.3. National prevalence data

### 6.3.1. Overview

The use of cannabis has increased dramatically over the past 20 years, with the proportion of Australians over the age of 14 years reporting ever having used increasing from 12% in 1973 to 34% in 1993. The National Household Surveys have been conducted as part of the National Drug Strategy under the auspices of the Commonwealth Department of Health and Family Services and these are the major source of data with respect to the use of licit and illicit drugs in Australia. The national trends from these surveys are likely to be similar to trends in cannabis use that have occurred in this State since the mid 1980s.

Analysis of the results over a 10 year period of the five NDS National Household Surveys conducted in 1985, 1988, 1991, 1993 and 1995 provides a long term perspective on use of cannabis.<sup>246</sup> By 1993, one third of all Australians reported that they had tried cannabis at some stage in their lives. The increase in the prevalence by young people is most pronounced, with more than half of those aged 14 to 19 years reporting lifetime use by the 1993 survey.

<sup>245</sup> Cf Donnelly N, Hall W. *Patterns of cannabis use*. Canberra, Australian Government Publishing Service, 1994.

<sup>246</sup> The information referred to in this section is contained in more detail in Makkai R, McAllister I. *Patterns of drug use in Australia, 1985-95*. Canberra, Australian Government Publishing Service, 1998, 35.

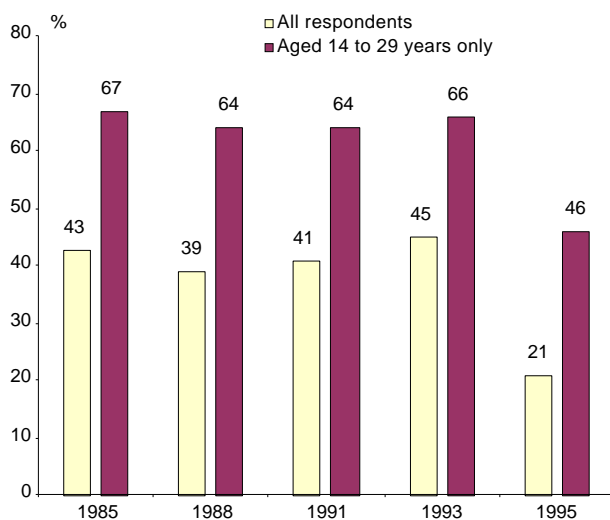
### 6.3.2. Exposure to cannabis

Lifetime prevalence is a useful indicator of the breadth of contact by the community with cannabis and the level of usage over a period by those who may no longer use it. For the 1985 to 1995 NDS surveys, respondents were asked whether or not they had been offered cannabis. However, in 1995 the question was altered to being offered cannabis in the previous year. This change produced a substantial drop in the estimates obtained in the most recent survey. Figure 6.2 shows the proportions that have been offered cannabis over the last decade. The results suggest that cannabis has continued to remain visible within the community.

In 1985, 43% of respondents said that they had been offered cannabis at some time. It is to be noted this proportion remained constant through the late 1980s and early 1990s. In the 1995 survey, the question referred to being offered the drug in the previous year, which resulted in a positive response rate of 21%.

It can be seen that between 1985 and 1993, a majority of those aged 14 to 29 had been exposed to cannabis. For instance, in the 1985 survey 67% said that they had been offered cannabis (Figure 6.2). When the same question was asked in the 1993 NDS Household Survey, 66% provided a positive response, a drop of only one percent. While comparison is affected by the change in wording used in the 1995 survey, nearly five out of 10 of those in the 14 to 29 age group said they had been offered cannabis. These data indicate widespread exposure to cannabis, with little change over the 10 year period which has been surveyed by the NDS Household Survey.

**Figure 6.2: Trends in exposure to cannabis, Australia, 1985 - 1995**



### 6.3.3. Lifetime prevalence

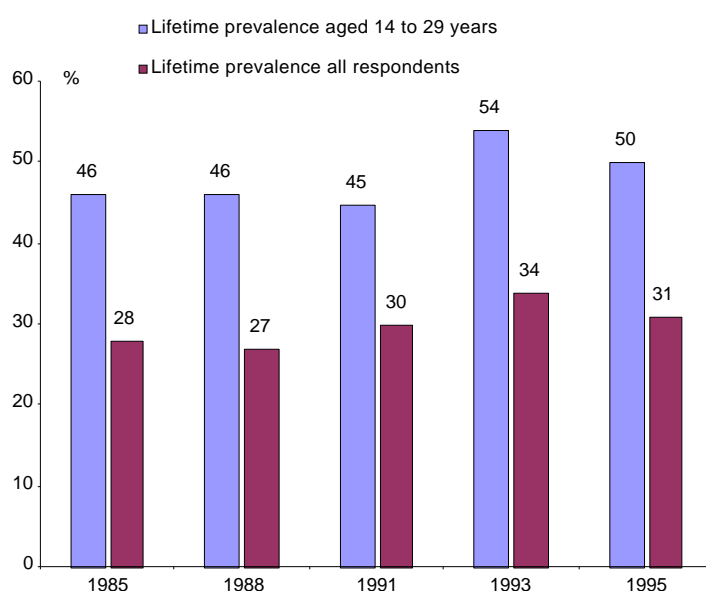
The rate of lifetime cannabis prevalence (those who report ever use) appears to have remained relatively constant from the 1980s to the early 1990s, fluctuating between 27% and 30% for all the adult population (Figure 6.3).

However, since the early 1990s it is believed there may have been an increase, as 34% of the Australian population reported having ever used cannabis in 1993. The decline recorded in 1995 (to 31% of the population) reporting ever use requires further confirmation as to whether it represents a downward trend. Certainly, evidence is emerging that cannabis use may have

increased again more recently. A similar recent upward trend has also been suggested in the United States.<sup>247</sup>

A similar pattern of stable usage from the late 1980s to the early 1990s also occurred in the 14 to 29 age group, with a rise to 54% recorded in the 1993 survey. There was a small drop (to 50%) recorded by this age group in the 1995 survey.

**Figure 6.3: Trends in prevalence of cannabis, Australia, 1985 - 1995**



### 6.3.4. Annual prevalence

Annual prevalence compared to lifetime prevalence has remained relatively unchanged since the 1988 NDS Household Survey. One in 10 of those aged 20 or more reported use in the past year up to 1991, with a slight increase to 11% in both the 1993 and 1995 surveys (Figure 6.3).

An analysis of national trends in cannabis prevalence was recently published in conjunction with the evaluation of the National Drug Strategy 1993-1997. This report indicates that the proportion of the Australian population who consumed cannabis in the last 12 months increased from 11.1% in 1988 to 13.1% in 1995 (Table 6.4). Over this period, there was a moderate increase in usage recorded for the 40 to 49 year old age group, and a moderate decrease in usage by the 50 and older age group. There is a clear pattern of consumption being concentrated in those aged 14 to 39 years of age.

Males were more likely than females to use cannabis. For instance, in 1995 there were 1.8 times as many males as females who had used cannabis in the past 12 months (14 to 19 age group - 35.5% vs 19.9%; 20 to 29 age group - 42.6% vs 33.2%). With increasing age, a greater proportion of males compared to females reported use of cannabis in the past 12 months. In 1995, there were 2.3 times as many males as females in the 30 to 39 age group and 3.5 times as many males as females in the 40 to 49 age group who had used cannabis in the past 12 months.

Over the period 1988 to 1995, increases were recorded in the annual prevalence of cannabis for all three age groups, the greatest increase occurring in the 14 to 19 age group. In 1995:

<sup>247</sup> Makkai T, McAllister I. *Marijuana in Australia: patterns and attitudes*. Canberra, Australian Government Publishing Service, 1997.

- over one in four (28.4%) of 14 to 19 year olds used cannabis in the previous 12 months (this was up from 20.8% in 1988 - an increase of 36.5%);
- almost one in three (32.9%) of 20 to 29 year olds used cannabis in the previous 12 months (this was up from 27.9% in 1988 - an increase of 17.9%); and
- about one in eight (13.2%) of 30 to 39 year olds used cannabis in the previous 12 months (up from 12.5% in 1988 - an increase of 5.6%).

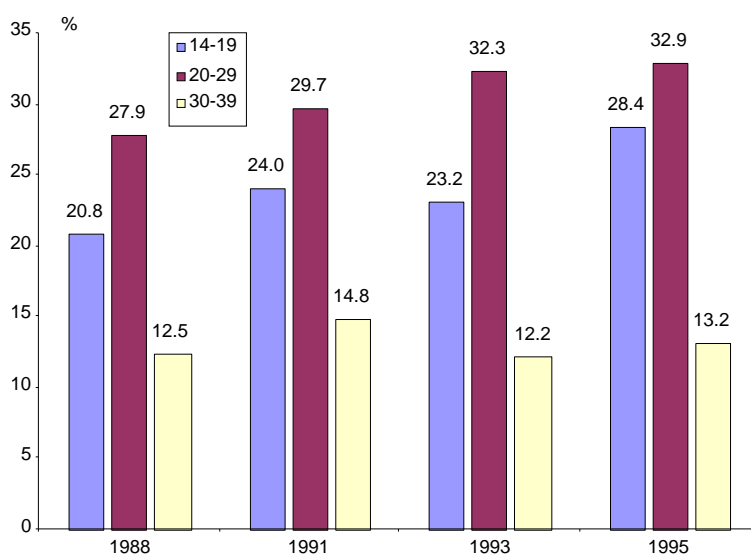
The trends for the three age groups 14 to 19, 20 to 29 and 30 to 39 are illustrated in Figure 6.4.

**Table 6.4: Prevalence (%) of cannabis use in the past 12 months by age group, Australia, 1988 - 1995**

Year	14-19	20-29	30-39	40-49	50-59	60+	Combined
<b>Males</b>							
1988	26.6	35.4	18.6	7.0	2.2	-	14.6
1991	32.0	37.5	19.1	5.8	2.1	0.8	16.5
1993	25.0	43.3	13.2	6.5	1.0	0.2	16.1
1995	35.5	42.6	18.8	7.8	1.9	-	17.8
<b>Females</b>							
1988	14.3	20.6	7.2	2.8	1.0	0.5	7.6
1991	17.0	21.8	11.2	4.3	0.7	1.0	9.9
1993*	21.4	21.3	11.3	2.6	0.6	-	9.5
1995	19.9	23.2	8.1	2.2	1.2	0.5	8.5
<b>Persons</b>							
1988	20.8	27.9	12.5	4.9	1.6	0.2	11.1
1991	24.0	29.7	14.8	5.0	1.4	0.9	13.2
1993*	23.2	32.3	12.2	4.5	0.8	0.1	12.7
1995	28.4	32.9	13.2	5.1	1.5	0.3	13.1

Source: NDS Household Surveys.  
 Note: For 1993 age ranges = 14-19, 20-29, 30-39, 40-54, 55-69, 70+.  
 For 1991 the 14-19 age group subject to rounding errors.

**Figure 6.4: Prevalence (%) of cannabis use in the past 12 months by age group, Australia, 1988-1995**



### 6.3.5. Age related trends

Age is a significant determinant of exposure to and use of cannabis. This variable is considered in more detail in Table 6.5, which provides a breakdown in annual prevalence by age group. The upper half of Table 6.5 contains the proportion of the total sample. The lower half of the table is based on those who have ever used cannabis. It was observed that the relationship between age and the use of cannabis has remained stable over the decade.

*“Older respondents are far less likely to have used cannabis in the past 12 months than younger respondents. In 1995, for example, 28% of all respondents aged 14 to 19 years had used cannabis in the past 12 months compared to 4% of respondents aged in their 40s or 50s. The estimates also suggest that the annual prevalence of the drug is increasing among adolescents and young adults.”<sup>248</sup>*

**Table 6.5: Prevalence (%) of cannabis use by age group, Australia, 1988 – 1995**

	1988	1991	1993	1995	Change 1988-1995
<b>All respondents</b>	n = 2,255	n = 2,853	n = 3,500	n = 3,849	
14-19	23	24	22	28	+5
20-29	28	28	32	33	+5
30-39	12	13	12	13	+1
40-59	4	3	4b	4	0
60+	*	*	*	*	*
<b>Lifetime prevalence only</b>	n = 605	n = 851	n = 1,183	n = 1,182	
14-19	79	73	62	80	+1
20-29	51	51	51	55	+4
30-39	31	26	25	26	-5
40-59	24	19	16b	20	-4
60+	*	*	*	*	*

Note: An asterisk denotes too few cases (n = <10) for reliable estimation.  
Age group 60+ differs in 1993.  
Source: 1988-1995 NDS Surveys.

There are some important distinctions to be made by comparing rates of lifetime use (ie ever use) and annual prevalence for the 14 to 19 and 20 to 29 age groups, which are evident in Table 6.5. The highest rate of annual prevalence occurs in the 20 to 29 age group, increasing by 5% (from 28% in 1988 to 33% in 1995). The second highest annual prevalence is recorded by the 14 to 19 age group, which also increased by 5% (from 23% in 1988 to 28% in 1995).<sup>249</sup>

A comparison of lifetime prevalence highlights the higher rate of use of cannabis in the past 12 months by the 14 to 19 age group. Over the period, this rate increased by 1% (from 79% in 1988 to 80% in 1995). The second highest rate was recorded by the 20 to 29 age group, which increased by 4% (from 51% in 1988 to 55% in 1995).<sup>250</sup>

However, when we focus just on those who have ever tried the drug, it is adolescents who are the group most likely to have used cannabis in the past year, followed by the 20 to 29 year olds. This indicates the use by 14 to 19 year olds in the past 12 months is likely to be equivalent to this age group’s lifetime prevalence rate.

<sup>248</sup> Makkai R, McAllister I. *Patterns of drug use in Australia, 1985-95*. Canberra, Australian Government Publishing Service, 1998, 35.

<sup>249</sup> These results are in the upper half of the table.

<sup>250</sup> These results are in the lower half of the table.

For example, in the 1995 survey 80% of 14 to 19 year olds who had ever used cannabis, also used it in the last 12 months, whereas 55% of 20 to 29 year olds who had ever used cannabis, also used it in the last 12 months.

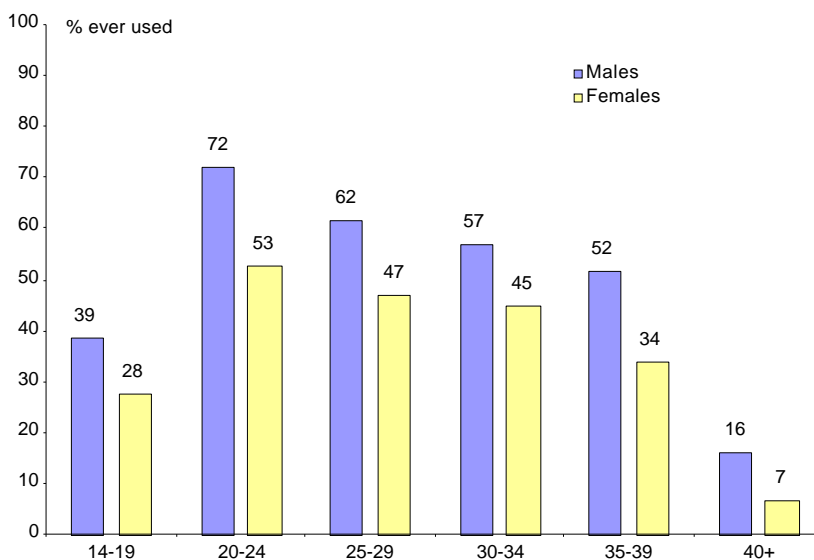
With respect to those aged 40 years and older, it can be seen that few have used cannabis in the past 12 months. Although the proportion of lifetime prevalence is not large among those aged in their 40s or 50s, a substantial minority have used cannabis in the past 12 months. For instance, in 1988, 24% of the 40 to 59 age group had used cannabis during the past 12 months, with a drop of 4% recorded in 1995, when 20% reported use within this period.

The five NDS surveys confirm that about one in four of all persons aged less than 30 years of age have used cannabis in the past 12 months. This level of usage increased to more than half for those reporting lifetime prevalence.

A recent study utilised pooled data from the five NDS Household Surveys conducted in 1985, 1988, 1991, 1993 and 1995, which provided a sample of 15,099. This information enables consideration of trends in life time and annual prevalence by age group and gender. This information confirms that in spite of age, ever use of cannabis is higher for males (Figure 6.5). It was concluded that

*“(o)ver the decade the highest prevalence rate is found amongst males aged 20 to 24 years. Seventy two per cent, almost three in four, have tried marijuana. Females also have the highest prevalence amongst this group with 53 per cent reporting they had tried the drug.”<sup>251</sup>*

**Figure 6.5: Ever use (%) of cannabis by age group and sex, Australia, 1985 - 1995**



In relation to age related patterns of cannabis use in the past 12 months, while there are similar patterns of prevalence as for life time prevalence, there are also some important differences. As can be seen in Figure 6.6, the highest rate of recent use occurs in the 14 to 19 age group, with 78% of males and 71% of females in this age group having used cannabis in the past 12 months.

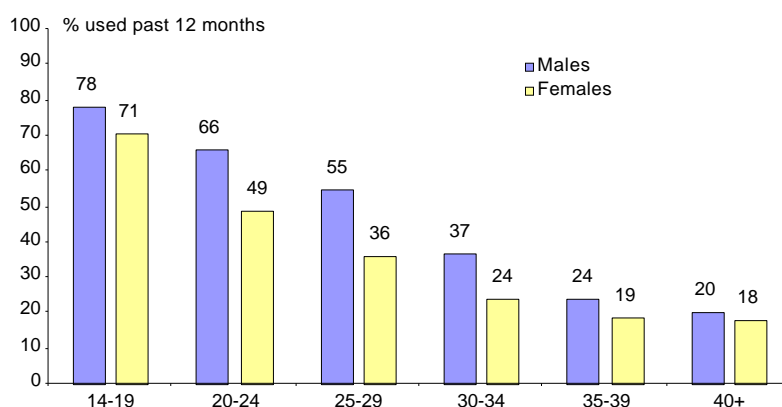
<sup>251</sup> Makkai T, McAllister I. *Marijuana in Australia: patterns and attitudes*. Canberra, Commonwealth Department of Health and Family Services, 1997, 15.

## Select Committee Into Misuse of Drugs Act 1981

The study by Makkai and McAllister also found a difference in the drop with age in the rate of use of cannabis in the past 12 months by males and females. For instance, with respect to the decrease in use from the early twenties to the late thirties, the male rate decreases by 42% whereas the female rate decreases by 30%. It suggested that as

*“fewer women use marijuana regularly in their twenties they may represent a more committed group hence their chances of continuing use of marijuana into their late thirties is higher. This would explain why a greater proportion of women in their twenties continue to use marijuana but it does not explain why the gender gap is greatest in the 20 to 29 year age bracket.”<sup>252</sup>*

**Figure 6.6: Use (%) of cannabis in past 12 months by age group and sex, Australia, 1985 - 1995**



### 6.3.6. Trends in consumption

Data of frequency of use over the preceding 12 months indicates frequent cannabis use has declined by 6%, from 43% in 1988 to 37% in 1995 (Table 6.6). It is to be noted there has been an increase of 10% (from 10% to 20%) in cannabis users reporting use several times a month.

**Table 6.6: Frequency (%) of consumption by those who have used cannabis in past 12 months, Australia, 1988 – 1995**

	1988	1991	1993	1995	Change 1988-1995
	n = 213	n = 315	n = 390	n = 390	
Once a week or more	43	39	33	37	-6
Once a month	17	18	18	17	0
Several times a month	10	6	19	20	+10
Few times a year	30	37	31	26	-4

Note: The question was 'How often do you (1988,1991: or did you) use cannabis/hash?' The response categories varied across the surveys, and have been collapsed in the four categories above. Response are for those who report using cannabis in the past 12 months.

Source: 1988 – 1995 NDS Surveys.

### 6.3.7. Age of initiation

Greater information about the ages when people commence use of cannabis provides valuable information about when drug education should commence. For instance, if drug education was

<sup>252</sup> Id 17.

provided before initiation to cannabis use, it could be ineffective and may even result in experimentation. Similar concerns about effectiveness of drug education need to be raised if it is provided after initiation.

The information in Table 6.7 addresses the issue of initiation of cannabis from data from the 1993 and 1995 NDS Household Surveys. It has a breakdown of age of initiation of cannabis with respect to those who had ever used, those who had used in the past 12 months and those who had used at least once per week or more often.

Of interest, highest rates of weekly or more often use are reported by those who commenced use at the youngest age groups. In addition to a sizeable group who first use cannabis at a relatively young age, there is also a group who first use later in their life. For instance, 13% of those aged more than 25 years of age first used cannabis in 1993, with 11% of this age reporting first use in 1995.

**Table 6.7: Use of cannabis (%) by age of initiation, Australia, 1993 – 1995**

Age of first use	1993			1995		
	Ever used	Used past 12 months	Use weekly or more	Ever used	Used past 12 months	Use weekly or more
	n = 1,023	n = 350	n = 120	n = 1,007	n = 365	n = 121
15 or less	14	24	37	18	28	38
16 years	13	20	16	11	16	22
17 years	14	13	15	13	15	13
18 years	12	14	12	17	14	11
19 years	10	5	*	7	3	*
20 years	10	8	*	10	8	*
21-25 years	15	10	*	12	9	*
26-35 years	9	5	*	6	5	*
35+ years	4	*	*	5	3	*
Mean age	19.4	18	17.5	19.1	18.1	16.8
Median age	18	17	16	18	17	16

Note: The question was 'About how old were you the first time you tried cannabis?' An asterisk denotes too few cases (n = >10) for reliable estimation. Estimates are for respondents aged 20 years or more.  
Sources: 1993, 1995 NDS Household Surveys.

There is a consistent pattern in both the 1993 and 1995 surveys that those who have used cannabis recently and use it frequently are more likely to have commenced use at a younger age. This pattern is also shown by the declines in the average and median ages of initiation with increasing frequency of use. In 1995, the mean age of initiation for those who had tried cannabis was 19.1 years. This declines by one year for those who had used cannabis in the past 12 months and by a further 1.3 years for those who used it weekly or more often.

### **6.3.8. Adolescent cannabis use**

There has been a significant increase over the past decade in the proportion of adolescents aged 14 to 19 who have tried cannabis (Figure 6.7). In 1985, 32% indicated they had tried the drug. This increased to 41% by 1995. While there is a lower annual prevalence, the estimates show an upward trend. For instance, the proportion of 14 to 19 year olds reporting use of cannabis in the past 12 months increased by 8% between 1988 and 1995.

In 1995, three in every 10 adolescents said that they had used cannabis in the previous 12 months – a significant figure. Confirmation of the increasing use of cannabis by adolescents is reflected in trends in consumption among those who have used the drug in the past 12 months.

## Select Committee Into Misuse of Drugs Act 1981

There has been an increase of 6% in the number of 14 to 19 year olds (from 27% in 1988 to 33% in 1995), who report use of cannabis at least once a week or more often (Table 6.8). The largest increase (of 14%) has been in relation to those who use cannabis at least monthly but less than weekly, increasing from 27% in 1988 to 41% in 1995.

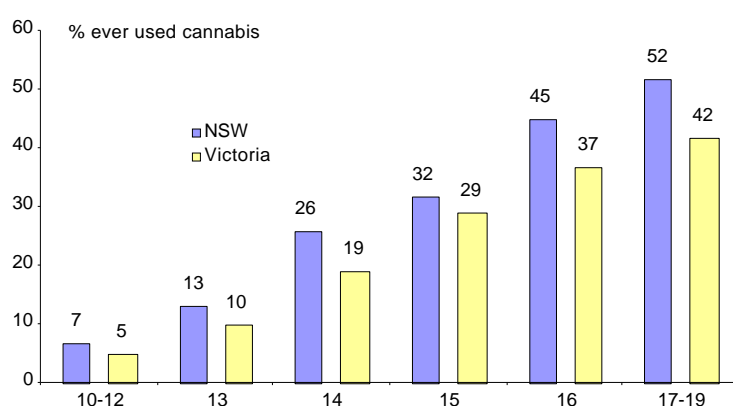
**Table 6.8: Frequency (%) of cannabis use among adolescents, Australia, 1988 – 1995**

	1988	1991	1993	1995	Change 1988-1995
	n = 134	n = 152	n = 88	n = 103	n = 103
Once a week or more often	27	33	30	33	+6
Once, several times a month	27	31	43	41	+14
Few times, once a year	46	36	27	26	-20

Source: 1985-1995 NDS Surveys.

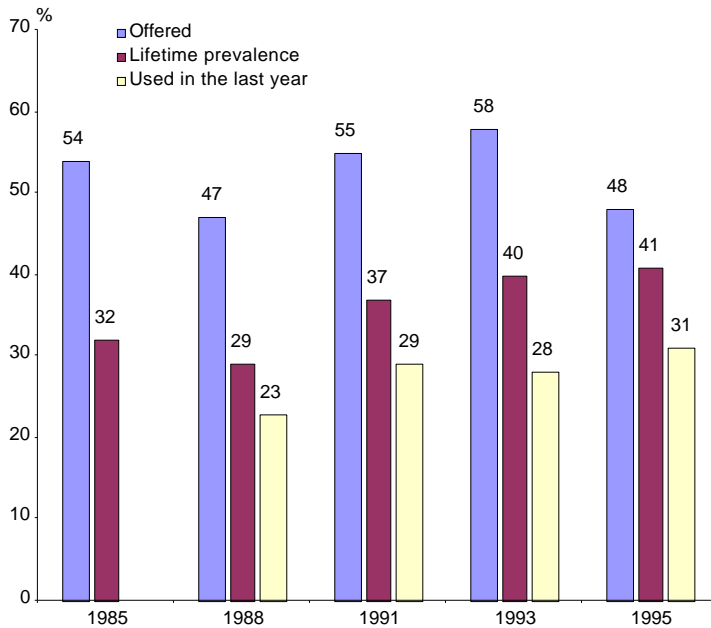
It is not possible to obtain a complete understanding of cannabis use by young people who are at school from the NDS Household Surveys, as these surveys cover persons aged 14 years and older. However, both Victoria and New South Wales conducted large scale surveys of secondary school students in 1992, which provide an understanding of age related patterns of ever use of cannabis by this group of adolescents (Figure 6.8).

**Figure 6.7: Age trends in adolescent lifetime prevalence of cannabis use based on school surveys, NSW and Victoria, 1992**



While there was a lower prevalence of ever use of cannabis by secondary school students from Victoria compared to New South Wales, in both States there was a similar pattern of increasing use with age. This data suggests among school students that in year 8 about 10% have ever used cannabis, by year 10 about one third have ever used cannabis and by year 12 about half have ever used. This data is similar to the data from the 1993 WA Child Health Survey reported earlier, which surveyed young people aged 12 to 16 years.

**Figure 6.8: Trends in adolescent exposure to and use of cannabis, Australia, 1985 – 1995**



## 6.4. Indicators of abuse

### 6.4.1. ADIS calls

From 1986 to 1998, a total of 19,664 cannabis related telephone calls were dealt with by ADIS. This was 16.4% of the total of 120,243 drug related calls received in this State (Table 6.9). Cannabis related calls constituted 37.2% of the 52,790 illicit drug related calls received over the period.

From 1986 to the end of 1989, the number of cannabis related calls per quarter fluctuated between about 200 and 300 calls per quarter. From the March quarter 1991 (369 calls) to the September quarter 1995 (692 calls), the number of quarterly calls increased by 87.5%. After peaking with 692 calls in the September quarter 1995, the number of calls have decreased and fluctuated at around 500 calls per quarter up to the June quarter 1998 (Figure 6.9).

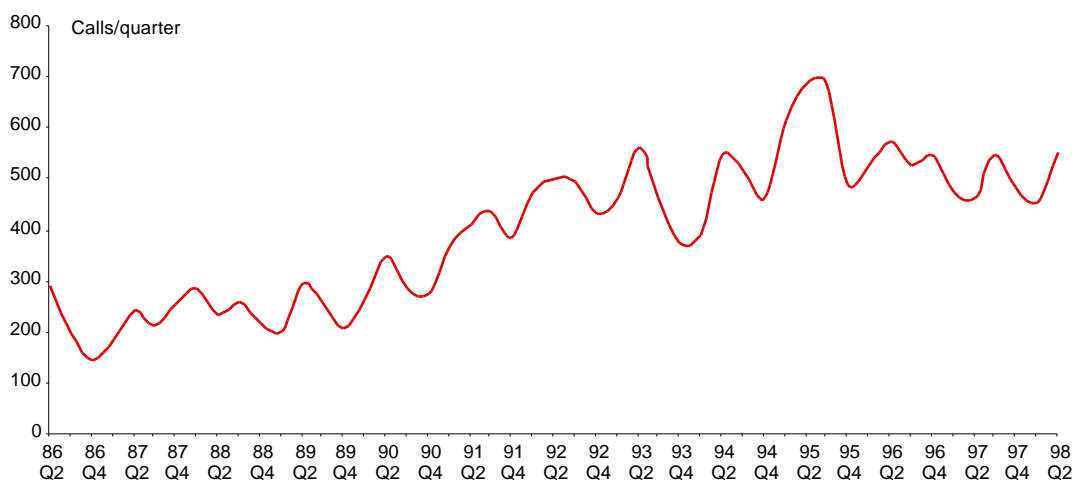
## Select Committee Into Misuse of Drugs Act 1981

**Table 6.9: Quarterly ADIS cannabis related telephone calls, 1986 - 1998**

Year	Quarter	No. calls	Year	Quarter	No. calls
1986	January-March	na	1992	January-March	474
	April-June	293		April-June	500
	July-September	200		July-September	496
	October-December	145		October-December	436
	<b>Total</b>	<b>638</b>		<b>Total</b>	<b>1,906</b>
1987	January-March	190	1993	January-March	463
	April-June	246		April-June	563
	July-September	212		July-September	463
	October-December	257		October-December	374
	<b>Total</b>	<b>905</b>		<b>Total</b>	<b>1,863</b>
1988	January-March	289	1994	January-March	392
	April-June	236		April-June	549
	July-September	264		July-September	518
	October-December	219		October-December	466
	<b>Total</b>	<b>1,008</b>		<b>Total</b>	<b>1,925</b>
1989	January-March	206	1995	January-March	619
	April-June	298		April-June	688
	July-September	263		July-September	692
	October-December	211		October-December	490
	<b>Total</b>	<b>978</b>		<b>Total</b>	<b>2,489</b>
1990	January-March	265	1996	January-March	526
	April-June	350		April-June	574
	July-September	290		July-September	530
	October-December	279		October-December	550
	<b>Total</b>	<b>1,184</b>		<b>Total</b>	<b>2,180</b>
1991	January-March	369	1997	January-March	477
	April-June	411		April-June	463
	July-September	439		July-September	547
	October-December	386		October-December	488
	<b>Total</b>	<b>1,605</b>		<b>Total</b>	<b>1,975</b>
			1998	January-March	455
				April-June	553

Source: Alcohol and Drug Information Service.

**Figure 6.9: Quarterly cannabis related calls to ADIS, 1986 - 1998**



## 6.4.2. Admissions to psychiatric hospitals

Over the period 1988 to 1997, there were a total of 85 first time admissions wholly caused by cannabis to psychiatric hospitals and units in WA. A total of 361 beddays resulted from this hospitalisation, estimated to have cost a total of about \$120,000. This was a mean of 8 first time admissions per year over the 10 year period (Table 6.10).

Of these 85 admissions, 70 admissions (82.3%) and 296 beddays (82.0%) were due to the non dependent abuse of cannabis. In relation to all types of drug caused mental disorders over this 10 year period, cannabis was responsible for 0.7% of the 11,639 admissions and 0.8% of the 46,071 beddays due to the abuse of drugs other than alcohol.

**Table 6.10: First ever admissions to psychiatric hospitals due to cannabis abuse, WA, 1988 - 1997**

	Beddays	\$	Admissions
1988	3	792	3
1989	13	3,796	7
1990	49	15,219	10
1991	18	5,643	4
1992	80	25,168	6
1993	45	14,535	8
1994	7	2,358	7
1995	33	11,649	14
1996	56	20,093	15
1997	57	20,805	11
<b>Total</b>	<b>361</b>	<b>120,058</b>	<b>85</b>

Note: Combined cases for cannabis dependence and non dependent cannabis abuse.

## 6.4.3. Admissions to ADA programs

Over the period 1988 to 1997, there were 866 cannabis related new admissions to all ADA programs (Table 6.11). It is noted these admissions mostly involved age groups below 40 years of age (Figure 6.10). Almost all admissions involved those seeking outpatient assistance, as there was a total of only 65 cannabis related admissions to residential programs over this period (Table 6.12).

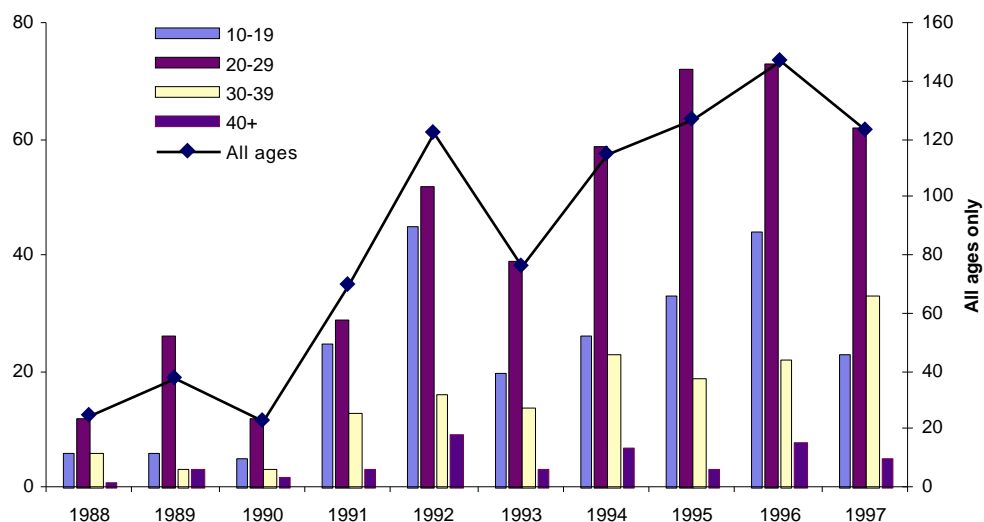
**Table 6.11: New cannabis related admissions to all ADA programs by age group, 1988 - 1997**

	Age group						All ages
	10-19	20-29	30-39	40-49	50-59	60+	
1988	6	12	6	-	-	1	25
1989	6	26	3	2	1	-	38
1990	5	12	3	2	-	-	23
1991	25	29	13	2	-	1	70
1992	45	52	16	4	-	5	122
1993	20	39	14	1	1	1	76
1994	26	59	23	5	1	1	115
1995	33	72	19	2	1	-	127
1996	44	73	22	7	1	-	147
1997	23	62	33	4	1	-	123
<b>Total</b>	<b>233</b>	<b>436</b>	<b>152</b>	<b>29</b>	<b>6</b>	<b>9</b>	<b>866</b>

**Table 6.12: All cannabis related admissions to ADA residential detoxification programs by age group, 1988 - 1997**

Year	Age group						All ages
	10-19	20-29	30-39	40-49	50-59	60+	
1988	-	1	-	-	-	-	1
1989	-	7	2	-	-	-	9
1990	-	2	-	-	-	-	2
1991	2	-	-	-	-	-	2
1992	-	-	-	-	-	-	-
1993	-	2	1	-	-	-	3
1994	-	-	-	-	-	-	-
1995	-	14	3	-	-	-	17
1996	1	7	2	2	-	-	12
1997	1	13	2	3	-	-	19
<b>Total</b>	<b>4</b>	<b>46</b>	<b>10</b>	<b>5</b>	<b>-</b>	<b>-</b>	<b>65</b>

**Figure 6.10: New cannabis related admissions to all ADA programs by age group, 1988 - 1997**



### 6.4.4. Mortality

There were no recorded deaths wholly caused from cannabis abuse in WA over the period 1982 to 1993. However, it is likely cannabis was a contributing factor in a number of deaths due to motor vehicle accidents, as it has been reported that THC was detected in 11% of road fatalities in WA in 1993.<sup>253</sup>

A recent study of traffic fatalities in WA noted that CNS acting drugs had become more prevalent in traffic fatalities in WA since the mid 1980s, increasing from about one in 20 deaths in 1985 (14 out of the 243 traffic fatalities) to one third of deaths in 1995 (68 out of the 209 traffic

<sup>253</sup> Healy M. *Road crashes in Western Australia 1993*. Perth, Research and Statistics Branch, Police Department, 1994.

fatalities).<sup>254</sup> This study of the traffic fatalities that occurred between July 1992 and December 1995 identified 197 cases where CNS acting drugs, including THCA<sup>255</sup> (the active metabolite of cannabis) were detected.

Of these 197 fatalities, it was found that 95 deaths involved cases where THCA was present. Of the 95 THCA positive fatalities, 27 (28.4%) involved THCA alone, 49 (51.6%) involved THCA and alcohol with the remaining 19 fatalities involving combinations of THCA and other drugs.

This study pinpointed a group of predominantly male drivers in the 15 to 24 age group who had elevated levels of both alcohol and THCA, and confirmed other research that the concurrent use of cannabis and alcohol increased the likelihood of traffic accidents. Research in the Netherlands, which also addressed this issue, concluded that “*the combined effects on drivers’ performance could well be greater than the sum of either drug acting separately*”.<sup>256</sup>

### 6.4.5. Charges

In the period 1990 to 1996, there was a total of 75,076 drug charges laid by the WA Police Service. Over this period, the rate for all drug charges peaked in 1992, with a rate of 517.6 charges per 100,000 population. This figure decreased over the remainder of the period.

There was little difference in the proportion of cannabis charges depending on seriousness, with a mean of 91.1% of possession/use charges and 89.2% of trafficking charges involving cannabis.<sup>257</sup> More recent data from the WA Police Service was not available at the time this report was being written.

In research undertaken by the Crime Research Centre and presented to the Select Committee, it was observed that cautioning of juveniles (which was introduced in this State in August 1991) may have been responsible for a fall in the number of drug charges laid against those aged less than 18.<sup>258</sup>

With respect to possession/use charges, the percentage of drug offences (in relation to all drug charges) involving those aged less than 18 declined from 13.6% in 1991 to 8.4% in 1996. Over the period, there was a similar decline in relation to trafficking charges, where trafficking charges (in relation to all drug charges) involving juveniles fell from 8.2% in 1991 to 5.6% in 1996.

However, as there was also a decline in the proportion of possession/use and trafficking charges recorded for those aged 18 to 25 over the 1991 to 1996 period, it is difficult to attribute the reduction as a consequence of the introduction of juvenile cautioning, as cautioning is not available for those aged 18 years and over.

The Select Committee received evidence from the WA Police Service regarding Operation Final Dose, an intensive campaign launched in August 1997, which was especially targeted at street level drug use and dealing in Northbridge and nearby inner city areas. A breakdown of statistics provided to the Select Committee for the first eight weeks of this operation (from 11 August to 5 October 1997) was presented in the Interim Report.<sup>259</sup>

A total of 986 separate charges were laid by the police in the first eight weeks of the operation, of which 798 (80.9%) were cannabis related (Table 6.13). Of the 798 cannabis related charges, there were 493 (61.8%) charges for possession or cultivation of cannabis, 265 (33.2%) charges

<sup>254</sup> Swensen G. *Drug related traffic fatalities in Western Australia*. Task Force on Drug Abuse. Statistical Bulletin No. 1, May 1996.

<sup>255</sup> Carboxytetrahydrocannabinol

<sup>256</sup> Robbe HWJ. *Influence of marijuana on driving*. Maastricht, Institute for Human Psychopharmacology, university of Limburg, 1994, 176.

<sup>257</sup> Western Australia, Parliament, Select Committee Into the Misuse of Drugs Act 1981. *Interim Report. Taking the profit out of drug trafficking*. Perth, Legislative Assembly, 1997, 133-134.

<sup>258</sup> Id 126

<sup>259</sup> Id 148-150.

## Select Committee Into Misuse of Drugs Act 1981

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for possession of smoking implements and 40 (5.0%) charges for provider level offences (ie other than simple offences).

**Table 6.13: Number of charges by drug group, Operation Final Dose, 11 August – 5 October 1997**

	Number of charges
<b>Amphetamines</b>	
Consumer	27
Provider	4
Sub total	31
<b>Cannabis</b>	
Consumer	
Possession/cultivation	493
Implements	265
Provider	40
Sub total	798
<b>Cocaine</b>	
Consumer	1
Provider	0
Sub total	1
<b>Heroin</b>	
Consumer	
Possession	81
Implements	24
Provider	41
Sub total	146
<b>LSD</b>	
Consumer	6
Provider	4
Sub total	10
<b>All drugs</b>	
Consumer	897
Provider	89
Total	986

Source: WA Police Service, evidence provided to Select Committee

## 6.5. Health consequences

Cannabis has been shown to remain in the fatty tissues in measurable amounts for over 28 days. While the body levels of THC depend on the dose taken and the smoking history, they are also subject to substantial individual variability. Therefore, it is very difficult to determine from blood levels of THC how recently cannabis has been smoked. The psychoactive effects of cannabis intoxication do not persist beyond a few hours, therefore rendering tests for THC unreliable in determining intoxication.

Pharmacological effects differ according to the method of consumption. If cannabis is smoked, a “high” is attained much more quickly. In contrast, the effects of cannabis taken orally are much less potent, although more long lasting. Cumulative effects are observed with alcohol and other central nervous system depressants, but no clear interaction has been noted with stimulants.

Research indicates some of the problems associated with cannabis use may be similar to those caused by alcohol and tobacco, both of which have a substantial effect on public health in

Australia.<sup>260</sup> When cannabis is smoked, problems may approximate those associated with cigarette smoking. Cannabis (like alcohol) is a depressant and hence depresses or slows down the activity of the central nervous system.

Since THC becomes stored in body tissues and is only released into the blood stream over a period of days or weeks, accumulation of THC may occur. As a result of this accumulation, regular cannabis users may be affected by cannabis when they subsequently use the drug and be unaware of the dangers of this. Another concern is the possible accumulation of THC in the brain, which may in time result in brain damage.

A number of recent studies, such as those produced in conjunction with the National Task Force on Cannabis, have highlighted a number of health, social and psychological problems related to the regular use of cannabis.<sup>261</sup> A detailed outline of these effects is contained in the report by Hall et al, *The health and psychological consequences of cannabis use*. A summary of some of the major effects outlined in this report follow.

### 6.5.1. Major effects

The major effects of cannabis include:

- feelings of self confidence, euphoria, well being and relaxation;
- altered perception of time and space, and heightened perceptions of taste, smell, touch, and hearing;
- dissociation of ideas;
- difficulties with concentration and memory;
- other cognitive impairment;
- psychomotor impairment; and
- delusions and hallucinations.

### 6.5.2. Acute effects

The acute effects of cannabis include:

- anxiety, dysphoria, panic and paranoia (especially in naive users);
- cognitive impairment (especially of attention and memory) for the duration of intoxication;
- psychomotor impairment, and probably an increased risk of injury if an intoxicated person attempts to drive a motor vehicle or operate machinery;
- an increased risk of experiencing psychotic symptoms among those who are vulnerable because of a personal or family history of psychosis; and
- an increased risk of low birth weight babies if cannabis is used during pregnancy.

### 6.5.3. Chronic effects

On the available evidence the major *probable* effects appear to be:

- respiratory diseases associated with smoking as the method of administration (such as chronic bronchitis) and the occurrence of histopathological changes that may be precursors to the development of malignancy;

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<sup>260</sup> Hall W, Nelson J. *Public perceptions of health and psychological consequences of cannabis use*. Canberra, Australian Government Publishing Service, 1995; Mundy J. "Decades of dope". (1997) *Connexions*. April/May 16–17.

<sup>261</sup> Ali R, Christie P. *Report of the National Task Force on Cannabis*. Canberra, Australian Government Publishing Service, 1994; Hall W, Solowij N, Lemon J. *The health and psychological consequences of cannabis use*. Canberra, Australian Government Publishing Service, 1995; Hall W, Nelson J. *Public perceptions of the health and psychological consequences of cannabis use*. Canberra, Australian Government Publishing Service, 1995.

- development of a cannabis dependence syndrome, characterised by an inability to abstain from or control cannabis use; and
- subtle forms of cognitive impairment, most particularly of attention and memory, which persist while the user remains chronically intoxicated, and may or may not be reversible after prolonged abstinence from cannabis.

#### **6.5.4. Respiratory effects**

Since cannabis smoke is inhaled deeply, held for much longer and contains more tar than tobacco, the adverse effects are greater. As a result, smoking 2 to 3 cannabis cigarettes may carry the same risk of lung damage as smoking a whole packet of tobacco cigarettes. This suggests that cannabis is destructive to lung parenchyma and epithelial cells and likely to cause cancer of the upper respiratory and digestive tracts.

Cannabis use is likely to lead to increased susceptibility to emphysema, mild airway obstruction and respiratory infections such as chronic bronchitis, sinusitis, asthma and rhinopharyngitis.

#### **6.5.5. Cardiovascular effects**

Cannabis inhalation results in an increase in heart rate, blood pressure and conjunctival injection. Persons with hypertension, cerebral vascular disease and ischaemic heart disease may be at increased susceptibility to these effects.

#### **6.5.6. Reproductive effects**

In males, cannabis use diminishes testosterone production and decreases sperm count, and also results in abnormal shape and chemical composition of the sperm cells. In females, cannabis can affect fertility by disrupting the reproductive cycle through changes to ovulation and menstrual cycles.

#### **6.5.7. Neuropsychiatric complications and psychological dependence**

Heavy cannabis use produces a change in personality and in behaviour (more dramatically demonstrated by children and adolescents than it is by adults) and is strongly believed to result in psychological dependence. It is not yet understood whether cannabis use causes all problems associated with its use, or whether some occur as a symptom of an underlying disorder such as mental illness, or social problems revolving around the user's family, friends or school.

#### **6.5.8. Physical dependence**

Frequent use of cannabis may produce mild physical dependence and (as a consequence) withdrawal symptoms. Withdrawal usually starts several hours after cessation of use, is usually mild and is over within a matter of days for most users.

### **6.6. Factors affecting cannabis use**

Research has identified a number of the factors associated with the initiation of cannabis use and for the continued heavy cannabis use, as follows.<sup>262</sup>

#### **Age and gender**

Age and gender are both strongly related to cannabis use. Australian research has found that prevalence of both cannabis initiation and heavy cannabis use increase during the teenage years.

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<sup>262</sup> Donnelly N, Hall W. *Patterns of cannabis use*. Canberra, Australian Government Publishing Service, 1994.

Another consistent finding in Australian studies is that cannabis prevalence rates are higher among males than females.<sup>263</sup>

### **Socio economic status**

A positive relationship has been found between income in adolescence and early adult life, and cannabis use. School surveys in Victoria and South Australia found an association between the amount of money earned or received per week and the prevalence of use of a number of drugs including cannabis, alcohol and tobacco. This may reflect those young people who are motivated to earn money to support their recreational activities.

Cannabis use appears to be higher among people of lower socioeconomic status, although at the younger age levels, rates of use are high among children of professional parents.<sup>264</sup> Interestingly, a predictor of trial of cannabis is education, the greater level of education received the more likely an individual was to have tried cannabis.<sup>6</sup>

### **Employment**

Some data have shown a higher prevalence of cannabis use among unemployed as compared to employed persons. This could be attributed to a number of possible explanations: unemployment is a consequence of increased drug use; unemployment may contribute to higher rates of drug use; or both unemployment and drug use might be consequences of other personal or social factors. The lack of research makes it difficult to draw a definite conclusion.<sup>265</sup>

### **Ethnic groups**

The current research about the relationship between various ethnic groups and cannabis use is very poor in Australia. Sample sizes from general population surveys do not allow for sufficient numbers of any ethnic group to provide stable prevalence estimates.<sup>266</sup>

### **Availability**

Although availability is often considered a factor in prevalence of use, in the case of cannabis, its illegal status makes it difficult to determine the extent to which increasing the availability of cannabis correlates with higher prevalence of its use. Crude estimates of availability from self report surveys (eg. how easy people believe it would be to obtain cannabis) have shown very little change over time. The issue of availability has, however, been supported in the case of alcohol consumption where studies have shown that, other things being equal, the larger the number of licensed premises and longer hours of trading, the higher the level of alcohol consumption and alcohol related problems.<sup>267</sup>

## **6.7. Young people and cannabis**

### **6.7.1. Introduction**

A broad spectrum of public and medical opinion exists regarding the risks associated with cannabis use by young people. At the one extreme, teenage experimentation has been seen as a 'stepping stone' to dependence and use of more damaging drugs.<sup>268</sup> The other view is that most teenage

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<sup>263</sup> Donnelly N, Hall W. *Patterns of cannabis use*. Canberra, Australian Government Publishing Service, 1994; National Drug Strategy. *Report of the National Task Force on Cannabis*. Canberra, Australian Government Publishing Service, 1994.

<sup>264</sup> Donnelly N, Hall W. *Patterns of cannabis use*. Canberra, Australian Government Publishing Service, 1994; National Drug Strategy. *Report of the National Task Force on Cannabis*. Canberra, Australian Government Publishing Service, 1994.

<sup>265</sup> Ibid.

<sup>266</sup> Donnelly N, Hall W. *Patterns of cannabis use*. Canberra, Australian Government Publishing Service, 1994.

<sup>267</sup> Donnelly N, Hall W. *Patterns of cannabis use*. Canberra, Australian Government Publishing Service, 1994; National Drug Strategy. *Report of the National Task Force on Cannabis*. Canberra, Australian Government Publishing Service, 1994.

<sup>268</sup> Bailey GW. "Perspectives in drug abuse in youth." (1989) 28 *Journal of the American Academy of Child and Adolescent Psychiatry* 151-162.

users of cannabis mature out of using this and other illicit drugs in their twenties. Although few would agree with earlier notions of inevitable progression in use, a benign view of regular cannabis use in teenagers has been challenged by recent West Australian data indicates that heavy teenage use carries a particular risk of continued heavy use in adulthood.<sup>269</sup>

## **6.7.2. Factors associated with use**

### **6.7.2.1. Use of alcohol and tobacco**

The 1993 WA Child Health Survey confirms that adolescents who have used other substances are significantly more likely to have also used cannabis. Those who have ever drunk alcohol (more than the small amount permitted by their parents) are 19.5 times more likely to have used cannabis than those who have never drunk alcohol (Table 6.14).

Adolescents who report having ever smoked tobacco are twice as likely to have used cannabis. Those who have smoked cigarettes daily for a month are almost 5 times more likely to have used cannabis. Adolescents who had used other substances of abuse (for example, volatile substances, ecstasy, amphetamines and LSD) had a three fold increased likelihood of having used cannabis.

Because the use of these substances is highly intercorrelated, it is necessary to take into account the strength of association between each of them. This was done by means of a statistical modelling technique (logistic regression), which showed that 87% of all adolescents who used cannabis could theoretically have been predicted simply on the basis of a knowledge of their use of these other substances.

Finally, the odds ratios in Table 6.14 are adjusted for the known correlation among these variables. This means that they may be used to assess the risks of multiple uses of these substances. For example, regular alcohol use and tobacco use daily increase the odds of cannabis use by a factor of 14.7 (ie 3.2 x 4.6).

**Table 6.14: Use of cannabis and other substances by WA adolescents, 1993**

	Proportion of adolescents using this substance (%)	Increased risk of using cannabis
<b>Alcohol</b>		
Ever used	60	19.5
Alcohol regular (3+ times per month)	12	3.2
<b>Tobacco</b>		
Ever used	29.5	2.1
Tobacco daily for a month or longer	14.5	4.6
<b>Other drugs</b>		
Ever used	4.6	2.9

Source: WA Child Health Survey.

### **6.7.2.2. Parental income**

Cannabis use, as with tobacco use, was found to vary with parental income. Its use was most prevalent in children from households with a parental income in the lowest income quintile (the lowest 20 per cent of parental incomes). Just over one quarter of adolescents (26%) from this income group reported using cannabis. Adolescents in the middle income quintile were least likely

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<sup>269</sup> Kandel DB, Yamaguchi K, Chen K. "Stages of progression in drug involvement from adolescence to adulthood: further evidence for the gateway theory." (1992) 53 *Journal of Studies into Alcohol* 447-457; Burke KC, Burke JD, Reiger DA, Rae DS. "Age at onset of selected mental disorders in five community populations." (1990) 47 *Archives of General Psychiatry* 511-518.

to use cannabis (around 10%). Just under 20% of 12 to 16 year olds from each of the remaining parental income quintiles reported its use.

### 6.7.2.3. School alienation

The use of cannabis also varied with 12 to 16 year olds' attitudes about going to school. Adolescents who hated school or didn't like school were more likely to have used cannabis, compared with those who liked school to any degree.

### 6.7.2.4. School culture

Cannabis use was seen to change as school culture varied. In schools where they reported other students using drugs before and after school, adolescents were more likely to have used cannabis. Similarly, where students reported high levels of alcohol drinking at school, they were more likely to have used cannabis. In schools with high student vandalism or high levels of theft, student use of cannabis was correspondingly high. There were no apparent associations between cannabis use and student fighting or bullying.

## 6.7.3. Alcohol and cannabis and deliberate self harm

The increase in the rate of suicide among Australian youth over the past two decades has focused community attention on the need to understand the types of problems and stresses which lead some young people to choose suicide as a solution to emotional distress. Suicide is now a leading cause of death among older adolescents. In 1993, it was the second most common cause of death (after motor vehicle accidents) for Australians aged 15 to 24 years.

Anecdotal reports from professionals working with young people and their families in clinical and educational settings suggest a recent increase in the number of adolescents who had thought about taking their own life. Prior to the WA Child Health Survey, no reliable community prevalence data on the extent of this behaviour among Australian adolescents was available. To address this need, and to establish the relationship between suicidal thoughts and other risk behaviours such as drug use and deliberate self harm, information was sought on whether, during the six months prior to the Survey, adolescents had thought about killing themselves.

During collection of the data, care was taken to ensure that all consenting adolescents (and their parents) were aware that the survey contained sensitive questions which they were not obliged to answer. Fewer than 1% of adolescents did not answer the questions about suicidal behaviour. For those who had concerns arising from their participation in the Survey, professional assistance was made available.

Of those adolescents who had deliberately tried to harm or kill themselves, one in four regularly drank alcohol, twice the proportion who had never deliberately harmed themselves (11%). Where 12 to 16 year olds reported using cannabis, 41% of those who had deliberately tried to harm themselves used the substance compared with 17% who had not tried to harm themselves.

Deliberate self harm (ie attempted suicide) is a major cause of hospitalisation of 15 to 19 year old adolescents, resulting in approximately 450 hospital admissions in Western Australia each year. Those admitted to hospital have an increased risk for future completed suicide and are frequently in need of assistance for a range of other health and social problems.<sup>270</sup>

Heavy drinking and drug abuse are known to be major risk factors for completed suicide among youth aged 15 to 25 years.<sup>271</sup> For this reason, it is important to clarify the extent to which these behaviours were associated with suicidal thoughts and deliberate self harm.

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<sup>270</sup> Burke KC, Burke JD, Reiger DA, Rae DS. "Age at onset of selected mental disorders in five community populations." (1990) 47 *Archives of General Psychiatry* 511-518.

<sup>271</sup> Ibid.

Among adolescents who reported suicidal thoughts, the Survey found that the proportion who had drunk alcohol regularly (22%) was twice that of those who never had suicidal thoughts (10%). For reported cannabis use, the picture was similar with 37 per cent of those adolescents who reported suicidal thoughts also using cannabis compared with 15 per cent of those who had never had suicidal thoughts.

#### **6.7.4. Why do young people use cannabis?**

Qualitative research by the Health Promotion Service has found the issue of illicit drugs and their use to be highly salient with all young people whether they were users, experimenters or non users.<sup>272</sup> Many research participants indicated that use of, and dealing in, illicit drugs was highly prevalent within schools. The perception among respondents was that anywhere between 80 to 90 per cent of the students at their schools regularly use illicit drugs (mainly cannabis).

While these findings are not based on quantitative research, they do highlight the perception many young people have that everyone is using illicit drugs. In most cases, illicit drugs begin to become an issue for adolescents from Year 8. Early experimentation and exposure with illicit drugs is typically facilitated by friends, older students at schools and often through older siblings.<sup>273</sup>

Other research suggests relationships with peers to be among the strongest and most consistent predictors of alcohol and other drug use.<sup>274</sup> Several studies had found that adolescents with peers who use licit or illicit drugs are more likely to use drugs.<sup>275</sup> It should be recognised, however, that this does not mean peers are forcing their friends to use illicit drugs.

Participants in qualitative research undertaken by the Health Promotion Service indicated that the decision whether to use drugs or not was up to the individual and was often based on personal view. Furthermore, having made this choice, others were to respect their decision and not judge their actions.<sup>276</sup>

*“I’ve been offered speed and stuff and I said no, I don’t do that sort of stuff and they said fair enough and went on their way.”* Year 9 Male

*“If they want to, and they’re not getting pressured or anything and it’s not too hard and it’s not hurting anyone else, then I think it’s their business, but if it’s hurting them and it’s still their choice then people can’t help but worry.”* Year 11 Female

The research found respondents fell into three groups:

- non users;
- experimenters; and
- experienced users.

Non users have made the decision not to use illicit drugs. They are not adolescents sheltered from exposure but have made a conscious decision not to use for a variety of reasons including the authority of their parents, their own aversion to the substance and fear of harm and/or addiction.

The experimenting users are those who are relatively new to illicit drugs and who infrequently dabble (at parties, on weekends, etc). This group was predominantly involved in cannabis use.

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<sup>272</sup> Health Promotion Services, Health Department of Western Australia. *Developing an effective public education program on illicit drugs* (unpublished), 1996.

<sup>273</sup> Ibid.

<sup>274</sup> Schaps E, Battistich V. “The etiology of problem behaviours.” In Goplerud (ed) *Preventing adolescent drug use: from theory to practice*. Maryland, US Department of Health and Human Services, 1991.

<sup>275</sup> Heaven PCL. *Adolescent health*. London, Routledge, 1996.

<sup>276</sup> Health Promotion Services, Health Department of Western Australia. *Developing an effective public education program on illicit drugs* (unpublished), 1996.

However, there was some involvement with ecstasy. Experimentation with illicit drugs is essentially a result of a combination of persuasion, curiosity, lack of information and choice.<sup>11</sup>

*“It’s not because I have problems, it’s like if I try something it’s because I want to try it or I’ve seen other people do it and they look real happy or whatever, but it’s not because I’ve got some sort of psychological problems and they always think that anyone who does drugs are real screwed up and need help, like they offered to get me a counsellor and I’m just going ‘no it’s alright’.”* Year 11 Female

Many respondents felt the perception of peer pressure as the cause of all adolescents’ choices was exaggerated. For many, curiosity is a key factor in their experimentation with and interest in illicit drugs.

Reflective of the overall lack of knowledge about illicit drugs present among adolescents, this group did not have high levels of concern about the effects of the drugs, but were more concerned about losing control and the addiction aspect.

Experienced users were typically older adolescents and had been exposed to and involved with illicit drug use for a longer period of time. This group perceive that they have total control over their use of illicit drugs. They do not consider themselves to be addicted. Many of this group had witnessed or suffered bad experiences as the result of illicit drug use. There seemed to be high levels of exposure to serious drug related situations with a close friend or family. Additionally, many had witnessed the involvement and escalation of crime as a way to pay for the increasing cost of drugs.

Overall, the research demonstrated that adolescents possess a distinct lack of quality, factual information about illicit drugs and their usage.

*“Don’t know what it’s going to do to you when you take it, half the time you get people who’ll take stuff and take it to school and they’ll spin out if they don’t know what it’s going to do to them. They’ll have a trip or something at school and they’ll just go psycho and they’ll come back and say I wish I hadn’t taken all this stuff.”* Year 9 Male

*“Why did they take it then?” ... “because they didn’t really know what it’s going to do to them.” ... “You don’t know what you’re doing and how much to take and what it’ll do to you”* Year 9 Male

### 6.7.5. Young people and the law

Section 22 of *Young Offenders Act 1994* permits a police officer not to charge a juvenile with a cannabis related offence in certain circumstances. This is a specific express statutory provision regulating the exercise of a police officer’s power of general discretion when deciding whether or not to proffer a charge in respect of various minor offences, including minor offences under the *Misuse of Drugs Act 1981*.

The Select Committee received evidence from a number of witnesses reiterating the view that relations between police and young people often involved the issue of drugs, especially cannabis in varying quantities. The police could justify searching and questioning young people by resorting to the broad powers under the *Misuse of Drugs Act 1981*, which enable them to stop and detain on the grounds of reasonable suspicion. For instance, the coordinator of the Youth Legal Service, Mr James McDougall, stated in evidence given to the Select Committee that

*“police contact is more than just superficial and leads to some form of police investigation, invariably the suspected behaviour will be related to drug use. The conclusion I draw from that is that the police drug powers are used as a very common tool for effecting whatever contact police wish to make with young people to conduct searches and to question them. The experience produces in young people a feeling of – to put it at its highest – persecution. A lot of those young people will not necessarily ever fall into either of the other two categories of*

*offending behaviour, but their police contact is almost invariably mediated through an issue relating to drugs.*"<sup>277</sup>

The possession of smoking implements by young people was given as an example of where young people could feel persecuted when they were referred by the police to a Juvenile Justice Team. The belief is that on these occasions the police have insufficient evidence and that, as a consequence, a significant amount of resources of the police, the courts and the Juvenile Justice Team have been wasted. In the meantime, the young person is left with the perception of being the proverbial 'meat in the sandwich'.

The effect of the ability of police to refer juveniles is one of 'net widening', with more young people being dealt with for drug offences than may have happened if there had not been the option of referral. Mr McDougall expanded on these themes in his evidence.

*"We hear of young people being referred by police to the Juvenile Justice Team for possession of an implement. For one reason or another the team may decide that it cannot deal with the charge. Perhaps the person does not admit responsibility or negotiations to achieve an agreed penalty do not produce an agreed result. In any event the matter may be referred back to the police for them to decide whether to issue a caution or refer the matter on to the court. Quite regularly those matters do not result in charges being laid and the matter ends at that point. My suspicion is that what is happening is that the police are deciding that they probably could not make a charge stick in court because of insufficient evidence and so they are referring the matter to the teams anyway."*<sup>278</sup>

The Select Committee's view is that the current arrangements for dealing with suspected or actual cannabis use by young people could be substantially improved. It can, in certain circumstances, arguably involve an inappropriate use of police resources and may not achieve the particularly desirable outcome, namely, of young people getting drug education, counselling or treatment.

It is recognised that the cautioning of young people should take account of their age, health, social and economic circumstances. Police dealings with young cannabis offenders is a prime opportunity for these factors to be assessed and addressed by appropriate health and community service agencies.

### 6.7.6. Education and prevention

Secondary school aged respondents in a recent qualitative study (conducted by Health Promotion Services) indicated a good awareness of the variety of drugs available. Few respondents, including the experienced users, had a good understanding of the effects of specific drugs, or even what the term 'getting high' really meant.

Respondents acknowledged their lack of knowledge and expressed an interest in receiving more factual information about illicit drugs. Information desired included effects of drugs, education about usage patterns and legal implications.

Given the levels of cannabis use among secondary school aged students, it would be pertinent to encourage the development of school based interventions which focus on drug education (particularly cannabis). Given illicit drugs are considered an issue for Year 8 students and recent Western Australian data indicates that a proportion of these students are using, it would be appropriate to discuss issues pertaining to cannabis use in some Year 7 classes. Individual schools are in the best position to determine the appropriateness of this inclusion. However, relevant materials should be made available. Drug education for all students should be kept in perspective and drug use should not be normalised.

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<sup>277</sup> Evidence to the Committee, 8 October 1997, 26.

<sup>278</sup> Evidence to the Committee, 8 October 1997, 27.

The National Health Strategy suggests schools are excellent places in which to promote better health. Health professionals are encouraged to develop strategies for involving the whole school community in health promotion activities. Health behaviours are learnt, amenable to change and have significant economic cost. Many health related behaviours are established during childhood and adolescence, and it is difficult to make changes after habits are well established. Research indicates the importance of improving the health of school aged children.

School communities provide an ideal opportunity for health promotion. The majority of children aged 5 to 17 years of age attend school regularly, therefore providing an excellent opportunity for improving the health of school aged children and parents.

While knowledge is a recognised component of a good school health curriculum, to enhance the likelihood of a behaviour change occurring children also need the appropriate skills, attitudes and values to enable them to make an informed decision. Therefore, school based curricular must aim to include a combination of knowledge, skills, attitudes and values. Since the objective of school health programs is to have a long term impact on health attitudes and behaviours, it is important that gains from a program are followed up with ongoing programs. If schools are serious about making a change to student behaviours, adequate time and resources must be allocated to health education and a comprehensive approach adopted.

Research shows that for 'medium' effects on general health practices, more than 30 hours of class tuition during one year is required. It is recommended in *'Time Allocation in the Primary School'* that 55 minutes per week be allocated to health education in primary schools. In addition, teachers must be adequately trained and provided with appropriate, up to date resources. Schools should also aim to enhance classroom learning with a healthy school environment and parent and community education and involvement.

In their submission to the Select Committee, the Health Promotion Service recommended that future initiatives include the following strategies:

- public education campaigns aimed to enhance the knowledge of the health effects of cannabis and the dangers of combining alcohol and cannabis targeting young people, particularly adolescents;
- school based initiatives targeting upper primary school students and secondary school students with an emphasis on a whole school approach to drug education; and
- parent education programs which provide parents with information and the skills to communicate effectively with their children.

The strong relationship between health risk behaviours has important implications for the design of programs of prevention. It suggests that far more effective targeting of these programs can be achieved if the whole range of risk behaviours is considered, rather than simply focusing on a single behaviour. However, this will require identifying modifiable causal risk factors which are common to each of the specific health risk behaviours.

There is now good evidence from model programs developed in the United States showing that broadly based prevention programs designed to reduce a range of risk behaviours (including school alienation, depression, drug use and suicidal behaviour) are more effective than those targeting a single risk behaviour.

### **6.7.7. Young people and families**

Many parents who discover or become aware that their teenage children have experimented or have used cannabis on a number of occasions may possibly find it difficult to identify and access community resources which are targeted at low levels of cannabis use. The established agencies (who largely deal with a much more serious spectrum of drug taking involving issues such as heroin, amphetamines, injecting drug use, dependence and offending) may not give sufficient priority to those who have experienced problems with low levels of cannabis use. A more detailed

consideration of the need for appropriate resources targeted at families concerned about cannabis and illicit drugs by their teenage children is provided in chapter 8.

## **6.8. Issues**

### **6.8.1. Public education**

Research has demonstrated strong public support for the government to provide education programs for secondary school students and the general population, with over 90% of all respondents agreeing that this was worthwhile.

A number of specific groups who are most at risk of adverse health consequences of acute or chronic cannabis use, and which would benefit most from efforts to discourage cannabis use have been identified in the research. These groups include:

- adolescents – particularly those with a history of poor school performance, whose achievement may be further limited by cognitive impairments produced by chronic cannabis use, and those who initiate cannabis use early in their teens, who will be at a higher risk of progression to other drug use and to dependence on cannabis;
- women of childbearing age – pregnant women who continue to use cannabis are probably at greater risk of having low birth weight babies and shortened gestation, and possibly increase the risk of their children being born with birth defects; and
- persons with preexisting illnesses – are at risk of exacerbating existing symptoms if they smoke cannabis. This would include people with cardiovascular diseases, respiratory diseases, schizophrenia, and people who are already dependent on alcohol and/or other drugs.

In addition, all cannabis users should be aware of the increased risk of motor vehicle accidents while intoxicated, and should be particularly aware of the danger of driving after combining alcohol and cannabis.

An Australian study found the public to be reasonably knowledgeable about some of the health effects of alcohol and tobacco, particularly the effects of long term use. They were less well informed (by comparison) about the health risks of cannabis (the term cannabis was used for the study). These findings probably reflect the greater attention in health promotion to alcohol and tobacco campaigns as compared to other drugs.

Despite this, two thirds of the sample believed that cannabis use could harm health. The most readily recognised health effects were the respiratory effects of smoking and ‘mental problems’, including memory loss. The risks of driving while intoxicated were only recognised after prompting. Many respondents, including a substantial proportion of those who thought that cannabis use by adults was not very risky, believed that cannabis use had adverse effects on adolescent health. Focus group discussion suggested that cannabis dependence was seen as a reflection of the user’s personality rather than a specific drug effect, since dependence apparently only afflicts a minority of users.<sup>279</sup>

Recommendations for future health promotion initiatives based on this information include:

- increase public knowledge of the factors that increase the risk of cannabis dependence, particularly daily use;
- recognition of the major health risks of cannabis use could be reinforced by educational materials and programs that stress the similarities between the health risks of alcohol, tobacco and cannabis;

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<sup>279</sup> Hall W, Solowij N, Lemon J. *The health and psychological consequences of cannabis use*. Canberra, Australian Government Publishing Service, 1994; Hall W, Nelson J. *Public perceptions of health and psychological consequences of cannabis use*. Canberra, Australian Government Publishing Service, 1995.

- focus on the increased risks associated when driving when intoxicated with cannabis, and a with combination of cannabis and alcohol; and
- a comprehensive approach should be adopted using a variety of different methods including mass media, school based educational programs, and brief interventions in medical settings.

## 6.8.2. Assistance for people who are cannabis dependent

The Select Committee is aware that there is a significant and growing number of people who develop serious health, psychological and psychiatric problems from the heavy use of cannabis. There is emerging research that there is a dependence syndrome and other health problems associated with long term cannabis use.<sup>280</sup> Recent American and Australian research has pinpointed that daily users of cannabis are the highest risk group for developing a cannabis dependence syndrome.

In late 1997, Professor Wayne Hall from NDARC provided an overview of cannabis dependence issues at the Australian Professional Society on Alcohol and Other Drugs Conference. At this Conference, Professor Hall was quoted as saying that

*“while the research was limited and while the use of alcohol and opiate dependence models with cannabis was questionable, existing studies showed that ‘about 9% of all users and about 33% to 50% of daily users had criteria for dependence at some point’.”<sup>281</sup>*

These figures are very alarming and clearly indicate that extreme caution should be exercised in any discussion involving liberalisation of WA’s cannabis laws.

As has been indicated earlier in this report, in Victoria there has been specific funding under the Turning the Tide initiative for research into this issue. The Select Committee is concerned that this group of adults, who under the present legal framework appear before a court, may not receive any effective drug counselling or treatment. If convicted, they may be fined or (in aggravated cases) jailed, thus exacerbating their underlying problems.

There is an apparent need to establish a specialist Cannabis Treatment Service in this State, to specifically deal with those who are dependent on cannabis or who are concerned about their level of cannabis use. Such a service could be administered or delivered by the State’s various CDSTs.

This service would also form an important resource in being able to assist those who were apprehended by the police who evidently had serious problems arising from heavy or regular cannabis use.

### **Recommendation 19**

***That the WA Drug Abuse Strategy Office research and implement a treatment service for problematic cannabis users, modelled on the cannabis intervention project in Victoria, and administered by an appropriately funded and skilled body, for example, CDSTs.***

## 6.8.3. The ‘gateway theory’

There has been considerable debate about the possibility that cannabis use in adolescence may lead to, or increase the likelihood of, the use of other illicit drugs, particularly cocaine and heroin.

<sup>280</sup> Swift W, Hall W, Copeland J. *Cannabis dependence among long term users in Sydney, Australia*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1997; Hall W. *Cannabis and psychosis*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1998; Didcott P, Reilly, D, Swift W, Hall W. *Long term cannabis users on the NSW north coast*. Sydney, National Drug and Alcohol Research Centre, University of NSW, 1997.

<sup>281</sup> Wood C. “Cannabis research and treatment.” *Connexions* December 1997/January 1998, 5.

## Select Committee Into Misuse of Drugs Act 1981

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While there is some evidence that there is a relationship between the degree of involvement with cannabis and the use of other illicit drugs, there is no evidence to suggest that the use of cannabis leads to the use of heroin or other ‘hard’ drugs.

However, some research suggests a sequence of drug use whereby users progress from alcohol and tobacco to cannabis then to other illicit drugs.<sup>282</sup> A Perth study found that 29% of adolescents who had used illicit substances (such as LSD, speed, cocaine or heroin) had not used cannabis.<sup>283</sup> An Indian study found that among 700 heroin users, only 11% had used cannabis first.<sup>284</sup>

It must be recognised that the majority of cannabis users do not progress to other illicit drugs such as heroin. The sequencing of initiation to the use of different drugs could simply reflect the association of each type of drug with different ages of initiation. It is also possible that there is a selective recruitment into cannabis use of less conforming adolescents who have a propensity to use illicit drugs, and that the sequence in which drugs are typically used reflects their differential availability. An alternative explanation for an apparent relationship between cannabis use and the use of other illicit drugs is that cannabis use increases the chance of using illicit drugs by socialising users in a drug using subculture.

It is likely that selective recruitment and socialisation hypotheses can account for the observed relationships, and the use of cannabis itself does not have a direct casual role in initiating the use of other illicit drugs; other social factors are much more critical in determining progression from the use of one drug to another.<sup>285</sup>

The following explanation of the gateway theory contained in a recent American report clarifies the confusion that may arise if a statistical association is treated as reflecting causality.

*“Marijuana does not cause people to use hard drugs. What the gateway theory presents as a causal explanation is a statistical association between common and uncommon drugs, an association that changes over time as different drugs increase and decrease in prevalence. Marijuana is the most popular illegal drug in the United States today. Therefore, people who have used less popular drugs, such as heroin, cocaine and LSD, are likely to have also used marijuana. most marijuana users never use any other illegal drug. Indeed for the large majority of people, marijuana is a **terminus** rather than a **gateway** drug.”<sup>286</sup>*

In its Interim Report, the Victorian Drugs and Crime Prevention Committee (Brideson Committee) discussed the gateway theory and noted that it is sometimes referred to as the stepping stone theory.<sup>287</sup> This theory hypothesises that alcohol or tobacco use leads to cannabis use, which then leads to the use of other illicit drugs. The Brideson Committee travelled throughout Australia and overseas taking evidence on illicit drugs, including social, economic and law and order impacts upon cannabis possession and consumption. It found that

*“(t)he gateway effect is often mistakenly identified with the ‘stepping stone’ view that alcohol/tobacco use **leads** to marijuana use, and marijuana use **leads** to harder illicit use. The research doesn’t strongly support the stepping stone view, or that there is a causal connection between the drug use stages.*

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<sup>282</sup> Kandel D B. “Issues of sequencing of adolescent drug use and other problem behaviours.” (1988) 3 *Drugs and Society* 55–76.

<sup>283</sup> Blaze-Temple D, Lo SK. “Stages of drug use: a community survey of Perth teenagers.” (1992) 87 *British Journal of Addiction* 215–225.

<sup>284</sup> Chowdhury A N. “Cannabis; a note from Bengal. Comments on Hall et al’s Australian national drug campaign monograph no. 25 ‘the health and psychological consequences of cannabis use.’ (1996) 91 *Addiction* 759–773.

<sup>285</sup> National Drug Strategy. *Report of the National Task Force on Cannabis*. Canberra, Australian Government Publishing Service, 1994.

<sup>286</sup> Zimmer L, Morgan JP. *Marijuana myths, marijuana facts*. NY, Lindesmith Center, 1997, 32.

<sup>287</sup> Victoria, Parliament, Drugs and Crime Prevention Committee. *Interim report of the inquiry into the Victorian government’s drug reform strategy*. Melbourne, Victorian Parliament, 1997, 145-148.

The gateway claim is **not** that all or most marijuana users are likely to go on to harder drug use. It is the (weaker) claim that most youth who **have** gone on to a certain stage of drug use (eg hard drugs) have been through the previous stage (eg marijuana). The most recent Australian figures, in fact, show that the vast majority (96 per cent) of those who had used marijuana had **not** gone on to use harder illicit. The gateway hypothesis claims merely that drug use at any level is unlikely to occur without drug use at the previous level.”<sup>288</sup>

On this issue, the Victorian Committee pointed out there were two sequences (ie ‘gates’) in drug use which had different policy implications.

“There are two gates in the gateway process, each relevant to a different policy issue:

- the gate from licit (alcohol/tobacco) to soft illicit (marijuana) drug use; and
- the gate from soft illicit (marijuana) to harder illicit (pills, cocaine, heroin).

The first gate is relevant to early intervention and education strategies. For example, the following argument might be presented: youth who never use alcohol rarely go on to marijuana. The average onset age for alcohol use is early teens. If that onset could be prevented or sufficiently delayed at the appropriate age through education, then marijuana use at later age might, *ex hypothesi*, be reduced.

Care needs to be taken with this sort of argument, however. There is nothing in the research to suggest that those youths who begin with alcohol/tobacco and go on to marijuana, would not begin with marijuana anyway, if for example, alcohol/tobacco were not available or if they were otherwise educated away from their use. For instance, if the selective recruitment hypothesis above applies, then perhaps non conformist youth would initiate marijuana use directly, if alcohol weren’t available.

The second gate has been spoken of in connection with the marijuana decriminalisation debate. The gateway effect has been appealed to by some to argue that heroin and other hard drug use will increase if marijuana is decriminalised.

If this suggestion is based on the genuine gateway observation that marijuana users are more likely than non marijuana users to go on to harder illicit drugs, then it might have some basis. For instance, it would not be unreasonable to expect that those forms of decriminalisation that lead to the wider availability and use of marijuana would increase the probability of more people entering into hard drug use.

However, this conclusion needs to be drawn cautiously. A lot depends on what the factors are that really underlie the gateway from marijuana to hard illicit. If the ‘drug subculture’ does play a role in the gateway movement from soft to hard illicit, then it might be argued that decriminalisation may help to remove marijuana users from the influence of the subculture and, in so doing, decrease the gateway effect and the probability of movement to harder drugs”.<sup>289</sup>

In the Victorian Committee’s view:

1. “(t)he gateway hypothesis claims merely that drug use at any level is unlikely to occur without drug use at the previous level;” and
2. “the gateway phenomenon needs to be taken into greater account when policy issues such as early intervention strategies and decriminalisation of marijuana are discussed”.<sup>290</sup>

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<sup>288</sup> Id 146.

<sup>289</sup> Id 147.

<sup>290</sup> Id 147-148.

## Select Committee Into Misuse of Drugs Act 1981

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The Select Committee received evidence on the issue of the gateway theory which suggested the use of drugs other than cannabis would occur as users had been exposed to more serious ('hard') drugs because of the common sources of supply of cannabis and other illicit drugs.

*"Evidence was presented to the Pennington Committee in Victoria that disputes the idea of cannabis being a gateway drug. It is not a gateway drug in the sense that a cannabis user will inevitably use heroin. If that were the case, why are one third of Australians not now using heroin? If there is a gateway effect, it seems to be about who people get their drugs from. If they get them from an illicit supplier – which they must, because it is an illicit substance – they can also be supplied with heroin, speed or, in the American situation, cocaine."*<sup>291</sup>

In *Drugs and our community*, the report of the Premier's Drug Advisory Council (the Pennington Committee), observations were made about the gateway theory. On the basis of this evidence, the Pennington Committee made a number of recommendations including that there be consideration of a treatment service for dependent cannabis users and development of programs to provide support for parents concerned about their children's use of cannabis. The inquiry also recommended that the possession and use of a small quantity of cannabis (less than 25 grams)<sup>292</sup> and the cultivation of up to 5 plants per household for personal use<sup>293</sup> should be decriminalised. The text of the Pennington Committee's discussion on the issue of the gateway theory and its influence on people progressing to use of 'hard' drugs is as follows.

*"Even if marijuana posed few health risks itself, it would still represent a problem if it tended to lead to the use of other more dangerous substances. Dutch experience indicates that marijuana is not a 'gateway' to heroin. While marijuana is available throughout Dutch cities, there are very low rates of heroin initiation. The most careful study to date, conducted during the 1970s in the United States, explored the marijuana-heroin link among the largely minority group adolescent population of Manhattan."*<sup>294</sup>

*Its findings confirmed a relationship between heroin and marijuana, but with an unexpected twist. Heavy marijuana smokers did appear at greater risk of becoming heroin users, but the mechanism did not seem to involve the drug experience itself. Rather, heavy marijuana use appeared to generate involvement in drug selling, either as a way of paying for the marijuana consumed or simply by association with drug sellers. Drug selling, in turn, gave adolescents access to heroin and the money to buy it. This suggests marijuana was a gateway for these adolescents because it was illicit."*<sup>295</sup>

*A number of cross national reviews indicate that response to cannabis would be more effective if it was clearly distinguished from more dangerous drugs. In particular, current levels of marijuana use are more likely to be reduced through education and persuasion than appears likely for other illicit drugs. Marijuana is already widely used and therefore less exotic than other drugs. Therefore there is less risk that discussion in school will create an awareness and curiosity that would otherwise have been absent. By the same token, the target efficiency of the messages – the probability that any given recipient would have seriously considered using the drug now or in the future – is higher for marijuana than any other illicit substance. Benefits of carefully developed education to discourage marijuana misuse seem to outweigh risks."*<sup>296</sup>

*During its investigations, Council was made aware that some Victorians may experience significant problems as a consequence of cannabis abuse. Development of a trial treatment service for cannabis users is recommended in Chapter 4. Provision of information and support*

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<sup>291</sup> Evidence to the Committee by David Ryder, Chairman WANADA, 8 October 1997, 40.

<sup>292</sup> Recommendation 7.1.

<sup>293</sup> Recommendation 7.2.

<sup>294</sup> Clayton RR, Voss HL. *Young men and drugs in Manhattan: a casual analysis*. Rockville, Maryland, National Institute of Drug Abuse, 1981.

<sup>295</sup> Kleiman MA. *Against excess*. NY, Basic Books, 1992.

<sup>296</sup> Ibid.

for parents responding to their children's marijuana use was also raised as a significant issue."<sup>297</sup>

## 6.9. Legal options

### 6.9.1. Introduction

Cannabis has not been legalised in any jurisdiction in Australia. In three jurisdictions (the Australian Capital Territory, the Northern Territory and South Australia) the possession of small quantities of cannabis is not a criminal offence if offenders pay a prescribed monetary penalty. This penalty is like a traffic infringement notice and avoids the stigma of appearance in court and a criminal conviction. If the infringement notice is not paid, this results in a court appearance and the strong likelihood of conviction.

The impact of the introduction of civil penalties for minor cannabis offences will be considered in a comprehensive evaluation of the South Australian Cannabis Expiation Notice (CEN) scheme. This is expected to be released later this year.

However, problems of comparisons between the schemes adopted in different jurisdictions exist as civil penalty options have been implemented in different ways, and good trend data are often lacking from the period before and after legislative changes have been implemented.

The term “decriminalisation” is commonly used to refer to schemes which provide for monetary sanctions for the possession and cultivation of small amounts of cannabis without a person receiving a conviction. These schemes still bring a person into contact with the criminal justice system, as they may be taken to a police station or, if a notice is not paid on time, be required to appear in court. However, as the possession or cultivation of marijuana is still illegal, it has been suggested that a more appropriate term is “prohibition with civil penalties”.<sup>298</sup>

### 6.9.2. South Australian scheme

The CEN scheme came into effect in South Australia on 30 April 1987, following amendment to the South Australian *Controlled Substances Act 1984*.<sup>299</sup> The CEN provides that where adults come to the attention of the police for a “simple cannabis offence”, they have the option of issuing the offender with an expiation notice.

Offenders issued with such a notice were not prosecuted if they paid a specified fee within 60 days of the notice being issued. If a person failed to pay the fee within the 60 day period, then he or she could be prosecuted, with the attendant possibility of conviction.

While it is beyond the scope of this brief overview to provide a more detailed analysis of the CEN, it is useful to refer to some observations made on the relatively low rate of payment of expiation and the effect of the scheme on policing practices.

*“The introduction of the Cannabis Expiation Notice (CEN) scheme in 1987 appears to have had a substantial netwidening effect; that is, there has been a significant increase since the scheme commenced in the total number of cannabis offences detected by police. At the same time, the National Drug Strategy drug use surveys show that use of cannabis in the community has increased only slightly, and at a rate similar to the other States. It is most likely that significantly increased detection of cannabis offences is a result of changes in police behaviour, rather than it being a reflection of greater use of cannabis within the community.*”

<sup>297</sup> Victoria, Premier's Drug Advisory Council. *Drugs and our community: report of the Premier's Drug Advisory Council*. Melbourne, Victorian Government, 1996, 75.

<sup>298</sup> McDonald D, Moore R, Norberry J, Wardlaw G, Ballenden N. *Legislative options for cannabis in Australia*. Canberra, Australian Government Publishing Service, 1994.

<sup>299</sup> s. 45A

## Select Committee Into Misuse of Drugs Act 1981

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*Only about 45 per cent of CENs are paid. It is possible that inability to pay is one factor in the expiation rate not being higher.”<sup>300</sup>*

A recent reform to the legislation has resulted in some changes in how expiable offences, such as cannabis offences, are dealt with in South Australia. These changes came into effect in 1996 and mean that offenders have a range of options for payment of the expiation fee, such as by instalment or by community service. As a result of the reforms, if the total amount of the expiation fee is \$50 or less, offenders now have 30 days to pay. However, if the amount is more than \$50, offenders have 60 days to pay.

Under the original legislation, if an offender wished to contest a matter it was necessary for them to let payment of the expiation fee lapse, so that they could then be summonsed and appear in court. However, under the 1996 reforms, the expiation form provides offenders with the option of prosecution, so that they may have the offence determined by a court. The current level of fees are outlined in Table 6.15.

**Table 6.15: Schedule of fees of expiable offences, South Australia**

Offence	Fee
<b>Possession of cannabis</b>	
less than 25 g	\$50
25 g or more but less than 100 g	\$100
<b>Possession of cannabis resin</b>	
less than 25 g	\$50
5 g or more but less than 20 g	\$150
<b>Smoking or consumption of cannabis or cannabis resin in a private place</b>	\$50
<b>Possession of equipment for smoking or consumption of cannabis or cannabis resin, whether in public or private</b>	
if in connection with one of the above offences	\$10
otherwise	\$50
<b>Cultivation of cannabis plants</b>	
10 plants or fewer (provided for grower's own use and not for sale or supply)	\$150

### 6.9.3. Australian Capital Territory scheme

The scheme in the ACT has operated since 1993 as a result of amendment of the ACT *Drugs of Dependence Act 1989*.<sup>301</sup> The scheme applies to both adults and juveniles and provides police with the option of serving a person with a Simple Cannabis Offence Notice (SCON) where the police officer reasonably believes that the person has committed a simple cannabis offence.

A simple cannabis offence is where the person has cultivated or participated in the cultivation of not more than five cannabis plants, or where the person possessed not more than 25 grams of cannabis. If the offender pays the SCON penalty of \$100 within 60 days, no further action is taken and accordingly a conviction will not be recorded.

### 6.9.4. Northern Territory scheme

In the Northern Territory, an infringement notice scheme has operated since 1 July 1996, as a consequence of amendment of the NT *Misuse of Drugs Act*.<sup>302</sup> Police may issue infringement

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<sup>300</sup> Atkinson L, McDonald D. *Cannabis, the law and social impacts in Australia*. Australian Institute of Criminology Trends and Issues in Crime and Criminal Justice. No 48, 1995.

<sup>301</sup> Drugs of Dependence Act 171A.

<sup>302</sup> Misuse of Drugs Act Part IIB.

notices with respect to the *cultivation* of cannabis plants, if the number of plants involved is not more than two. With respect to *possession* of cannabis, Schedule 3 of the Act provides for differing quantities of types of cannabis which determine whether an infringement notice may be issued (Table 6.16). The penalty for the expiation of an infringement notice is \$200.<sup>303</sup> If the notice is not paid, the offender is taken to court and prosecuted for the actual offence.

**Table 6.16: Threshold quantities (grams) of cannabis for NT infringement notice**

Drug	Amount (grams)
Cannabis oil	1.0
Cannabis plant material	50.0
Cannabis resin	10.0
Cannabis seed	10.0

Note: Cannabis plant material includes the flowering, fruiting tops, leaves, stalks and seeds.

### 6.9.5. Other schemes

The Victorian Cannabis Cautioning Program Pilot (CCPP) was conducted in the Melbourne Police District I (Broadmeadows) and ran for a period of six months (from 21 July 1997 to 21 January 1998). A description of the pilot, the Executive Summary and the seven recommendations of the evaluation are contained in Appendix 5. A more detailed discussion of the Victorian CCPP follows later in this chapter.

The Tasmanian Government announced in early July 1998 that a 12 month trial cannabis cautioning scheme, modelled on the Victorian scheme, would commence in that State on 13 July 1998.<sup>304</sup>

## 6.10. Impact of decriminalisation

### 6.10.1. Introduction

An overview of experience in the United States indicates that states which introduced systems for civil penalties for cannabis use may not have differed from other states in their patterns or trends in cannabis use. Similarly in the Netherlands (where personal cannabis use is dealt with via an administrative ‘expediency principle’, and such use is generally permitted to go unpenalised) there does not appear to have been any major changes in the prevalence of cannabis since the policy of ‘de facto’ decriminalisation was introduced in 1976.<sup>305</sup> In other countries, there has been little association between legal rules and patterns of cannabis use.<sup>306</sup>

It has been found that decriminalisation of cannabis laws has had significant economic advantages in terms of law enforcement costs. The budgetary impact of the introduction of civil penalties in the 1970s in a number of American States was referred to in a report prepared for the National Task Force on Cannabis.

*“In California it was estimated that in the decade following the Moscone Act of 1976, which made possession of an ounce or less of cannabis a citable misdemeanour instead of a felony, the State saved a minimum of one billion dollars.”<sup>307</sup>*

<sup>303</sup> Misuse of Drugs Act 20D.

<sup>304</sup> “Cannabis cautions in Tasmania.” *The West Australian* 9 July 1998, 40.

<sup>305</sup> National Drug Strategy. *Report of the National Task Force on Cannabis*. Canberra, Australian Government Publishing Service, 1994.

<sup>306</sup> Reuband KH. “Drug use and drug policy in Western Europe.” (1995) 1 *European Drug Addiction* 32-41.

<sup>307</sup> McDonald D, Moore R, Norberry J, Wardlaw G, Ballenden N. *Legislative options for cannabis in Australia*. Canberra, Australian Government Publishing Service, 1994, 53.

## 6.10.2. Australian experience

In South Australia, where the decriminalisation of simple cannabis offences was introduced in 1987, there are today lower levels of cannabis use than in Western Australia, where cannabis has been consistently illegal. In the Australian Capital Territory, where cannabis was decriminalised in 1993, the position is less clear, with the prevalence of those who have used in the past 12 months being similar to the rate in WA (Table 6.17).

A study has been conducted, in conjunction with Phase 2 of the research into the social impacts of the Cannabis Expiation Notice scheme in South Australia, into whether patterns of cannabis use have been affected by decriminalisation.<sup>308</sup> Longitudinal data based on NDS Household Surveys covering the period from 1985 to 1995 provides comparisons between those jurisdictions where cannabis use was not decriminalised (Tasmania, Victoria, WA, Queensland and the Northern Territory) and those jurisdictions where there was prohibition with civil penalties applied (South Australia and the ACT).

The research by Donnelly et al concluded that while the increase in lifetime cannabis prevalence in South Australia over the period 1985 to 1995 was significantly greater than the rest of Australia, over the same period of time there were also significant increases in the rates of change in lifetime cannabis use in those States which had not decriminalised (Table 6.18). At the 5% level of significance, the rate of change in South Australia did not differ from the rate of change recorded in Tasmania or Victoria.

Due to limitations in detail collected in the NDS Household Surveys, weekly cannabis use is only available for the period 1988 to 1995 (Table 6.19). In relation to this measure of prevalence, it was noted that there was

*“a near statistically significant interaction between jurisdiction and survey in the logistic regression analysis that compared rates of change in weekly cannabis use in South Australia with those in the rest of Australia. This was probably due to a marked increase in rates of weekly cannabis use in South Australia between 1988 and 1991.”*<sup>309</sup>

The trends in weekly cannabis use indicate there is a statistically significant difference between rates of change in Tasmania ( $p=0.02$ ) and Western Australia ( $p=0.055$ ) compared to South Australia over the period 1991 to 1995. This means that the rates of change in weekly use were greater in Tasmania and Western Australia than occurred in South Australia, whereas in other jurisdictions this change was not at the statistically significant level.

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<sup>308</sup> Donnelly N, Hall W, Christie P. *Effects of the CEN scheme on levels and patterns of cannabis use in South Australia: evidence from the National Drug Strategy Household Surveys 1985-1995*. Sydney, National Drug and Alcohol Research Centre, University of New South Wales and Drug and Alcohol Services Council, South Australia, 1998.

<sup>309</sup> Ibid 7.

**Table 6.17: Cannabis use in different parts of Australia, 1995**

Part of Australia	Proportion who have ever tried cannabis	Proportion who have used cannabis in the past 12 months
<b>Areas where personal use of cannabis is not a criminal offence</b>	<b>34%</b>	<b>12%</b>
South Australia (n=600)	32%	12%
Australian Capital Territory (n=500)	42%	16%
<b>Areas where personal use of cannabis is a criminal offence</b>	<b>30%</b>	<b>13%</b>
New South Wales (n=600)	30%	13%
Victoria (n=600)	31%	13%
Queensland (n=500)	26%	10%
Western Australia (n=500)	37%	16%
Tasmania (n=300)	30%	13%
Northern Territory (n=250)	52%	21%

Source: Commonwealth Department of Health and Human Services. *National Drug Strategy Household Survey Survey Report 1995*. Canberra, Australian Government Publishing Service, 1996.

**Table 6.18: Adjusted ever use (%) of cannabis by jurisdiction, 1985 - 1995**

	1985	1988	1991	1993	1995	Linear trend
South Australia	25.7	24.5	31.5	37.4	36.3	***
Tasmania	21.1	-	23.6	30.2	32.9	***
Victoria	26.4	23.1	28.2	31.2	32.0	***
New South Wales	25.6	29.7	31.5	33.0	33.0	**
Western Australia	31.9	34.7	36.0	36.6	37.0	*
Queensland	26.6	24.0	27.0	30.5	29.5	*
Australian Capital Territory	35.0	-	41.3	42.5	39.1	ns
Northern Territory	44.1	-	47.2	49.8	52.1	ns

Note: \*\*\* p<0.001, \*\* p<0.01, \* p<0.05, ns not significant

Source: Social Impacts of the cannabis expiation notice scheme in South Australia. Phase 2 research, Working paper No. 5, Table 1.

**Table 6.19: Adjusted weekly use (%) of cannabis within each jurisdiction, 1988 - 1995**

	1988	1991	1993	1995	Overall Chi (p)
South Australia	2.9	7.0	6.5	4.9	0.08
Tasmania	-	1.6	5.3	6.8	0.02
Victoria	3.7	3.1	3.5	3.5	0.95
New South Wales	4.3	4.5	3.7	4.3	0.9
Western Australia	8.0	6.5	4.7	8.9	0.055
Queensland	2.5	3.6	3.4	4.1	0.6
Australian Capital Territory	-	3.7	6.2	3.2	0.12
Northern Territory	-	10.4	9.0	10.5	0.8

Source: Social Impacts of the cannabis expiation notice scheme in South Australia. Phase 2 research, Working paper No. 5, Table 2.

### 6.10.3. Effect on policing

As indicated in the Interim Report, the *Misuse of Drugs Act 1981* contains comparatively serious penalties for less serious offences, such as possession or use, or possession of smoking implements. For instance, most simple offences have a fine of up to \$3,000, imprisonment for up to 3 years or both. There are lower penalty thresholds with fines of up to \$2,000 or imprisonment up to 2 years or both for the following offences:

- being at premises where cannabis is being smoked;
- having possession or use of less than 100 grams of cannabis leaf material;
- having less than 80 cigarettes containing any amount of cannabis; or
- having possession or cultivation of less than 25 cannabis plants.

However, the general tariff or average penalty for a first time offender convicted of simple possession (cannabis or utensil with detectable traces thereof) is a fine ranging from \$100 to \$150. It is noted that the *Misuse of Drugs Act 1981* also provides that the possession of less than 25 grams of cannabis resin is a simple offence.

It is possible that police officers may at times find it difficult to enforce the law with respect to simple offences involving cannabis, because by prosecuting a person there is the possibility of the stigma of a conviction and other possible ramifications (including lower employment prospects and disruption of family relationships). It is argued that these outcomes may be disproportionate to the apparent harms (including health) that may arise with respect to a simple cannabis offence, with a concomitant possible loss of respect by offenders for the law itself and disillusionment by police.

The Australian Illicit Drug Report 1996-97 has raised the issue of police resources being wasted in pursuing the less serious cannabis offences, when such resources could be targeted at serious drug offences. As noted above, cannabis offences (including those of simple possession ranging to commercial dealing/cultivation) make up about eight out of every 10 drug offences.

*“This absorbed a significant proportion of resources dedicated to drug law enforcement. In addition, compared to most other illicit drug use, there appears to be a comparatively low rate of associated crime and harm to both individuals and the community. The decriminalisation of personal cannabis use and production may greatly reduce both police and legal resource expenditure.”<sup>310</sup>*

If the desirability of a reduction in police and legal resource expenditure were the *sole* objective in any law reform of this area of criminal law, the arguments supporting further liberalisation of cannabis laws would be overwhelming. However, there are other objectives which are of equal importance, such as minimising the irrefutable medical and psychological health harms associated with the consumption of cannabis. There are also concerns that further liberalisation of cannabis laws may have a prejudicial impact on educating the broader community about the danger of these harms.

On the other hand, given the widespread use of cannabis despite its illegality, there is a tendency to bring the law into disrepute in those jurisdictions where the law criminalises simple offences. It is arguable that the law should reflect community values and practices.

The Select Committee believes that the concerns relating to the large amount of police and court resources involved in dealing with those who commit minor cannabis offences cannot be totally overlooked. There is a need for the police to be encouraged to adopt a more flexible approach when they apprehend those who have committed a non serious cannabis offence. As police work may require officers to exercise discretion when they deal with a wide range of antisocial behaviour, this gives them some flexibility in applying the law on a day to day basis.

### 6.10.4. Community attitudes

#### 6.10.4.1. National surveys

A series of public opinion polls in Australia since 1977 have asked questions about the legal status of cannabis. The Morgan Gallup polls have been the source of the most consistent data, as they

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<sup>310</sup> Australian Bureau of Criminal Intelligence. *Australian illicit drug report 1996-97*. Canberra, Australian Bureau of Criminal Intelligence, 1997, 26.

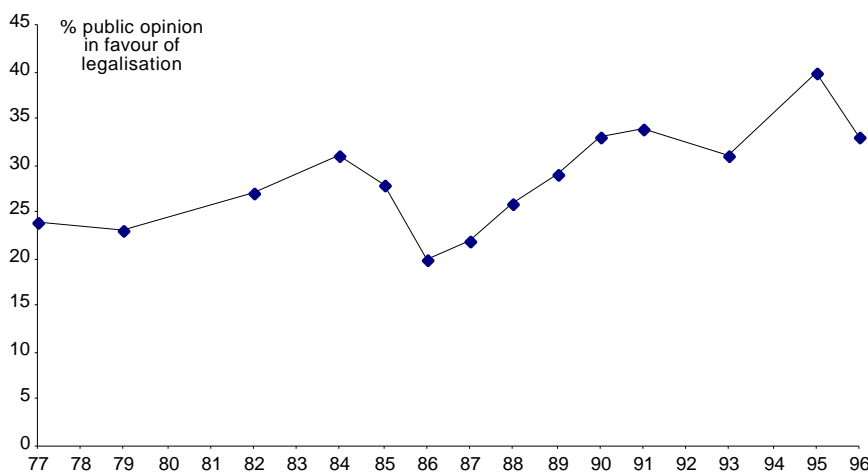
have sampled this issue on a number of occasions over the past two decades. The results of the Morgan Gallup poll plus the results from the NDS Household Surveys, the National Social Science Surveys (in 1984-85 and 1986-87), and the 1987, 1990 and 1993 Australian Election Study surveys have been combined in a recent publication.<sup>311</sup>

These data are reproduced in Figure 6.11 and suggest two broad peaks of support for legalisation of cannabis. The first peak occurred in the mid 1980s, when about three out of every 10 supported change, and again in the mid 1990s, when one in three were in favour. There was a major decline in support in the mid 1980s. The recent relative decline in support (from 40% in 1995 to 33% in 1996) does not enable conclusions to be made at this stage as to whether this drop was a temporary fluctuation in an upward trend, or the commencement of another decline in support.

A recent key report has considered trends in public opinion and provides a helpful summary of the major factors which research has identified as determining community attitude on drug related issues. The report concluded that on the basis of the results from the five NDS Household Surveys (1985, 1988, 1991, 1993 and 1995)

*“there is a large and stable majority opposed to the legalisation of marijuana. Although the trends in opinions over the past decade suggest that there has been a gradual increase in support for reform, the surveys also show that the majority who oppose such a change hold their opinion more strongly than the minority who support such change.”<sup>312</sup>*

**Figure 6.11: Trends in public opinion towards legalising cannabis in Australia, 1977 - 1996**



NDS Household Surveys have considered this issue. Given the survey collects demographic data, it is possible to identify factors which determine public opinion on the legal status of cannabis. One area of interest is generational differences towards decriminalisation of cannabis laws.

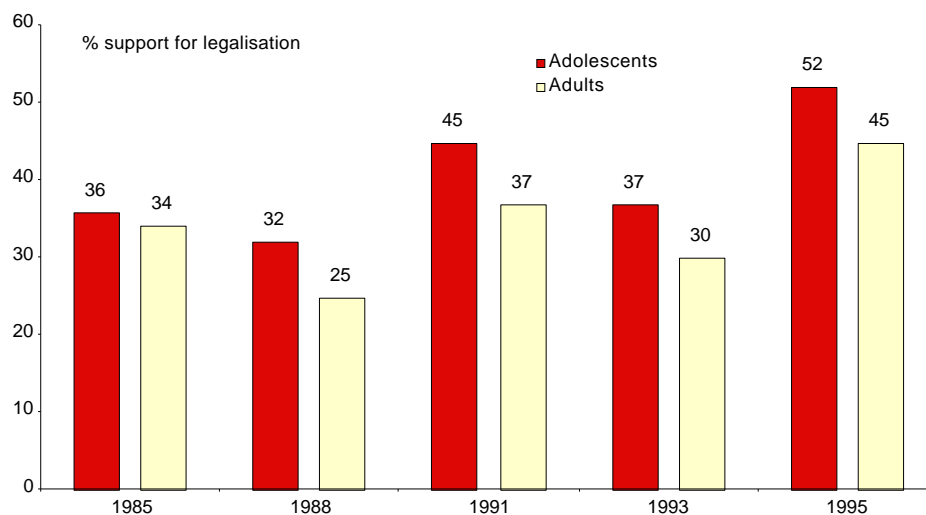
There is a similar pattern of support among adolescents (as with adults) in support of decriminalisation of the law on cannabis use. Based on the five NDS surveys, about 40% of adolescents and 34% of adults support decriminalisation. The gap between adolescent and adult

<sup>311</sup> Makkai T, McAllister I. *Marijuana in Australia: patterns and attitudes*. Canberra, Commonwealth Department of Health and Family Services, 1997, 83.

<sup>312</sup> Makkai T, McAllister I. *Public opinion towards drug policies in Australia 1985-95*. Canberra, Commonwealth Department of Health and Family Services, 1998, 30.

support on this issue has been between 7 and 8% (except for the 1985 survey, when there was only a 2% difference) (Figure 6.12).

**Figure 6.12: Trends in public opinion towards legalising cannabis in NDS Household Surveys, Australia, 1985 - 1995**



### 6.10.4.2. WA surveys

A telephone survey was undertaken in this State in December 1993, canvassing the knowledge and attitudes of 400 West Australians aged 17 years and older.<sup>313</sup> The survey dealt with two possible strategies to reduce the harm associated with illicit drug use:

- the provision of needles and syringes; and
- the possibility of changing the laws in relation to cannabis.

A total of 244 (61%) respondents were from the metropolitan area, with 156 (39%) from Geraldton and Bunbury. There were a number of findings in relation to the issue of cannabis decriminalisation. Over a third (36.7%) believed cannabis should be made as legal as alcohol; 53.2% believed it should not. The survey found attitudes to decriminalisation were not affected by right or left wing affiliation and that majority support for cannabis decriminalisation existed across the political spectrum. The survey posed two scenarios about decriminalisation of possession and use of small amounts of cannabis for personal use.

In the first scenario, respondents were asked “*Do you believe that the possession of small amounts of cannabis for personal use should remain a criminal offence in WA. That is, result in a criminal record and possibly a jail sentence if convicted?*”

In the second scenario, respondents were asked “*Penalties for people charged with possession of small amounts of cannabis for personal use should be like those for speeding in a motor vehicle, they should get a fine but not a criminal record*”.

In the first scenario, the criminal penalties were described but those associated with decriminalisation were not described. In the second scenario, likely non criminal penalties were

<sup>313</sup> Lenton S. *Illicit drug use, harm reduction and the community: attitudes to cannabis law and needle and syringe provision in Western Australia*. Perth, National Centre for Research into the Prevention of Drug Abuse, Curtin University of Technology, 1994.

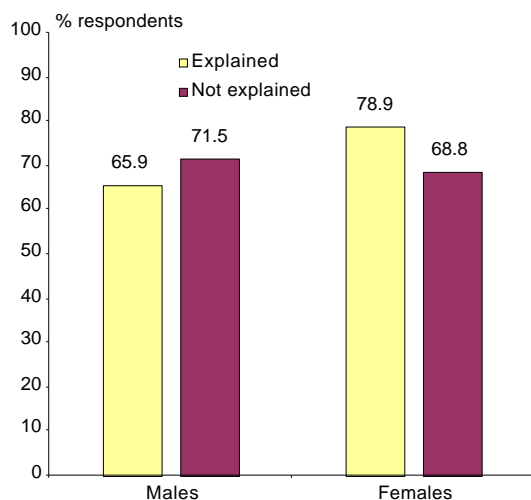
described. When possible penalties were *not* described, 64% of respondents were in favour of decriminalisation. Where penalties were described, support for decriminalisation increased to 71.5% of respondents. Females were significantly more in favour of decriminalisation than males when the term was explained (Figure 6.13).

In relation to age, the highest level of support for decriminalisation whether the term was explained or not was recorded for the 20 to 29 age group (Figure 6.14).<sup>314</sup> Of interest it was also noted that the majority of respondents believed that most cannabis users did not experience problems.

*“Just under two thirds (63.0%) of respondents believed that many people in our community use cannabis without experiencing serious problems due to its use, and a similar proportion (63.3%) believed that the court system is overburdened by minor cannabis offences. Forty four percent of the sample believed it would be a bad thing for our community if people were legally able to grow small amounts of cannabis for their personal use, while 50.7% did not.”<sup>315</sup>*

It is unclear whether there has been a change in the level of community support for the propositions considered since the December 1993 survey. It is to be noted that the national data referred to earlier in this chapter would indicate that about 35% of the Australian public favoured legalisation, a lower level of support than found in the Lenton survey. While there may have been a recent drop in support for legalisation (as indicated earlier), it is possible there is a higher level of support in this State compared to the whole of Australia.

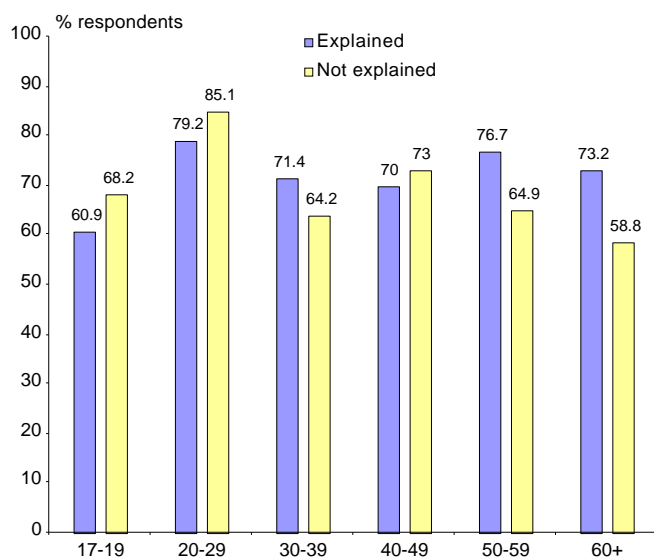
**Figure 6.13: Respondents (%) in favour of cannabis decriminalisation by gender and whether decriminalisation explained, WA, December 1993**



<sup>314</sup> See text of report for more details of significance of differences between age groups.

<sup>315</sup> Ibid, vii.

Figure 6.14: Respondents (%) in favour of cannabis decriminalisation by age group and whether decriminalisation explained, WA, December 1993



## 6.11. Cannabis cautioning schemes

### 6.11.1. Victorian cannabis cautioning program pilot

During its visit to Victoria, the Select Committee met with a number of Victorian police officers and obtained details about that State's cannabis cautioning program pilot (CCPP) scheme. The pilot was conducted in 'I' police district (in Broadmeadows area of Melbourne), over a six month period, from 21 July 1997 to 21 January 1998.

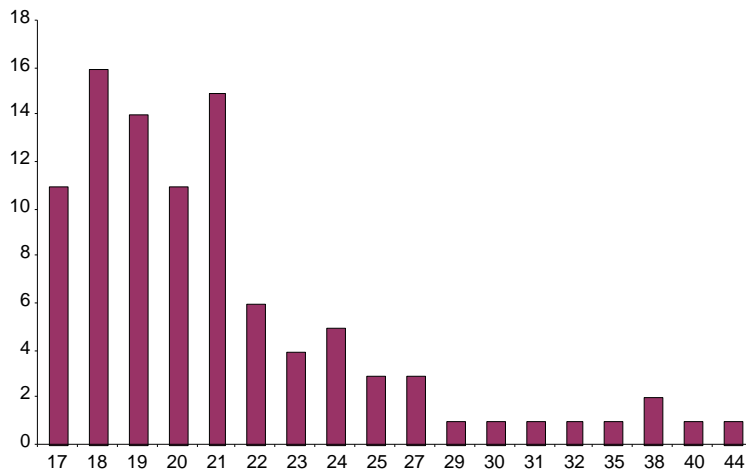
The Victorian scheme required a police officer to satisfy a number of criteria before the officer may issue a caution instead of charging a person with a cannabis offence. It is noted that if an offender has had prior cautions or offences this does not necessarily preclude an offender being cautioned, unless such prior convictions relate to drug offences. These criteria are as follows:

- verification of the identity of offender;
- the person must be 18 years of age or older;
- there must be sufficient admissible evidence that the offender is using or in possession of a small quantity of cannabis;
- the person must not have been involved in any other criminal or traffic offence at the same time;
- the cannabis must have been only for personal use;
- the quantity of cannabis involved must not exceed 50 grams;
- the type of cannabis may only involve dried leaf, stem, stalks and seeds, not hash, hash oil or a cannabis plant;
- the person must admit offence;
- the person must consent to caution;
- the person must not be cautioned for cannabis on more than two separate occasions; and
- the person must sign the 'cannabis receipt' section of the 'Cannabis Caution Notice' form and audit bag.

**Results of pilot scheme**

Cautions were issued to a total of 97 individuals, the mean age of whom was 21.6 years. Of these 97 individuals, 90 (93%) were male and 7 (7%) were female. It is to be noted that nearly 70% of those cautioned were aged between 17 and 21 years of age (Figure 6.15).<sup>316</sup> More than half, 55 (57%), of those cautioned had no prior offence record.<sup>317</sup>

**Figure 6.15: Age distribution of those cautioned during Victorian cannabis cautioning program pilot, July 1997 – January 1998**



It is believed that the CCPP was an initiative specifically targeted at first time offenders in Police District I, as it had “the highest percentage of first time offenders charged for the use and/or possession of cannabis offences”.<sup>318</sup> It is possible that the police in District I were more active in prosecuting drug offenders, or that the demographic characteristics of this region meant there were greater numbers of those involved in cannabis use than in other Victorian police districts.

Therefore, with the extension of cannabis cautioning throughout Victoria from 1 September 1998, there are likely to be lower proportions of first time offenders who will be dealt with under the scheme. If this were to be the case, the high level of apparent public support for cannabis cautioning in Victoria may to some extent be eroded. While this issue is not dealt with in the report, there is reference at a number of places of the need to develop a policing approach that is consistent with harm minimisation.

*“Extending the practice of cautioning to adult offenders detected for the use and/or possession of cannabis provides the balance between enforcing the law whilst at the same time addressing issues of harm minimisation. This is achieved by providing the offender with information and advice about the legal consequences and adverse health effects associated with cannabis use.”<sup>319</sup>*

Under the revised protocol for a statewide cannabis cautioning scheme (to operate in Victoria from 1 September 1998), the option for police to issue a cannabis caution is removed if at the time of the caution there is another “drug related offence involved or detected,”<sup>320</sup> or if the

<sup>316</sup> Victorian Police Service, Strategic Development Department. *Cannabis cautioning program pilot*. Victoria, Victorian Police Service, 1998, Table G 28, G-65.

<sup>317</sup> Ibid G-59

<sup>318</sup> Ibid 15.

<sup>319</sup> Ibid 32.

<sup>320</sup> Ibid 6.

## Select Committee Into Misuse of Drugs Act 1981

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person has been cautioned for a cannabis offence in Victoria on more than one prior occasion. The statewide scheme retains the same threshold of 50 grams of cannabis, which is defined as being a “small” quantity only for personal use.<sup>321</sup>

It is not clear what meaning will be given to an offence being “drug related”. For instance, would an offender be eligible if he or she had been apprehended for stealing, so long as the purpose of the robbery was not to obtain income to purchase drugs as the person was heroin dependent?

Thus, it would appear under the Victorian scheme that an individual can have numerous convictions for prior offences, so long as he or she has only been cautioned once and still be eligible for cautioning. It is debatable whether the intended benefit of the cautioning scheme to increase awareness of the health and legal risks of the use of cannabis will be effective with respect to those who are older, used cannabis for a longer period of time and have had extensive contact with law.

The evaluation of the CCPP was finalised in May 1998. Unfortunately it does not provide any data about the possible long term effects of the scheme. The major reason the Victorian Police Service agreed to mount the CCPP (as evidenced by the stated objects of the scheme) was to demonstrate cost savings in police time and other associated law enforcement costs. Data from police who were surveyed on this point indicated that

*“(n)inety seven per cent (97%) of members consulted reported that time savings resulted from the CCPP. Thirty two respondents (73%) who had issued cautions were of the view that cautioning saved at least one hour of police time as compared with the previous method of prosecuting the offender. This represents a significant saving of police time.”<sup>322</sup>*

It is important that longer term outcomes of cannabis cautioning are properly identified, as savings in police time are only one facet of the overall impact of a change in the way the law on cannabis is administered. For instance, it would be important to determine what changes occurred in cannabis use by cautioned offenders, given that the underlying position is that cannabis is a prohibited drug. The rationale to caution in the first place is to provide the offender with an opportunity to appreciate the potential legal and social harms to him or herself if he or she had been convicted.

Under the CCPP there is reference that the quantity of cannabis that is involved shall be a “small” quantity (ie less than 50 grams). As pointed out in the report, this threshold is determined by the amount of 50 grams as stipulated in Schedule 11 of the Victorian *Drugs Poisons and Controlled Substances Act 1981*<sup>323</sup> (compared with 25 grams in the WA *Misuse of Drugs Act 1981*). The evaluation found that half of those cautioned had possession of amounts of one gram or less of cannabis, and that 82% of cautions involved amounts of five grams or less of cannabis.<sup>324</sup>

The use of the term ‘small’ does give a signal to offenders that their offence is not at the serious level of offending. This term may be useful to the police, as it also supports the public perception that police want to differentiate between different types of offenders. *“What we are trying to do is to move all of our attention up to the middle and upper levels of the drug trafficking arena”.*<sup>325</sup> It is suggested that this term may be misinterpreted and could be seen as implying that cannabis use is not a serious issue. A more appropriate term would be to refer to such quantities of cannabis as ‘personal use quantities’.

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<sup>321</sup> The criteria for the CCPP are contained in Appendix 5.

<sup>322</sup> Victorian Police Service, Strategic Development Department. *Cannabis cautioning program pilot*. Victoria, Victorian Police Service, 1998, 29.

<sup>323</sup> Ibid 8.

<sup>324</sup> Ibid 4.

<sup>325</sup> Ibid 21.

The Select Committee agrees that the report does indicate substantial resource savings associated with the CCPP. The evaluation reports substantial resource savings associated with the CCPP and that the Victorian Police Service generally support the scheme, as it relieves them of the resource intensive issues of processing people who they would have otherwise charged with an offence. It gives the possibility that police will be able to devote greater attention to more serious drug problems, especially in relation to heroin and amphetamines, which occupy a greater level of community concern as their use is known to be responsible for a significant amount of crime.

It is noted that the Victorian police are to undertake a 6 month Drug Diversion Pilot, commencing 1 September 1998, in Police District I. This is targeted at first time offenders with small non traffickable amounts of drugs other than cannabis, such as heroin and amphetamines.<sup>326</sup> The drug diversion pilot will involve mandatory attendance at a drug treatment service as a condition of police issuing a caution.<sup>327</sup>

### 6.11.2. WA cannabis strategy

#### 6.11.2.1. Introduction

The Select Committee is concerned that the Victorian CCPP does not fully address all the relevant issues such as health and educational consequences, especially in relation to young people.

A broad range of evidence regarding cannabis use was provided to the Select Committee. Given the prevalence data (especially in relation to young people presented earlier in this chapter, which indicates the extent of cannabis usage in our community), the Select Committee was in favour of the introduction of a cannabis cautioning scheme in this State. However, some members of the Select Committee were of the view that prevalence factors and police resource factors should not be the sole or primary factors in support of the trial or that the State's cannabis possession and consumption laws should be further liberalised.

It is the Select Committee's view that the merits of saving police and court resources should not be the *sole* desirable outcome for evaluating the trial cannabis cautioning scheme in WA. In the Select Committee's view, the trial scheme should be primarily offender focussed rather than police focussed.

#### 6.11.2.2. Advantages

During his appearance before the Select Committee, the WA Commissioner of Police, Mr R Falconer, reflected on the response of the WA Police Service to the Victorian cautioning scheme. His views on this issue (see below) would indicate a perception by police that there are advantages in terms of police resources and detrimental effects on people who may be needlessly taken before a court and possibly convicted for a simple cannabis offence.

*“But a helluva lot of kids who I have found with needles in their arms have said that they started out smoking grass. It was the gateway. Many books and articles have been written about cannabis being a gateway and about the effects of cannabis. I am not talking about people who smoke a joint occasionally, but people who are heavy smokers. We must be careful in policing – this is not a recent innovation – that we are not putting too many of our scarce resources and the court's time into a lower level cannabis prosecutions.*

*To that end, we are making inquiries about an experiment in Victoria which is not decriminalisation – that is a misnomer – but is about using discretion, which we use all the time and generally wisely, and having a formal cautioning system. The Victorian model is like*

<sup>326</sup> Toy MA. “Radical new drug program. First time cannabis users across Victoria will get a caution after a successful trial program.” *The Age* 7 July 1998; Brady N. “Agencies support new police approach. Welfare workers welcome moves to keep drug users out of the courts.” *The Age* 7 July 1998; Murdoch L. “Soaring drug use changes attitudes.” *The Age* 7 July 1998.

<sup>327</sup> Chief Commissioner Neil Comrie. *Media release: Drug cautioning program to be expanded.* 6 July 1998.

## Select Committee Into Misuse of Drugs Act 1981

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*our three strikes and you are out system. People will be given two cautions which will be recorded. If they come back for a third dose, they will get a brief and will go to court. The statistics show that a whole lot of people have a single cannabis bust, although some might have a second one. This system would give our people an effective and proper way of still dealing with the issue, but the person concerned would get a caution in the same way as we give traffic cautions and cautions to children who commit offences early in their life. It is not to say that it is still not an offence against the State or that it is not recorded, but it stops the person going through the court system and the police being tied up in the court system and correspondence, etc.”<sup>328</sup>*

The Select Committee believes there will be positive outcomes from the trial West Australian cautioning scheme on broadly similar lines to the Victorian approach, *if* the health and education factors could be effectively addressed at the time of the administration of the relevant caution. In summary, the benefits of a cautioning scheme for simple cannabis offences include:

- reduction of expenditure by the police and courts;
- minimisation of so called ‘conviction harm’;
- avoidance of the net widening effect of people being brought before the courts;
- no social or employment stigma of a criminal record; and
- provides the opportunity for those with problematic cannabis use to be identified and be given the option of treatment without the need of legal coercion.

### 6.11.2.3. Shortcomings

The adoption of a cautioning scheme would assist police to expand the application of the principles of harm minimisation which are now an integral part of policing in WA and other jurisdictions (as was outlined in chapter 3) if, once again, the health and education factors were appropriately addressed. However, it could be said that such a scheme could result in sending the wrong message to young cannabis users and may be seen to be trivialising the incontrovertible degree of harm associated with regular cannabis use.

Further, it could also be argued that the cautioning scheme does not address the desirability of severing ties between young people and drug dealers (particularly those who deal in more harmful drugs) because the scheme has no effect upon their ability to purchase cannabis from drug dealers. In short, the scheme does not apply to cannabis cultivation offences (unlike South Australia) and as such the full force of the criminal law can still be applied to young people who cultivate cannabis in small numbers for their own consumption.

It is strongly believed the effectiveness of the cautioning scheme must be linked to a comprehensive public education campaign which addresses the health, law and order concerns about cannabis use. The Select Committee is of the view that there has been a totally inadequate recognition in the broader community of the health, psychological and social risks that are associated with cannabis use and that this ignorance can greatly prejudice the health of young users.

We believe that the limited information about cannabis in existing health campaigns may have created an impression that it is not regarded as a drug which has risks, thereby tacitly supporting its use. The Select Committee received evidence from the Chairperson of the WA Network of Alcohol and other Drug Agencies, Mr David Ryder, on this point.

*“The message must be targeted and tailored to the audience. There is almost a view that there is a dichotomy between those who advocate stronger legislation and police powers versus the health sector. That is a mistaken view. The message should be given that cannabis is a drug like any other drug. It has its risks and it is not safe, but neither is alcohol, and certainly neither are cigarettes, yet they are the legal drugs that cause the major problems on virtually*

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<sup>328</sup> Evidence to Select Committee. Transcript 9 October 1997, 65.

any index. However, it is a pragmatic public health view that if people are going to use, fewer costs may be incurred by going along these lines. It is about getting the message right.”<sup>329</sup>

In summary, the shortcomings of a cautioning scheme for simple cannabis offences include:

- a statutory cautioning scheme already exists in this State for juvenile offenders under the *Young Offenders Act 1994*;
- warning notices about health effects on the back of the cautioning notice may be ineffective (for example, these may be ignored or difficult to read – similar to the anti smoking health warnings on cigarette packets or conditions on parking infringement notices);
- the cost and the responsibility for assessing and providing assistance to those who are cannabis dependent would need to be borne by relevant departments, treatment bodies or CDSTs;
- the message to the community about cannabis health harms may be blurred;
- some members of the community may be concerned that prevalence of use may increase;
- toleration of simple cannabis offences may make it difficult to enforce rules about cannabis use in prisons and custodial institutions;
- the possibility that prospective employers or overseas governments may seek full disclosure of previous cautions for cannabis use; and
- police/administration of justice cost/time savings are relatively easy to quantify, as opposed to the possible blurring of the impact of anti drug use education campaigns.

### 6.11.2.4. Conviction ‘harm’

One argument in support of liberalising the present cannabis related laws in WA is that a successful prosecution of a minor cannabis offence (eg possess/use or possession of utensils) may cause an offender (particularly young people) to suffer considerable harm or prejudice when seeking employment or travelling overseas to certain countries.

The Select Committee has received ample evidence to indicate that it is extremely unlikely for a young person with an otherwise unblemished record, facing a first, second or third conviction for a simple cannabis offence, to be imprisoned.<sup>330</sup> It was drawn to the Select Committee’s attention that in those instances where those charged with cannabis related offences appear before the courts there is a perception that there is a wide variation in sentences. This has the effect of sustaining the perception by those young people, for instance, who become involved with the criminal justice system in relation to cannabis offences that there is little coherence in the way the law is applied.

The *Spent Convictions Act 1988* does allow for certain offences, including simple cannabis offences, in certain circumstances to be ‘spent’. The same applies in respect of spent conviction orders made pursuant to section 39 of the *Sentencing Act 1995*. Sections 18 to 29 of the *Spent Conviction Act 1988* prohibit various forms of discrimination against persons who have had certain offences declared spent, including discrimination in their current or prospective employment.

Subject to certain exceptions, lesser convictions as defined in section 10 of the *Spent Convictions Act 1988* (which may include spent convictions for simple cannabis offences) may be declared spent after 10 years. However, convictions declared spent under section 39 of the *Sentencing Act 1995* are spent immediately upon the spent conviction order being made by the convicting court.

The Select Committee is of the view that the 10 year prescribed period under the *Spent Convictions Act 1988* is too long, particularly for a young adult, and can possibly have the effect of prejudicing the broader rehabilitation of young offenders with simple cannabis convictions. A shorter period of five years, coupled with an appropriate associated non offending condition during the period, is an incentive for good behaviour and an opportunity to wipe the slate clean.

<sup>329</sup> Evidence to the Select Committee. Transcript 8 October 1997, 40.

<sup>330</sup> Simple offence refers to possession or use simpliciter of cannabis, or utensils with detectable traces of cannabis.

Such a reduction may in certain circumstances assist in negating the duration of the impact of the so called conviction harm.

### **6.11.2.5. Cautioning and education trial**

On 10 August 1998, the WA government announced a trial cannabis cautioning and education scheme (CCES). The trial is for a 12 month period commencing 1 October 1998 with a review after the first 6 months. This trial is to be conducted in two regions in the State:

- the Mirrabooka police district; and
- the Bunbury Police Service sub district.

The scheme will cover adults who have in their possession up to 50 grams of cannabis and who will receive a caution and avoid prosecution on condition of attending an education and intervention session. Those cautioned are required to attend an educational session to be conducted through existing Community Drug Service Teams within a two week period from the caution being issued.

As juveniles can presently be cautioned for simple cannabis offences, they will not be included in the trial. However, if the trial is extended, it is the Government's intention to extend it to juveniles as well as adults.

The issuing of a cautioning notice will *not* be available to those who:

- commit other cannabis offences such as possession of plants;
- have possession of cannabis derivatives (ie hashish or cannabis oil);
- have possession of a smoking implement; or
- commit a subsequent offence of possession of less than 50 grams of cannabis.

In conjunction with the trial CCES, the Government has announced the Marijuana Education Campaign as part of the *Drug Aware* program. The public education campaign has four components:

- prevention of cannabis use through advertisements in print and radio targeted at youth and their parents emphasising the various harms from cannabis use;
- encouragement for dependent cannabis users to quit through advertisements and information about the availability of community based treatment and support services;
- the distribution of a pamphlet available through general practitioners which outlines the harms of cannabis use; and
- mobilisation of community based organisations and Local Drug Action Groups against the harms of cannabis use.

The emphasis of the CCES is to reduce cannabis use by providing an opportunity through a caution and intervention to change the behaviour of those who use cannabis. Supporting information provided in the documentation released through WADASO, in conjunction with the launch of the scheme, outlines the context of the CCES.

*“Rates of cannabis use and comparisons with other States indicate that the criminal justice resources applied to simple cannabis offences, and the penalties imposed on individuals, are not contributing to the policy objective of discouraging cannabis use. Also, there is a substantial portion of the community which believes that convicted individuals, who are a very small proportion of those committing the same offence, suffer a penalty that by its imposition of a permanent criminal record, is disproportionate to the behaviour.”*

The approach of the CCES is derived from research in the addictions and medical fields where brief interventions, including motivational interviewing, have been shown to be effective in helping people change their drug use consumption and reduce associated problems. The

intervention is based on the assumption that most participants will not enter the session ready to change their pattern of cannabis use.

The standard format of the intervention is a one hour session with a subsequent telephone follow up consultation. The one hour session will include the provision to participants of factual information about the harms of cannabis, elicit their degree of willingness to change, an action plan to implement their decision to reduce cannabis use and identification of appropriate resources to sustain such changes.

It is not known at this time what fees, if any, may be charged by CDSTs for attendance at the educational intervention session.

***Finding 4***

***That the Select Committee endorses the Government announcement of a trial cannabis cautioning scheme in WA, particularly given its focus on health and education aspects of consumption of cannabis.***

***Recommendation 20***

***That the Government give consideration to amending section 39 of the Sentencing Act 1995 to provide upon conviction for a first simple cannabis offence that unless the court is convinced to the contrary, that a spent conviction be recorded.***

***Recommendation 21***

***That the Spent Convictions Act 1988 be amended to create a new category of lesser convictions solely relating to those convictions for offences relating to the possession and use of small quantities of cannabis (max. 50 grams) with the period of any non offending prior to having any such conviction capable of being declared spent be 5 years, and such declarations shall apply automatically, as a matter of law, without the need for the person concerned to make any written application in respect thereof.***

***Recommendation 22***

***That at the conclusion of the comprehensive media health campaign on cannabis targeted at the broader community, the WA Drug Abuse Strategy Office comprehensively assess its outcomes.***



# Chapter 7: Responding to other drugs

## 7.1. Introduction

Information provided in this chapter summarises the major health consequences<sup>331</sup> that may arise from the use of drugs from the following groups:

- psychostimulants;
- volatile substances;
- LSD and other hallucinogens;
- ecstasy and other designer drugs; and
- prescription drugs.

Health consequences from the use of some of these drugs may occur as an acute illness, be due to poisoning (ie ‘overdose’), or from dependence due to the use of a drug over a period of time. Acute psychiatric conditions, such as drug induced psychoses, may occur as a result of the abuse of some of these drugs. With respect to young people, it should be noted that as illicit drug use may be experimental or occurs on intermittent occasions, relatively few individuals may become dependent.

While it can be argued that some drug use is apparently harmless and causes little harm to the user, there are sound policy reasons to be especially concerned (from a public health perspective) about the use of a number of these illicit drugs. Two classes of drugs, opioids and psychostimulants are of particular concern as they are often injected. This means these two groups of drugs not only pose serious risks to users, but also to the wider community because of the high risk of the spread of blood borne viruses (BBVs) such as HIV, Hepatitis B (HBV) and Hepatitis C (HCV).

A more detailed discussion of current programs and other measures to reduce the transmission of BBVs amongst populations of injecting drug users (IDUs) is contained in chapter 8. As there are a number of complex treatment, public health and policy concerns in relation to the use of illicit opioids, relevant information about this group of drugs was dealt in chapter 5.

Other reasons for concern about drugs such as opioids and psychostimulants is that their use can lead to physical dependence with attendant neuroadaptation and increased tolerance. The abuse of psychostimulants, such as amphetamines and cocaine, has also been recognised as a major contributor to assaults and other forms of violence, and psychiatric illnesses, such as paranoid psychoses.

### 7.1.1. Indicators of abuse

Data are presented for each of these major groups of drugs to highlight priority areas and identify trends by using the following indicators:

- admissions to hospitals;<sup>332</sup>
- admissions to psychiatric hospitals;
- admissions to ADA treatment programs;
- mortality data based on cause of death;<sup>333</sup> and
- drug related telephone calls received by ADIS.

Where available, prevalence data will also be referred to, as this provides valuable information about patterns of self reported use involving particular age groups and can identify long term

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<sup>331</sup> A brief summary of major effects of these and other drugs is contained in Appendix 7.

<sup>332</sup> Including injuries, poisoning and suicide attempts.

<sup>333</sup> As determined by the Australian Bureau of Statistics according to ICD 9.

trends. As illicit drug use may involve surveys of relatively few individuals, prevalence data is subject to qualification due to issues of sampling error and reliability of estimates.

### **Hospitalisation data**

The hospitalisation data that will be used refers to conditions which are both *wholly* caused by drugs (such as non dependent abuse, dependence and poisoning) and *partially* attributable to drugs (such as illnesses and injuries). It should be noted that hospitalisation data does not measure drug related health events where the individual was only treated as an outpatient. Inpatient hospitalisation data is a particularly useful indicator of two broad types of drug related health events:

- acute problems such as overdoses; and
- chronic problems associated with long term drug abuse, which will involve those who have abused drugs over an extended period of time.

Hospitalisation data is routinely collected from all public and private hospitals in this State<sup>334</sup> under long standing administrative arrangements which are underpinned by legislative provisions as to privacy and confidentiality, from two sources:

- records of inpatient stays in private and public hospitals extracted from the Hospital Morbidity Data System (HMDS) which is maintained by the HDWA; and
- new admissions of inpatients to psychiatric units and hospitals recorded by the Mental Health Register.

It should be noted inpatient data provides an incomplete understanding of health problems that arise from drug abuse, as users of illicit drugs are often reluctant to seek treatment at a hospital due to a perception that they are difficult to manage and unmotivated to seek treatment.

In relation to mortality, the analysis in this chapter is concerned with only those deaths *wholly* attributable to drugs other than alcohol. The causes of deaths for which drugs are totally responsible include:

- poisoning (commonly referred to as “drug overdoses”); and
- mental disorders such as psychoses, drug dependence and nondependent abuse.

As there are a number of conditions for which drugs other than alcohol are a component cause of death, this analysis will slightly underestimate the total number of drug caused fatalities.<sup>335</sup>

## **7.1.2. Prevalence**

Prevalence data will be utilised to provide national and cross jurisdictional comparative data. It is necessary to refer to a number of recent State and national surveys to be able to develop a composite picture of prevalence in this State. At the State level, these surveys include the:

- WA Child Health Survey (WACHS) of young people, which was conducted in 1993;
- 1994 survey of metropolitan high school students; and
- 1997 Health Department survey of adult use of tobacco, alcohol and illicit drug consumption (TAIDCS).

The national surveys with a West Australian component which will be referred to are the:

- 1995 National Drug Strategy Household Survey (NDSHS); and

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<sup>334</sup> It should be noted as the Central Drug Unit is classified as a hospital, records of inpatient stays at the CDU are captured by the HMDS.

<sup>335</sup> The English and Holman methodology indicates that on average two deaths per year are partially caused from illicit drug abuse.

- 1996 Australian School Student's Alcohol and Drugs (ASSAD) Survey.

### **Reliability of data**

In a number of instances, sampling error would be too high because of small sample sizes at the jurisdiction level. Therefore, it is necessary to rely on national survey data to assist in developing a better understanding of longitudinal trends. At the State level, the most reliable prevalence data in relation to illicit drugs is for cannabis, as there are usually sufficient numbers of respondents in surveys. However, with respect to other illicit drugs, the small sample sizes mean that jurisdictional level data is often unreliable due to large standard errors.

There are also difficulties due to changes in definitions of drug use and wording of questionnaires over time. Accordingly, it may be difficult to compare results from different surveys. A comment in a recent report highlights the difficulty in surveying illicit drug use.

*“By its very nature being illegal, consumption of illicit drugs is difficult to measure. Notwithstanding the techniques used to elicit accurate information from study subjects (for example, sealed self completion questionnaire), the population who use illicit drugs, and particularly so for hard or injectable drugs, comprises in part, marginalised persons not readily identifiable, or unable or unwilling to participate. Accordingly, it is recognised that the prevalences revealed from national population surveys are likely to be underestimates of consumption rates”.*<sup>336</sup>

A more detailed analysis of prevalence concerned with opioids and the use of drugs by young people is contained in chapters 5 and 8, respectively.

## **7.2. Overview**

### **7.2.1. Introduction**

Between 1988 and 1995, the proportion of the Australian population which had used at least one illicit drug in the previous 12 months increased from approximately one in eight (11.5%) persons to slightly less than one in six persons (17.2%). This trend was largely due (but not limited) to the increased prevalence of cannabis consumption. Males were more likely than females to have used at least one illicit drug and consumption was concentrated in persons aged under 50 years (Table 7.1).

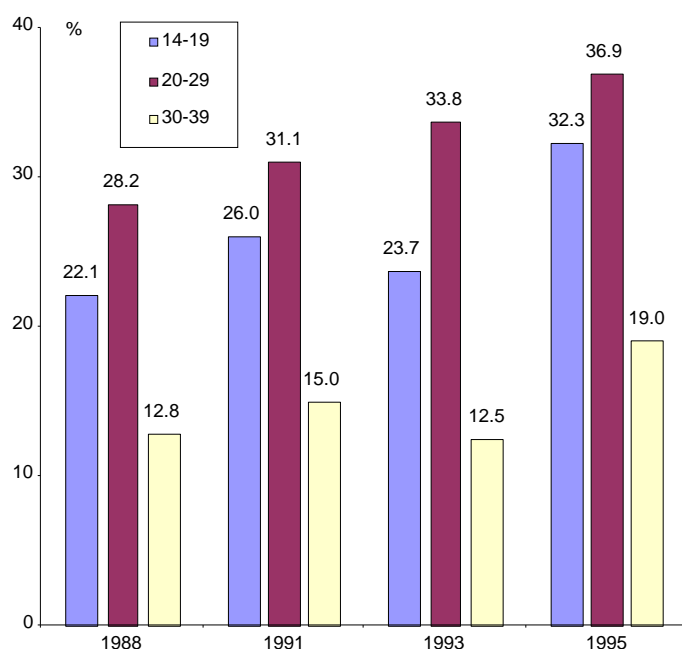
In 1995 approximately one in three (32.3%) persons aged 14 to 19 years had used at least one illicit drug (an increase from one in five persons in 1988). Over one in three persons (36.9%) aged 20 to 29 years (an increase from one in four persons in 1988), and one in five (19%) persons aged 30 to 39 years (an increase from one in eight persons in 1988), had used at least one illicit drug in the previous 12 months (Figure 7.1).

For older age groups, although at relatively low levels, prevalence of illicit drug use doubled in the same period. Overall, it is believed that similar patterns in the use of illicit drugs have occurred in WA. While detail is not available about the use of most illicit drugs, the section in this chapter which deals with cannabis contains more detailed prevalence data about this particular illicit drug.

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<sup>336</sup> Williams P. *Progress of the National Drug Strategy: key national indicators. Evaluation of the National Drug Strategy 1993-1997, statistical supplement.* Canberra, Department of Health & Family Services, 1997.

**Figure 7.1: Prevalence (%) of use of at least one illicit drug in the past 12 months by age group, Australia, 1988 – 1995**



**Table 7.1: Prevalence (%) of use of at least one illicit drug used in past 12 months by age group, Australia, 1988 – 1995**

Year	14-19	20-29	30-39	40-49	50-59	60+	Combined
<b>Males</b>							
1988	27.8	36.0	18.6	7.7	2.	0.4	15.0
1991	34.0	39.1	19.4	6.7	3.5	2.0	17.6
1993	25.0	43.5	13.4	8.2	1.0	0.6	16.9
1995	38.4	46.2	24.9	12.0	3.6	1.9	21.4
<b>Females</b>							
1988	15.7	20.6	7.7	3.5	1.0	0.5	7.9
1991	20.0	23.0	11.2	5.4	1.4	1.0	10.7
1993	22.6	23.5	11.6	2.6	0.6	-	10.1
1995	25.0	27.6	13.7	8.0	4.0	3.8	13.1
<b>Persons</b>							
1988	22.1	28.2	12.8	5.6	1.6	0.5	11.5
1991	26.0	31.1	15.0	6.0	2.4	1.5	14.2
1993	23.7	33.8	12.5	5.5	0.8	0.2	13.5
1995	32.3	36.9	19.0	10.1	3.8	2.9	17.2

Source: NDS Household Surveys.  
 Note: For 1993 age ranges = 14-19, 20-29, 30-39, 40-54, 55-69, 70+.  
 For 1991 the 14-19 age group subject to rounding errors.

## 7.2.2. ADIS calls

### 7.2.2.1. Introduction

The Alcohol and Drug Information Service (ADIS) has operated since June 1986 and is a 24 hour statewide service operated by the ADA. The object of ADIS is to provide confidential counselling and referral on alcohol and other drug problems for drug users, their relatives and friends. It also

provides information about drugs and related health issues to students, health and welfare workers and the general public.

Non identifying data are routinely collected for each call. This includes the type of drug mentioned, status of the caller,<sup>337</sup> age and sex of caller, postcode of residence of caller and outcome of the call. ADIS also provides an 1800 toll free number for users outside the metropolitan area.

The Parent Drug Information Service (PDIS) was launched in October 1996 as an initiative to provide specialist information, support, counselling and referral to key treatment and support services for parents concerned about drug use by their children.

### 7.2.2.2. Overview

From 1986 until 1992, there was a greater number of licit drug related calls received each year. However in 1993, and most recently in 1997, there were a greater number of illicit drug related calls (Table 7.2). Trends in the number of licit and illicit drug related calls received each quarter since mid 1992 have been similar.

The number of licit calls received per year peaked in 1995, when more than 7,700 calls were received. Since 1995 the number of licit calls has dropped, with a total of nearly 5,300 licit drug calls received in 1997. It is likely that increased concern about illicit opioids has been responsible for the greater number of illicit compared to licit calls that have been received each quarter since the beginning of 1997 (Figure 7.2; Table 13, Appendix 13).

#### **Licit calls**

From 1987<sup>338</sup> up to 1997, the number of licit calls increased per year by 52.6%, from 3,449 licit drug calls received in 1987 to 5,264 received in 1997. A closer examination of the major drug groups shows that alcohol related calls constituted between approximately half and two thirds of all calls (Table 7.3). It can be seen that there has been a marked increase in the number of tobacco related calls received by ADIS. From 1994 to 1997, between 800 and 1,200 calls per year were concerned with tobacco smoking and related health concerns.

There were a greater number of tranquilliser/sedative/barbiturate related calls received over the period 1989 to 1995. Since 1996, the number of calls received for this group have dropped, with only 425 calls received in 1997 (Table 7.3).

#### **Illicit calls**

The number of illicit calls received per year nearly trebled, from 2,145 in 1987 to 6,136 in 1997 (Table 7.4). A breakdown by type of drug highlights the growing impact on the community of illicit opioids, with the number of illicit opioid calls increasing nearly four fold (from 672 calls in 1987 to 2,550 in 1997). The number of illicit opioid calls in 1997 was the greatest number ever received in relation to this drug group.

It can be seen that over the six year period from 1992 to 1997, the number of cannabis related calls has fluctuated between about 1,900 and 2,500 per year, indicating the level of community concern about this drug (Table 7.4).<sup>339</sup>

There are relatively fewer calls received by ADIS each year concerned about ecstasy compared to other hallucinogens. Over the period 1991 to 1995, the number of hallucinogen related calls increased (peaking with 400 calls in 1995) then dropped (to 161 calls in 1997).

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<sup>337</sup> For example user, friend, relative.

<sup>338</sup> 1987 was the first full year of operation.

<sup>339</sup> More detailed information will be presented about trends in cannabis related calls in chapter 6.

## Select Committee Into Misuse of Drugs Act 1981

### Psychostimulant and illicit opioid calls

There has been a marked change in the nature of psychostimulant and illicit opioid drug related calls from 1986 to 1998 (Figure 7.3; Table 13, Appendix 13)). The number of *psychostimulant* calls peaked in the beginning of 1995, then sharply dropped. Since 1996, there were about 200 psychostimulant related calls per quarter. However, there is a suggestion of recent increased level of concern about this drug, with calls rising since the September quarter 1997.<sup>340</sup>

From 1986 to the end of 1993, there were about 200 illicit *opioid* related calls per quarter. However, since the beginning of 1994 the number of calls per quarter more than trebled, reaching about 650 calls per quarter by the end of 1997. There is evidence of some decrease in community concerns, as the number of calls per quarter has fallen up to the June quarter 1998.<sup>341</sup>

**Table 7.2: Annual ADIS licit and illicit drug related calls, 1986 – 1997**

Drug	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Total licit	1,828	3,449	4,837	5,245	5,646	5,534	5,565	4,931	5,966	7,734	6,080	5,264
Total illicit	1,456	2,145	2,682	2,656	3,470	4,632	5,241	5,272	5,815	6,923	5,733	6,136
% illicit	44.3%	38.3%	35.7%	33.6%	38.1%	45.6%	48.5%	51.7%	49.4%	47.2%	48.5%	53.8%
<b>All calls</b>	<b>3,284</b>	<b>5,594</b>	<b>7,519</b>	<b>7,901</b>	<b>9,116</b>	<b>10,166</b>	<b>10,806</b>	<b>10,203</b>	<b>11,781</b>	<b>14,657</b>	<b>11,813</b>	<b>11,400</b>

Note: Data for 1986 relates to the period April - December.

**Table 7.3: Annual ADIS licit drug related calls by drug group, 1986 – 1997**

Drug	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Alcohol	977	2,288	3,237	2,948	3,226	3,150	3,413	2,853	3,347	4,437	3,561	2,629
Tobacco	47	181	215	568	608	445	513	557	829	1,248	849	1,272
Analgesics	na	na	na	90	124	163	151	128	140	235	191	113
Opioids	na	na	na	na	na	na	na	na	na	na	384	448
Tranquillisers/ sedatives/barbiturates	253	346	548	773	865	841	621	522	720	790	544	425
Anti-depressants	na	na	na	165	177	234	226	169	258	340	337	198
Other	551	634	837	701	646	701	641	702	672	684	214	179
<b>All licit drugs</b>	<b>1,828</b>	<b>3,449</b>	<b>4,837</b>	<b>5,245</b>	<b>5,646</b>	<b>5,534</b>	<b>5,565</b>	<b>4,931</b>	<b>5,966</b>	<b>7,734</b>	<b>6,080</b>	<b>5,264</b>

Note: Data for 1986 relates to the period April - December.  
na = not available.

<sup>340</sup> The quarterly data for Figure 5.6 is contained in Table 13, Appendix 13.

<sup>341</sup> More detailed information about opioids is contained in chapter 5.

Figure 7.2: Quarterly ADIS licit and illicit drug related calls, 1986 – 1998

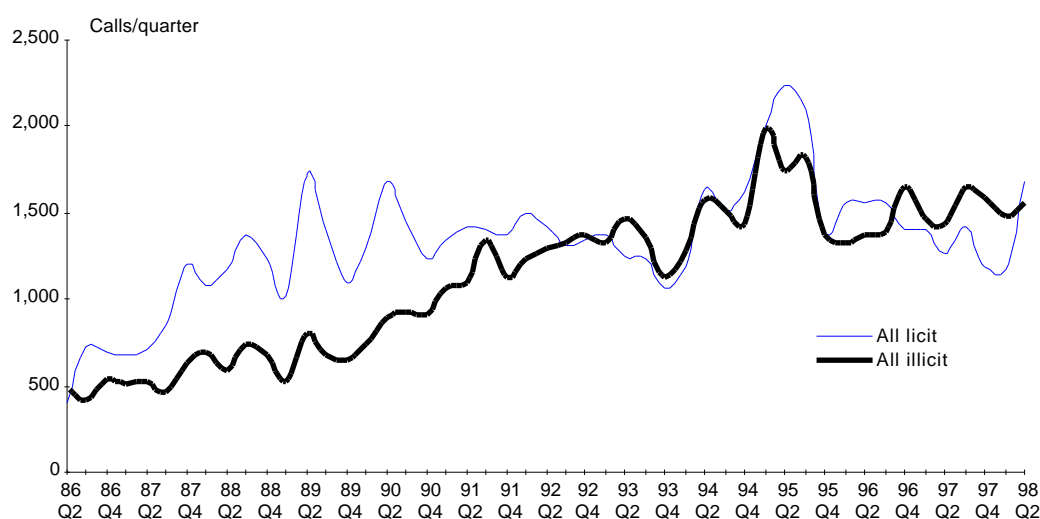
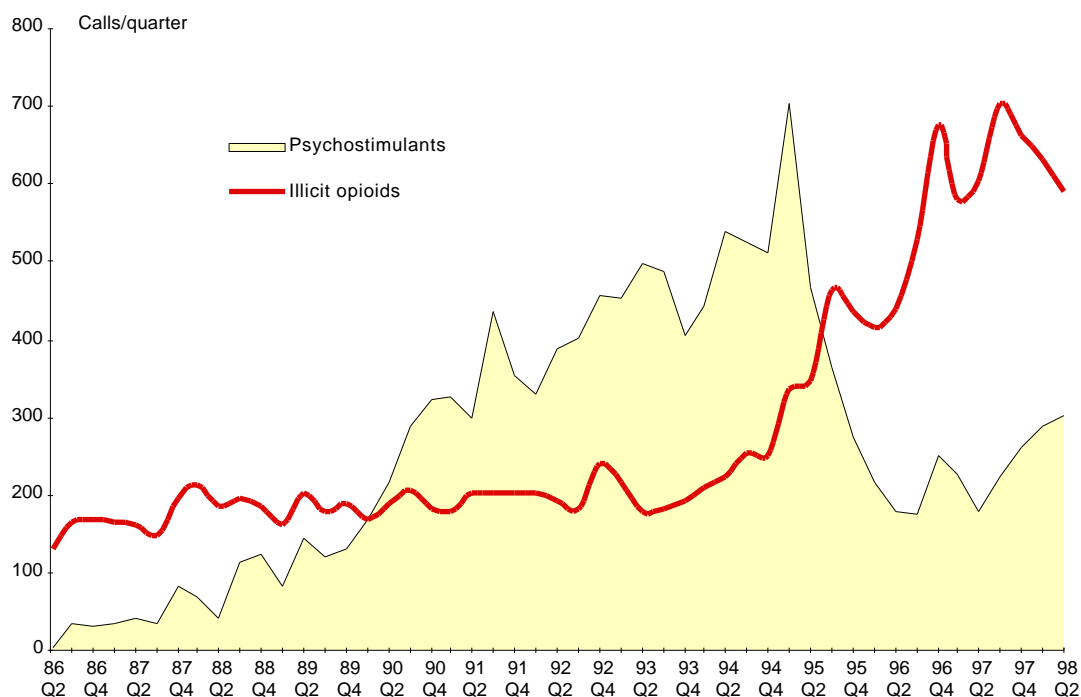


Table 7.4: Annual ADIS illicit drug related calls by drug group, 1986 – 1997

Drug	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
<b>Opioids</b>												
Heroin	459	672	781	731	747	783	817	768	937	1,580	na	na
Unspecified opioid	na	na	na	na	na	na	na	na	na	na	1,911	2,399
Methadone	na	na	na	na	na	na	na	na	na	na	151	151
<b>Total illicit opioids</b>	<b>459</b>	<b>672</b>	<b>781</b>	<b>731</b>	<b>747</b>	<b>783</b>	<b>817</b>	<b>768</b>	<b>937</b>	<b>1,580</b>	<b>2,062</b>	<b>2,550</b>
<b>Cannabis</b>	<b>638</b>	<b>905</b>	<b>1,008</b>	<b>978</b>	<b>1,184</b>	<b>1,605</b>	<b>1,906</b>	<b>1,863</b>	<b>1,925</b>	<b>2,489</b>	<b>2,180</b>	<b>1,975</b>
<b>Psychostimulants</b>												
Unspecified	68	138	279	406	937	1,351	1,498	1,789	1,957	1,737	na	na
Amphetamines	na	na	na	na	na	na	na	na	na	na	657	750
Amphetamines (prescribed)	na	na	na	na	na	na	na	na	na	na	76	104
Cocaine	na	56	71	69	61	62	74	54	64	71	82	37
<b>Total psychostimulants</b>	<b>68</b>	<b>194</b>	<b>350</b>	<b>475</b>	<b>998</b>	<b>1,413</b>	<b>1,572</b>	<b>1,843</b>	<b>2,021</b>	<b>1,808</b>	<b>815</b>	<b>891</b>
<b>Hallucinogens</b>	<b>25</b>	<b>40</b>	<b>76</b>	<b>84</b>	<b>134</b>	<b>253</b>	<b>332</b>	<b>331</b>	<b>329</b>	<b>400</b>	<b>232</b>	<b>161</b>
<b>Volatile substances</b>	<b>na</b>	<b>na</b>	<b>na</b>	<b>132</b>	<b>163</b>	<b>232</b>	<b>200</b>	<b>205</b>	<b>255</b>	<b>312</b>	<b>179</b>	<b>148</b>
<b>Polydrug</b>	<b>266</b>	<b>316</b>	<b>354</b>	<b>178</b>	<b>171</b>	<b>211</b>	<b>111</b>	<b>101</b>	<b>161</b>	<b>158</b>	<b>95</b>	<b>256</b>
<b>Steroids</b>	<b>na</b>	<b>na</b>	<b>na</b>	<b>na</b>	<b>na</b>	<b>na</b>	<b>na</b>	<b>na</b>	<b>na</b>	<b>na</b>	<b>36</b>	<b>32</b>
<b>Ecstasy</b>	<b>na</b>	<b>18</b>	<b>113</b>	<b>78</b>	<b>73</b>	<b>135</b>	<b>303</b>	<b>161</b>	<b>187</b>	<b>176</b>	<b>134</b>	<b>123</b>
<b>All illicit drugs</b>	<b>1,456</b>	<b>2,145</b>	<b>2,682</b>	<b>2,656</b>	<b>3,470</b>	<b>4,632</b>	<b>5,241</b>	<b>5,272</b>	<b>5,815</b>	<b>6,923</b>	<b>5,733</b>	<b>6,136</b>

Note: Data for 1986 relates to the period April - December.  
na = not available.  
Changes introduced in 1996 to drug groups have been matched where possible to previous categories.

Figure 7.3: Quarterly ADIS psychostimulant and illicit opioid related calls, 1986 – 1998



### 7.2.2.3. Drug related calls by parents

An analysis has been made of ADIS and PDIS data for the period March 1997 to March 1998 to identify calls received from parents. This information does not identify the age of the young person.

Over the period March 1997 to March 1998, there were a total of 4,387 calls received from parents, of which 779 (17.8%) were received by PDIS and 3,608 (82.2%) were received by ADIS. Calls from parents concerned about their child's use of a drug constituted 36.1% of all drug related calls dealt with by the two services in this period (Table 7.5). In relation to ADIS calls, of the total of 12,146 drug related calls received, a total of 3,608 (29.7%) calls were from parents.

**Table 7.5: Monthly drug related calls from parents, March 1997 – March 1998**

	Mar-97	Apr-97	May-97	Jun-97	Jul-97	Aug-97	Sep-97	Oct-97	Nov-97	Dec-97	Jan-98	Feb-98	Mar-98	Total
<b>ADIS calls (all types of callers)</b>														
Alcohol	239	263	199	187	199	182	230	226	193	211	215	165	205	2,714
Amphetamines	64	45	65	67	53	76	94	70	80	117	96	91	90	1,008
Cannabis	172	182	137	144	148	172	227	183	165	140	139	157	159	2,125
Cocaine	2	3	4		3	3	7	2	2	5	4	4	2	41
Ecstasy	10	8	6	7	6	9	9	17	11	21	14	11	12	141
Hallucinogens	15	11	7	15	15	17	7	8	9	12	11	9	10	146
Opioids	220	260	224	220	207	274	349	259	226	269	229	228	233	3,198
Volatile substances	11	14	18	19	13	14	13	9	8	6	9	5	10	149
Polydrug	12	14	36	21	29	20	22	31	25	20	5	9	5	249
Steroids	1	1	3	4			2	2	1	5	3	4	3	29
Tobacco	54	67	58	191	213	115	133	133	47	74	165	84	78	1,412
Tranquillisers	50	22	33	30	32	36	38	28	24	36	35	27	30	421
Anti-depressants	19	11	14	13	14	17	12	17	21	21	23	8	14	204
Other prescribed	31	23	35	21	29	20	19	30	9	24	29	21	18	309
<b>Total drug calls</b>	<b>900</b>	<b>924</b>	<b>839</b>	<b>939</b>	<b>961</b>	<b>955</b>	<b>1,162</b>	<b>1,015</b>	<b>821</b>	<b>961</b>	<b>977</b>	<b>823</b>	<b>869</b>	<b>12,146</b>
<b>Parent related calls received by:</b>														
PDIS	110	52	52	41	37	57	131	67	52	32	50	57	41	779
ADIS	257	259	259	240	250	306	372	286	272	276	262	295	274	3,608
<b>From parents</b>	<b>367</b>	<b>311</b>	<b>311</b>	<b>281</b>	<b>287</b>	<b>363</b>	<b>503</b>	<b>353</b>	<b>324</b>	<b>308</b>	<b>312</b>	<b>352</b>	<b>315</b>	<b>4,387</b>
Parents %	40.8	33.7	37.1	29.9	29.9	38.0	43.3	34.8	39.5	32.0	31.9	42.8	36.2	36.1

### 7.2.3. Admissions to hospitals – all causes

The most recent analysis of data for drug related admissions to hospitals covers the period 1982 to 1992.<sup>342</sup> Over this period, the number of admissions per year in relation to *drugs other than alcohol* increased by more than 20% (from 1,675 in 1982 to 2,192 in 1992) (Table 7.6).

**Table 7.6: Annual admissions to hospitals due to drugs other than alcohol, WA, 1982 - 1992**

Year	Number of admissions
1982	1,675
1983	1,893
1984	1,873
1985	1,797
1986	1,842
1987	1,690
1988	1,792
1989	1,818
1990	1,896
1991	2,060
1992	2,192
<b>1982-1992</b>	<b>20,528</b>

Of the 20,528 admissions over the 11 year period, the greatest number of admissions involved the barbiturate, tranquilliser and sedative group of drugs. By type of drug there were (Table 7.7):

- barbiturates/tranquillisers/sedatives - 9,652 admissions (47.0%);
- opioids - 3,883 admissions (18.9%);

<sup>342</sup> Swensen G, Unwin E. *Indicators of drug use in Western Australia, 1982-1992*. Perth, Epidemiology Branch, Health Department of Western Australia, 1995.

## Select Committee Into Misuse of Drugs Act 1981

- other unspecified and combinations of drugs - 3,038 admissions (14.8%);
- anti-depressants - 2,771 admissions (13.5%);
- volatile substances - 829 admissions (4.1%);
- psychostimulants - 249 admissions (1.2%);
- hallucinogens - 88 admissions (0.4%); and
- cocaine - 18 admissions (0.1%).

### 7.2.3.1. Illicit drugs

Illicit drugs were responsible for few admissions to hospitals. Over the 11 year period, hallucinogens, psychostimulants, cocaine and volatile substances together accounted for 1,184 (5.8%) of all drug related admissions, with possibly a further 2% of admissions due to heroin.<sup>343</sup>

### 7.2.3.2. Gender

Of these 20,528 hospital admissions, 8,677 (42.3%) involved males and 11,851 (57.7%) involved females. There were a number of differences in the proportions of male and female hospital admissions according to drug type (Table 7.7).

- For males, barbiturates, tranquillisers and sedatives were responsible for the greatest proportion of drug caused hospital admissions (42.4%), followed by other or unspecified drugs (21.2%).
- For females, barbiturates, tranquillisers and sedatives were responsible for the greatest proportion of drug caused hospital admissions (50.4%), followed by opioids (20.5%).
- Antidepressants were responsible for a greater proportion of drug caused hospital admissions in females than in males (15.5% compared with 10.8%).
- Volatile substances were responsible for a greater proportion of drug caused hospital admissions in males than in females (6.9% compared with 2.0%).

**Table 7.7: Hospital admissions due to drugs other than alcohol, by type of drug and sex, WA, 1982 - 1992**

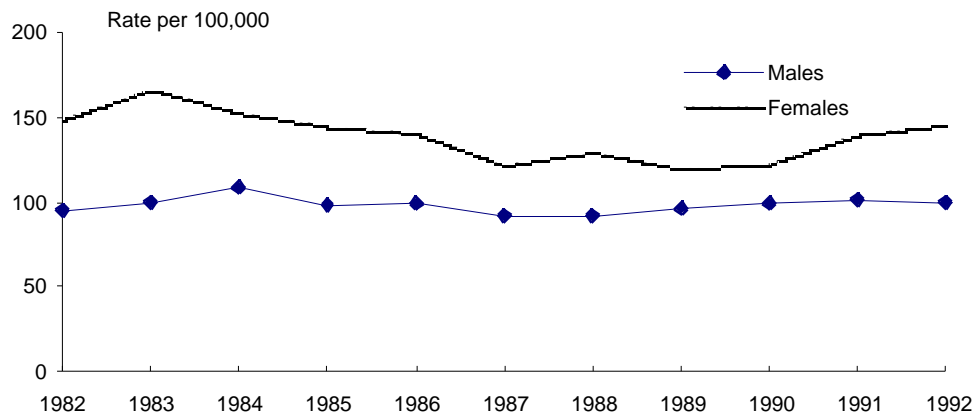
	Males		Females		Persons
	Number of admissions	% of admissions by drug type	Number of admissions	% of admissions by drug type	Number of admissions
Opiates	1,448	16.7	2,435	20.5	3,883
Barbiturates/tranquillisers/sedatives	3,676	42.4	5,976	50.4	9,652
Anti-depressants	938	10.8	1,833	15.5	2,771
Cocaine	4	0.0	14	0.1	18
Psychostimulants	114	1.3	135	1.1	249
Hallucinogens	58	0.7	30	0.3	88
Volatile substances	596	6.9	233	2.0	829
Other/unspecified drugs	1,843	21.2	1,195	10.1	3,038
<b>All drug types</b>	<b>8,677</b>	<b>100.0</b>	<b>11,851</b>	<b>100.0</b>	<b>20,528</b>

### 7.2.3.3. Trends

The age standardised rates for hospital admissions were greater for females than males. The male rates remained stable at around 100 admissions per 100,000 person years. The female rates have fluctuated but no real trends are apparent. The male:female rate ratios remained steady over the 11 year period, in the range 0.6 to 0.8 (Table 7.8; Figure 7.4).

<sup>343</sup> It was not possible to distinguish heroin separately, as it is included in the opioid group.

**Figure 7.4: Age standardised rates of hospitalisation due to drugs other than alcohol by sex, WA, 1982 - 1992**



**Table 7.8: Age standardised rates of hospitalisation due to drugs other than alcohol by sex, WA, 1982 - 1992**

	Males	Females	Persons	Male:female rate ratios
1982	95	148	121	0.6
1983	100	166	132	0.6
1984	108	152	129	0.7
1985	98	144	121	0.7
1986	99	140	119	0.7
1987	92	121	106	0.8
1988	92	129	110	0.7
1989	96	119	108	0.8
1990	99	122	110	0.8
1991	101	139	119	0.7
1992	100	145	123	0.7

## **7.2.4. Admissions to hospitals – poisoning**

### **7.2.4.1. Introduction**

Conditions caused by drugs are classified as poisoning only when the substance involved is not used in accordance with a doctor's instructions. A diagnosis of poisoning under the ICD9 CM<sup>344</sup> is applied if the admission was the result of an error made in a drug prescription, or in the administration of the drug by a doctor, nurse, the patient, or another person, or if an overdose of a drug was intentionally taken or administered and resulted in drug toxicity.

Chronic conditions related to drug dependence or non dependent abuse are not classified as poisoning, but are assigned codes within the HMDS for both the condition and the abuse or dependence. However, an acute condition due to an overdose of a drug (such as heroin) is classified as a poisoning, with an additional code assigned for the acute manifestation, and with optional E codes assigned for the circumstances of the episode.

For example, acute pulmonary oedema due to an overdose of heroin is classified as poisoning due to heroin with an additional code assigned for acute pulmonary oedema and optional E code assigned for the circumstances. There are four sets of E codes used by the ICD9 CM:

- accidental poisoning (E850-E858);
- suicide or attempted suicide and self inflicted injury (E 950.0-E950.5);
- assault by poisoning (E962.0); and
- undetermined (E980.0-E980.5).

For the period 1982 to 1992, the major causes of hospitalisation due to poisoning by drug type (Table 7.9) were:

- barbiturates/tranquillisers/sedatives - 9,293 admissions (56.4%);
- opioids - 3,526 admissions (21.4%);
- anti-depressant - 2,771 admissions (16.8%);
- volatile substances - 663 admissions (4.0%);
- psychostimulant - 169 admissions (1.0%);
- hallucinogens - 54 admissions (0.3%); and
- cocaine - 15 admissions (0.1%).

### **7.2.4.2. Gender**

In the 11 year period 1982 to 1992 there were 16,491 hospital admissions due to drug caused poisoning, of which 6,261 (38.0%) were male and 10,230 (62.0%) were female. Overall, tranquillisers, opioids, and antidepressants were responsible for the greatest proportion of drug caused hospital admissions due to poisoning in both sexes, being responsible for more than 75% of male admissions and 85% of female admissions (Table 7.9).

### **7.2.4.3. Trends**

The age standardised rates for the three major groups of drugs were greater for females (Table 7.11, Figure 7.6). than males (Table 7.10, Figure 7.5).

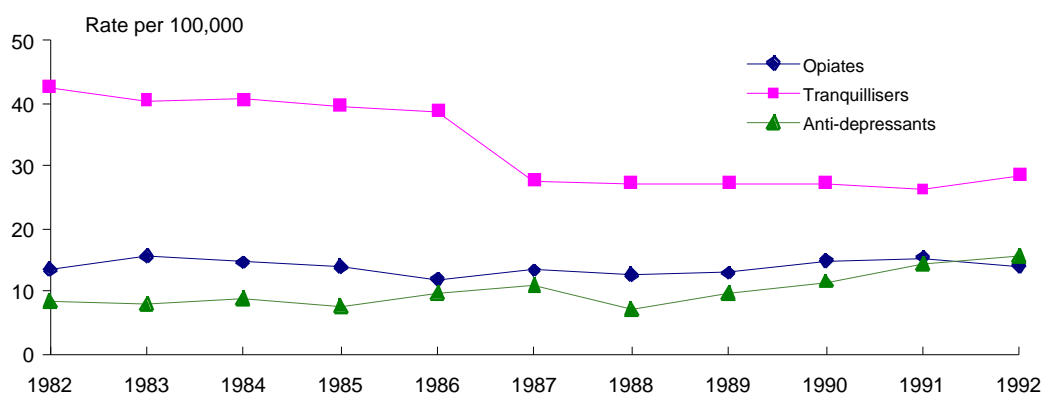
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<sup>344</sup> *Tabular list of diseases ICD-9-CM. Australian version of the International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification.* Sydney, National Coding Centre, Faculty of Health Sciences, University of Sydney, 1995.

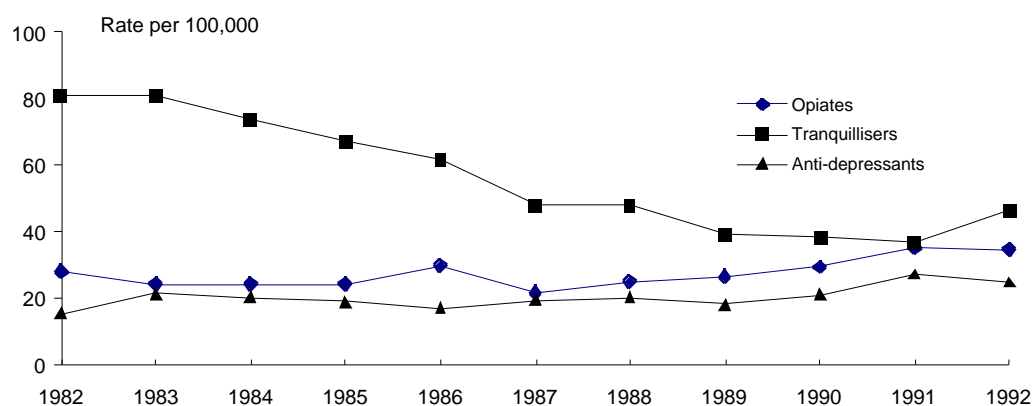
**Table 7.9: Hospital admissions due to poisoning by type of drug and sex, WA, 1982 - 1992**

	Males		Females		Persons	
	n	%	n	%	n	%
Opioids	1,238	19.8	2,288	22.4	3,526	21.4
Barbiturates	119	1.9	192	1.9	311	1.9
Sedatives	520	8.3	810	7.9	1,330	8.1
Tranquillisers	2,872	45.9	4,780	46.7	7,652	46.4
Antidepressants	938	15.0	1,833	17.9	2,771	16.8
Cocaine	3	0.0	12	0.1	15	0.1
Psychostimulants	66	1.1	103	1.0	169	1.0
Hallucinogens	37	0.6	17	0.2	54	0.3
Volatile substances	468	7.5	195	1.9	663	4.0
<b>All types of drugs</b>	<b>6,261</b>	<b>100.0</b>	<b>10,230</b>	<b>100.0</b>	<b>16,491</b>	<b>100.0</b>

**Figure 7.5: Male age standardised rates of hospitalisation due to drug caused poisoning by type of drug, WA, 1982 - 1992**



**Figure 7.6: Female age standardised rates of hospitalisation due to drug caused poisoning by type of drug, WA, 1982 - 1992**



**Table 7.10: Male age standardised rates of hospitalisation due to drug caused poisoning by type of drug, WA, 1982 - 1992**

	Opioids	Barbiturates	Sedatives	Tranquillisers	Anti depressants	Psychostimulants	Volatile substances
1982	13.4	2.6	4.3	42.5	8.2	0.1	12.1
1983	15.4	3.4	2.8	40.4	7.8	0.1	11.3
1984	14.5	3.5	5.1	40.6	8.7	0.3	12.3
1985	13.7	1.1	4.2	39.5	7.6	0.5	9.4
1986	11.9	0.9	5.5	38.6	9.6	0.7	7.2
1987	13.2	0.4	5.9	27.5	10.8	0.8	5.4
1988	12.5	0.8	6.3	27.1	6.9	1.3	4.6
1989	12.8	0.6	6.6	27.1	9.5	0.5	4.6
1990	14.9	0.2	7.4	27.1	11.5	0.8	3.2
1991	15.3	0.5	7.0	26.2	14.4	1.7	5.4
1992	14.0	0.6	7.8	28.5	15.4	1.0	3.7

**Table 7.11: Female age standardised rates of hospitalisation due to drug caused poisoning by type of drug, WA, 1982 - 1992**

	Opioids	Barbiturates	Sedatives	Tranquillisers	Anti depressants	Psychostimulants	Volatile substances
1982	27.9	5.0	5.6	80.6	15.6	0.3	4.2
1983	24.5	6.3	6.6	80.6	21.5	0.5	4.7
1984	24.4	4.5	6.8	73.4	20.4	0.6	5.3
1985	24.5	3.2	8.8	67.0	19.3	0.5	3.0
1986	29.8	2.7	10.0	61.4	17.2	0.4	2.2
1987	21.6	0.9	9.7	48.0	19.7	2.3	3.4
1988	25.0	0.7	11.4	48.0	20.5	1.8	1.8
1989	26.6	0.3	11.6	39.1	18.5	1.7	2.3
1990	29.5	0.3	9.9	38.4	21.2	1.2	1.7
1991	35.1	1.1	11.4	36.8	27.3	2.0	4.3
1992	34.9	0.4	8.4	46.3	24.9	2.2	2.4

## 7.2.5. Admissions to psychiatric hospitals

### 7.2.5.1. Overview

The Select Committee requested the Health Department to provide data of drug related admissions to all psychiatric hospitals and psychiatric units over the period 1988 to 1997. This research provides an important understanding of the impact of the abuse of the major drug groups, where this has involved a serious episode of mental illness. The information that has been provided covers all *first ever admissions* of unique individuals by year over the 10 year period, which encompasses the State's two most recent serious epidemics of drug problems (in relation to amphetamines and, more recently, heroin).

A total of 16,625 individuals were hospitalised in the 10 year period, involving 8,549 (51.4%) males and 8,076 (48.6%) females. The impact of these drug related admissions on the State's mental health inpatient system was significant, involving a total of 78,577 beddays, costing an estimated total of \$25 million (Table 7.12).<sup>345</sup> It is likely the overall cost of providing inpatient treatment for those with drug related mental disorders would be higher, if hospitalisation involving admissions other than first time admissions were included.

### 7.2.5.2. Drug related cause

The most significant cost involved mental disorders caused by alcohol (ie alcohol dependence, non dependent abuse and alcoholic psychoses), costing \$10.2 million, with the self inflicted injury group responsible for \$8.2 million of total costs. It is likely most of the drugs used by the self inflicted injury group were prescription drugs.

By major diagnostic group in order of significance, a total of 8,996 (54.1%) admissions involved self inflicted injury (ie suicide attempt involving a drug), alcohol related conditions were responsible for 4,986 (30.0%) admissions, 1,279 (7.7%) admissions were caused by drug dependence, 634 admissions (3.8%) were caused by the non dependent abuse of drugs other than alcohol and 730 (4.4%) admissions were caused by drug psychoses (Table 7.12).

There is a greater cost burden on the hospital system to treat those with drug psychoses and alcoholic psychoses compared to other causes as follows (ranked in order of decreasing mean length of stay):

- drug psychoses (\$3.1 million) – 13.2 beddays;
- alcoholic psychoses (\$3.6 million) – 11.6 beddays;
- alcohol dependence (\$5.1 million) – 9.1 beddays;
- drug dependence (\$2.6 million) – 6.3 beddays;
- non dependent drug abuse, drugs other than alcohol (\$0.9 million) – 4.3 beddays;
- self inflicted injury (\$8.2 million) – 2.8 beddays; and
- non dependent alcohol abuse (\$1.5 million) – 2.1 beddays.

### 7.2.5.3. Type of drug

It is possible to identify mental disorders attributable to specific drugs within the constraints of the morbidity classification system which assigns diagnostic codes for all inpatient stays in hospitals including mental disorders.<sup>346</sup> There are two major diagnostic groups (non dependent

<sup>345</sup> The annual bedday cost for the period 1988 – 1995 was estimated by CPI adjustment based on annual bedday cost of \$365 for 1995/96 for all types of inpatient psychiatric programs in WA. Department of Health & Family Services, Mental Health Services Branch. *National mental health report 1996: fourth annual report, changes in Australia's mental health services under the National Mental Health Strategy 1995-96*. Canberra, Department of Health & Family Services, 1997, 142.

<sup>346</sup> *Australian version of the International Classification of Diseases, 9<sup>th</sup> Revision, Clinical Modification (ICD-9-CM)*. National Coding Centre, Faculty of Health Sciences, University of Sydney, 1995.

## Select Committee Into Misuse of Drugs Act 1981

drug abuse and drug dependence) to identify mental disorders caused by specific drugs, which have been combined in Table 7.13.

A more detailed breakdown of the number of beddays and admissions for each of the major drug groups over the 10 year period shows that about one third of the total cost for treating mental disorders (\$6.6 million) was due to alcohol abuse, about one quarter of the total cost (\$2.2 million) was due to the 'other drug' group and about one tenth of the total cost (\$1.0 million) was due to opioids (Table 7.13).

**Table 7.12: First ever admissions of drug related mental disorders by sex, WA, 1988 - 1997**

	Males			Females			Persons		
	Beddays	\$	Admissions	Beddays	\$	Admissions	Beddays	\$	Admissions
Alcohol dependence	12,020	3,750,751	1,332	4,481	1,389,627	472	16,501	5,140,378	1,804
Drug dependence	4,893	1,560,304	789	3,175	1,022,150	490	8,068	2,582,453	1,279
Non dependent abuse-alcohol	3,279	1,042,318	1,442	1,392	455,082	766	4,671	1,497,400	2,208
Non dependent abuse-other drugs	1,882	610,551	407	869	289,424	227	2,751	899,975	634
Self inflicted injury	9,896	3,158,088	3,359	15,718	5,059,297	5,637	25,614	8,217,385	8,996
Alcoholic psychoses	8,522	2,719,632	763	2,812	879,052	211	11,334	3,598,684	974
Drug psychoses	7,028	2,284,329	457	2,610	855,652	273	9,638	3,139,982	730
<b>Total</b>	<b>47,520</b>	<b>15,125,973</b>	<b>8,549</b>	<b>31,057</b>	<b>9,950,284</b>	<b>8,076</b>	<b>78,577</b>	<b>25,076,257</b>	<b>16,625</b>

### 7.2.5.4. Alcohol vs other drug related mental disorders

Over the 10 year period, there were a total of 16,625 admissions (a total of 78,577 beddays) for drug related mental disorders to psychiatric inpatient facilities in this State. Alcohol caused mental disorders represented a significant proportion of this hospitalisation, being responsible for a total of 4,986 admissions (30.0%) (ie the three major disorders of alcohol dependence, non dependent alcohol abuse and alcoholic psychoses) (Table 7.12).

The remaining total of 11,639 admissions for mental disorders caused by drugs other than alcohol involved 1,279 admissions due to drug dependence, 634 admissions due to non dependent drug abuse, 730 admissions due to drug psychoses and 8,996 admissions due to self inflicted injury (Table 7.14).

An analysis to identify the role of drugs other than alcohol found that there were 849 admissions (5.1%) for the 'other drugs' group and 630 admissions (3.8%) for the 'opioids group' (Table 7.13). It is to be noted that the differentiation of groups of drugs other than alcohol was restricted to those admissions which had diagnoses of drug dependence or non dependent drug abuse. It was not possible in this particular analysis to differentiate specific drugs in relation to the large number of drug related admissions recorded for the self inflicted injury group (a total of 8,996 admissions).

**Table 7.13: First ever admissions of drug related mental disorders (drug dependence and non dependent abuse) by type of drug and sex, WA, 1988 - 1997**

	Males			Females			Persons		
	Beddays	\$	Admissions	Beddays	\$	Admissions	Beddays	\$	Admissions
Alcohol**	15,299	4,793,069	2,774	5,873	1,844,709	1,238	21,172	6,637,778	4,012
Tobacco*	24	8,218	4	12	3,256	2	36	11,474	6
Cannabis**	270	36,071	61	91	8,350	24	361	44,421	85
Hallucinogens**	170	54,564	31	28	16,354	12	198	70,918	43
Barbiturates**	269	88,591	45	461	86,126	53	730	174,717	98
Opioids**	1,787	609,303	389	1,258	423,617	241	3,045	1,032,920	630
Amphetamines**	533	176,689	126	215	97,963	73	748	274,652	199
Cocaine***	7	2,519	2	5	1,794	1	12	4,313	3
Other drugs**	3,715	1,135,289	538	1,974	1,126,439	311	5,689	2,261,728	849
<b>Total</b>	<b>22,074</b>	<b>6,904,313</b>	<b>3,970</b>	<b>9,917</b>	<b>3,608,608</b>	<b>1,955</b>	<b>31,991</b>	<b>10,512,921</b>	<b>5,925</b>

Note: \* Non dependent abuse only  
 \*\* Non dependent abuse and dependence  
 \*\*\* Dependence only.

**Table 7.14: Annual first ever admissions of drug related mental disorders by type of drug related cause, WA, 1988 - 1997**

	Alcohol related			Other drug related				All drugs
	Alcohol dependence	Non dependent alcohol abuse	Alcoholic psychoses	Drug dependence	Non dependent drug abuse	Drug psychoses	Self inflicted injury	
<b>Beddays</b>								
1988	2,293	737	1,436	1,002	188	634	2,886	9,176
1989	2,415	486	1,321	1,019	123	621	2,775	8,760
1990	2,050	331	1,140	1,026	238	626	2,616	8,027
1991	2,364	340	1,185	795	115	1,580	2,467	8,846
1992	2,539	350	1,527	593	447	967	2,606	9,029
1993	1,583	346	1,194	688	397	1,509	2,376	8,093
1994	1,152	736	1,122	554	492	732	2,972	7,760
1995	800	468	907	724	224	1,098	3,091	7,312
1996	755	571	653	1,110	253	1,157	2,625	7,124
1997	550	306	849	557	274	714	1,200	4,450
<b>Total</b>	<b>16,501</b>	<b>4,671</b>	<b>11,334</b>	<b>8,068</b>	<b>2,751</b>	<b>9,638</b>	<b>25,614</b>	<b>78,577</b>
<b>Admissions</b>								
1988	247	231	100	126	41	44	1,032	1,821
1989	233	253	91	124	55	49	1,007	1,812
1990	218	234	66	138	48	54	970	1,728
1991	261	203	91	102	41	73	952	1,723
1992	196	172	112	111	58	69	928	1,646
1993	189	204	98	94	75	95	866	1,621
1994	136	265	128	80	103	78	980	1,770
1995	129	226	122	175	55	88	946	1,741
1996	121	271	105	214	76	107	892	1,786
1997	74	149	61	115	82	73	423	977
<b>Total</b>	<b>1,804</b>	<b>2,208</b>	<b>974</b>	<b>1,279</b>	<b>634</b>	<b>730</b>	<b>8,996</b>	<b>16,625</b>
<b>Mean stay (beddays)</b>	<b>9.1</b>	<b>2.1</b>	<b>11.6</b>	<b>6.3</b>	<b>4.3</b>	<b>13.2</b>	<b>2.8</b>	<b>4.7</b>

**Table 7.15: First ever admissions of drug related mental disorders due to drug dependence (excluding alcohol) by type of drug and sex, WA, 1988 - 1997**

	Males			Females			Persons		
	Beddays	\$	Admissions	Beddays	\$	Admissions	Beddays	\$	Admissions
Opioids	1,468	509,224	312	1,034	573,411	195	2,502	1,082,634	507
Barbiturates	225	74,841	23	326	190,511	32	551	265,352	55
Cocaine	7	2,519	2	5	3,588	1	12	6,107	3
Cannabis	44	15,809	10	21	15,000	5	65	30,809	15
Amphetamines	172	58,348	38	74	50,865	20	246	109,213	58
Hallucinogens	2	718	1	-	0	-	2	718	1
Opioid combinations	20	6,215	2	45	25,698	3	65	31,913	5
Other drugs	2,955	892,309	401	1,670	1,026,371	234	4,625	1,918,680	635
<b>Total</b>	<b>4,893</b>	<b>1,559,983</b>	<b>789</b>	<b>3,175</b>	<b>1,885,444</b>	<b>490</b>	<b>8,068</b>	<b>3,445,426</b>	<b>1,279</b>

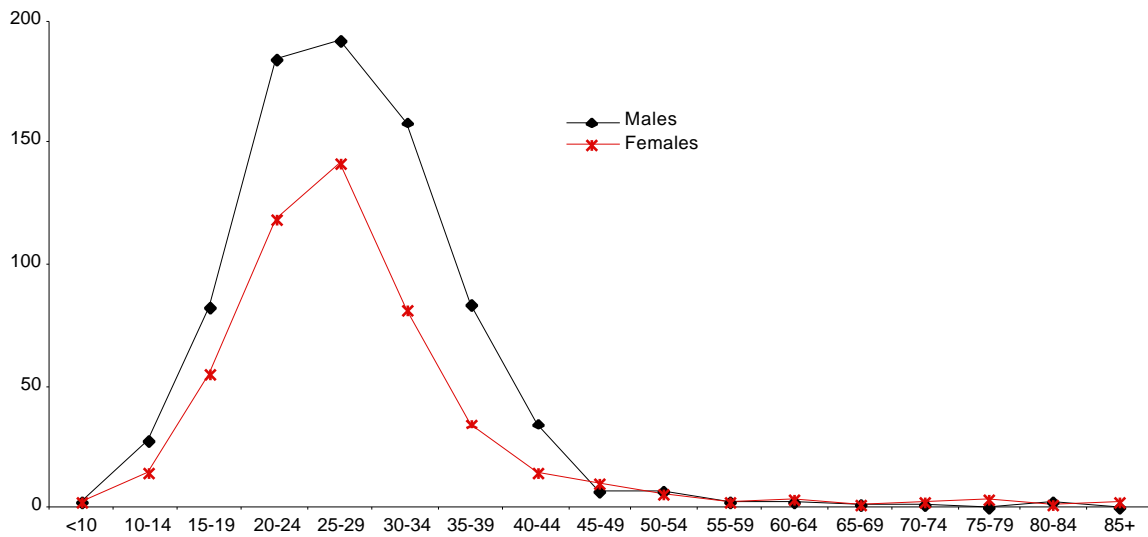
### 7.2.5.5. Drug dependence (excluding alcohol)

There were a total of 1,279 admissions in the 10 year period due to drug dependence which involved opioids, barbiturates, cocaine, cannabis, amphetamines, hallucinogens, opioid combinations and other drugs (Table 7.15). Overall, about two out of every three admissions involved males. Both males and females had a similar mean length of stay of 6.2 beddays and 6.5 beddays, respectively. It is estimated it cost the mental health system a total of nearly \$3.5 million to treat this group, of which 55% (\$1.8 million) involved females.

From 1988 to the early 1990s, there were similar numbers of admissions each year with respect to opioids and amphetamines, the two most significant causes of drug dependence. There has been a particularly pronounced increase in the number of opioid related admissions since the mid 1990s, increasing more than ten fold (from 17 admissions in 1993 to 177 admissions in 1996). There has been a decrease to 94 admissions in 1997 (Table 7.16).

Both male and female admissions for drug dependence mostly involved the 20 to 34 age group, with very few admissions occurring in the 40 year and older age group (Figure 7.7; Table 7.17).

**Figure 7.7: First ever admissions of drug related mental disorders due to drug dependence (excluding alcohol) by sex and age group, WA, 1988 - 1997**



**Table 7.16: Annual first ever admissions of drug related mental disorders due to drug dependence (excluding alcohol) by type of drug, WA, 1988 - 1997**

	Opioids	Barbiturates	Cocaine	Cannabis	Amphetamines	Hallucinogens	Opioid combinations	Other drugs	Total
<b>Beddays</b>									
1988	57	1	-	-	-	-	-	944	1,002
1989	58	76	-	-	1	-	-	884	1,019
1990	6	81	-	2	8	-	19	910	1,026
1991	62	82	-	-	9	-	-	642	795
1992	51	19	-	-	16	-	34	473	593
1993	104	102	-	-	43	-	-	439	688
1994	404	34	-	-	77	-	-	39	554
1995	486	39	8	19	71	-	-	101	724
1996	819	58	-	32	5	2	6	188	1,110
1997	455	59	4	12	16	-	6	5	557
<b>Total</b>	<b>2,502</b>	<b>551</b>	<b>12</b>	<b>65</b>	<b>246</b>	<b>2</b>	<b>65</b>	<b>4,625</b>	<b>8,068</b>
<b>Admissions</b>									
1988	14	1	-	-	-	-	-	111	126
1989	10	7	-	-	1	-	-	106	124
1990	3	6	-	1	3	-	1	124	138
1991	9	4	-	-	2	-	-	87	102
1992	8	3	-	-	6	-	2	92	111
1993	17	7	-	-	7	-	-	63	94
1994	49	7	-	-	15	-	-	9	80
1995	126	7	2	5	16	-	-	19	175
1996	177	6	-	7	2	1	1	20	214
1997	94	7	1	2	6	-	1	4	115
<b>Total</b>	<b>507</b>	<b>55</b>	<b>3</b>	<b>15</b>	<b>58</b>	<b>1</b>	<b>5</b>	<b>635</b>	<b>1,279</b>

**Table 7.17: First ever admissions of drug related mental disorders due to drug dependence (excluding alcohol) by sex and age group, WA, 1988 - 1997**

	Males	Females	Persons
<10	2	2	4
10-14	27	14	41
15-19	83	55	138
20-24	185	118	303
25-29	192	141	333
30-34	159	81	240
35-39	84	35	119
40-44	35	14	49
45-49	7	10	17
50-54	7	5	12
55-59	2	2	4
60-64	2	3	5
65-69	1	1	2
70-74	1	2	3
75-79	-	3	3
80-84	2	1	3
85+	-	2	2
<b>Total</b>	<b>789</b>	<b>490</b>	<b>1,279</b>

### 7.2.5.6. Non dependent drug abuse

There were a total of 2,842 admissions in the 10 year period due to non dependent drug abuse which involved alcohol, tobacco, cannabis, hallucinogens, barbiturates, opioids, amphetamines and other drugs (Table 7.18). Overall, about two out of every three admissions involved males. Males had a slightly longer mean stay than females, with a mean of 2.8 beddays for males compared to 2.3 beddays for females.

It is estimated it cost the mental health system a total of just over \$3 million to treat those admitted for the first time from 1988 to 1997 with mental disorders due to the non dependent abuse of drugs, of which just over half of this cost (\$1.6 million) involved males.

Since 1994, there has been an increase in the number of admissions with respect to opioids, with 37 admissions recorded in 1997 (a four fold increase on the 9 admissions recorded in 1993). The number of amphetamine related admissions peaked in 1994, when there were 41 admissions. By 1997, this had substantially dropped when only 6 admissions were recorded (Table 7.19).

Both male and female admissions for non dependent drug abuse involve a relatively young age group, with most admissions occurring in the 15 to 19 and 20 to 24 age groups. There are very few admissions occurring in the 40 year and older age group (Figure 7.8; Table 7.20).

**Table 7.18: First ever admissions of drug related mental disorders due to non dependent drug abuse by type of drug and sex, WA, 1988 - 1997**

	Males			Females			Persons		
	Beddays	\$	Admissions	Beddays	\$	Admissions	Beddays	\$	Admissions
Alcohol	3,279	1,042,087	1,442	1,392	851,919	766	4,671	1,894,007	2,208
Tobacco	24	8,218	4	12	6,523	2	36	14,741	6
Cannabis	226	73,249	51	70	34,412	19	296	107,661	70
Hallucinogens	168	53,716	30	28	17,720	12	196	71,436	42
Barbiturates	44	13,747	22	135	89,928	21	179	103,675	43
Opioids	299	100,070	75	179	93,759	43	478	193,829	118
Amphetamines	361	118,310	88	141	91,381	53	502	209,691	141
Other	760	242,925	137	304	184,735	77	1,064	417,660	214
<b>Total</b>	<b>5,161</b>	<b>1,652,322</b>	<b>1,849</b>	<b>2,261</b>	<b>1,370,377</b>	<b>993</b>	<b>7,422</b>	<b>3,012,700</b>	<b>2,842</b>

### 7.2.5.7. Self inflicted injury (excluding alcohol)

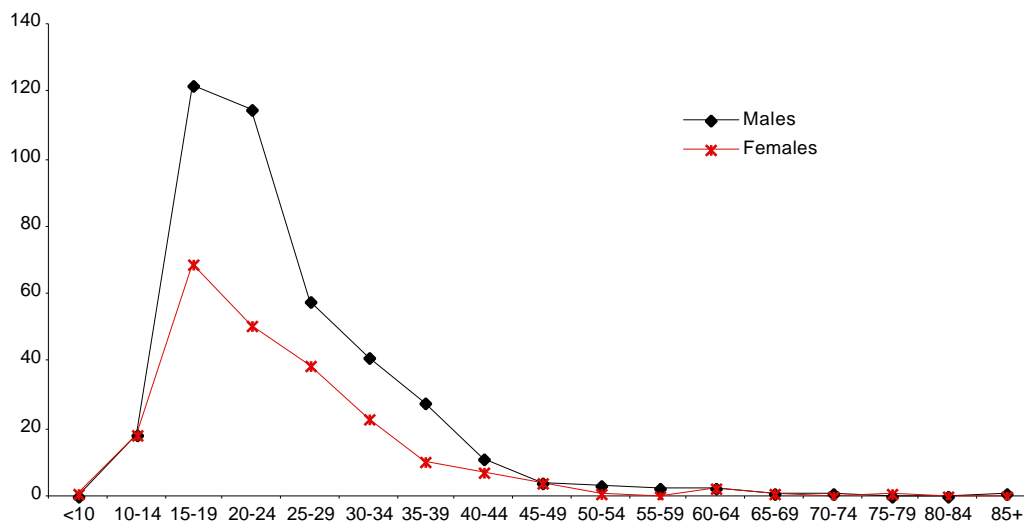
By way of comparison, the age distribution for self inflicted injury has been included in this analysis. It is to be noted that there is a peak in admissions especially involving the 15 to 19 age group (Table 7.21; Figure 7.9). Compared to the previous diagnostic groups, there is a high number of females compared to males, across all age groups. A number of local studies confirm the need for strategies which target young people (especially females) who use drugs in suicide attempts.<sup>347</sup>

### 7.2.5.8. Drug psychoses (excluding alcohol)

With respect to drug psychoses, a greater number of admissions involved males than females. There is a peak of drug psychoses admissions in the 20 to 24 age group, with most admissions occurring between the ages of 15 and 35. It is to be noted that in the 50 and over age group, there is an increase in the number of admissions for drug psychoses (Table 7.22; Figure 7.10).

<sup>347</sup> Serafino S, Swensen G, Thomson N. *Attempted suicide in Western Australia, 1981-1993*. Perth, Epidemiology Branch, Health Department of WA, 1996.

**Figure 7.8: First ever admissions of drug related mental disorders due to non dependent drug abuse by sex and age group, WA, 1988 - 1997**



**Table 7.19: Annual first ever admissions of drug related mental disorders due to non dependent drug abuse by type of drug, WA, 1988 - 1997**

	Alcohol	Tobacco	Cannabis	Hallucinogens	Barbiturates	Opioids	Amphetamines	Other	Total
<b>Beddays</b>									
1988	737	12	3	2	13	48	3	107	925
1989	486	-	13	8	10	-	8	84	609
1990	331	-	47	8	4	2	23	154	569
1991	340	6	18	3	6	10	43	29	455
1992	350	-	80	121	57	11	43	135	797
1993	346	-	45	23	32	34	137	126	743
1994	736	-	7	8	3	123	181	170	1,228
1995	468	12	14	2	41	54	23	78	692
1996	571	-	24	5	11	78	25	110	824
1997	306	6	45	16	2	118	16	71	580
<b>Total</b>	<b>4,671</b>	<b>36</b>	<b>296</b>	<b>196</b>	<b>179</b>	<b>478</b>	<b>502</b>	<b>1,064</b>	<b>7,422</b>
<b>Admissions</b>									
1988	231	2	3	2	5	3	3	23	272
1989	253	-	7	3	6	-	5	34	308
1990	234	-	9	6	5	2	11	15	282
1991	203	1	4	3	6	1	12	14	244
1992	172	-	6	8	9	4	16	15	230
1993	204	-	8	5	3	9	30	20	279
1994	265	-	7	2	2	25	41	26	368
1995	226	2	9	2	3	11	10	18	281
1996	271	-	8	5	2	26	7	28	347
1997	149	1	9	6	2	37	6	21	231
<b>Total</b>	<b>2,208</b>	<b>6</b>	<b>70</b>	<b>42</b>	<b>43</b>	<b>118</b>	<b>141</b>	<b>214</b>	<b>2,842</b>

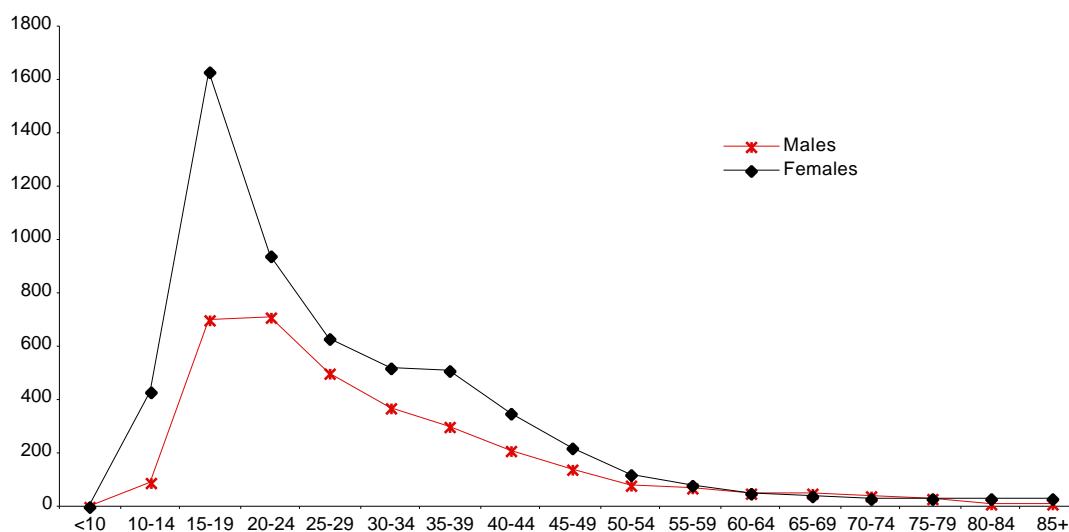
**Table 7.20: First ever admissions of drug related mental disorders due to non dependent drug abuse by sex and age group, WA, 1988 - 1997**

	Males	Females	Persons
<10	-	1	1
10-14	18	18	36
15-19	122	69	191
20-24	115	51	166
25-29	58	39	97
30-34	41	23	64
35-39	28	10	38
40-44	11	7	18
45-49	4	4	8
50-54	3	1	4
55-59	2	-	2
60-64	2	2	4
65-69	1	1	2
70-74	1	-	1
75-79	-	1	1
80-84	-	-	-
85+	1	-	1
<b>Total</b>	<b>407</b>	<b>227</b>	<b>634</b>

**Table 7.21: First ever admissions of drug related mental disorders due to self inflicted injury (excluding alcohol) by sex and age group, WA, 1988 - 1997**

	Males	Females	Persons
<10	-	1	1
10-14	86	428	514
15-19	701	1,626	2,327
20-24	710	942	1,652
25-29	497	635	1,132
30-34	375	516	891
35-39	301	506	807
40-44	212	348	560
45-49	139	220	359
50-54	80	125	205
55-59	67	81	148
60-64	55	51	106
65-69	48	40	88
70-74	37	32	69
75-79	26	30	56
80-84	12	26	38
85+	13	30	43
<b>Total</b>	<b>3,359</b>	<b>5,637</b>	<b>8,996</b>

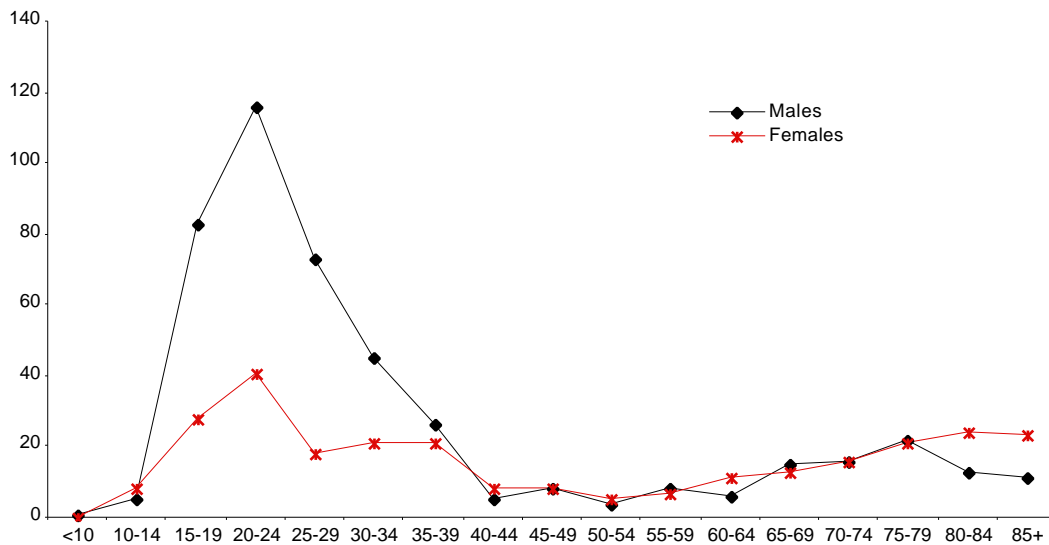
**Figure 7.9: First ever admissions of drug related mental disorders due to self inflicted injury (excluding alcohol) by sex and age group, WA, 1988 - 1997**



**Table 7.22: First ever admissions of drug related mental disorders due to drug psychoses (excluding alcohol) by sex and age group, WA, 1988 - 1997**

	Males	Females	Persons
<10	1	-	1
10-14	5	8	13
15-19	83	28	111
20-24	116	41	157
25-29	73	18	91
30-34	45	21	66
35-39	26	21	47
40-44	5	8	13
45-49	8	8	16
50-54	4	5	9
55-59	8	7	15
60-64	6	11	17
65-69	15	13	28
70-74	16	16	32
75-79	22	21	43
80-84	13	24	37
85+	11	23	34
<b>Total</b>	<b>457</b>	<b>273</b>	<b>730</b>

**Figure 7.10: First ever admissions of drug related mental disorders due to drug psychoses (excluding alcohol) by sex and age group, WA, 1988 - 1997**



## 7.2.6. Mortality

### 7.2.6.1. Introduction

This analysis draws upon recent research by the Health Information Centre which applied aetiologic fractions to quantify all drug caused mortality.<sup>348</sup> This methodology takes account of those deaths wholly caused by drugs (ie those causes with an aetiologic fraction of 1.0) and those deaths which are partially caused by drugs (ie those causes with an aetiologic fraction of less than 1.0).

### 7.2.6.2. Overview

There were an estimated 20,657 drug caused deaths in this State from 1984 to 1994, of which tobacco smoking was responsible for 16,424 deaths (79.5%), alcohol abuse was responsible for 3,532 deaths (17.1%) and the abuse of other drugs was the cause of 701 deaths (3.4%) (Table 7.22).

Over the 11 year period there was an estimated mean total of 1,878 drug caused deaths each year, of which 1,492 were caused by tobacco smoking, 321 were caused by alcohol abuse and 65 were caused by other drugs. A preponderance of these deaths involved males, accounting for:<sup>349</sup>

- 70% of deaths caused by smoking;
- 70% of alcohol caused deaths; and
- 62% of deaths attributed to other drugs.

### 7.2.6.3. Deaths caused by drugs other than alcohol or tobacco

It should be noted in the following analysis that aetiologic fractions have been used to quantify mortality wholly or partially attributable to any of the drug groups listed below. This methodology produces a slightly higher number of deaths than if only deaths wholly attributable

<sup>348</sup> Unwin E. *Drug-caused deaths in Western Australia 1984-1994*. Perth, Health Information Centre, Health Department of WA, 1996.

<sup>349</sup> Id 4.

## Select Committee Into Misuse of Drugs Act 1981

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to drugs are counted. In some instances, such as in relation to cocaine and hallucinogens, deaths are enumerated as aggregate totals because of rounding up, only whole numbers appear in individual cells. The total of 17 deaths recorded as being due to 'other causes' enumerates drug related mortality caused by illnesses such as hepatitis B and low birth weight due to prematurity.

### Gender

Analysis of the 701 deaths caused by drugs other than tobacco or alcohol that occurred in the period 1984 to 1994 found that 437 (62.3%) involved males (Table 7.24) and 264 (37.7%) involved females (Table 7.25). There was a greater proportion of male deaths compared to female deaths for most causes. For instance, nearly three quarters of opioid deaths involved males, almost all deaths due to volatile substances involved males and just over half of deaths caused by barbiturates and other/unspecified drugs involved males. However, for the tranquillisers/sedatives/antidepressant group, just over 40% of deaths involved males.

### Type of drug

With respect to illicit drugs, it can be seen that in this 11 year period that opioids<sup>350</sup> were responsible for nearly 40% of all deaths, whereas no deaths were caused by cannabis (Table 7.26). Deaths attributable to specific drugs included:

- opioids - 267 deaths (38.1%);
- volatile substances - 30 deaths (4.3%);
- barbiturates - 30 deaths (4.3%);
- amphetamines - 5 deaths (0.7%);
- cocaine - 5 deaths (0.7%); and
- hallucinogens - 3 deaths (0.4%).

**Table 7.23: Annual estimated number of estimated drug caused deaths by type of drug, WA, 1984 - 1994**

	Tobacco	Alcohol	Other drugs	All drugs
1984	1,442	301	60	1,803
1985	1,399	314	62	1,775
1986	1,545	316	66	1,927
1987	1,424	306	63	1,793
1988	1,534	340	49	1,923
1989	1,543	348	51	1,942
1990	1,468	317	58	1,843
1991	1,510	310	57	1,877
1992	1,471	325	61	1,857
1993	1,566	316	71	1,953
1994	1,522	339	102	1,963
<b>1984-1994</b>	<b>16,424</b>	<b>3,532</b>	<b>701</b>	<b>20,657</b>

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<sup>350</sup> A more detail analysis of the recent increase in opioid related deaths in WA is provided in chapter 5.

**Table 7.24: Annual estimated number of male deaths caused by drugs other than alcohol or tobacco, WA, 1984 - 1994**

Type of Drug	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1984-1994
Cannabis	-	-	-	-	-	-	-	-	-	-	-	-
Opioids	12	18	12	13	17	18	18	13	15	20	41	197
Amphetamines/ psychostimulants	-	-	-	-	-	-	-	3	-	1	-	4
Cocaine	-	-	-	-	-	-	-	-	-	-	-	3
Hallucinogens	-	-	-	-	-	-	-	1	1	1	-	3
Barbiturates	5	3	3	2	-	2	-	1	1	-	-	17
Tranquillisers/sedatives/ anti-depressants	5	5	4	4	3	1	3	2	4	6	11	48
Volatile substances	1	1	5	4	1	3	5	3	-	3	3	29
Other/ unspecified drugs	8	7	15	19	9	10	14	10	13	13	8	126
Other causes	-	1	1	1	1	1	1	1	1	1	1	10
<b>Total</b>	<b>32</b>	<b>35</b>	<b>40</b>	<b>43</b>	<b>31</b>	<b>35</b>	<b>41</b>	<b>34</b>	<b>35</b>	<b>46</b>	<b>65</b>	<b>437</b>

**Table 7.25: Annual estimated number of female deaths caused by drugs other than alcohol or tobacco, WA, 1984 - 1994**

Type of Drug	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1984-1994
Cannabis	-	-	-	-	-	-	-	-	-	-	-	-
Opioids	8	9	8	3	8	5	2	3	11	8	5	70
Amphetamines/ psychostimulants	-	-	-	-	-	-	1	-	-	-	-	1
Cocaine	-	-	-	-	-	-	-	-	-	-	-	2
Hallucinogens	-	-	-	-	-	-	-	-	-	-	-	-
Barbiturates	4	2	3	2	-	1	-	-	-	1	-	13
Tranquillisers/sedative/ anti-depressants	10	5	5	8	2	3	2	5	2	5	18	65
Volatile substances	-	-	-	-	-	-	-	-	1	-	-	1
Other/ unspecified drugs	6	11	9	7	7	6	11	14	11	10	13	105
Other causes	-	-	1	-	1	1	1	-	-	2	1	7
<b>Total</b>	<b>28</b>	<b>27</b>	<b>26</b>	<b>20</b>	<b>18</b>	<b>16</b>	<b>17</b>	<b>22</b>	<b>26</b>	<b>26</b>	<b>38</b>	<b>264</b>

**Table 7.26: Annual estimated number of all deaths caused by drugs other than alcohol or tobacco, WA, 1984 - 1994**

Type of drug	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1984-1994
Cannabis	-	-	-	-	-	-	-	-	-	-	-	-
Opioids	20	27	20	16	25	23	20	16	26	28	46	267
Amphetamines/ psychostimulants	-	-	-	-	-	-	1	3	-	1	-	5
Cocaine	1	-	-	-	1	-	-	-	-	-	-	5
Hallucinogens	-	-	-	-	-	-	-	1	1	1	-	3
Barbiturates	9	5	6	4	-	3	-	1	1	1	-	30
Tranquillisers/sedatives/ anti-depressants	15	10	9	12	5	4	5	7	6	11	29	113
Volatile substances	1	1	5	4	1	3	5	3	1	3	3	30
Other drugs	14	18	24	26	16	16	25	24	24	23	21	231
Other causes	-	1	2	1	1	2	2	1	1	3	3	17
<b>Total</b>	<b>60</b>	<b>62</b>	<b>66</b>	<b>63</b>	<b>49</b>	<b>51</b>	<b>58</b>	<b>57</b>	<b>61</b>	<b>71</b>	<b>102</b>	<b>701</b>

## **7.3. Psychostimulants**

### **7.3.1. Introduction**

Amphetamines are the most commonly abused psychostimulant drug. Other psychostimulants include cocaine, ‘crack’, methylphenidate, phentermine (Duromine), diethylpropion (Tenuate Dospan) and caffeine. Amphetamines originated as pharmaceutical drugs and were widely used for a number of years to treat medical conditions such as epilepsy, obesity, narcolepsy, depression and hyperkinetic children.

Methylphenidate (Ritalin) is a psychostimulant related to the amphetamines and shares some of their properties but is less potent. It increases activity, delays fatigue and lifts mood but has minimal effect upon appetite or blood pressure. The most controversial use of methylphenidate is in the treatment of the behavioural disorder in children previously known as hyperkinesis, which is now known as attention deficit hyperactivity disorder (ADHD). There has been increasing concern about the long term effects of using Ritalin to treat children for ADHD. One such concern identified in recent American research was that those children prescribed Ritalin are more likely to smoke and three times as likely to abuse cocaine as adults.<sup>351</sup>

During the 1950s and 1960s, amphetamines were quite widely used, as they were available as over the counter drugs (for example in Japan) or by prescription in a number of other countries. However, with mounting evidence that users readily became dependent on amphetamines, during the 1970s restrictions were placed on their availability by prescription in the UK and in Australia. The best known amphetamines in Australia (when they were available on prescription until the late 1970s), in decreasing order of potency, were dexamphetamine (eg Dexedrine), methamphetamine (eg Methedrine) and amphetamine (eg Benzedrine).

### **7.3.2. Prevalence**

#### **7.3.2.1. WA data**

##### **Youth**

A survey of 12 to 17 year old WA secondary school students was conducted by Health Promotion Services in metropolitan and rural schools in 1996. Given the small percentages and comparatively large confidence intervals, extreme caution is advised when making conclusions about prevalence of use in the population. Comparison with other, earlier studies of young people’s illicit drug use is problematic due to small sample sizes and different research methodology.

The 1996 ASSAD survey found that 5.2% of 12 to 17 year olds had used amphetamines in the last year, and 2.3% had done so in the last month. In the 16 to 17 year old age group, 9.5% of males and 8% of females had used amphetamines in the last year; 4.7% of males and 1.5% of females had used in the last month. In comparison, 5% of males and 3.5% of females in the 12 to 15 years age group had used in the last year; 2.4% of males and 1.7% of females had done so in the last month.

##### **Adults**

The Tobacco, Alcohol and Illegal Drugs Consumption Survey (TAIDCS) of Western Australians aged 18 years and over was conducted by Health Promotion Services in 1997. Comparison with previous national figures is problematic due to the small WA sample sizes in the National Surveys, and is compounded by the small numbers of people using these illicit drugs.

The 1997 survey found that 13.2% of 18 to 24 year olds had used amphetamines in the last year, and 6.1% of 18 to 24 year olds had done so in the last month. In comparison, 4.8% of 25 to 34 year olds had used amphetamines in the last year, and 2.1% had done so in the last month.

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<sup>351</sup> Motluk A. “Calm before the storm.” *New Scientist* 18 April 1998.

Among the adult population aged 18 years and over, 3.1% had used amphetamines in the last year, and 1.4% had used in the last month. Amphetamine use was higher among males than females, with 4.3% of adult males reporting use in the last year compared to 1.8% of females.

### 7.3.2.2. National data

An analysis of national trends in illicit drug prevalence was recently published in conjunction with the evaluation of the National Drug Strategy 1993-1997.<sup>352</sup> This data shows some variability in the proportion of the Australian population which used illicit amphetamines in the previous 12 months between 1988 and 1995. Overall prevalence remained at about 3%. It is to be noted that usage was concentrated in the 14 to 39 years age group and that males were more likely than females to have used amphetamines (Table 7.27; Figure 7.11).

Use of amphetamines by 14 to 19 year old persons declined from 6.0% to 2.4% between 1988 and 1995. In the same period, prevalence of illicit amphetamine use increased from 5.0% to 8.4% for the 20 to 29 age group, whereas the 30 to 39 age group remained relatively stable, at just over 1.0%.

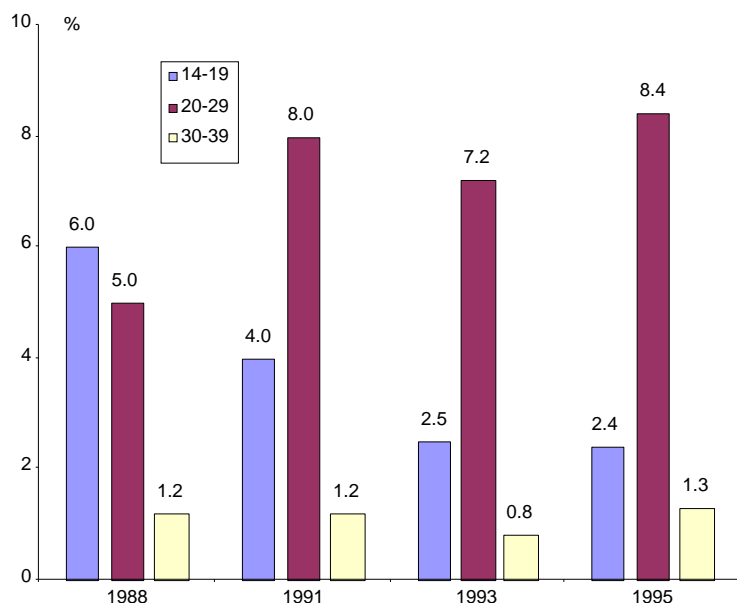
**Table 7.27: Prevalence (%) of illicit amphetamine use in the past 12 months by age group, Australia, 1988 - 1995**

Year	14-19	20-29	30-39	40-49	50-59	60+	Combined
<b>Males</b>							
1988	8.9	6.7	1.6	0.7	-	-	2.5
1991	6.0	11.5	2.7	0.4	1.4	0.4	4.0
1993	1.7	11.5	0.8	-	0.2	-	2.8
1995	2.9	10.5	2.1	0.6	-	-	2.8
<b>Females</b>							
1988	2.9	3.3	0.9	-	1.0	-	1.2
1991	3.0	4.4	-	-	-	0.5	1.2
1993	3.4	2.9	0.9	-	-	-	1.1
1995	1.9	6.3	0.5	0.5	-	-	1.5
<b>Persons</b>							
1988	6.0	5.0	1.2	0.4	0.5	-	1.9
1991	4.0	8.0	1.2	0.2	0.7	0.4	2.6
1993	2.5	7.2	0.8	-	0.1	-	1.9
1995	2.4	8.4	1.3	0.6	-	-	2.1

Source: NDS Household Surveys.  
 Note: For 1993 age ranges = 14-19, 20-29, 30-39, 40-54, 55-69, 70+.  
 For 1991 the 14-19 age group subject to rounding errors.  
 Sampling variability ages 40 + too high for most practical uses.

<sup>352</sup> Williams P. *Progress of the National Drug Strategy: key national indicators. Evaluation of the National Drug Strategy 1993-1997 statistical supplement.* Canberra, Department of Health & Family Services, 1997.

Figure 7.11: Prevalence (%) of illicit amphetamine use in the past 12 months by age group, Australia, 1988 - 1995



### 7.3.3. Indicators of abuse

#### 7.3.3.1. ADIS calls

Over the period 1986 to 1998 a total of 13,113 psychostimulant related telephone calls were dealt with by ADIS; this was 10.9% of the total of 120,243 drug related calls received in WA (Table 13, Appendix 13). Psychostimulant related calls constituted 24.8% of the total of 52,790 illicit drug calls received.

Compared to the low number of calls up to the end of 1989, over the five year period 1990 to 1994 the number of psychostimulant related calls received per quarter increased by nearly two and one half times, from just over 150 calls in the March 1990 quarter, to a peak of nearly 500 calls in the December 1994 quarter (Table 7.28).

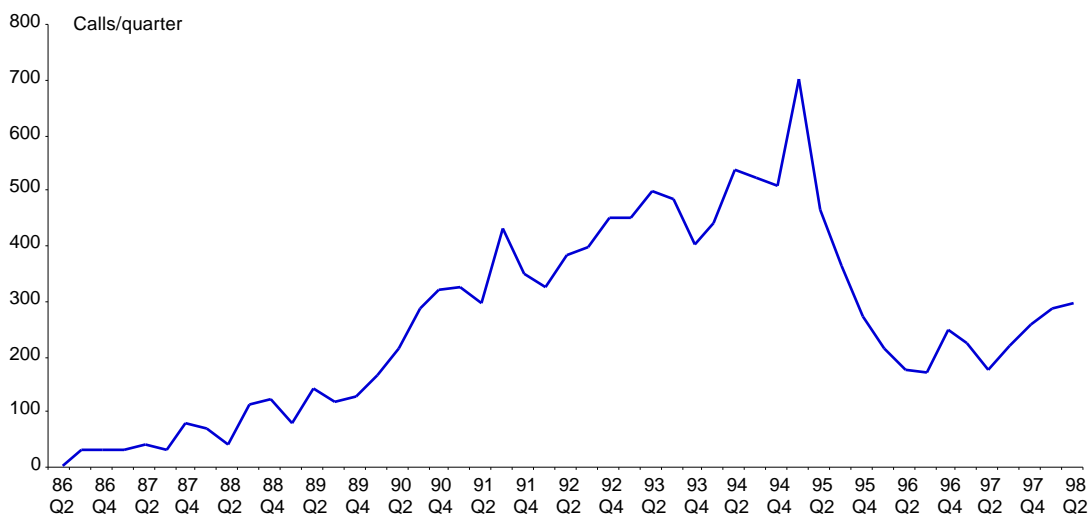
There has been a marked drop in the number of psychostimulant calls after the peak at the end of 1994. From the March quarter 1996 to the June quarter 1997, the number of calls was relatively static, fluctuating between about 180 and 260 calls per quarter. However, since the September quarter 1997 (237 calls) to the June quarter 1998 (301 calls), the number of quarterly calls increased by 27.0% (Figure 7.12).

**Table 7.28: Quarterly ADIS psychostimulant related telephone calls, 1986 - 1998**

Year	Quarter	No. calls	Year	Quarter	No. calls
1986	January-March	-	1992	January-March	329
	April-June	-		April-June	387
	July-September	36		July-September	401
	October-December	32		October-December	455
	<b>Total</b>	<b>68</b>		<b>Total</b>	<b>1,572</b>
1987	January-March	36	1993	January-March	453
	April-June	41		April-June	499
	July-September	34		July-September	487
	October-December	83		October-December	404
	<b>Total</b>	<b>194</b>		<b>Total</b>	<b>1,843</b>
1988	January-March	70	1994	January-March	443
	April-June	42		April-June	540
	July-September	115		July-September	526
	October-December	123		October-December	512
	<b>Total</b>	<b>350</b>		<b>Total</b>	<b>2,021</b>
1989	January-March	83	1995	January-March	703
	April-June	143		April-June	467
	July-September	119		July-September	365
	October-December	130		October-December	273
	<b>Total</b>	<b>475</b>		<b>Total</b>	<b>1,808</b>
1990	January-March	168	1996	January-March	215
	April-June	217		April-June	177
	July-September	290		July-September	174
	October-December	323		October-December	249
	<b>Total</b>	<b>998</b>		<b>Total</b>	<b>815</b>
1991	January-March	327	1997	January-March	227
	April-June	298		April-June	180
	July-September	436		July-September	223
	October-December	352		October-December	261
	<b>Total</b>	<b>1,413</b>		<b>Total</b>	<b>891</b>
			1998	January-March	289
				April-June	301

Source: Alcohol and Drug Information Service.

**Figure 7.12: Quarterly psychostimulant related calls to ADIS, 1986 - 1998**



### 7.3.3.2. Admissions to hospitals

#### All causes

Over the period 1982 to 1992 there was a total of 249 admissions to hospitals caused by psychostimulants, of which 114 (45.8%) were males and 135 (54.2%) were females.

Psychostimulants accounted for 1.2% of the total of 20,528 inpatient admissions to hospitals due to drugs other than alcohol that occurred in WA over this period (Table 7.29).

**Table 7.29: Psychostimulant related hospital admissions by sex, WA, 1982 - 1992**

	Males		Females		Persons	
	n	%	n	%	n	%
Psychostimulants	114	1.3	135	1.1	249	1.2
All drugs (other than alcohol)	8,677	100.0	11,851	100.0	20,528	100.0

#### Poisoning

Over the period 1982 to 1992 there was a total of 169 hospital admissions due to poisoning by psychostimulants, of which 66 (39%) were males and 103 (61%) were females (Table 7.30).

Psychostimulants accounted for 1.1% of the total of 15,891 inpatient admissions to hospitals due to poisoning caused by drugs (other than alcohol) that occurred over this period.

**Table 7.30: Psychostimulant related hospital admissions due to poisoning by sex, WA, 1982 - 1992**

	Males		Females		Persons	
	n	%	n	%	n	%
Psychostimulants	66	1.0	103	1.0	169	1.1
All types of drugs	6,261	100.0	8,580		15,891	100.0

#### Trends

The age standardised rate (ASR) of hospitalisation in relation to psychostimulant drugs were very low over the period for both males and females, although small increases were recorded over the latter part of the period, especially involving females (Table 7.31).

**Table 7.31: Age standardised rate of hospitalisation due to poisoning by psychostimulants, WA, 1982 - 1992**

	Males	Females
1982	0.1	0.3
1983	0.1	0.5
1984	0.3	0.6
1985	0.5	0.5
1986	0.7	0.4
1987	0.8	2.3
1988	1.3	1.8
1989	0.5	1.7
1990	0.8	1.2
1991	1.7	2.0
1992	1.0	2.2

### 7.3.3.3. Admissions to psychiatric hospitals

#### Overview

Over the period 1988 to 1997, there were a total of 199 admissions caused by amphetamines due to drug dependence or non dependent drug abuse, which resulted in 748 beddays of inpatient stays at psychiatric hospitals and units in this State. It is estimated it cost the mental health system a total of nearly \$250,000 to treat those admitted for the first time from 1988 to 1997 with mental disorders due to amphetamines. This was a mean of 20 first time admissions per year to inpatient psychiatric facilities in this State over the 10 year period (Table 7.32).

Of these 199 admissions, 141 admissions (70.8%) and 502 beddays (67.1%) were due to the non dependent abuse of amphetamines. In relation to all types of drug caused mental disorders over this 10 year period, amphetamines were responsible for 0.9% of the 11,639 admissions and 1.6% of the 46,071 beddays due to the abuse of drugs other than alcohol.

**Table 7.32: Annual first ever admissions of drug related mental disorders due to amphetamine abuse, WA, 1988 - 1997**

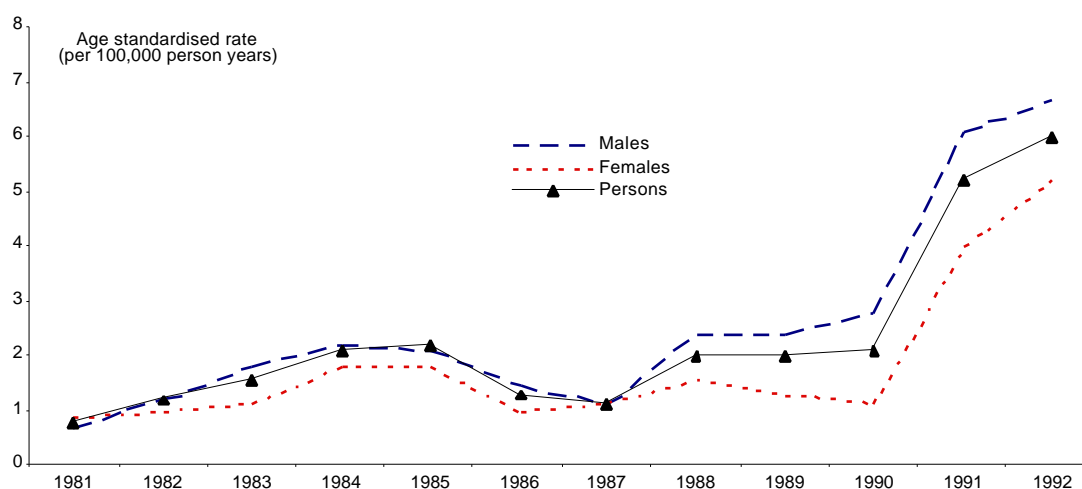
	Beddays	\$	Admissions
1988	3	792	3
1989	9	2,628	6
1990	31	9,629	14
1991	52	16,302	14
1992	59	18,561	22
1993	180	58,140	37
1994	258	86,920	56
1995	94	33,182	26
1996	30	10,764	9
1997	32	11,680	12
<b>Total</b>	<b>748</b>	<b>248,598</b>	<b>199</b>

Note: Combined cases for amphetamine dependence and non dependent amphetamine abuse.

#### Trends

Over the period 1981 to 1990, the age standardised rate (ASR) of hospitalisation for psychostimulant related psychoses was around 1.5 to 2 per 100,000 person years. However in 1991 and 1992 the rate of admission for this diagnostic group has increased by nearly three fold for males and five fold for females (Figure 7.13; Table 7.33).

**Figure 7.13: Age standardised rate of hospitalisation of drug related mental disorders due to psychostimulant related psychoses by sex, WA, 1981 - 1992**



**Table 7.33: Age standardised rate of hospitalisation of drug related mental disorders due to psychostimulant related psychoses by sex, WA, 1981 - 1992**

	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
Males	0.7	1.2	1.8	2.2	2.1	1.5	1.1	2.4	2.4	2.8	6.1	6.7
Females	0.9	1.0	1.1	1.8	1.8	1.0	1.1	1.6	1.3	1.1	4.0	5.2
Persons	0.8	1.2	1.6	2.1	2.2	1.3	1.1	2.0	2.0	2.1	5.2	6.0

Note: Age standardised rate per 100,000 person years.

## 7.3.4. Amphetamines

### 7.3.4.1. Effects

Amphetamines are potent drugs that have a multiplicity of biological effects, including hyperthermic, anorectic, cardiovascular and central nervous system stimulant actions. The stimulant action of amphetamines is similar to the naturally occurring hormone adrenalin.

As a major action of amphetamines is to inhibit sleep and fatigue, the drug is particularly attractive to people like truck drivers and students, who may wish to stave off normal fatigue, to enable them to work for extended periods of time with little sleep or food. Truck drivers have been identified as a particularly high risk group, as amphetamine allows them to drive for long periods of time without rest and increase the number of trips they can complete in a given period.

### 7.3.4.2. Health and social problems

Concern that amphetamine users are a high HIV risk group arises from the tendency for the drug to be used intravenously and in conjunction with alcohol and other drugs. Multiple drug use may also occur among amphetamine users due to the use of depressant drugs (such as alcohol, hypnosedatives, and barbiturates) to combat side effects (such as sleeplessness).

A number of health and social problems have been identified to be due to the long term effects of amphetamines, including:

- malnutrition (because amphetamines suppress appetite), illnesses related to nutrition, vitamin deficiencies, and increased susceptibility to disease;
- violence in the form of intense and sudden acts of aggression (stemming from paranoia, feelings of persecution and distortion of perception); and
- mental health problems (such as depression) occurring in a cyclic form such as when a chronically depressed person uses amphetamines, becomes dependent on them, tries to discontinue usage, suffers depression as a withdrawal symptom, and resorts to further amphetamine use.

### **7.3.4.3. Withdrawal syndrome**

In common with other forms of psychostimulant withdrawal, people experiencing amphetamine withdrawal usually experience a three phase process - described as the “crash”, withdrawal, and extinction.

In the initial period (the “crash”), which follows a period of intensive and extended use (a “run”), users frequently experience fatigue and exhaustion, extending from several hours to several days.

In the withdrawal phase, which may last for a number of weeks or even months, users typically experience one or more of the following effects:

- lethargy/fatigue;
- long but disturbed sleep;
- irritability;
- strong hunger;
- deep depression that may lead to attempted suicide;
- fits of violent action;
- anxiety attacks;
- psychic disruption and loss of self control which may result in aggression;
- headaches;
- trouble breathing;
- sweating;
- muscle cramps;
- gastrointestinal cramps; and
- severe secondary reactions (eg influenza and pneumonia).

In the extinction phase, users normal mood and behaviour is interrupted by episodic craving, often in response to conditioned cues. These episodes of intense craving may last minutes or hours, and may recur months or even years after cessation of use.

Most of the above florid symptoms usually dissipate within a few days or weeks of cessation of use of amphetamines. There is usually a significant improvement in mood, energy, and paranoid thinking within a short time. However, users will also experience other symptoms for a number of months after extinction, such as interruption to normal sleep patterns, memory loss, confusion and paranoid thinking and perceptual abnormalities.

## **7.3.5. Cocaine**

### **7.3.5.1. Introduction**

While cocaine was only discovered by Europeans in the nineteenth century, it had been used for centuries by South American Indians, who chewed the leaves. In Western European countries, it is believed that until the mid 1980s cocaine had tended to be used by people from well educated and higher socioeconomic groups given the high cost of its crystalline form which is inhaled.

In the mid 1980s, ready made free base cocaine was extensively marketed in American cities and became known as “crack.” Crack, a much cheaper and more accessible version of cocaine, is extensively used among lower socioeconomic groups, particularly in the inner city areas dominated by racial and ethnic minorities in the United States of America. Crack use has also spread to Western European countries, where low price has allowed it to become accessible to and used by young people.

In the US, crack has been found to be the cause of serious social and health problems (such as violent crime, prostitution, psychiatric problems and antenatal problems, with 10% of pregnant women reporting use at least once during pregnancy) amongst significant numbers of users.

### 7.3.5.2. Prevalence

The extent of cocaine use in the US can be gauged from surveys which estimate that in 1992:

- 25 million people had used cocaine at least once;
- 6 million people had used it within the previous month; and
- 3 million people were using the drug continuously.

Surveys have shown that cocaine use is much less prevalent in Australia. For instance, a 1989 report by the Parliamentary Joint Committee on the National Crime Authority 1988-1989 estimated that 84,500 people had used cocaine in the past 12 months and 6,640 people were regular users.

There is evidence to indicate that cocaine use has remained stable in Australia between 1985 and 1991. On a national basis however, surveys suggest there has been an increase in prevalence by women in their early twenties and early thirties,<sup>353</sup> although use in WA appears not to have increased significantly.

### 7.3.5.3. Overview

Cocaine is derived from the coca shrub and when inhaled or injected, affects a number of neurotransmitter systems in the brain and anatomical sites within the central nervous system. While there is a lack of consensus by researchers, the preponderance of evidence suggests while cocaine does not produce the specific physiological withdrawal symptoms observed with the abstinence of alcohol, benzodiazepines and opiates, it nevertheless is a highly addictive drug.

It may be inhaled intranasally (“snorted”), inhaled when converted to the free base form (“free basing”), and injected intravenously (“mainlined”).

#### ***Intranasal inhalation***

When extracted from coca leaves, cocaine is in the form of a salt (cocaine hydrochloride) which can be inhaled into the nostril, where it is rapidly absorbed into the bloodstream across the nasal mucosa.

#### ***Inhalation (“free basing”)***

Cocaine hydrochloride may be converted to the free base form, through processing by use of volatile solvents, which must be separated before use. When free base cocaine is burnt, the fumes are inhaled, producing a very rapid and efficient absorption across the membranes of the lungs.

#### ***Injection***

The third method involves dissolving the cocaine salt and injecting it intravenously.

#### ***Withdrawal phase***

Cocaine withdrawal generally involves three phases, the “crash”, withdrawal, and extinction.

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<sup>353</sup> Fox R, Mathews I. *Drug policy: fact, fiction and the future*. Annandale, NSW, Federation Press, 1992.

The first phase (the “crash” phase) refers to withdrawal symptoms experienced immediately after the cessation of use, most often experienced in the first 2 to 4 days after cessation of use. Users experience a number of symptoms, including agitation, depression, high craving and fatigue.

The second phase of withdrawal may extend over 1 to 2 months, and is characterised by depression, lack of energy and anxiety, high craving and angry outbursts.

The last phase, extinction, may extend over a long period of time (possibly for a number of years) and is characterised by episodic cravings, usually in response to conditioned cues. (A similar phenomenon, which can be responsible for relapse, also occurs in relation to tobacco smokers and heroin users.)

**Adverse effects**

The adverse effects of cocaine use depend on a combination of factors:

- form of the drug;
- mode of administration;
- dosage; and
- frequency of use.

The major consequences of cocaine use, which also tend to occur in relation to the use of other psychostimulants, have been grouped in Table 7.34.

**Table 7.34: Adverse effects of psychostimulant abuse**

Low dose effects	High dose effects	Long term effects
Improved performance	Loss of coordination	Heightened reflexes
Increased confidence	Tremors	Muscle twitching
Increased energy	Dizziness	Increased pulse rate
Exhilaration	Muscle twitches	Loss of appetite
Enhances physical and mental well being	Severe agitation	Insomnia
Increased rate of respiration resulting in rapid shallow breathing	Confusion	Cardiac arrhythmias including malignant arrhythmias
Increased temperature	Paranoid symptoms	Angina
Spasm of local blood vessels	Headaches	Myocardial infarction
Enlarged pupils	Cold sweat	Psychosis – paranoid delusions, auditory and visual hallucinations
Cardiac arrhythmias	Pallor	Tactile hallucinations
Suppressed appetite	Nausea and vomiting	Violent or aggressive behaviour
Insomnia	Weak, rapid pulse	Decreased libido/impotence
	Anxiety reaction	

## 7.4. Volatile substances

### 7.4.1. Introduction

A volatile substance is a compound which gives off a vapour or fumes at room temperature. The recreational sniffing of gases and solvents has become relatively common, particularly among adolescents in Australia, with the mean age of solvent abusers being 12 to 15 years. Petrol sniffing has been noted among some Aboriginal communities, where it has been a cause of serious harm, especially among younger people.<sup>354</sup>

Historically, the use of petrol as an inhalant was largely confined to areas in the Northern Territory and in central Australian communities. Qualitative data suggests that petrol sniffing has

<sup>354</sup> Goodheart RS, Dunne JW. “Petrol sniffer’s encephalopathy.” (1994) 160 *Medical Journal of Australia* 178.

occurred in some indigenous communities since the 1970s. Other research has documented reports in some central Australian indigenous communities as early as the 1950s.<sup>355</sup> The use of petrol and other solvents as inhalants has largely been documented to occur among young indigenous people in remote geographical locations. However, recent reports have documented localised petrol sniffing “outbreaks” in certain rural areas in Queensland, New South Wales and Western Australia, where it has not previously occurred.

Petrol sniffing is cyclical in nature and varies greatly from community to community, and between gender and age. Its pattern is unpredictable, although the mobility of community members at particular times can lead to outbreaks of petrol sniffing in other regions. For example, at ceremony time it has been reported that outbreaks of sniffing have occurred as a result of young people moving into different regions. Reports and anecdotal evidence indicate that more males tend to sniff petrol than do females and the average age tends to be late adolescence.

### 7.4.2. Prevalence

In this section, a range of sources of data from surveys will be referred to, which provide information about the use of volatile substances. Recent prevalence studies of young people indicate that experimental use of inhalants and other volatile substances is relatively common. However, much higher levels and frequencies of use occur in marginalised groups of young people.

#### 7.4.2.1. Marginalised young people

Problematic use of this group of substances usually involves marginalised young people who have left school, infrequently attend school or have come to official attention. Accordingly, detailed data about usage patterns has in a number of instances been sought through surveys that utilise interviews by youth workers<sup>356</sup> and other professionals<sup>357</sup> who have access to such populations of young people.

With respect to use of volatile substances, the survey by Watts of 386 young offenders who were remanded to the former Longmore Remand and Assessment Centre over the period September 1991 to March 1992, found that 20% were currently using glue, another 6% had ceased use of glue and 5% sniffed petrol. One in ten of the respondents reported they used glue daily, which involved the use of at least one tube or tin of glue in a single session.

The ADA survey involved interviews with 238 young people, of whom 174 had ever used volatile substances. There was a group of 80 current users of volatile substances, 44 of whom were males and 36 were females, with ages ranging from 10 to 19 (with 74% aged between 13 and 16). Only 28 (38%) attended school. It was found that three quarters of current users had been using for over four months, with two in five having used for over 18 months. This group were engaged in intensive use, with 80% using for more than two hours at a time.

Of interest, this project was supervised by a clinical psychologist and undertaken by trained research assistants. An assessment was made of whether users of petrol or glue were brain damaged or were possibly brain damaged. It was found all petrol sniffers and 58% of glue users had this level of neurological damage. The comprehensive survey by Dr Patricia Baines investigated a wide range of social, economic and ethnographic issues that were associated with and caused volatile substance abuse. Her survey led to the development of better community resources and social support structures in the North East metropolitan area (in particular Midland) to prevent abuse of volatile substances.

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<sup>355</sup> Brady M. *Heavy metal. The meaning of petrol sniffing in Australia*. Canberra, Aboriginal Studies Press, 1992.

<sup>356</sup> Baines P. *Public perceptions of and concerns about volatile substance use of young people in the north east region of the Perth metropolitan area*. Perth, North East Region Youth council, 1992; Rose J, Daly A, Midford R. *Volatile substance use in Perth*. Perth, Alcohol and Drug Authority, 1992.

<sup>357</sup> Watts P. *Youth in custody project. A profile of juvenile offenders' drug use patterns*. Perth, Youth Suicide Steering Committee, 1992.

### 7.4.2.2. Prevalence surveys

The 1996 ASSAD survey of WA school students found that among 12 to 15 year olds, inhalants had been used by nearly one in five in the past year, about one in ten had used in the past month, and about one in twenty had used in the past week (Table 10, Appendix 13). Similar rates were recorded for 16 to 17 year olds.

In the 1993 and 1995 NDS Household Survey there were higher rates of inhalant use by males compared to females for all Australians aged 14 years and older. Comparing the results of the 1993 and 1995 surveys, male ever use of inhalants ranged from 4.7% to 5.2% respectively, whereas female use of inhalants ranged from 2.4% to 0.5% respectively (Table 2, Appendix 13).

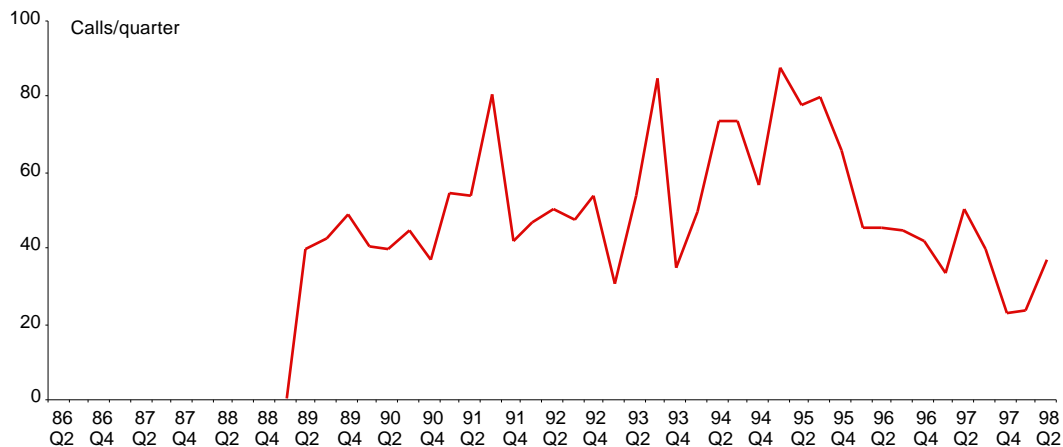
In the 1994 survey of drug abuse by metropolitan high school students, relatively low rates of current use of inhalants were recorded, ranging from 1.7% of year 8 students to 3% of year 11/12 students (Table 12, Appendix 13).

### 7.4.3. Indicators of abuse

#### 7.4.3.1. ADIS calls

Over the period 1989 to 1998, a total of 1,887 volatile substance related telephone calls were dealt with by ADIS; this was 1.6% of the total of the 120,243 drug related calls received in WA (Table 13, Appendix 13). Over the period 1989 to 1998,<sup>358</sup> the number of volatile substance related calls received per quarter was relatively constant, fluctuating at around 50 calls per quarter (Table 7.35; Figure 7.14).

Figure 7.14: Quarterly volatile substance related calls to ADIS, 1986 - 1998



<sup>358</sup> Volatile substances were not separately collated prior to April 1989.

## Select Committee Into Misuse of Drugs Act 1981

**Table 7.35: Quarterly ADIS volatile substance related telephone calls, 1986 - 1998**

Year	Quarter	No. calls	Year	Quarter	No. calls
1986	January-March	-	1992	January-March	47
	April-June	-		April-June	51
	July-September	-		July-September	48
	October-December	-		October-December	54
	<b>Total</b>	-		<b>Total</b>	<b>200</b>
1987	January-March	-	1993	January-March	31
	April-June	-		April-June	54
	July-September	-		July-September	85
	October-December	-		October-December	35
	<b>Total</b>	-		<b>Total</b>	<b>205</b>
1988	January-March	-	1994	January-March	50
	April-June	-		April-June	74
	July-September	-		July-September	74
	October-December	-		October-December	57
	<b>Total</b>	-		<b>Total</b>	<b>255</b>
1989	January-March	-	1995	January-March	88
	April-June	40		April-June	78
	July-September	43		July-September	80
	October-December	49		October-December	66
	<b>Total</b>	<b>132</b>		<b>Total</b>	<b>312</b>
1990	January-March	41	1996	January-March	46
	April-June	40		April-June	46
	July-September	45		July-September	45
	October-December	37		October-December	42
	<b>Total</b>	<b>163</b>		<b>Total</b>	<b>179</b>
1991	January-March	55	1997	January-March	34
	April-June	54		April-June	51
	July-September	81		July-September	40
	October-December	42		October-December	23
	<b>Total</b>	<b>232</b>		<b>Total</b>	<b>148</b>
			1998	January-March	24
				April-June	37

Source: Alcohol and Drug Information Service.

### 7.4.3.2. Admissions to hospitals

#### Overview

Over the period 1982 to 1992, there was a total of 829 hospital admissions due to all causes as a consequence of the abuse of volatile substances, of which 596 (71.9%) were males and 233 (28.1%) were females. Volatile substances accounted for 0.4% of the total of 20,528 inpatient admissions to hospitals due to drugs (other than alcohol) that occurred in WA over this period (Table 7.36).

**Table 7.36: Volatile substance related hospitalisation due to all causes by sex, WA, 1982 - 1992**

	Males		Females		Persons	
	n	%	n	%	n	%
Volatile substances	596	6.9	233	2.0	829	0.4
All drugs (other than alcohol)	8,677	100.0	11,851	100.0	20,528	100.0

#### Poisoning

Over the period 1982 to 1992, there was a total of 663 hospital admissions due to poisoning by volatile substances, of which 468 (70.6%) were males and 195 (29.4%) were females (Table 7.37). Volatile substances accounted for 4.2% of the total of 15,891 inpatient admissions to hospitals due to poisoning caused by drugs other than alcohol that occurred over this period.

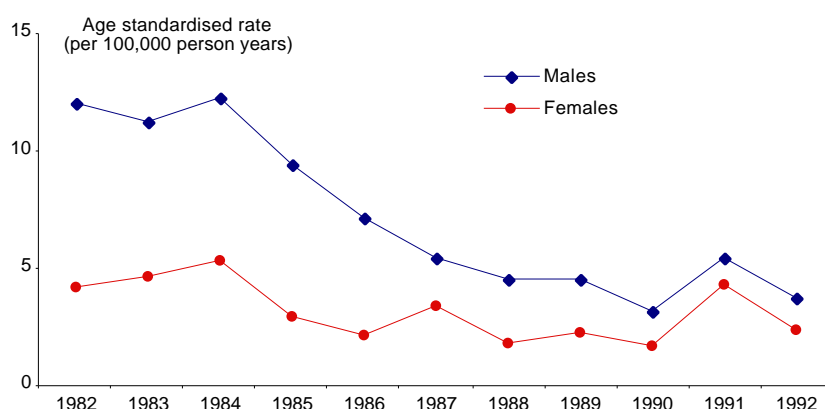
**Table 7.37: Volatile substance related hospitalisation due to poisoning by sex, WA, 1982 - 1992**

	Males		Females		Persons	
	n	%	n	%	n	%
Volatile substances	468	7.2	195	1.9	663	4.2
All drugs (other than alcohol)	6,261	100.0	8,580	100.0	15,891	100.0

**Trends**

Over the period 1982 to 1992, there was a steady decrease in the male age standardised rate of hospitalisation for poisoning due to the abuse of volatile substances to WA hospitals (Figure 7.15). The male rate was at about 12 per 100,000 up to 1984, then declined to a rate of 3.7 by 1992. The female rate, which was lower than the male rate, has decreased slightly since the late 1980s.

**Figure 7.15: Age standardised admission rates of hospitalisation due to poisoning by volatile substances by sex, WA, 1982 - 1992**

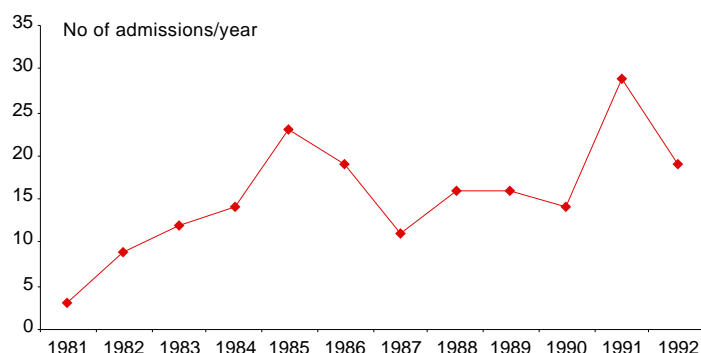


**7.4.3.3. Admissions to psychiatric hospitals**

Over the period 1981 to 1992, there was a total of 952 beddays from inpatient stays in psychiatric hospitals in this State due to volatile substance dependence. The burden of these admissions on the hospital system was relatively small, as the treatment of volatile substance dependent patients amounted to only 3.1% of the total of 30,544 beddays over the period 1981 to 1992 that were attributable to mental disorders caused by drugs other than alcohol.

A total of 185 admissions were recorded over this period (a mean of 15 admissions per year). While there were relatively few admissions for inpatient treatment, it is noted there was an upward trend over the period, with peaks recorded in 1985 and 1991 (Figure 7.16).

Figure 7.16: Annual admissions to psychiatric hospitals due to volatile substance dependence, WA, 1981 - 1992



#### 7.4.3.4. Mortality

Over the period 1984 to 1994, a total of 30 deaths were due to volatile substance abuse in WA, of which 29 were deaths of males. More recent data is not presently available to provide more current information.

While petrol sniffing has been researched and known about for a number of years, reliable mortality and morbidity data is limited as many collections do not enumerate petrol related illnesses or deaths. Most data is confined to State coronial records and are estimates; however, this data does not separate deaths in terms of indigenous and non indigenous identity.

It has been estimated that there were a total of 133 deaths in Australia over the period 1980 to 1988 attributable to the use of volatile substances (Table 7.38). It is to be noted these data includes 2 deaths, one involving both fluorocarbon spray and lighter fluid, and the other involving both correction fluid and natural gas.

A number of important findings from this mortality data include that:

- aerosol sprays were responsible for 30 deaths (22.6%);
- 50 (37.6%) deaths involved the 15 to 19 year age group; and
- 13 (31.0%) of the 42 deaths in the 30 years and older age group were due to liquid petroleum gas.

**Table 7.38: Deaths caused by volatile substances by age group, Australia, 1980 - 1988**

Substance	Age (years)					Total
	<10	10-14	15-19	20-29	30+	
Aerosol sprays						
Hydrocarbon	-	2	-	1	1	4
Fluorocarbon	-	1	10	-	-	11
Other	-	1	6	4	4	15
Liquid petroleum gas	-	-	2	5	13	20
Petrol	-	-	11	7	2	20
Typing correction fluid	-	2	6	-	1	9
Natural gas	-	1	-	2	7	10
Lighter fluid or gas	-	2	5	1	-	8
Anaesthetics	-	-	3	6	4	13
Glues, etc	-	-	2	-	1	3
Thinners, cleaning fluids	-	3	2	-	5	10
Others	-	-	3	3	4	10
<b>Total</b>	-	<b>12</b>	<b>50</b>	<b>29</b>	<b>42</b>	<b>133</b>

Source: National Drug Abuse Information Centre.

The main difficulty in recording deaths due to petrol sniffing or other inhalant use is that deaths are recorded under their medical manifestation, not their solvent use. For example, deaths from end stage renal failure and respiratory disease due to petrol sniffing are often recorded as the former rather than the latter, which essentially result in an underestimation of the morbidity and mortality rates of petrol sniffing. Currently, there are no comprehensive data collection mechanisms for the measurement and identification of mortality from petrol and other inhalant use to address these difficulties in data collection.

There are significant levels of morbidity relating to petrol sniffing. Many communities care for people who are physically and mentally disabled as a result of sniffing and many individuals sustain permanent damage as a result of both short term and longer term chronic sniffing. In the context of urban indigenous communities, a recent study indicates petrol sniffing is not limited to indigenous young people living in remote communities.<sup>359</sup>

#### **Recommendation 23**

*That the WA Drug Abuse Strategy Office review currently available West Australian information about the extent of volatile substance use, identify areas for additional research and establish a working party to determine additional services and strategies to reduce the use of volatile substances in the metropolitan and regional areas.*

### **7.4.4. Patterns of use**

Volatile substance abusers (VSAs) tend to fall into one of three patterns of use related to age:

- the largest group are occasional or experimental users, who tend to have an average age of 12 or 13 years;
- polydrug abusers, who are an older group (usually in their mid to late teens), who abuse volatile substances in conjunction with a range of other drugs, and who are likely to use volatile substances in a moderate or episodic binge fashion; and

<sup>359</sup> Perkins et al “The prevalence of drug use in urban Aboriginal communities.” (1994) 89 *Addiction* 1319-1331.

- inhalant dependent individuals, who exclusively and frequently abuse volatile substances, often on a daily basis – this group tends to involve older adolescents and young adults.

### **7.4.5. Harm**

In a British study, it was found that nearly one in five sudden deaths were caused by volatile substance abuse, where there was no history of previous VSA.<sup>360</sup> In the UK over the period 1971 to 1989, it was estimated that 963 young people had died from VSA, of whom 88% were males and nearly half of all deaths involved persons aged 16 years or younger.<sup>361</sup> Nearly one third of these 963 deaths involved gas fuels (butane from lighter refills or domestic gas cylinders), with a further one in five deaths due to deodorant aerosols, and 21% due to glues. While more than half of the mortality in the study was due to the direct toxic effects (resulting in acute cardiac arrhythmias), 16% of deaths were due to suffocation from a plastic bag, 13% due to the inhalation of vomitus, and 12% due to trauma (especially following the use of glues).

In Australia, deaths due to petrol sniffing have in the past been a particularly serious problem amongst Aboriginal communities, with 35 deaths (average age of 19.2 years) being due to petrol inhalation over the period 1980 to 1988.<sup>362</sup>

### **7.4.6. Types of volatile substances**

There is a large range of volatile substances, such as petroleum fuels, propellants from aerosol products, chlorinated hydrocarbons, glue, nail polish remover, antifreeze, paint thinners and anaesthetic products (Table 7.39).

### **7.4.7. Organic solvents and aerosols**

This group includes alcohols, esters and ketones, aliphatic and aromatic hydrocarbons and halogenated hydrocarbons. Commonly abused products include adhesives, plastic cement and thinners which contain toluene and xylene, cleaning agents, typist correction fluid and thinners which contain trichloroethane and trichloroethylene. Fluorocarbon propellants, known collectively as freons, are used in aerosols and as refrigerants, while bromochlorodifluoromethane (BCF) is used in fire extinguishers.

Vapours may be inhaled directly from the container, or from a rag or clothing saturated in the substance and held over the nose and mouth. Alternatively, the substance may be placed in a plastic bag from which the concentrated vapours are inhaled. This may result in a perioral rash which is well described in chronic volatile substance abusers.

Most hydrocarbons are central nervous system depressants and early effects of inhalation resemble alcohol intoxication. Inhalation provides rapid onset and relatively short duration of effect. Continued inhalation may lead to increased intoxication when confusion, perceptual distortion and hallucinations often cause aggressive behaviour. At higher doses ataxia, dysarthria, convulsions and coma may ensue. Regular abusers become skilled at controlling the amount of substance inhaled to prolong the effects.

Chronic abuse of solvents is associated with a variety of medical problems with a real risk of death. Mechanisms by which individual solvents damage organs and organ systems are not well understood. The situation is compounded as many products contain more than one solvent, and the effects of solvent combinations are little understood.

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<sup>360</sup> Chalmers EM. "Volatile substance abuse." (1991) 154 *Medical Journal of Australia* 269, 270.

<sup>361</sup> Johns A. "Volatile solvent abuse and 963 deaths." (1991) 86 *British Journal of Addiction* 1053.

<sup>362</sup> Brady M. *Heavy metal. The meaning of petrol sniffing in Australia*. Canberra, Aboriginal Studies Press, 1992, 54.

**Table 7.39: Commonly abused volatile substances**

Compound	Principal sources
Acetone	Nail polish remover, adhesives, general solvent
Aliphatic hydrocarbons	Petrol, white spirit
Bromochlorodifluoromethane (BCF)	Fire extinguishing agent
n-Butane	Bottled fuel gas
Butanone (methyl ethyl ketone, MEK)	Adhesives, general solvent
Carbon tetrachloride	Grain fumigant, Laboratory solvent
Chloroform	Laboratory solvent
Chlorodifluoromethane (Halon 22)	Aerosol propellant
Dichlorodifluoromethane (Halon 12)	Aerosol propellant, refrigerant
Dichloromethane	Paint stripper
Dichlorotetrafluoroethane (Halon 114)	Aerosol propellant
Diethyl ether	Laboratory solvent
Enflurane	Anaesthetic
Ethyl acetate	Adhesives
Halothane	Anaesthetic
n-Hexane	General solvent
Isoflurane	Anaesthetic
Methyl iso-butyl ketone (MIBK)	General solvent
Nitrous oxide	Anaesthetic
Propane	Bottled fuel gas
Tetrachloroethylene (Perchloroethylene)	Dry-cleaning and degreasing agent
Toluene	Adhesives, acrylic paints, paint stripper
1,1,1-Trichloroethane (methylchloroform)	Dry-cleaning and degreasing agent, typewriter correcting fluid
Trichloroethylene	Dry-cleaning and degreasing agent, chewing gum remover
Trichlorofluoromethane (Halon 11)	Aerosol propellant, refrigerant
Xylene	Woodwork adhesives

### 7.4.8. Petrol and fuel gases

Petrol sniffing appears to be a problem in societies which may be seen as disadvantaged. The Senate Select Committee on Volatile Substance Abuse in 1985 reported on petrol inhalation among youth of Aboriginal communities as a separate issue from volatile substance abuse among urban youth, dedicating approximately 40% of the document to the problem.

Petrol is a mixture of  $C_4$  to  $C_{12}$  hydrocarbons, the relative amounts of the various constituents depending on the origin and preparation of the petrol. The unsaturated hydrocarbons have mild anaesthetic properties, while the saturated hydrocarbons have a narcotic effect. The principal additive is tetraethyl lead, which also has intoxicant properties. Tetraethyl lead and its metabolites are highly neurotoxic.

Fifteen to twenty inhalations of petrol will cause euphoria and intoxication for three to six hours. Prolonged inhalation or rapid inhalation of a highly concentrated vapour (such as when a petrol soaked cloth is held to the nose) may lead to violent excitement followed by loss of consciousness, coma or death. Organic lead toxicity is regarded as the major long term health hazard from petrol sniffing, although some of the aliphatic hydrocarbons (for example, toluene, *n*-hexane) if present may contribute to the pathological changes.

The syndrome of ataxia, tremor and encephalopathy seen in chronic sniffers is attributed to tetraethyl lead toxicity. Other long term sequelae of chronic sniffing include nutritional disturbances, anaemia and cardiac, liver and renal effects. Cognitive functioning may also be impaired and there is evidence that some of these changes are irreversible.

Abuse of the fuel gases propane and butane occurs and, although not as well documented in the literature, has an important association with suicide.

## **7.4.9. Volatile substance abuse and young people**

The Select Committee received evidence from a number of witnesses of the extensive amount of harm to individuals, their families and the community which arose from the abuse of volatile substances. The issue of volatile substance abuse (VSA) was particularly serious in Kalgoorlie and surrounding districts.

It is clear that this is a particularly serious problem which requires a combination of actions, including controls over access to volatile substances, and the development of recreational and other leisure and activity programs to enable young people to avoid the boredom that facilitates VSA.

It was also pointed out by witnesses that, in some instances, transgenerational factors affected young people who became involved in VSA, such as when parents themselves had problems from the abuse of alcohol, and older siblings introduced younger children to volatile substances.

The Select Committee is also aware of reports of significant levels of chronic abuse of volatile substances in the Perth metropolitan area. For instance, a recent article in a community newspaper reported concerns of parents of children sniffing glue and solvents in the Rockingham area. It was recommended to local retailers that they should make glues and solvents inaccessible to young people so that they could not be stolen. The MLA for Rockingham, Mr Mark McGowan said “(h)e was surprised the sale of such products to minors was not illegal”.<sup>363</sup>

The North East Regional Youth Council has been funded to provide a number of programs to assist young people in the Midland area who are abusing volatile substances.<sup>364</sup> It is believed that the majority of these abusers involve Aboriginal young people.

Volatile substance abuse has at times caused difficulty for the police, with young people intoxicated from using volatile substances loitering around the Perth railway station and other inner city areas. There have also been difficulties with this issue late at night in the city and in Northbridge. At times, this has involved significant amounts of resources by police and welfare organisations in taking these intoxicated young people home or to appropriate safe accommodation.<sup>365</sup>

It was suggested by representatives from Holyoake (who have a specific young people’s program) that there was a need for a sobering up type centre in Perth, where young people who were intoxicated with volatile substances and other illicit drugs could be taken.

The purpose for such a facility would be to provide in the first instance a place of safety, as otherwise if they remained on the streets late at night they could be assaulted or exposed to other risks. Such a shelter would also be an opportunity for youth workers and other outreach workers to make contact with this hard to reach group who were at high risk of social, legal and health problems.

### ***Recommendation 24***

***That a working party consisting of the key stakeholders and agencies be established to consider the feasibility of developing a sobering up program especially targeted at young people who are affected by volatile substances and other illicit drugs.***

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<sup>363</sup> “MP hears of drugs, solvent concerns.” *Courier* 3 July 1998.

<sup>364</sup> See Appendix 9 for details of these programs.

<sup>365</sup> This specific issue is outlined in further detail in chapter 8 in relation to the proposal by the Perth City Mission for the *On Track, Safe Transitions Youth Project* (see also Appendix 8).

## 7.4.10. Gaps in the law

The Select Committee notes that in the United Kingdom the *Intoxicating Substances (Supply) Act 1985* criminalises the sale of products to young people such as toluene, paint and glues. This Act is targeted at situations where a retailer has a reasonable belief that the young person is likely to inhale the fumes from these products. The provisions of this Act are reproduced below.

### Intoxicating Substances (Supply) Act 1985

#### *Offence of supply of intoxicating substance*

- 1 (1) It is an offence for a person to supply or offer to supply a substance other than a controlled drug -
- (a) to a person under the age of eighteen whom he knows, or has reasonable cause to believe, to be under that age; or
  - (b) to a person -
    - (i) who is acting on behalf of a person under that age; and
    - (ii) whom he knows, or has reasonable cause to believe, to be so acting,if he knows or has reasonable cause to believe that the substance is, or its fumes are, likely to be inhaled by the person under the age of eighteen for the purpose of causing intoxication.
- (2) In proceedings against any person for an offence under subsection (1) above it is a defence for him to show that at the time he made the supply or offer he was under the age of eighteen and was acting otherwise than in the course or furtherance of a business.
- (3) A person guilty of an offence under this section shall be liable on summary conviction to imprisonment for a term not exceeding six months or to a fine not exceeding level 5 on the standard scale (as defined in section 75 of the Criminal Justice Act 1982),<sup>366</sup> or to both.
- (4) In this section ‘controlled drug’ has the same meaning as in the Misuse of Drugs Act 1971.

There is much appeal with having a clear statement of responsibilities and duties placed on those who are in a position to facilitate the abuse of these substance by knowingly selling products which are used by those involved in VSA. Reform of the law in this area would also resolve some uncertainty in the law in relation to volatile substances.

#### ***Recommendation 25***

***That a working party be established to consider the merits of legislating to prohibit the sale of substances to those who are suspected or known to abuse volatile substances.***

## 7.4.11. Volatile nitrites

Amyl nitrite has been used medically since 1867 for the relief of angina pectoris. In the United States in the 1960s, the non medicinal use of amyl nitrite as a euphoriant and an enhancer of sexual performance became popular. Similar use has been reported in Australia. The extent of use

<sup>366</sup> At present £2,000.

of volatile nitrites is unknown but may be extensive among certain populations, notably homosexual males.

The effects of nitrite inhalation are predominantly smooth muscle relaxation and dilatation of the vascular beds. Toxic effects include confusion, headache, vasomotor collapse, methaemoglobinaemia and haemolytic anaemia.

### **7.4.12. Inhalational anaesthetics**

Inhalational anaesthetics are a class of pure and powerful drugs. When used clinically they are low in organ toxicity and generally safe. Their pharmacology and toxicology are widely documented. This group of drugs includes chloroform, cyclopropane, enflurane, ethylene, ether, fluroxene, halothane, methoxyflurane and trichloroethylene.

Toxicity of this group of drugs relates mostly to hepatic injury, cardiac arrhythmias and nephrotoxicity. Halothane is associated with malignant hyperthermia in susceptible individuals. While the acute effects of anaesthetic vapours are well known and the effects of long term low level inhalation (particularly increased risk of miscarriage in pregnant operating theatre staff) have been more recently studied, little is known about the long term results of repeated subanaesthetic self dosing, although partial anoxia and overdose are known risks.

Self administration of anaesthetic agents for their euphoriant effects is not new. In fact, it was such use in the mid nineteenth century that led to the realisation of the anaesthetic effects of ether and nitrous oxide. In more recent times, abuse of inhalation of anaesthetics appears to be restricted to those with access to the drugs.

Ether and chloroform abuse has been described and several halothane deaths amongst hospital staff have been reported, although this has not been seen to be a problem in Australia. Nevertheless, there were 13 deaths associated with non clinical inhalation of anaesthetic agents in Australia in the period 1980 to 1987.

Nitrous oxide was the first known inhalational anaesthetic. In addition to its current use in anaesthesia, small portable cylinders are carried in ambulances for analgesic use. It is also approved for use in the production of certain food products, notably in cartridges for soda syphons and whipped cream dispensers.

Hazards of nitrous oxide inhalation include hypoxia, which may be fatal. At least five deaths in Australia have been associated with nitrous oxide abuse since 1980.

### **7.4.13. Methods of use**

Substances are generally placed into a plastic bag, or some other vessel, and placed directly over the nose and mouth and inhaled deeply. The effect of substances inhaled in this manner produces alterations in the level of consciousness including a pleasurable feeling of intoxication and visual hallucinations.

### **7.4.14. Adverse consequences**

As volatile substances are fat soluble and are stored in the fat deposits within the body (particularly in the brain) this leads to a prolonged effect on the level of consciousness even hours after the inhalation has stopped. Many studies report VSA as a group activity, with abusers often having low levels of academic achievement at school, and associated patterns of problems within the school environment, such as truancy and delinquency.

VSA may cause behavioural and perceptual difficulties, with intoxication producing a range of symptoms, from mid euphoria, exhilaration, gross disorientation and in rare instances coma. Common signs include dizziness, irritation to the eyes and throat, slurred speech, staggering gait,

headaches, impaired judgement, irritability and excitement. Less frequently, VSAs may become delirious, with accompanying clouding of consciousness, illusions and hallucinations.

The most important problem of volatile solvent use is the occurrence of potentially fatal cardiac arrhythmias due to intoxication. Respiratory depression can also occur. Pathological changes occurring in solvent abuse include myocardial damage and cerebral oedema. There is general agreement that repeated exposure to solvents induces tolerance, though there are doubts about physical addiction; however, psychological dependence is common.

Another major concern with petrol sniffing is lead poisoning (except when unleaded petrol is used). At this time, there is no generally accepted means of treating organic lead poisoning, and the neurological and other manifestations of tetra-ethyl lead poisoning (TEL) absorption must be deemed to be effectively irreversible.

### **7.4.15. Physical effects**

The effects of a single use, whilst potentially very dangerous, usually wear off after a few hours and the cardiovascular symptoms predominate. The most common toxic effects are cardiac arrhythmias and asphyxia from enhancement of inhalation of volatile substances via the use of plastic bags, etc. Chronic headache, sinusitis, diminished cognitive function, ataxia and peripheral neuropathy all accompany chronic use. The neurological sequelae convey the most long term morbidity and disability.

Other symptoms include:

- chronic or frequent cough;
- tinnitus;
- chest pain or angina;
- nosebleeds;
- extreme tiredness or weakness;
- increased nasal secretions;
- red, watery eyes;
- a dreamlike state with hallucinations;
- depression and/or anxiety;
- shortness of breath;
- indigestion;
- dizziness;
- stomach ulcers; and
- deep inhalation over short periods of time may cause disorientation, unconsciousness or seizures.

The sniffing of some petrols may cause a particular type of lead poisoning, features of which are:

- liver damage;
- acute and chronic inflammation of the kidneys and multiple abscesses;
- cerebellar hemisphere degeneration; and
- inorganic lead poisoning causing anaemia and other effects on the blood.

### **7.4.16. Withdrawal effects**

Effects of inhalation are immediate, lasting from 5 to 45 minutes after cessation of sniffing. While initial effects may fade after several minutes (depending on the method of inhalation) effects may be felt for several hours. For most users, effects will pass within an hour of ceasing inhalation of the volatile substance. Chronic users may experience withdrawal symptoms similar to those experienced from a general anaesthetic.

Hangover effects may persist for several days, and may be characterised by:

- tremor;
- headache;
- nausea;
- vomiting;
- mild abdominal pain;
- loss of appetite;
- fatigue;
- muscular cramps; and
- delirium.

## **7.5. LSD and other hallucinogens**

### **7.5.1. Introduction**

LSD (lysergic acid diethylamide) was synthesised in 1943 and is a powerful hallucinogen with a history of medical use in the 1950s to release repressed emotions and memories, and of non medical use in the 1960s when hippy culture and intellectuals valued its supposedly mind expanding properties. More recently, there appears to have been a resurgence in LSD use, which it has been suggested (at least in the UK) is linked to the development of favourable milieu in conjunction with the “acid house” and rave youth culture.

Dose units in the mid 70s typically contained 250 micrograms of LSD, more than enough for a full blown psychedelic experience. Today’s LSD is marketed in single dose units (usually absorbed on paper squares) of 50 to 70 micrograms, enough to have a noticeable effect but not normally enough for a full blown “trip”.

### **7.5.2. Prevalence**

#### **7.5.2.1. WA data**

##### **Youth**

A survey of 12 to 17 year old West Australian secondary school students was conducted by Health Promotion Services in metropolitan and rural schools in 1996. The 1996 ASSAD survey found that 9.1% of 12 to 17 year olds had used LSD or other hallucinogens in the last year, and 4.3% had done so in the last month.

In the 16 to 17 year old age group, 19.7% of males and 17.7% of females had used hallucinogens in the last year; 9.7% of males and 7.1% of females had used in the last month. In comparison, 7.1% of males and 5.6% of females in the 12 to 15 years age group had used in the last year; 3.8% of males and 2.4% of females had done so in the last month (Table 11, Appendix 13).

##### **Adults**

The Tobacco, Alcohol and Illegal Drugs Consumption Survey (TAIDCS) of Western Australians aged 18 years and over was conducted by Health Promotion Services in 1997. The 1997 survey found that 15.9% of 18 to 24 year olds had used LSD in the last year, and 4.3% of 18 to 24 year olds had done so in the last month. In comparison, 4.6% of 25 to 34 year olds had used LSD in the last year, and 1.7% had done so in the last month (Table 1, Appendix 13).

Among the adult population aged 18 years and over, 3.4% had used LSD in the last year and 1.0% had used in the last month. LSD use was higher among males than females, with 5.2% of adult males reporting use in the last year compared to 1.7% of females. Similarly, 1.6% of adult males reported using LSD in the last month compared to 0.4% of adult females reporting use in the last month.

### 7.5.2.2. National data

An analysis of national trends in illicit drug prevalence was recently published in conjunction with the evaluation of the National Drug Strategy 1993-1997.<sup>367</sup> This data suggests that the proportion of the Australian population who had used hallucinogens in the previous 12 months increased moderately from 1.4% to 1.8% between 1988 and 1995. Consumption was concentrated in the 14 to 39 age range. Males were more likely than females to have used hallucinogens.<sup>368</sup>

While there has been some volatility in proportions between 1988 and 1995, approximately one in twenty 14 to 19 year olds and 20 to 29 year olds used hallucinogens in the previous 12 months, for each year of the survey. In both age groups, males were approximately twice as likely as females to have used hallucinogens. Use of hallucinogens does not appear to persist for most users beyond age 30. For example, in 1988 5% of persons aged 20 to 29 had used hallucinogens in the previous 12 months, and in 1995 (when most of this cohort would have moved to the 30 to 39 year age group), less than 2% were (still) using.

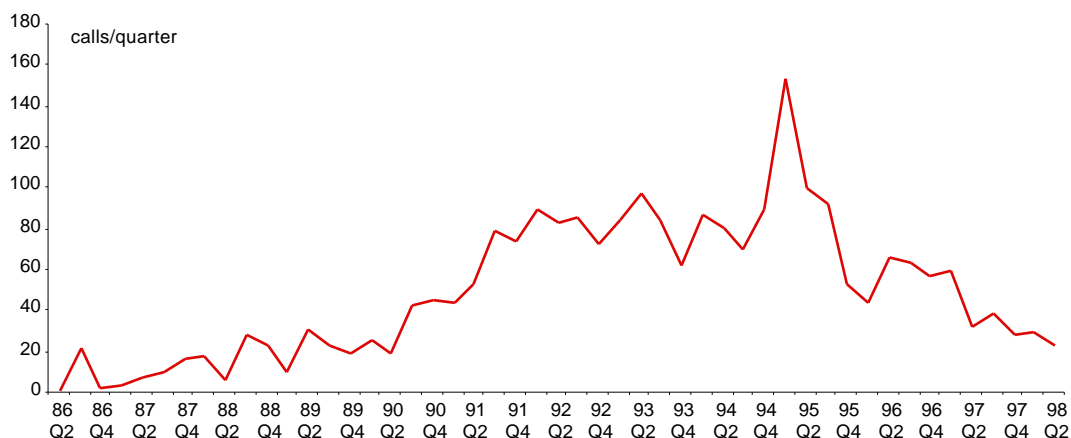
### 7.5.3. Indicators of abuse

#### 7.5.3.1. ADIS calls

Over the period 1986 to 1998, a total of 2,450 hallucinogen related telephone calls were dealt with by ADIS; this was 2.0% of the total of the 120,243 drug related calls received in this State. Hallucinogen related calls recorded by ADIS refer to calls which concerned the use of drugs such as LSD and psilocybin.

Over the period 1986 to mid 1990, the number of hallucinogen related calls received per quarter was relatively constant, fluctuating at around 20 calls per quarter. However, the number of calls increased three and a half times from the September quarter 1990 (43 calls) to the March quarter 1995 (154 calls). The number of calls have subsequently declined, with a total of 23 calls in the June 1998 quarter (Table 7.40; Figure 7.17).

**Figure 7.17: Quarterly hallucinogen related calls to ADIS, 1986 - 1998**



<sup>367</sup> Williams P. *Progress of the National Drug Strategy: key national indicators. Evaluation of the National Drug Strategy 1993-1997 statistical supplement*. Canberra, Department of Health & Family Services, 1997.

<sup>368</sup> Id Table 33 (p. 53).

**Table 7.40: Quarterly ADIS hallucinogen related telephone calls, 1986 - 1998**

Year	Quarter	No. calls	Year	Quarter	No. calls
1986	January-March	-	1992	January-March	90
	April-June	-		April-June	83
	July-September	22		July-September	86
	October-December	3		October-December	73
	<b>Total</b>	<b>25</b>		<b>Total</b>	<b>332</b>
1987	January-March	4	1993	January-March	85
	April-June	8		April-June	98
	July-September	11		July-September	85
	October-December	17		October-December	63
	<b>Total</b>	<b>40</b>		<b>Total</b>	<b>331</b>
1988	January-March	18	1994	January-March	87
	April-June	6		April-June	81
	July-September	29		July-September	71
	October-December	23		October-December	90
	<b>Total</b>	<b>76</b>		<b>Total</b>	<b>329</b>
1989	January-March	10	1995	January-March	154
	April-June	31		April-June	100
	July-September	23		July-September	92
	October-December	20		October-December	54
	<b>Total</b>	<b>84</b>		<b>Total</b>	<b>400</b>
1990	January-March	26	1996	January-March	45
	April-June	19		April-June	66
	July-September	43		July-September	64
	October-December	46		October-December	57
	<b>Total</b>	<b>134</b>		<b>Total</b>	<b>232</b>
1991	January-March	45	1997	January-March	60
	April-June	54		April-June	33
	July-September	80		July-September	39
	October-December	74		October-December	29
	<b>Total</b>	<b>253</b>		<b>Total</b>	<b>161</b>
			1998	January-March	30
				April-June	23

Source: Alcohol and Drug Information Service.

## 7.6. Ecstasy and other designer drugs

### 7.6.1. Introduction

Since many of these drugs are made by ‘backyard’ chemists, quality control is poor and toxic by products are often inadvertently injected or ingested by addicts. Numerous deaths and tragic side effects have occurred as a result of the use of designer drugs, including a number of cases of Parkinson’s disease (see below). There is concern, based on the experience in the US, that designer drugs are difficult to control, for as soon as a new drug has been covered by amendments to schedules of prohibited substances, a different formulation is likely to be manufactured.<sup>369</sup>

The two major classes of designer drugs that are now widely available are phenylethylamines (mescaline analogues) and synthetic opioids. Although the drugs in each group have similar effects, they differ significantly in potency and in toxicity. This wide range in potency is due to the lack of quality control in production. The type and amount of any specific compound may vary from purchase to purchase, which makes use extremely dangerous.

Ecstasy or 3,4-methylenedioxymethamphetamine (MDMA) is by far the most common of the phenylethylamines. A derivative of amphetamine, it shares the properties of both amphetamines and hallucinogens, in its side effects and residual effects. MDA (3,4-methylenedioxyamphetamine), also referred to as the “love drug”, first appeared in the US in

<sup>369</sup> Chesher G. “Designer drugs - the ‘what’s’ and the ‘whys’.” (1990) 153 *Medical Journal of Australia* 157; Henderson GL. “Designer drugs past history and future prospects.” (1988) 33 *Journal of Forensic Sciences* 569; Baum RM. “New variety of street drugs poses growing problem.” (1985) 63 *Chemical and Engineering News* 7.

1967.<sup>370</sup> It was popular because it caused feelings of euphoria and empathy without hallucinations. A number of deaths have been linked to this drug and to a synthetic error in making it, which inadvertently produced the by product HMDA (3,4 methylenedioxyphenyl-3-aminobutane).

Ecstasy is normally formulated into tablets or capsules containing 100-120 mg of the drug, the usual dose for an experience lasting several hours. Laboratory analyses of ecstasy tend to show, compared to LSD preparations, a variety of substances are sold as ecstasy, including amphetamine, mixtures of LSD and amphetamine, and other MDMA like drugs such as MDA and MDEA (3,4-methylenedioxymethamphetamine).

A survey in the early 1990s of ecstasy use in Australia reports that it is not as widely used as amphetamines.<sup>371</sup> The abuse potential of MDMA may be lower, as with increased use the negative aspects of use tend to increase while the positive effects decrease. For this reason, few people attend treatment services with problems due to the use of ecstasy.

MDMA has similar effects to amphetamines, although users report the drug produces a more positive mood and a greater sense of intimacy compared to amphetamines. Ecstasy's mixed hallucinogen/stimulant properties usually lead to increased energy and euphoria allied with calmness, feelings of warmth towards other people and heightened perceptions, though normally not hallucinations.

Ecstasy has gained a reputation as a "dance drug", for by stimulating the nervous system, it energises the muscles and allows people to dance for hours on end. It also increases blood pressure and temperature. Twenty or so deaths in the UK that have been attributed to the drug were largely induced by this effect on the body's thermoregulatory system, with users dying of heatstroke (with temperatures of 140° F and muscles burning up) combined with the overheating and dehydration caused by prolonged dancing in hot humid atmospheres.

## **7.6.2. Prevalence**

### **7.6.2.1. WA data**

#### **Youth**

A survey of 12 to 17 year old WA secondary school students was conducted by Health Promotion Services in metropolitan and rural schools in 1996. The 1996 ASSAD survey found that 3.1% of 12 to 17 year olds had used ecstasy in the last year, and 1.3% had done so in the last month (Table 11, Appendix 13).

In the 16 to 17 year old age group, 6.3% of males and 5.6% of females had used ecstasy in the last year; 2.7% of males and 0.8% of females had used in the last month. In comparison, 2.8% of males and 1.9% of females in the 12 to 15 years age group had used in the last year; 1.4% of males and 0.9% of females had done so in the last month.

#### **Adults**

The Tobacco, Alcohol and Illegal Drugs Consumption Survey (TAIDCS) of illicit drug use by Western Australians aged 18 years and over was conducted by Health Promotion Services in 1997. The 1997 survey found that 9.8% of 18 to 24 year olds had used ecstasy in the last year, and 2.6% of 18 to 24 year olds had done so in the last month. In comparison, 3.7% of 25 to 34 year olds had used ecstasy in the last year, and 1.1% had done so in the last month (Table 1, Appendix 13).

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<sup>370</sup> Evanko D. "Designer drugs - treating the damage caused by basement chemists." (1991) 89 *Postgraduate Medicine* 67.

<sup>371</sup> Solowij N, Lee N. *A survey of ecstasy (MDMA) users in Sydney*. Sydney, National and Alcohol Research Centre, University of NSW, 1991.

## Select Committee Into Misuse of Drugs Act 1981

Among the adult population aged 18 years and over, 2.3% had used ecstasy in the last year, and 0.6% had used in the last month. Ecstasy use was higher among males than females, with 3.2% of adult males reporting use in the last year compared to 1.3% of females.

### 7.6.2.2. National data

An analysis of national trends in illicit drug prevalence was recently published in conjunction with the evaluation of the National Drug Strategy 1993-1997.<sup>372</sup> This data shows that after doubling between 1988 and 1993 (to 1.2%) the proportion of the Australian population which had used ecstasy or other designer drugs in the previous 12 months declined by 1995 to 0.9%. Consumption was concentrated in the 20 to 29 years age group and males were more likely than females to have used these drugs (Table 7.41; Figure 7.18).

Except for 1991, use of ecstasy or other designer drugs in the previous 12 months was relatively rare for 14 to 19 year olds. Consumption is concentrated in the 20 to 29 year age group. In this group, there appears to have developed a trend towards greater use between 1988 and 1995. However, even in this age group, just one in 25 persons (4%) used the drugs in the previous 12 months.

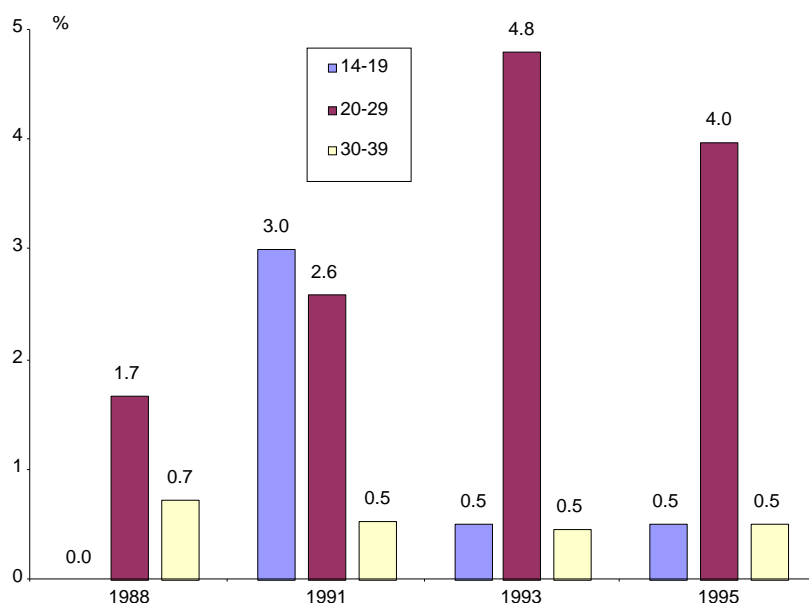
**Table 7.41: Prevalence (%) of ecstasy (or other designer drug) use in the past 12 months by age group, Australia, 1988 - 1995**

Year	14-19	20-29	30-39	40-49	50-59	60+	Combined
<b>Males</b>							
1988	-	2.8	1.6	1.4	-	0.4	1.2
1991	4.0	3.6	1.1	0.8	-	0.8	1.7
1993	0.5	6.9	0.8	0.8	-	0.4	1.9
1995	0.9	5.1	0.6	-	-	-	1.1
<b>Females</b>							
1988	-	0.6	-	-	-	-	0.1
1991	1.0	1.6	-	0.4	-	-	0.5
1993	0.5	2.5	0.2	-	-	-	0.6
1995	0.1	2.9	0.4	-	-	-	0.6
<b>Persons</b>							
1988	-	1.7	0.7	0.7	-	0.2	0.7
1991	3.0	2.6	0.5	0.6	-	0.4	1.1
1993	0.5	4.8	0.4	0.4	-	0.1	1.2
1995	0.5	4.0	0.5	-	-	-	0.9

Source: NDS Household Surveys.  
 Note: For 1993 age ranges = 14-19, 20-29, 30-39, 40-54, 55-69, 70+.  
 For 1991 the 14-19 age group subject to rounding errors.  
 Sampling variability ages 40 + too high for most practical uses.

<sup>372</sup> Williams P. *Progress of the National Drug Strategy: key national indicators. Evaluation of the National Drug Strategy 1993-1997 statistical supplement*. Canberra, Department of Health & Family Services, 1997.

**Figure 7.18: Prevalence (%) of ecstasy use in the past 12 months by age group, Australia, 1988 - 1995**



### 7.6.3. Indicators of abuse

#### 7.6.3.1. ADIS calls

Over the period 1987<sup>373</sup> to 1998, a total of 1,565 ecstasy related telephone calls were dealt with by ADIS; this was 1.3% of the total of 120,243 drug related calls received in WA. Ecstasy related calls refers to calls which concerned the use of drugs which are also known as MDMA.

Over the period from the December 1987 quarter to the March 1991 quarter, the number of ecstasy related calls received per quarter fluctuated between about 15 and 25 calls per quarter.

However, the number of calls increased nearly three and a half times from the June 1991 quarter (30 calls) to the September quarter 1992 (103 calls). The number of calls subsequently declined and has fluctuated between about 25 and 50 calls per quarter up to the June 1998 quarter (Table 7.42; Figure 7.19).

<sup>373</sup> Ecstasy calls were not separately tabulated prior to December quarter 1987.

Figure 7.19: Quarterly ecstasy related calls to ADIS, 1986 - 1998



Table 7.42: Quarterly ADIS ecstasy related telephone calls, 1986 - 1998

Year	Quarter	No. calls	Year	Quarter	No. calls
1986	January-March	-	1992	January-March	49
	April-June	-		April-June	64
	July-September	-		July-September	103
	October-December	-		October-December	87
	<b>Total</b>	<b>-</b>		<b>Total</b>	<b>303</b>
1987	January-March	-	1993	January-March	56
	April-June	-		April-June	45
	July-September	3		July-September	28
	October-December	15		October-December	32
	<b>Total</b>	<b>18</b>		<b>Total</b>	<b>161</b>
1988	January-March	25	1994	January-March	54
	April-June	20		April-June	50
	July-September	44		July-September	39
	October-December	24		October-December	44
	<b>Total</b>	<b>113</b>		<b>Total</b>	<b>187</b>
1989	January-March	16	1995	January-March	63
	April-June	29		April-June	23
	July-September	20		July-September	54
	October-December	13		October-December	36
	<b>Total</b>	<b>78</b>		<b>Total</b>	<b>176</b>
1990	January-March	14	1996	January-March	46
	April-June	26		April-June	27
	July-September	17		July-September	28
	October-December	16		October-December	33
	<b>Total</b>	<b>73</b>		<b>Total</b>	<b>134</b>
1991	January-March	13	1997	January-March	29
	April-June	30		April-June	21
	July-September	45		July-September	24
	October-December	47		October-December	49
	<b>Total</b>	<b>135</b>		<b>Total</b>	<b>123</b>
			1998	January-March	37
				April-June	27

Source: Alcohol and Drug Information Service.

### 7.6.4. Rave parties

A document titled *Operational Guidelines for Rave Parties, Concerts and Large Public Events*, is a resource produced by the Environmental Health Service, Health Department of Western Australia, in collaboration with key stakeholders. These guidelines were published in November 1995. A copy of these guidelines is included in Appendix 6.

The impetus for developing this comprehensive set of guidelines to regulate rave parties stems from the death in 1995 of the Sydney school girl Anna Wood, following her attendance at a rave party.

An edited version of the Coroner's report follows.<sup>374</sup> This extract describes the effects of ecstasy, how usage may cause death, and the facilities and trained personnel recommended to avoid harm that may arise from prolonged energetic dancing.

**Death of Anna Victoria Wood**

*The manner and cause of Anna Wood's death is now clear to me to the standard required by law. Because of this and as the death involves no indictable offence against any known person, I have decided to dispense with the holding of an inquest. This case has generated a great deal of public debate and interest. Pronouncements have been made by a number of sources and some of those have been found to be manifestly inaccurate. Whilst often in a case such as this one, the public interest may dictate that an inquest be held, in deciding to dispense with the holding of one I have taken into account the wishes of Anna's family, and my own view that the manner and cause of death is now clear. I feel that the public interest can best be served by giving reasons for dispensing with an inquest and also giving in some small detail, my conclusions as to the cause of Anna Wood's death.*

*It is the wish of the parents of Anna Wood that I state publicly and clearly my findings as to the probable cause of Anna's death, so as to allay the rumours and misconceptions which have arisen since Anna died.*

**Manner and cause of death**

*Anna Wood, a 15 year old girl presented to Royal North Shore Hospital on the morning of 22 October, 1995 with a clinical history of respiratory arrest, following alleged ingestion of methylenedioxymethamphetamine (MDMA or ecstasy) late the previous evening. She had apparently remained relatively well for some time after ingestion of the drug, and continued dancing strenuously. She periodically ingested water, and had been vomiting before 5 am. She was apparently taken to the home of a friend and placed in bed. Apparently there were continued episodes of dry retching, intermittent sleep, confusion and possible convulsion like movements.*

*By about 10 am, Anna had lapsed into unconsciousness at her friend's place. There was a period of hypoxia, possibly up to 12 minutes. On arrival, ambulance staff commenced resuscitative treatment for respiratory arrest. Anna was transported to Royal North Shore Hospital and treatment for suspected overdose was continued. She was quickly admitted to Intensive Care. On 23 October, 1995 there was evidence of absent cerebral blood flow, which was confirmed the next day. 'Brain death' was pronounced at 2.45 pm on 24 October, 1995.*

*I must stress that whilst urine analysis on admission confirmed the presence of MDMA, no other substances were demonstrated.*

*Dr Paul Botterill, a Forensic Pathologist at the NSW Institute of Forensic Medicine, conducted an exhaustive post mortem. He described the cause of Anna's death as being hypoxic encephalopathy. He reiterated in detail in his post mortem report his opinion as to how Anna came to suffer this cerebral oedema.*

*I shall quote from aspects of Dr Botterill's report.*

*"The cause of death was hypoxic encephalopathy following the protracted period of respiratory arrest which has followed the ingestion of MDMA. The precipitant event is not clearly established. It is not clear whether the respiratory arrest represented a direct toxic effect of MDMA or other unidentified contaminant substances (particularly in association with*

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<sup>374</sup> Death of Anna Wood. Reasons for dispensing with the holding of an inquest, No. 2094 of 1995. [<http://www.houseoflove.com.au/drugs/annawood/annawood.html>]

*exertion and/or water ingestion), an idiosyncratic response to those substances or some other pathological process ... coincidentally associated with the substance ingestion. The possible roles of airway compromise prior to resuscitation and or aspiration of vomitus are also difficult to assess.*

*Death following ingestion of MDMA is uncommon .... Some features in this case (the history of drug taking with protracted dancing, subsequent vomiting, possible convulsions and semi comatose state) are consistent with the reported cases, but other features are not typical of the reported cases from the early 1990's. I have discussed this case with Dr J.A. Henry of the National Poisons Unit, Guy's Hospital, London, who is aware of a number of recent British cases with similar features.*

*Those reported cases, and other very recent deaths followed ingestion of relatively small doses of MDMA and large quantities of water, and were associated with hyponatraemia (low sodium level) and water intoxication. Advanced hyponatraemia can be associated with hallucinations, inappropriate behaviour, altered temperature regulation (including hypothermia), seizures, coma, diabetes insipidus and respiratory arrest. The exact mechanism of this effect is not clear, but appears to involve both water intoxication and ingestion of MDMA.... It is conceivable that the features in this case, including the development of a syndrome of inappropriate ADH secretion may have been modified by the period of hypoxia associated with the respiratory arrest."*

*Dr Botterill was quite confident as to his findings and took a great deal of time and care with his research into death following MDMA ingestion. This phenomenon is quite rare in this country.*

*As I have indicated he spoke to Dr John Henry, a consultant Physician with the Medical Toxicology Unit at Guy's Hospital, London. I requested Dr Henry to carry out a review of the case. In view of the rarity of this phenomenon, no one person can claim real expertise. However Dr Henry has seen comparatively more cases than his colleague in Australia. Dr Henry's review has now been completed and was forwarded to me on 30 May, 1996. Dr Henry states.*

*"It is clear that Miss Wood had ingested ecstasy (MDMA), had been dancing intermittently and had drunk large amounts of fluid. Her illness and death bore all the hallmarks of cerebral oedema, and it can be concluded that she died of acute water intoxication, secondary to MDMA ingestion.*

*Her case closely parallels a widely publicised case which occurred in Britain recently .... I am aware of at least two other fatalities. There have also been a number of non fatal cases ....*

*It may be asked why the drug is associated with the complication of potentially fatal cerebral oedema, and whether this complication should be regarded as ecstasy toxicity or acute water intoxication...*

*Ecstasy is a drug which combines most of the pharmacological effects of amphetamine sulphate with an alert euphoric empathic state in which all inputs are heightened, giving it the combination of pharmacological properties which have led to its widespread use as a dance drug. Prolonged dancing has led to a number of deaths due to hyperthermic collapse. People continue dancing for many hours without replacing fluids (because of the appetite suppressant effects of amphetamines) and this led to the harm limitation messages that it would be good to drink fluids if one was using ecstasy as a dance drug.*

*This information may well have saved a number of lives, but it may also have induced many people to drink large amounts of fluids without any understanding of the reasons for so doing. As long as one is replacing lost fluid, there is no problem. However if excess fluid is drunk, there is a potential problem, because in a proportion of people the drug reduces the kidney's ability to rid the body of excess water (the so called syndrome of inappropriate anti diuretic*

*hormone secretion - SIADH). Thus, drinking several litres of water over and above the body's requirements over a short space of time, may cause hyponatraemia due to dilution of the body's sodium content, and cerebral oedema (swelling of the brain) due to this dilution. This swelling can force pressure on vital centres at the base of the brain, which in extreme cases may cause breathing to cease.*

*Some people may wish to label this death as a case of water intoxication in an attempt to exonerate the drug as a cause of death. However, although water intoxication was the mode of death the excess fluid ingestion would not have occurred if the drug had not been taken, and secondly the drug aggravates excessive water ingestion by causing SIADH.*

*I thus conclude that the cause of death must be given as ecstasy ingestion.”*

**Conclusions**

*It can be seen, therefore, that Drs Botterill and Henry have jointly reached the same conclusion as to the cause of Anna Wood's death. In effect, Dr Henry discards several possible scenarios postulated by Dr Botterill and agrees with his probable cause.*

*The message given by Drs Botterill and Henry, particularly as to the non exoneration of MDMA as a cause of death is a sobering one, and one which ought to be noted by all those who use this drug, particularly in a dance party setting.*

*Dr Henry concludes his opinion by saying this:*

*“The Department of Health in this country has included in its publicity the words ‘water is an antidote to dancing, not an antidote to ecstasy.’ People are recommended now to drink one pint of water or isotonic fluid per hour if they are dancing vigorously and not more than one cup of fluid per hour if they are not dancing vigorously. This modification of the original harm limitation message may help to avoid the two potentially fatal extremes of hyperthermic collapse (heatstroke) and hyponatraemia (water intoxication).”*

*It is not unlikely that a tragedy such as this will occur again in NSW. In an effort to reduce the chance of that happening, I propose to recommend that the NSW Health Department publishes a pamphlet, which will have the twofold effect of educating those who use the drug as to its dangers, and also educating the community as to the appropriate care of the individual who becomes ill following ingestion of the drug. I would like to see the pamphlet disseminated as widely as possible.*

*The Department deferred the publishing of such a pamphlet until this case is finalised. The pamphlet's message will have to be carefully considered and worded. I thank those who have assisted me in finalising this matter, particularly Drs Paul Botterill and John Henry. To the members of Anna's family I extend my sympathy on their loss.*

**Finding**

*That Anna Victoria WOOD died on 24 October, 1995 at Royal North Shore Hospital, St. Leonards, N.S.W. of hypoxic encephalopathy, following acute water intoxication secondary to ingestion of MDMA (methylenedioxymethamphetamine).*

**Recommendation**

*That the Health Department of NSW publishes a pamphlet aimed at those who use MDMA (ecstasy), which clearly indicates the possible consequences of MDMA ingestion, and the action to be taken by any person who becomes ill or who may be with a person who becomes ill following ingestion of MDMA.*

*John Abernathy, NSW Deputy State Coroner, Glebe, NSW*

**Recommendation 26**

***That the Health Department of WA review its operational guidelines for rave parties, concerts and large public events to incorporate the recommendation of the NSW Health Department as endorsed by the NSW Coroner in the Anna Wood case, dealing with the risks that arise with the excessive or under consumption of fluids associated with use of ecstasy at rave/dance parties.***

## **7.6.5. Other phenylethylamines**

Phenylethylamines were initially called hallucinogenic amphetamines, but this term is not accurate. At low doses, these substances produce mild stimulation; attenuation of colour, colour intensity, and texture; and the sensation of a fantasy state. Only at larger doses (near toxic levels) do hallucinations and sympathomimetic effects occur. General effects include euphoria, mood intensification, empathy, and visual changes.

One of the earlier used phenylethylamine derivatives was methamphetamine, known by users as “speed”, “crank” or “meth”. Use of the dextro form of this substance, called “Ice” increased in the late 1980s in Hawaii and California. Ice is smoked and is popular because of its long effect, which may last for 8 to 24 hours. Its popularity may have increased as an alternative to the dangers of injecting drug use, and because of its rapid onset and slightly decreased cardiostimulatory effects. Contamination in the production process can produce toxic by products that may cause seizures or acute lead intoxication.

### **Acute effects**

The most common acute reaction to the phenylethylamines is anxiety or panic. Other acute effects include dissociative feelings, depression, paranoia, and severe guilt. These effects are seen more often in first time users or in persons who are unaware that they have used a contaminant.

### **Chronic effects**

Chronic effects of phenylethylamines are more common in persons predisposed to psychotic illness. Presenting symptoms include disturbances in thought, visual and auditory hallucinations, and paranoid delusions with progression among some users to a true schizophrenic illness requiring the same long term therapy as the psychiatric form.

## **7.6.6. Fentanyl derivatives**

During the late 1970s, drug related law enforcement efforts increased, which reduced the heroin supply available in the United States. In response to this, underground chemists attempted to synthesise analogues of fentanyl and meperidine to fill demand.

The first fentanyl analogue to be recognised was alpha-methyl-fentanyl, which was sold as “synthetic heroin” or “China white”. Nine additional homologues have appeared on the street. These derivatives have a much higher potency than regular street heroin, up to 100 times that of morphine. The 3-methyl-fentanyl derivative is 1,600 times more potent than heroin. Inadvertent overdoses due to respiratory depression have occurred in addicts who were unaware of the content of the drug. Many died with the needle still in their arm.

Fentanyl derivatives produce more analgesia than euphoria; effects last from 2 to 4 hours. The same symptoms and signs of intoxication that occur with the opioids in general are seen with these substances and include miosis, central nervous system depression, and respiratory depression.

## **7.6.7. Meperidine derivatives**

A compound called “new heroin” was released in California in 1982. It proved to be one of the most devastating synthetic errors made by underground chemists. In attempting to synthesise MPPP (1-methyl-4-phenyl-4-propionoxypiperidine), a derivative with effects similar to those of

meperidine, an illicit laboratory produced MPTP (3-methyl-4-phenyl-1,2,3,6-tetrahydropyridine) as a by product.

Numerous cases of rapid onset of Parkinson's disease were reported as a result of this error. In some cases symptoms were reversed with discontinuation of the drug, but in others long term antiparkinsonian treatment was required. Therefore, the possibility of the recent use of an MPTP contaminated substance should be considered in addicts with symptoms of Parkinson's disease, such as muscle rigidity, or the mutism seen in catatonic schizophrenia.

### **7.6.8. Analogues of the future**

Underground chemists have been trying to make phenylethylamine derivatives with fewer amphetamine like effects. The analogues 2-CB (2-carbon homologue of DOB [4-bromo-2,5-dimethoxyamphetamine]) and 2-CD (2-carbon homologue of DOM [4-methyl-2,5-dimethoxyamphetamine]) are already available on the street. A new substance called "U-4-E-UH" (2-amino-4-methyl-5-phenyl-2-oxazoline), a derivative of the European diet pill Aminorex, is available on both the East and West coasts of the United States. It is conceivable that with bacterial engineering, new designer substances could be developed and produced in large quantities.

## **7.7. Prescription drugs**

### **7.7.1. Introduction**

This section is concerned with the excessive consumption of central nervous system (CNS) acting drugs. The information that is provided is primarily from national surveys. This information is intended to complement information in chapter 8 about the development of specialised services targeted at females and young people who have become dependent on or have problems from the use of these types of drugs.

### **7.7.2. Prevalence**

Data from the 1989-90 National Health Survey found the use of CNS acting drugs increases with age, with higher prevalence for females in each age group compared to males (Figure 7.20).<sup>375</sup> More recent data confirms these patterns and highlights that these drugs typically are obtained by prescription from GPs.

This information led to initiatives like the Minor Tranquilliser Campaign,<sup>376</sup> which has produced changes in prescribing practices, the use of alternative methods for alleviating stress and the development of specialist support services for women, such as the Perth Women's Centre.<sup>377</sup>

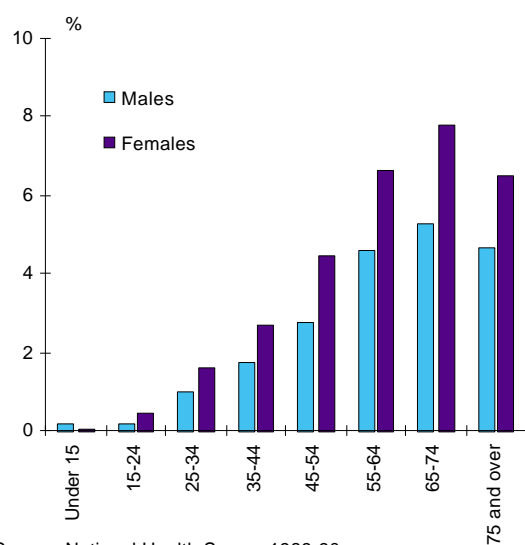
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<sup>375</sup> Australian Bureau of Statistics. *1989-90 National Health Survey - summary of results Australia*. Cat No. 4364.0. Canberra, Australian Bureau of Statistics, 1991.

<sup>376</sup> *Tranquillisers can become a habit. Minor tranquilliser education campaign planning document*. Perth, Health Promotion Services Branch, Health Department of WA, May 1989.

<sup>377</sup> Hancock L, Walsh R, Redman S, Hennrikus D, Sanson-Fisher RW, Gibbert RW. "Psychotropic drug use in the Australian community: benzodiazepines." In White J (ed). *Drug problems in society - dimensions and perspectives*. Adelaide, Drug and Alcohol Services Council, 1992.

Figure 7.20: Prevalence (%) of tranquilliser and sedative use by sex and age group, Australia, 1989 - 1990



Source: National Health Survey 1989-90

It should be emphasised that tranquillisers effectively and safely alleviate anxiety, insomnia and muscle spasm, and can be effectively used to treat acute alcohol withdrawal. Concern about these and other CNS acting drugs is in relation to their prolonged use, when it is believed initial benefits may be outweighed due to health and psychological problems associated with dependency and other side effects.<sup>378</sup>

Recent surveys confirm a long term trend over the past two decades that Australians have been consuming lesser amounts of some of the more commonly prescribed CNS acting drugs. CNS acting drugs, also known as mood altering or psychoactive drugs, are usually distinguished according to their action, being either tranquillisers, sedatives or antidepressants.<sup>379</sup> There are a number of reasons for this decrease, such as a better understanding by prescribers about the adverse consequences of these drugs from long term use, increased awareness by the community of these consequences, and changes in the scheduling of drugs under the Pharmaceutical Benefits Scheme.

However, it should be noted that recent overseas research into efforts by health authorities to reduce long term use of mood altering drugs such as benzodiazepines (minor tranquillisers), indicates that potentially more lethal drugs (such as antidepressants) may be substituted by prescribers.<sup>380</sup> There needs to be further research into whether there has also been a similar substitution of benzodiazepines by antidepressant medication prescribed in Australia,<sup>381</sup> as there is evidence to indicate this may have occurred in this State.<sup>382</sup>

<sup>378</sup> Mazza D, Dennerstein L, Ryan V. "Psychotropic drug use by women: current prevalence and associations." (1995) 163 *Medical Journal of Australia* 86-89.

<sup>379</sup> Lockwood A, Berbatis C. "Psychotropic drugs in Australia: consumption patterns." (1989) 153 *Medical Journal of Australia* 604-611.

<sup>380</sup> Hancock L, Walsh R, Redman S, Hennrikus D, Sanson-Fisher RW, Gibberd RW. "Psychotropic drug use in the Australian community: benzodiazepines." In White J (ed). *Drug problems in society - dimensions and perspectives*. Adelaide, Drug and Alcohol Services Council, 1992.

<sup>381</sup> Alchin TM, Tranby HW. *Some economics of antidepressant use in Australia. Working paper 93/13*. Department of Economics, University of Western Sydney, 1993.

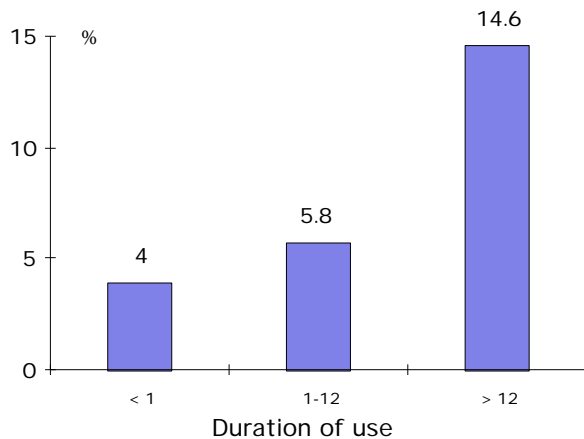
<sup>382</sup> Western Australia Task Force on Drug Abuse. *Protecting the community: the report of the Task Force on Drug Abuse, Vol. 2*. Perth, Ministry of Premier & Cabinet, 1995, 380.

In spite of the reductions in the prescription of some of the commonly used CNS acting drugs, there still remain consistently higher rates of prevalence and frequency of use by females, compared to males. It is difficult to isolate medical factors to fully explain the higher rates of consumption by females compared to males, given it has been

*“estimated that only 10% of all psychotropic drugs are taken for specific conditions the remainder being for vague complaints. There is evidence that tranquillisers are prescribed to women for a wide range of life problems, including bereavement, marital separation, reaction to violence both domestic and otherwise”.*<sup>383</sup>

The extensive use of CNS acting drugs can be appreciated from the results of a recent study of adult females, which found nearly one quarter of women over the preceding 12 months had used at least one form of this medication. In terms of recency of usage, 4% had used a CNS acting drug for less than a month, 6% had used for at least a month and for less than 12 months, and 15% had used for more than 12 months (Figure 7.21).<sup>384</sup>

**Figure 7.21: Duration of use (months) of psychotropic drugs by Australian women, 1995**



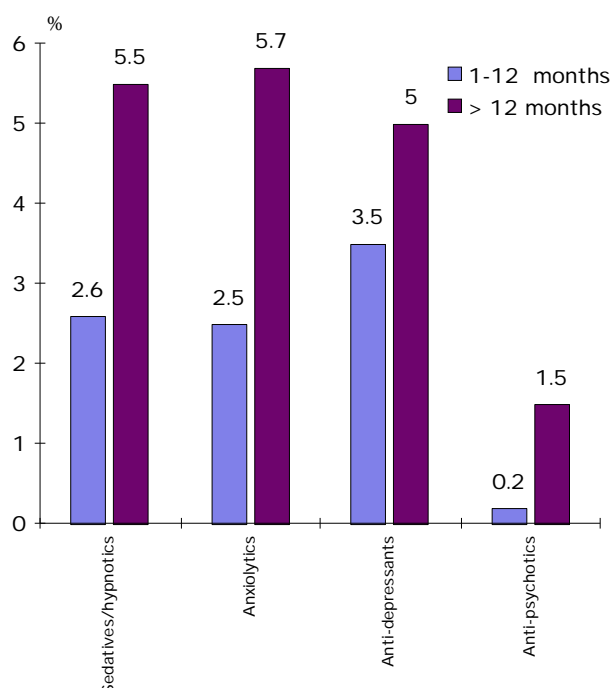
Source: Mazza, Dennerstein & Ryan (1995)

This research also found that an approximately equal number of adult females (8%) reported use of each of the three major groups of CNS acting drugs, and that between 5-6% of these women had used these drugs for more than 12 months (Figure 7.22). The higher rates of use of CNS acting drugs by females has meant that gender has become recognised as a key dimension in understanding the individual, familial and social factors that underlie the use of these drugs and for the need for gender sensitive approaches to prevention and treatment.

<sup>383</sup> Baily S. *Planning prevention strategies for alcohol and other drug related problems among women.* Sydney, Drug and Alcohol Directorate, NSW Health Department, 1991, 133.

<sup>384</sup> Mazza D, Dennerstein L, Ryan V. “Psychotropic drug use by women: current prevalence and associations.” (1995) 163 *Medical Journal of Australia* 86-89.

Figure 7.22: Duration of use (months) of major groups of psychotropic drugs by Australian women, 1995



Source: Mazza, Dennerstein & Ryan (1995)

One factor recognised as contributing to CNS acting drugs being overprescribed to women is that healthy females more frequently become involved in preventive health behaviours compared to males, with the result “*that patients who present to GPs with psychosocial symptoms are difficult to define and who require long consultations are quite often prescribed psychoactive medication*”.<sup>385</sup>

It is also important to acknowledge that in relation to the adverse effects of alcohol (because of gender differences in the amount of body weight and adipose tissue) females are

“*more susceptible to the physical effects of alcohol, including liver cirrhosis, breast cancer, pancreatitis and brain damage (and) ... are more likely to have a history of depression, attempted suicide, eating disorders and polydrug use*”.<sup>386</sup>

The acceptance of the need for a gender sensitive approach has also been responsible for the development of a more comprehensive framework for addressing drug related problems than has previously been the case. This shift in thinking has occurred because

“*the impact of other people’s drinking has considerable impact on women. Women experience violence, impoverishment and loss of self esteem as a result of the intoxicated state of significant others. Such problems need to be acknowledged as legitimate drug related problems*”.<sup>387</sup>

<sup>385</sup> Bailly S. *Planning prevention strategies for alcohol and other drug related problems among women*. Sydney, Drug and Alcohol Directorate, NSW Health Department, 1991, 37.

<sup>386</sup> Kelly B, McGregor D. “Models of alcohol and other drugs service delivery among women.” In Copeland J, Swift W (eds). *1994 national women and drugs conference: challenge, consensus and change. Issues papers*. Sydney, Drug and Alcohol Directorate, NSW Health Department, 1994, 69.

<sup>387</sup> Bailly S. *Planning prevention strategies for alcohol and other drug related problems among women*. Sydney, Drug and Alcohol Directorate, NSW Health Department, 1991, 48.

The Select Committee received evidence from witnesses who had contact with a range of individuals (particularly with young people) who abused Rohypnol (flunitrazepam) and subsequently engaged in anti social behaviour. Witnesses indicated that this drug, commonly referred to by abusers as “Rohies”, was frequently attributed as being responsible for them committing violent criminal offences, as well as less serious crime such as shop lifting. On this point, a witness from the Legal Aid Commission’s Criminal Law Section provided evidence which amplified on these issues.

*“Mr Payne: I have heard of people committing offences on the drug. I think it relates to the effect of the drug. The offences committed made no sense from an economic point of view. Some of those offences under Rohypnol involve violence, such as stabbings. ... Rohypnol leads to bizarre offences. Offenders cannot say why they committed the crime, and they talk about a dream like state in which they are not certain they have done anything. It can involve a house break in. ... afterward they say, I do not think that they were deliberately lying, that they did not know what happened to the goods taken from the house.”<sup>388</sup>*

Of interest, in the United States and interstate there is information that this drug as being used to facilitate a number of so called “date rapes”, by being concealed in drinks given to young women in social settings. Rohypnol is a potent, sedative, hypnotic, long acting drug and though occasionally used as a primary intoxicant, it is more often consumed in conjunction with other drugs especially alcohol. While taken on its own, it is unlikely to cause death. However, in combination with alcohol, it is potentially lethal as it enhances CNS depression.

The effect of disinhibition that occurs from abuse of Rohypnol is greatly increased when it is consumed in conjunction with alcohol. Extended use of Rohypnol can cause physical and psychological dependence, resulting in symptoms such as headaches, muscle pain, extreme anxiety and confusion. Withdrawal from Rohypnol can cause hallucinations, convulsions, delirium, shock and cardiovascular collapse.

Concerns have been raised that disinhibition results in high risk sexual activity. As noted above Rohypnol has gained notoriety because of instances of reported use by men to drug women and sexually abuse them whilst sedated. Once Rohypnol is placed in a liquid, it is colourless, tasteless and dissolves easily, thus facilitating these crimes. In the United States it has been observed that

*“this drug has gained popularity among (American) youth as a cheap means of intoxication and subsequently has become the focus of numerous criminal investigations. College men are alleged to slip Rohypnol tablets into unsuspecting women’s drinks and then sexually abuse their sedated victims.”<sup>389</sup>*

The Health Department of WA rescheduled Rohypnol from being a Schedule 4 drug to a Schedule 8 drug on 19 June 1998, as a result of a recommendation by the National Drugs and Poisons Scheduling Committee. This is an Australia wide response to growing evidence of abuse of this drug. This move is likely to significantly reduce access to this drug and accordingly the Select Committee does not make a recommendation on this issue.

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<sup>388</sup> Evidence by Mr Lex Payne to Select Committee, 8 October 1997, 6.

<sup>389</sup> Saum CA, Inciardi JA. “Rohypnol misuse in the United States.” (1997) 32 *Substance Use and Misuse*, 723.



## **Chapter 8: Special issues**

### **8.1. Parent groups**

#### **8.1.1. Introduction**

Parent groups have existed in most Australian jurisdictions for a number of years and as such represent a viewpoint by the community in responding to the consequences of the use of drugs. A number of groups have been formed by a parent who has been deeply affected by the death of a son or daughter and subsequently has been joined by other parents with first hand experience with their own children's use of drugs. Some groups may also be supported by health care workers, educators and other professionals who become members and participate in activities.

Parent groups tend to have a small membership base and are likely to focus on specific issues to memorialise their loss, such as by establishing a treatment and rehabilitation service, developing education materials targeted at young people and illicit drug use and/or advocating changes in drug laws. There are some notable examples, such as Cyrenian House in Perth and Odyssey House in Sydney, which were initially formed by a parent who had lost a child through drug abuse and subsequently have become important providers of treatment and support services.

The following discussion provides an overview of some of the groups formed by parents and other concerned individuals and which have been active in recent years in a number of Australian jurisdictions. This information has been obtained from a number of sources, including home pages, published material and from an article by Charlotte Wood in the October/November 1997 issue of *Connexions*.

#### **8.1.2. Community based supports for parents**

An important function undertaken by parent groups is that they frequently offer telephone advice or direct support to bereaved and grieving parents and other family members following the death by a drug overdose of a young person. Community support tends to be more readily elicited in circumstances which focus on well publicised instances involving the death of young people from a heroin overdose.

However, there appears to be less community support and interest for those who have experienced a heroin related death in their family. This apparent lack of visible support especially adds to the grief of the families of older heroin abusers (ie those aged in their late twenties and mid thirties) and contributes to the marginalisation of those affected by heroin abuse.

It is to be noted that there appear to be no community based parent groups to support families with children who have not died, but have become problematic or chronic drug abusers. In these cases, the families are likely to experience considerable distress and stress, especially if their child has experienced one or more of the sequelae of drug dependence, such as having been involved in crime, been apprehended, appeared before a court, been convicted and sentenced or attended a number of rehabilitation agencies.

Parents who have become concerned about their child's use of an illicit drug (such as cannabis) report difficulty in being able to obtain assistance that is tailored to their circumstances. This difficulty is somewhat understandable, as mainstream alcohol and other drug treatment agencies are mostly dealing with those at the most severe end of drug related problems. In the latter type of situation, a harm minimisation approach is most appropriate to prevent further social deterioration and damage occurring to the health of a young person already seriously involved in drug use.

## **Select Committee Into Misuse of Drugs Act 1981**

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Parents can find it difficult to identify who to approach to assist them. If their request for assistance is not understood or assistance obtained is inadequate or inappropriate, then in the long term they may be deterred from again seeking assistance.

Some of these concerns were articulated in submissions received. Victory Over Illegal Drugs (VOID) provided a submission to the Select Committee in which they emphasised the need for a broad based approach which dealt with all aspects of all drug problems involving young people including school based education, detoxification programs, provision of methadone and naltrexone in jails and support for a heroin trial. It was stated that

*“(a)s the efforts at policing have largely been ineffective, money should be diverted from these to counselling, treatment and education. If all drugs were treated equally, and their supply was under pharmaceutically controlled standards of dosage and purity, many overdose deaths and serious diseases such as HIV and Hepatitis would be averted, or their incidence reduced. If users did not need to steal, deal or prostitute themselves to get enough money to support illegal habits, much damage to society in general would not occur. If drug supply was legal, controlled and taxed, the huge profits to criminals would disappear, and with them the likelihood of corruption in customs, police, government, prisons and the justice system.”<sup>390</sup>*

VOID has recently released a 25 minute video targeted at secondary school students containing interviews with young people and their views and concerns about drugs. The impetus for the video came from a group of parents who are members of VOID, one of whom had a 22 year old son who had died from a heroin overdose three years ago.<sup>391</sup>

Accordingly, the Select Committee believes that a network of community based support groups backed up by a team of specialist counsellors with good skills in family therapy needs to be developed. It is possible that some Local Drug Action Groups could be resourced to provide an early contact point for those parents concerned about their children’s experimental and recreational use of drugs.

Support for parents in these circumstances has been provided by a number of the service providers, especially Palmerston and Holyoake, who provide counselling and support. It is also known that a wider spectrum of health care providers such as GPs, psychologists and social workers have developed expertise in assisting families in this predicament. Frequently, counselling provided from the mainstream health and welfare professions is the most appropriate form of assistance, as usually the young person’s drug use is the culmination and manifestation of a number of psychological and behavioural issues that have occurred over a number of years preceding drug use.

In May 1998 the WADASO commenced the Parent Support Project, an initiative to expand the range of supports for parents with concerns about their children’s drug usage. The object of the project is to maximise the opportunities for intervention at an early stage, rather than after chronic problems have developed. The project will involve consultation with parents and identify resources, including professional support and closure relationships with provider groups and LDAGs.

### ***Recommendation 27***

***That the WA Drug Abuse Strategy Office ensures that community based resources are developed to assist parents concerned about their children’s use of drugs, and that a network of qualified and experienced counsellors and therapists with a high level of skills in assisting families be actively promoted as a front line service for families.***

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<sup>390</sup> Submission to the Select Committee by Victory Over Illegal Drugs.

<sup>391</sup> Wanneroo Times. “Video against drugs.” 7-13 July 1998.

### 8.1.3. Family based policies

An issue on which parent groups tend to have different views is harm minimisation. This divergence of views reflects a range of views in wider Australian society over the scope of harm minimisation. Examples of these differences have included the proposal in 1997 to prescribe heroin under the proposed ACT trial to a small number of heroin dependent individuals, and the decriminalisation of illicit drugs.

It is recognised that some of the principles of harm minimisation strategies that have been adopted may not be appropriate or relevant for families experiencing difficulties involving drug use by their teenage children. Thus, while some of the options advocated by parents who have lost children as a result of a drug overdose require consideration, for parents with children who are using drugs at an experimental or recreational, harm minimisation principles appear to condone the use of drugs.

The Select Committee notes that the American *1998 National Drug Control Strategy* has as its first goal to “*Educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco.*” Objective 5 of this goal seeks to “*support parents and adult mentors in encouraging youth to engage in positive, healthy lifestyles and modelling behaviour to be emulated by young people.*”

An interagency agreement with the Office of National Drug Control Policy (ONDCP), the Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration and the Centre for Substance Abuse Prevention will implement a number of efforts to organize, train, motivate, and raise the awareness of parents and adult mentors to assist them to help children and youth remain drug free. There will be an emphasis on using culturally specific approaches when appropriate. The following are examples of planned activities in 1998.

The Positive Activities Campaign will create public service announcements and support materials, such as a Mentoring and Resource Guide to help parents, public leaders and other community groups increase their involvement with youth. This effort will be closely coordinated with ONDCP's \$195 million national youth anti drug media campaign.

The Parent/Mentor Program, Parenting is Prevention, provides \$8.2 million to SAMHSA and the CSAP to reinvigorate existing parent/mentoring programs as well as create new avenues for reaching children at special risk for drug use, such as, those from extreme poverty and the abused and neglected. The activities of this initiative include:

- mobilising traditional parent anti drug organizations to help them update and expand their capacity to increase the number of parent groups involved at the school and community levels on a nation wide basis;
- identifying parent and youth training program models and conducting parent training events at the national, state and community levels; and
- enhancing parent leadership capabilities through education and skills building workshops targeting national and state level organizations in order to reach children who are at special risk of substance abuse.

A cooperative agreement with the Department of Justice and Child Welfare League of America was signed in December 1997. Its purpose is to train child welfare professionals to provide service and referrals to families suffering from addiction. Several workshops will be held: (1) two 3 day training of trainers workshops; (2) five 2 day regional training workshops, and; (3) fifteen or more local collaborative 2 day workshops.

Parents trained at these workshops are expected to effectively recruit, select and manage parent volunteers. These volunteers will initiate and maintain parent groups to increase the resiliency of their families to alcohol, tobacco and illicit drug use. In addition, a conference of experts on Asian American groups was convened in February 1998 to discuss effective strategies to reach parents and youth in this population.

The State Government has included in the text of *Together Against Drugs* a number of statements for parents to receive educational and other preventive materials. The community needs to provide young people and their parents in this situation with options to resolve these issues, to prevent the development of more serious levels of drug use or even dependence. The Select Committee believes there is an advantage for the articulation of broader principles by government which recognises that families may experience difficulties with their children's use of drugs.

***Recommendation 28***

***That the WA Drug Abuse Strategy Office include specific sets of principles and values which support healthy and drug free families and that appropriate resources and targets be developed as part of this strategy.***

### **8.1.4. Cyrenian House**

Cyrenian House was established in 1981 by Ric Hamersley, following the death in Perth of his daughter due to an overdose of a combination of prescription and other drugs. Tragically, this death was unexpected as Julie Hamersley had completed a period of detoxification and rehabilitation at Odyssey House and had returned to Perth to live with her family to consolidate her abstinence.

The WA Council on Addictions Inc is the parent body for the organisation known as Cyrenian House and provides a range of residential and day programs to people with drug and/or alcohol abuse problems. A feature is the development of an integrated program of aftercare and extended support following completion of the residential program. Cyrenian House also offers a family program to assist people affected by the dependency of problems of others. It draws on a wide range of approaches with emphasis placed on 12 Step recovery models and family systems theory. A creche is available for childcare of clients' children.

In July 1998 Cyrenian House relocated to its residential program (formerly based in Palmerston Street) to its purpose built facility Saranna on 12.92 hectares of land at Gnangara. Saranna was originally conceived, consistent with the organisation's concern for those caring for dependent children, as providing a longer term residential program for women with substance use problems to obtain treatment and detoxification. Further details of the programs offered by Cyrenian House are outlined in chapter 4, which deals with the major service providers in this State.

### **8.1.5. Palmerston**

In mid 1997, following an upsurge of requests, Palmerston Centre in conjunction with the Grief Recovery and Funeral Education Centre (GRAFEC) piloted a counselling and support group for parents whose children had died following an overdose. Because of the specialised nature of the issues involving grief and bereavement, a number of experienced practitioners (including a group facilitator and a registered psychologist) were engaged to run these groups.

Following the results of the successful pilot the WADASO agreed in April 1998 to provide funding to enable the group to continue. The agreed funding will be \$5,760 for each group, with up to a maximum of 6 groups per year, with a small fee for service of \$10 per session for waged, \$5 for unwaged and free for those who can't afford the fee. The annual amount of \$34,560 has been incorporated into Palmerston's 1998/99 contract.

The format of the parent bereavement group would be a 2 to 3 hour group per week with additional individual and couple counselling as required. The aims of the support group include that:

- participants identify and resolve blocks to a healthy grief process;
- participants develop and implement grief management strategies;

- the isolation, stigma and marginalisation of being the parent of a dead drug user is reduced;
- the relationships of the identified target group are improved; and
- participant's levels of social, physical, emotional and cognitive functioning move towards pre trauma levels.

Favourable results were reported of the pilot program which ran for a 12 week period (ie of 12 group sessions of two and a half hours per week) with an average weekly group attendance of 7. A total of 8 people completed the full program. The following reported comments of some of the participants in the pilot are contained in an evaluation report and indicate the value of this initiative.

*“Losing a child through drug overdose becomes a different experience than losing a child in any other way.”*

*“Prior to joining this group I felt totally alone.”*

*“I didn't realise how strong an effect the group would have and how much it would give me.”*

*“The most useful experience in coping with our daughter's death. I can't imagine where I'd still be without it.”*

### 8.1.6. Families and Friends for Drug Law Reform

The Families and Friends for Drug Law Reform (ACT) Inc (FFDLR) was established by Mr Brian McConnell, following the death of his son in Canberra. Views expressed by the FFDLR reflect a theme echoed by other parent groups, that public discussion of heroin related deaths dehumanises those who have died and that their death is deserved. Another theme articulated by this and other parent groups is that public reaction to many of these deaths conveys little understanding or concern for those who have lost a family member, a sibling, a parent, a child or friend and fails to acknowledge that those who die from using drugs are valued and loved.

These concerns may be expressed through events intended to elicit community participation in the grieving process by commemorating those who have died from using illicit drugs, as follows.

*“It came as a sad realisation to members of Families and Friends for Drug Law Reform that there was no public focus of the worth of the many, many who have died from the use of illicit drugs and who remain loved as friends and family members.*

*A memorial would help break a silence of prejudice and ignorance which has left many to bear their grief in an isolation tinged with shame. There was anger too, anger at the lack of help, at the pressures on us to abandon those we loved. There were also strong feelings that the death of most if not all those for whom we mourn today should have been avoided. They met their death not so much from any inherent danger of the drugs involved but from policies and practices that shrouded the composition of the drug and forced on many the life of an outcast.*

*The locust tree, Robinia pseudoacacia, under which we gathered on 16 December 1996 was chosen because of its particular associations for the family of one of our members whose brother died earlier this year. The tree then was bare. Its thorns stood out against the winter sky. Spring brought new growth and the green that now shelters us. It also brought a cascade of white blossoms the last of which fell only a few weeks prior to the ceremony.*

*The plaque and stone of the memorial will stand watch by the tree during the coming winter. While the tree is in blossom in September and October next year we plan to hold another ceremony. We would like that occasion to be a celebration of the end of deaths from illicit drugs - the most fitting memorial of those we remember today.”<sup>392</sup>*

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<sup>392</sup> <http://www.wps.com.au/drug/lawreform/memorial.htm>

The FFDLR has outlined its goals and objectives in its draft charter, as follows.<sup>393</sup>

*“We the signatories to this charter, recognise that the present prohibition policies:*

- *are not preventing the use and abuse of illegal drugs;*
- *do not protect our young people, their families or their friends from related tragedy;*
- *put the control of those drugs outside the law;*
- *cause marginalisation of, and prejudice to, people in our community;*
- *work against the application of human rights for dependant drug users; and*
- *cause unintended harm and limit harm reduction strategies.*

*We further resolve to work toward, support and promote:*

- *activities that raise awareness of the issues;*
- *activities that will overcome stereotyping and marginalisation;*
- *education programs that are directed toward harm reduction;*
- *research that provides information to help in the search for better solutions;*
- *meaningful searches for better drug policy solutions;*
- *cautious and well researched steps to changes to our laws that will cause less harm; and*
- *removal of criminal sanctions for personal use of illegal drugs.”*

### 8.1.7. Drug Aid

Drug Aid<sup>394</sup> is a Queensland based organisation which was established by Ms Pat Assheton, whose 26 year old son Guy Tremain died from a heroin overdose in February 1997. In September 1997, Drug Aid organised a remembrance service followed by unveiling of a plaque on a memorial stone and the planting of a tree. The following excerpt from the publicity material from this parent group echoes a common theme of family suffering.

*“The stigma attached to drug use has stopped many families from speaking out in the past. Families have now united across Australia to dispel myths that drug users are ‘no hopers’. Many excelled academically and/or athletically and had beautiful loving natures. Our children were very much loved and are sadly missed.*

*Families no longer want their loved ones remembered as a statistic and feel that they were ill treated and discriminated against whilst alive. We wish to restore their dignity and respect and allow families and friends to support one another and remember their children with pride.*

*The drug problem is a national disgrace and those who withhold life saving help should feel the shame, not the families. Many families who have been hurt by drug dependency want to help others to prevent further tragedy that arises from drug use.”*

The following edited excerpt about the life and death of Mr Guy Wayne Tremain, provides a good understanding of the impact on families when one of their members who has become dependent on heroin. This personal account by Ms Pat Assheton highlights the institutional impediments that families may experience when they try to obtain treatment and support services over the time that the person had struggled with their dependence.

*“I came home at 1.10 pm on Saturday, 15th February 1997 to find my son, Guy Tremain, dead. He had died the night before, Valentine's night, whilst I was out, from an accidental heroin overdose, compounded by the drug Deptran, a powerful anti depressant.*

*Guy had a bright, sunny personality which lit up the room when he walked in. He made everyone feel at home and entertained us all. He had an extremely quick wit, was marvellous*

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<sup>393</sup> <http://www.wps.com.au/drug/lawreform/>

<sup>394</sup> <http://www.drugaid.com.au/>

*at maths and did mental gymnastics with figures which could impress the most accomplished professors. He was articulate, popular, inquisitive and adventurous. Shakespeare was his passion and he took the part of Gloucester in King Lear not long before he got sick. An absolute whiz at games and cards, he left Sydney and the computer industry where he had carved out a successful niche for himself when only 18 years of age, for the bright lights and excitement as a croupier with Jupiters Casino on the Gold Coast, where he worked for 4 years.*

*During this time his use of marijuana increased alarmingly, with his desperate battle for sleep driving him further and further into dope, as he constantly fought insomnia brought about by working the graveyard shift, working nights and sleeping days. His sleep patterns never recovered and caused him great distress until the day he died.*

*Guy was an avid collector from childhood. He had impressive collections, immaculately maintained ranging from special edition notes minted in Australia and overseas, stamp and card collections, jewellery, to records, video tapes and much more. They brought him immense pleasure and he attended courses to learn more about his relevant interests. He had an unrelenting passion for Elizabeth Taylor and knew every film and circumstance that was published about her, as indeed he did about most stars and films. The word was if you wanted to know anything about the entertainment industry, ask Guy.*

*Guy loved driving and always hoped one day that he would get to race. Guy loved movies and hoped one day his acting would take him into films. Guy loved business and was frustrated by restrictions that held him back from starting his own business but was always full of ideas and plans. Guy loved money which not always led him down the right track. Guy loved children and wanted to marry and have a family.*

*It was love for a girl during a time when he had lost his way that led him to heroin. He wrote a book about his experience which was erased from the hard drive which sent him into his final, fatal run. Upon his death, Guy had lost everything that was dear to him in the world, from his family and friends to all his collections, from his love of life and joys to his dignity and hope.*

*Guy was 26 years old when death ended his mighty two year battle with heroin. A desperate struggle waged by this very brave, horrendously abused, lonely, battle scarred and confused young man, desperately trying to win his life back from the grip of an ugly disease. But was the disease heroin itself or the laws of this land and its bureaucracy?*

*A police force which can refuse to act on information regarding supply sources because another person will only take that pushers place. A police force which can pull addicts off the street for just walking down the road, strip them of their dignity, jam their hands up their bottom because they might be carrying drugs 'up there', whack them in holding cells without medication for withdrawal symptoms, advise parents and friends to 'dob them in' and 'throw them out' so they may hit rock bottom and if we don't we are labelled 'enablers'.*

*A bureaucracy which sits back and watches from their ivory towers as thousands of young people suffer agonising lives and then die, refused help unless they are 'clean', (no codeine in their urine) then only if a bed is available. A bureaucracy which watches the young of this country be openly tempted, hooked and supplied with lethal substances not subject to quality control and then say 'too bad' if they die.*

*A bureaucracy that would rather make criminals out of children and allow them to drown in mental and physical anguish, loathed and disowned by society. A bureaucracy which supports limited, rigid and conditional help to be available only when these sick people are in a window of time when they are not using. This must coincide with a bed being available, meeting a strict criteria, and what's more, having the \$300 or so dollars to pay for admission, which is non refundable if they get 'kicked out' tomorrow. A system which knows an addict in acute addiction will need to commit crimes and or prostitute themselves, even risk death just in order to buy their 'medicine'. A bureaucracy which refuses to acknowledge the might of addiction.*

*Guy was guilty of and suffered from all the above and more. My family died inside as we watched, helpless, as he drowned in pain and shame. He tried valiantly to gain control, to get well.*

*Where Guy took ten steps backward and one step forward he was now taking three steps forward and one step backward. He was slowly emerging but still had so much to face. The question is, if Guy had lived and fully recovered from addiction, would he have recovered from such diseased treatment?*

*Guy's life has not ended with his death. The ABC aired nationally a 27 minute story of Guy's life and death on Saturday 2nd August, 1997, on their program Australian Story, called 'Valentine's Day'.*

*Valentine's Day struck a chord with ABC viewers. The ABC and our family have been inundated with requests to buy the video of Valentine's Day. Schools have also been ringing to ask for a copy of the program so they can show it to pupils as part of their drug education strategy and parents have also been asking if they can buy a copy. The program features the music of Elton John's 'Song for Guy, REM's 'Everybody Hurts' and a U2 track, which musically illustrates and enhances the impact of the unfolding events."*

### **8.1.8. Anna Wood drug and alcohol education project**

This is a student education project managed by the Australian Medical Association (AMA) Charitable Foundation. The Anna Wood Project was formed following the death of Sydney teenager Anna Wood after taking ecstasy at a dance party in late 1995. An extract from the Coroner's findings following an inquiry is included in chapter 7, in the section dealing with ecstasy.

The Wood family wanted to establish a fundraising program to help educate young people about drugs, and having contact with the AMA, decided to place the program under the umbrella of the AMA Charitable Foundation. The Foundation's role is to raise and provide seeding funds for projects that focus on social issues influencing health. The Anna Wood Project began in 1995 and funds are now being used to implement strategies to support both school and community drug education programs.

Primary target group is young people aged 11 to 16 years. Secondary target group is parents. The Project has three broad goals to:

- create a national resource centre for alcohol and other drug education;
- develop best practice guidelines on the teaching of alcohol and other drug issues; and
- provide Australian students with quality education resource material in the alcohol and other drug area.

To meet these goals, two programs are being developed: a CD-ROM to be distributed to all schools in NSW, and a display stand to be distributed to public libraries. As the Foundation had limited resources, it hasn't looked at all aspects of drug education, such as the safe use of drugs, treatment, and rehabilitation, but has confined itself to focusing on preventing young people from experimenting with drugs.

In the CEIDA article, Ms Sue Murray (Executive Director, AMA Charitable Foundation) stated that while the project "recognises harm minimisation policy as a valuable framework, there are other organisations that can better deal with the different parts of the spectrum than we can."

Because of this philosophy, the Anna Wood Project would not support programs advocating the safe use of drugs, although the AMA itself might do so. The programs developed by the Foundation are based on providing information, looking at attitudes, providing students with skills

to resist negative influences and then hopefully they can make an informed choice to not use drugs if and when the situation arises.

Ms Murray stated that “no one resource is going to change the drug problem. However, if everybody is working toward the same end ... we have a much greater opportunity to impact on the drug problem in this country.”

The Project is guided by an expert panel of representatives from the alcohol and other drug field. These include NSW Health, Sydney University’s Health Education Unit, professionals working in adolescent health, the NSW Department of School Education and (for the library project) the State Library of NSW.

Funding for the Project comes from community fundraising campaigns, individual and corporate donations, and government funds. Project funding of \$75,000 was provided by the Premier's Department, and Department of School Education and NSW Health in the State Government. The Project will approach the Federal Government for further support to expand its activities nationally. Two fundraising and awareness raising Live the Future days have been held in schools throughout Australia in 1996 and 1997. All royalties from a book about Anna Wood go to the Project.<sup>395</sup>

#### ***Living the future CD-ROM***

A CD-ROM with a target audience of 11 to 13 year olds is being developed. In order to build on existing resources, it will focus on prescribed and over the counter medications as a way to explore the underlying issues of why young people may or may not use drugs.

Prescribed and over the counter medications were chosen as the subject for the CD-ROM because there were no existing materials in schools covering this issue. The choice of these drugs is that their use is perceived to involve the same issues and pressures that influence young people to experiment with illegal drugs.

Prescribed and over the counter medications were chosen as being appropriate for target audiences and relevant to their experience. “*Teachers feel comfortable with this area, and especially in primary school, parents need to feel comfortable with the content areas their children are being exposed to,*” Ms Murray said.

#### ***Live the future library project***

This is a pilot project whereby 10 of the 100 existing public libraries in NSW will be provided with a free standing unit containing resources about alcohol and other drugs. The resources were chosen in consultation with the Centre for Education and Information on Drugs and Alcohol, the State Library of NSW and Sydney University's Health Education Unit. Training will be provided to librarians as part of the project and will include knowledge of local services and resources so that people wanting more than prevention information can be referred to an appropriate local service. The target audience for this project is 11 to 16 year olds and, secondarily, parents.

In 1997, NSW Health provided a seconded health promotion worker to implement phase one of the project. It is now in phase two, with a project officer being seconded by NSW Health to the State Library of NSW to see the marketing and evaluation stages of the pilot project completed.

### **8.1.9. Damien Trimingham Foundation**

The Damien Trimingham Foundation is a charity aiming to support parents of drug users and to educate them about drug use. It was founded by Mr Tony Trimingham,<sup>396</sup> whose 22 year old son died from a heroin overdose in 1997 in Sydney.

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<sup>395</sup> Anna’s Story by Bronwyn Donahagy, published by Harper Collins.

<sup>396</sup> trimmo@ozemail.com.au

The impetus by Mr Trimmingham to become involved in developing a support and educational service for bereaved parents followed the strong positive response he received from writing a letter to the Sydney Morning Herald which argued for a new approach to deal with the problem of heroin use. He was concerned that there was limited political support for the law reform agenda contained in the NSW Wood Royal Commission into police corruption.

Harm minimisation and the promotion of intelligent debate are the central tenets of the Foundation's philosophy. Comments from Mr Trimmingham that were reported in the CEIDA article outline the approach that is advocated.

*"There are a few fixed things that we believe in, and the source of that is harm minimisation. But that encompasses a bit of law reform, we're certainly in favour of a national conference on this issue, we're for the Canberra heroin trials - but beyond that, everyone who belongs to our group would have a wide range of opinions."*

The Foundation embraces the harm minimisation philosophy because drugs are seen as a multifaceted problem, therefore needing multi solutions. The Foundation also supports the work of 12 step and abstinence based programs, but is concerned at the lack of diversity in treatment programs and what it sees as a chronic shortage of beds in detoxification services. The Foundation is closely aligned with the Sydney branch of the national organisation Families and Friends for Drug Law Reform, with which it has held a number of public meetings to discuss heroin use and drug law reform.

Up to end of 1997, the Foundation had received about \$10,000 in donations. It had also applied to the NSW Health Department and to the NSW Users and AIDS Association's TRIBES Project for project funding.

### **8.1.10. Parents Reaching Youth Through Drug Education**

Parents Reaching Youth Through Drug Education (PRYDE) is a volunteer group which aims to stop and prevent drug use among young people.

PRYDE in Australia grew out of a wider international parent movement which had its origins in a chance meeting between three mothers of heroin users in Stockholm. The movement spread to the US in the 1960s, as a reaction to concerns about the number of young people who were smoking cannabis daily. The National Federation of Parents for Drug Free Youth was formed as a lobby group at that time, and then later an education group, Parents' Resources Institute for Drug Education (PRIDE Inc), was provided with US Government funding. The Australian organisation started in 1983.

The CEIDA article included remarks by Ms Yvonne Vane-Tempest, the educator for PRYDE in Australia on the organisation's international affiliation. *"While we are a part of that international parent movement and part of the international PRIDE family of nations, we've changed our spelling to PRYDE - Parents Reaching Youth through Drug Education to more accurately reflect our primary mandate of preventative education through parents."*

The primary aim of PRYDE is to work towards 'drug free youth'. The organisation advocates no use of illegal drugs, and no illegal use of legal drugs, such as underage use of alcohol or tobacco. PRYDE advocates that it is possible to create a drug free world for the next generation, which can be achieved if there are *'informed parents who are in a unique position to prevent their child from ever becoming involved in drugs. We believe that all adults, whatever role, have to make a strong anti drug stand.'*

PRYDE does not support any promotion of safe use of illicit drugs; rather, it advocates prevention of all illicit drug use. In the CEIDA article, its position was stated to be that *"what we need to be thinking about is not harm minimisation but harm awareness - we want to minimise the harm by saying to people, 'don't use mind altering substances because they have the potential to do serious harm to mental and physical health'."*

PRYDE recognises the harm caused by legal drugs and advocates no tobacco use and cautions parents to exercise care in their own example concerning the consumption of alcohol. The philosophy is that parents could send very conflicting messages, if they were to advocate that mind altering drugs could be used responsibly or safely.

While there are PRYDE groups throughout Australia, they operate independently of one another but in accordance with the articles of association as set out in the PRYDE brochure. The organisation charges a nominal membership fee to cover costs, but all activities are done by volunteer labour.

The PRYDE office also acts as an information bureau on different alcohol and other drug issues and receives telephone calls from throughout Australia. PRYDE produces some of its own resources but also recommends selected existing publications, such as the AMA's brochure on cannabis. Callers who require counselling or other services (such as detox) are referred to other service providers. The organisation does not see itself as political, but it does make submissions on drug policy issues to governments.

## 8.2. Youth

### 8.2.1. Introduction

This section deals with programs targeted at young people who require assistance with alcohol and other drug related problems. It needs to be emphasised that only a relatively small number of young people have contact with the major drug rehabilitation agencies in this State. The majority of young people do not engage in criminal offending or become dependent on illicit drugs. For most young people where drug use does occur, it occurs at an experimental level without problematic consequences.

For the majority of adolescents, the ages between 12 years and 16 years are a time of marked psychological and social growth. The demands, expectations and temptations they encounter are more numerous and carry larger risks than those experienced by adolescents only a generation ago. By the age of 16 years, a significant percentage of Western Australian teenagers have tried cannabis, alcohol and cigarettes and many have become sexually active. The majority of adolescents engage in these behaviours infrequently. However, when such behaviours become more frequent or enduring, they have the potential to put young people's health at risk and to restrict their future life prospects by disrupting the normal processes of development and the learning of life skills required for coping successfully in adult life.

Alcohol, tobacco and cannabis are the drugs most adults and adolescents are likely to use. The majority of young people will not experiment with, or regularly use, other illicit drugs. Formative qualitative and quantitative research conducted for the Drug Aware Campaign by Health Promotion Services in April 1996 concluded that "experimentation with illicit drugs is essentially a result of a combination of persuasion, curiosity, lack of information and need for choice. Clearly, adolescents need to be challenged and involved in decisions and exercise choice in what they do in their lives."<sup>397</sup>

There is evidence to suggest parental role models may influence the drug use behaviours of their children.<sup>398</sup> Research also suggests that the degree to which adolescents talk openly with their

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<sup>397</sup> Health Promotion Services. *Formative qualitative research for drug aware heroin prevention campaign* (unpublished). Perth, Health Promotion Services, Health Department of WA 1997.

<sup>398</sup> Kafka RR, London P. "Communication in relationships and adolescent substance use: the influence of parents and friends." (1991) 26 *Journal of Adolescence* 587-598; Coombs RH, Paulson MJ, Richardson MA. "Peer vs parental influence in substance use among Hispanic and Anglo children and adolescents." (1991) 20 *Journal of Youth and Adolescence* 73-88.

parents influences the extent of their drug use.<sup>399</sup> Other research suggests parents who exert minimal control or influence over their children, provide little emotional support to them, or infrequently disapprove of problem behaviour are more likely to have children who use alcohol and other drugs, hence supporting the need for programs which teach parents skills to use with their children.<sup>400</sup> In addition, a literature review cited by Mundy found parents to be a greater influence than peers on adolescent drug taking behaviour.<sup>401</sup>

In recent investigative research conducted with young people who use illicit drugs other than heroin, or who have experimented with heroin, often cited motivations to experiment with the drug included: wanting to try every drug and experience its intoxication (heroin is popularly reported to be extremely calming and pleasurable); the taboo associated with heroin is based on increased risk and it is therefore, the ultimate drug 'badge', the best means of proving oneself to be 'hard core'; and its association with death can be attractive to young people who wish to find the ultimate rebellion against what is perceived as unjust or uncaring authority.

This same research showed that respondents' reasons for not beginning or continuing heroin use are most concerned with a perceived high probability of dependence and consequent negative social consequences. The respondents did not associate these negative outcomes with other illicit drugs: 'Ecstasy & speed [amphetamines] didn't change my friends - heroin did'.<sup>402</sup>

This confirms the negative value young people had ascribed to heroin use in previous qualitative research:

*"Respondents were clear that they did not want to be associated or attached to labels such as sniffers/junkies and that these subgroups were generally not condoned... were considered losers with no hope who had lost control and had no future prospects. Whilst the reference to junkie was made in direct reference to heroin... respondents appeared to have relatively good things to say about people who use cannabis and ecstasy and generally associated those drugs with good times, raves, good music..."*<sup>403</sup>

## 8.2.2. Interventions

It is now understood that no single health promotion campaign will solve drug related problems, and that any change towards prevention of illicit drug use or harm reduction for those who do use will only be effected by a comprehensive campaign. Such a campaign would include public education and promotion (including mass media, and community, school based and professional training) alongside legislative, economic, environmental and organisational strategies.

The Illicit Drug Education Program, which is conducted by the Health Promotion Services, is one component in such a campaign. The program's goal is to reduce the harm associated with illicit drug use among Western Australians, particularly young people. It aims to provide young people, community members, parents and health and education professionals with reliable and accurate information on the short and long term individual and public health implications of illicit drug use within a harm reduction context.

The program takes a primary role in public education and collaborates on environmental and organisational strategies, for example working with councils, police and industry on healthy public

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<sup>399</sup> Silburn SV, Zubrick SR, Garton A et al. *Western Australian child health survey: family and community health*. Perth, Australian Bureau of Statistics and TVW Telethon Institute for Child Health Research, 1996; Health Promotion Services. How parents influence adolescent alcohol consumption. *Alcohol and Other Drugs Bulletin No. 2*. Perth, Health Promotion Services, Health Department of WA 1996.

<sup>400</sup> Elmquist DL. "A systematic review of parent oriented programs to prevent children's use of alcohol and other drugs." (1995) 25 *Journal of Drug Education* 251-279.

<sup>401</sup> Mundy J. "Lessons to be learned: the challenge of teaching about drugs." *Connexions* April/May 1996 4-12.

<sup>402</sup> Health Promotion Services. *Formative qualitative research for drug aware heroin prevention campaign* (unpublished). Perth, Health Promotion Services, Health Department of WA 1997.

<sup>403</sup> Health Promotion Services. *I guess if it was there and someone offered me it I'd probably take it*. (unpublished). Perth, Health Promotion Services, Health Department of WA 1997, 10.

policy and producing information resources in the form of postcards. It produces and distributes a range of publications which dispel existing misconceptions about illicit drugs, provide information on the adverse health and social effects of illicit drug use, and offer harm reduction strategies for drug users. The Program supports the Alcohol and Drug Information Service (ADIS) and Parent Drug Information Service (PDIS), and collaborates with the WADASO on the Drug Aware Campaign.

The Select Committee was impressed with the expert evidence provided to it by three researchers who had conducted major surveys of young people. These were Dr Stephen Zubrick, Head of Division for Psychosocial Research and Mr Sven Silburn (both of whom work with TVW Telethon Institute for Child Health Research) and Dr Stephen Houghton, Associate Professor, School of Education, University of WA.

It was pointed out to the Select Committee that broader social changes which affect the conditions of child rearing and social adaptation as young people move into adult society have been identified in comprehensive research undertaken in Europe. The effect of these major changes has been to increase family conflict and cause substantial changes in family structure, which have had the effect of lessening parental support for young people.

In addition this research has identified an increasing level of youth alienation. This has stemmed from economic changes which have affected employment and increased stratification between younger and older generations because of conditions of modern living. The Institute of Child Health had undertaken the WA Child Health Survey to investigate these issues in WA.

Findings from the WA Child Health Survey in relation to cannabis use and other illicit drugs are reported below in this chapter and in a number of places elsewhere in this report. In relation to family income and the use of cannabis, the most prevalent illicit drug used by young people, the following information was provided to the Select Committee. There is

*“(a) peak of use of marijuana in the lowest income families usually occurring at about the age of 15 years; a peak of use in the highest income families at about the age of 16 years; and a trough of use in middle income families who, by and large, when we look across tobacco, alcohol and marijuana use, tend to be the lower users of those substances. This suggests to us in many ways that some of the public health promotion campaigns have affected the middle income earners but we have some work to do on high income and very low income families.”<sup>404</sup>*

The Select Committee was told of an Education Department project at the Clarkson Senior High School and Clarkson Primary School which was aimed at developing a health promoting school. The project was based on three elements of the school environments which can make a difference for children by preventing disruptive behaviours, promoting positive coping and reducing antisocial behaviours. These are:

- school ethos which deals with the social development of students of enhancing their academic outcomes;
- building strong links with families in the local community; and
- developing curriculum materials and resourcing teachers to equip them to teach life skills.

*“When you think about prevention, it is important to think about at what points in the course of the development of a problem are opportunities available to make a difference. One can start either very late, once adolescents are in their late teens and are starting to use drugs, or early in life and look at all developmental opportunities for making a difference.”<sup>405</sup>*

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<sup>404</sup> Evidence to the Committee by Dr Zubrick, 26 September 1997, 29.

<sup>405</sup> Id 30.

## Select Committee Into Misuse of Drugs Act 1981

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Further evidence indicated that as it was possible to identify disruptive and other problem behaviours at an early age, preventative programs could be mounted to reduce the rates of problem behaviours, such as drug use, which tended to manifest during adolescence.

*“Disruptive behaviour can be identified early in childhood. Disruptive children may be identified by their primary school teachers when entering grade one. The teachers can predict with about 90 per cent accuracy which children will be in trouble with the law by the time they are adolescents. If we can use effective interventions to reduce the rates of disruptive behaviour in early childhood and early education years, that could make a difference at the preschool, primary school or high school levels.”*<sup>406</sup>

In a submission to the Select Committee, concerns were raised about the need to develop early intervention programs to assist in the better management of children who have been diagnosed as having Attention Deficit Hyperactivity Disorder (ADHD). It was highlighted that those diagnosed with ADHD may be at more risk of becoming drug abusers as young adults.<sup>407</sup>

The Victorian Drugs and Crime Prevention Committee has also addressed the issue of developing early intervention strategies to reduce risk factors for young people beginning to offend that were identified in recent UK Home Office research. These include poor parental supervision, conflict in the home environment, trouble by friends or siblings with the police, poor school performance, exclusion from school and truancy.

*“If a young person experiences four or five of these risk factors, the likelihood of them offending is 80 per cent for males and 60 per cent for females. Therefore, it is important to concentrate on reducing these risk factors in order to prevent the onset of offending.”*<sup>408</sup>

### **Recommendation 29**

***That the School Drug Education Project be enhanced by including strategies which would enable schools to identify students at an early age (including those diagnosed with ADHD) who are at a high risk of becoming problematic drug users and to provide resources to schools to assist these students and their families.***

## **8.2.3. Surveys of drug use and other health related behaviours**

### **8.2.3.1. 1996 ASSAD survey**

#### **Introduction**

At the time this report was being written, full results from the component of the 1996 Australian School Students' Alcohol and Drugs (ASSAD) national survey had not been released. Responsibility for analysing the ASSAD survey rests with the Health Promotions Service, which has undertaken and participated in key State and national research into prevalence for a number of years. The first report, concerned with cigarette consumption, was published in July 1997,<sup>409</sup> followed by publication of the results for alcohol consumption in October 1997.<sup>410</sup>

In 1984, the Australian Cancer Society and its affiliated member organisations conducted the first of a series of national surveys examining the smoking and drinking behaviours of Australian

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<sup>406</sup> Ibid.

<sup>407</sup> Submission to the Select Committee from the Learning and Attentional Disorders Society of WA Inc.

<sup>408</sup> Victoria, Parliament, Drugs and Crime Prevention Committee. *Interim report of the inquiry into the Victorian government's drug reform strategy*. Melbourne, Victorian Parliament, 1997, 164.

<sup>409</sup> Health Promotion Services. *Cigarette consumption among 12 to 17 year old Western Australian school students in 1996, summary report*. Perth, Health Promotion Services, Health Department of WA, 1997.

<sup>410</sup> Health Promotion Services. *Alcohol consumption among 12 to 17 year old Western Australian school students in 1996, summary report*. Perth, Health Promotion Services, Health Department of WA, 1997.

secondary school students. These surveys have been managed by the Centre for Behavioural Research in Cancer at the University of Melbourne for the Anti Cancer Council of Victoria (ACCV), with the aim of providing reliable estimates of smoking and drinking prevalence. A major object of these surveys has been to identify priority area for education interventions. Subsequent ACCV surveys were conducted in 1987, 1990 and 1993.

The fifth ASSAD survey was conducted in 1996 and for the first time included questions about secondary school students' smoking, alcohol consumption and the use of illicit drugs. The 1996 survey also included items concerned with skin cancer prevention.

**Summary**

The results for the 1996 ASSAD national survey are outlined in Tables 10 and 11 in Appendix 13. The definition of recency and frequency of use adopted in this survey involved a scale of seven levels of *frequency* and four levels of *recency* for each substance. An extract from the questionnaire concerned with cannabis use, Question 33, is provided below.

*How many times, if ever, have you smoked or used marijuana: (grass, hash, cannabis, dope, mull, pot, a joint)?*

	None	Once or twice	3-5 times	6-9 times	10-19 times	20-39 times	40 or more times
In the last week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last 4 weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In the last year	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Cannabis**

The 1996 survey highlights the high rates of usage of cannabis by WA school students, with prevalence increasing as students become older. For instance, 33.5% of males in the 12 to 15 age group report cannabis use in the past 12 months, compared to 55.9% for the 16 to 17 age group who report cannabis use in the past 12 months. Overall, 38.9% of males and 33.5% of females in the 12 to 17 age group had used cannabis in the last year. A similar age related increase occurs with school students who report cannabis use in the last month.

These results indicate sex related differences. In the 12 to 15 age groups, a greater proportion of males than females use cannabis at all levels of frequency of use. However, with increasing age the disparity between males and females decreases. For instance, in the 16 to 17 age group 59.5% of males and 57.2% of females have cannabis in the past year (Table 10, Appendix 13).

The increased rate of uptake of cannabis use that occurs with increasing age suggests this usually occurs in the transition from junior to senior high school. For instance, the prevalence of use in the past 12 months for males increased by 77.6% from 33.5% (12 to 15 age group) to 59.5% (16 to 17 age group) and for females prevalence more than doubled from 26.4% (12 to 15 age group) to 57.2% (16 to 17 age group).

**Other drugs**

The survey confirms the low rates of prevalence for other drugs, such as heroin and cocaine, whose use is known to pose high risks to users through dependence and the transmission of BBVs through injecting (Tables 10 and 11, Appendix 13).

LSD has been used by slightly less than one in 10 of all school students surveyed in 1996. However, as is the case with cannabis use, a marked increase in use is reported by older students, with 19.7% of males and 17.7% of females in the 16 to 17 age group reporting use in the past year. There is a similar increase in reported use of ecstasy by older students, with rates of use of this drug being about one third of the rate for LSD use by 16 to 17 year olds.

A surprising finding was the extent of usage of inhalants. Use of this drug group is more frequent in the 12 to 15 age group, where nearly one in five young people have used in the past year and about one in ten have used in the past month.

Tranquillisers have been used by 12% of males and 14% of females across all ages. However, the increased prevalence of females (18.9%) who have used in the past year is of concern.

High rates of amphetamine use are reported by male compared to female students. This difference is most noticeable in the 16 to 17 year old group, where 4.7% of males report use in the past month compared to 1.6% of females.

Tobacco is the exception to an overall pattern of higher levels of drug use by males compared to females, with higher rates of use in the past week reported by females aged 12 to 15 (F 17.4% vs M 14.0%) and 16 to 17 (F 29.2% vs M 24.5%).

### **8.2.3.2. 1993 WA Child Health Survey**

The TVW Telethon Institute for Child Health Research carried out a large scale epidemiological survey of the health and well being of WA children and adolescents during 1993 and 1994. The study has been funded by Healthway (Western Australian Health Promotion Foundation), the Rotary Health Research Foundation, the Health Department of Western Australia and the State Statistics Committee.

The primary objectives of the WA Child Health Survey have been to define priority targets for existing health, education and social services, and to build an epidemiological knowledge base from which preventive strategies can be developed to facilitate the social, emotional, academic and vocational competency of young people. A notable feature of this survey is its emphasis on elucidating the developmental and environmental factors which enable and develop adolescent competency, resiliency, and employment readiness.

The specific aims of the study were as follows.

- Estimate the prevalence and distribution of mental health problems in Western Australian children aged 4 to 16 years.
- Estimate the prevalence and distribution of other chronic medical conditions and handicaps (eg asthma, cerebral palsy and intellectual handicap) and how they contribute to mental ill health and reduced function.
- Estimate the prevalence and distribution of adverse health behaviours (eg. smoking, alcohol and drug misuse, and unprotected sexual activity).
- Describe children and adolescents' use of health care, education, juvenile justice and social services.
- Develop estimates of risk and markers identifying children at increased risk for various health, educational and vocational outcomes.
- Identify markers resulting in protection from and amelioration of poor mental health and adverse health behaviour(s).

The WA Child Health Survey sample frame included both country region and metropolitan estimates. A random sample of 1,776 consenting households throughout WA was obtained with 1,462 (82%) consenting to participate. A total of 2,737 children and adolescents between the ages of 4 and 16 was surveyed.

Collection districts across the entire State were sampled and 27 trained interviewers conducted the household interviews. The average interview with parents lasted 90 minutes. The 788 adolescents between the ages of 12 and 16 in the survey provided self report information about a range of health and lifestyle issues. Finally, for the 2,319 children attending WA schools, consent was obtained to seek information from their school Principals and teachers. Information from schools was returned on 96% of these children.

**Alcohol consumption**

Consumption of alcohol by 12 to 16 year olds beyond the small amount permitted by their parents increased steadily with age, with 14% of 12 and 13 year olds reporting they had consumed alcohol more than just once or twice and that by the age of 16 years, 61% reported regular consumption of alcohol (Table 8.2; Figure 8.1).

Of those 15 and 16 year olds who reported having consumed alcohol more than just once or twice, the survey found:

- 26% had first used alcohol before the age of 13 years;
- 43% had started to use alcohol when 13 or 14 years old; and
- 21% had first used alcohol when 15 or 16 years old.

Of concern, the survey confirms that consumption of alcohol to the extent of intoxication increased with age, with just over 6 per cent of 12 to 14 year-olds and 35% of 15 to 16 year olds (of whom 59% were females) reporting consumption to become intoxicated.

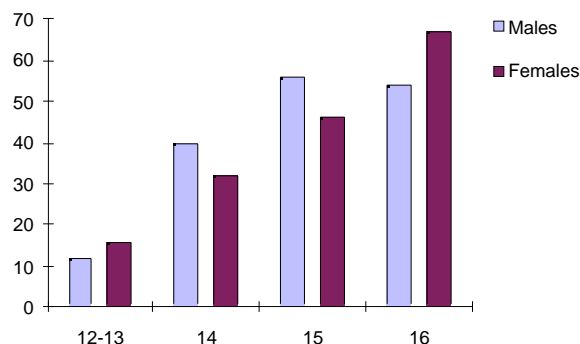
Consumption of alcohol to the point of vomiting was reported by 26% of 15 to 16 year olds, with boys being more likely to have done so on more than one occasion (Table 8.2).

**Table 8.1: Frequency (%) of alcohol use of adolescents by age group, WA, 1993**

	Age group (years)	
	12-14	15-16
<b>Drinking within the past month <sup>(a)</sup></b>		
Never drank	80.3	48.4
1-2 times	14.8	28.2
3-9 times	1.7	13.2
10 or more times	1.0	7.0
<b>Intoxicated (drunk) at any time within the past 6 months</b>	6.4	35.2
<b>Drunk causing vomiting since commenced drinking</b>		
Once	4.4	14.1
More than once	0.4	11.8

Note: (a) Excludes frequency not stated

Figure 8.1: Adolescents (%) who have drunk alcohol more than once or twice by age and sex, WA, 1993



Source: WA Child Health Survey, 1995

Comparison with the 1987 population survey of drug and alcohol use by Perth teenagers suggests little change in adolescent alcohol consumption, as in 1987, 72% of Perth teenagers aged 15 to 16 years reported that they had drunk alcohol.<sup>411</sup> The comparable result was 76% in the 1993 Child Health Survey.

### Cannabis

Adolescents' use of cannabis rose steadily with age, from about 7% at 13 years of age to 34% at 16 years of age. A greater percentage of 15 to 16 year old males (34.5%) had used cannabis compared to females (32%), with males also more likely than females to be regular<sup>412</sup> users (21.8% compared to 14.1%) (Table 8.2).

Overall, 18% of 12 to 16 year old Western Australians reported use of cannabis, although the frequency of use was generally low. The Child Health Survey also found that of the estimated 14,200 young people aged 15 to 16 who had ever used cannabis, 34% had not done so within the last year and 13% had used it less than monthly. The remaining 53% of 15 to 16 year olds who had ever used cannabis, did so regularly, with 27% reporting monthly use, and 26% reporting weekly or daily use.<sup>413</sup>

An important finding was that cannabis use, like tobacco use, varied with family income, as follows:

- use was highest in adolescents from households with a family income in the lowest income quintile (ie the lowest 20% of family incomes);
- use was lowest in adolescents from households with a family income in the middle income quintile; and
- about 20% of adolescents from each of the remaining family income quintiles reported its use.

In considering the importance of other factors that might be related to an adolescent's use of cannabis, the Child Health Survey found that adolescents who hated school or did not like school were more likely to have used cannabis, compared with those who liked school to any degree and that cannabis use varied according to school culture.

<sup>411</sup> Lo SK, Blaze-Temple D, Binns CW. "Perth teenage drug consumption - differences between students and non-students." (1985) *Drug Education Journal of Australia*.

<sup>412</sup> Defined as monthly, weekly or daily use.

<sup>413</sup> Zubrick SR, Silburn SR, Barton A, Burton P, Dalby R, Carlton J, Shepherd C, Lawrence D. *Western Australia Child Health Survey: developing health and well-being in the nineties*. Perth, Australian Bureau of Statistics and Institute for Child Health Research, 1995, 32.

Three factors were identified which indicate that cannabis was more likely to be used in schools where:

- respondents reported other students using drugs before and after school;
- students reported high levels of alcohol drinking at school; and
- there were high levels of student vandalism or theft.

**Table 8.2: Frequency (%) of cannabis use of adolescents by age group and sex, WA, 1993**

	Age group (years)		
	12-14	15-16	12-16
<b>Males</b>			
Used cannabis	9.4	34.5	18.5
Frequency of use			
Infrequent <sup>(a)</sup>	7.4	12.7	9.3
Regular <sup>(b)</sup>	2.0	21.8	9.2
<b>Females</b>			
Used cannabis	5.8	32.0	16.6
Frequency of use			
Infrequent <sup>(a)</sup>	2.9	18.0	9.1
Regular <sup>(b)</sup>	2.9	14.1	7.5

Note: <sup>(a)</sup> Less than monthly, <sup>(b)</sup> Monthly, weekly or daily.  
Source: Western Australian Child Health Survey, 1995.

### 8.2.3.3. NDS National Household Surveys 1985 - 1995

A valuable analysis of national trends in illicit drug prevalence with respect to 14 to 19 year olds was published in conjunction with the evaluation of the National Drug Strategy 1993-1997.<sup>414</sup> This data had been obtained from the five most recent National Drug Strategy National Household Surveys conducted in 1985, 1988, 1991, 1993 and 1995. Some of this information, which deals with national data for the 14 to 19 age group, has been utilised in this section, as similar trends are likely to occur in this State.

Between 1985 and 1995, the proportion of the population aged 14 to 19 years which had *never* used illicit drugs declined from two thirds (66.9%) to just over one in two (54.8%). Males were less likely than females to abstain from consuming illicit drugs (Table 8.3; Figure 8.2).

It would appear that, with increased opportunity and availability of illicit drugs, the proportion of 14 to 19 year olds who have used illicit drugs has declined with each year of age.

In 1995, two thirds (66.7%) of 14 year olds had *never* used an illicit drug; this was a decrease from 92% in 1985. By 19 years of age only 36.1% had *never* used an illicit drug, a decrease from 55.9% in 1985.

<sup>414</sup> Williams P. *Progress of the National Drug Strategy: key national indicators. Evaluation of the National Drug Strategy 1993-1997 statistical supplement.* Canberra, Department of Health & Family Services, 1997.

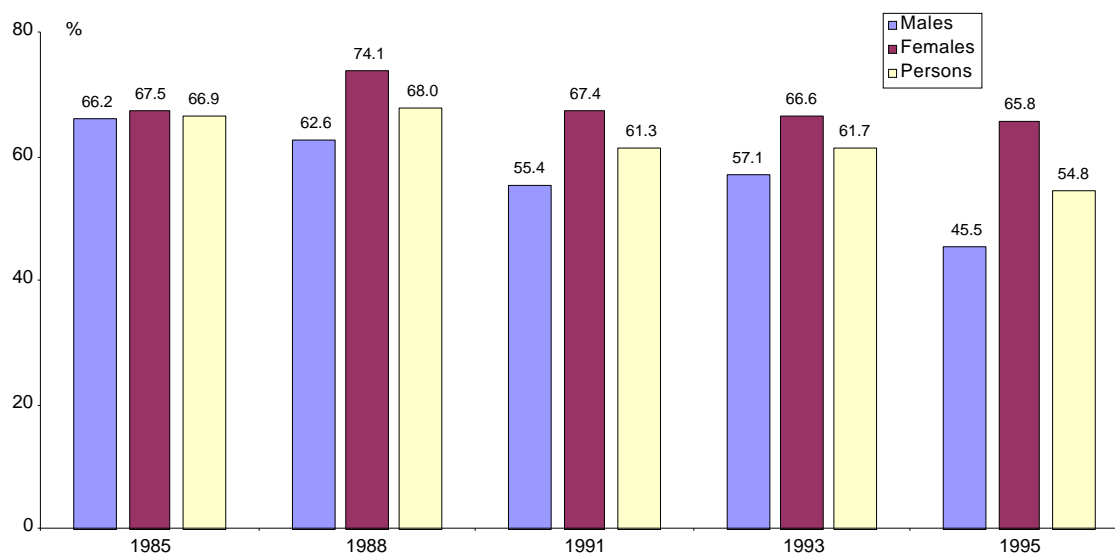
**Table 8.3: Proportion (%) of adolescents aged 14 to 19 who have never used illicit drugs in the past 12 months, Australia, 1985 - 1995**

Year	Age group						
	14	15	16	17	18	19	14-19
<b>Males</b>							
1985	88.78	80.74	62.68	51.03	53.02	56.91	66.18
1988	90.00	81.82	66.67	80.00	40.91	33.34	62.64
1991	74.35	61.90	53.85	48.08	52.94	45.65	55.39
1993	na	na	na	na	na	na	57.07
1995	55.04	60.50	53.05	37.55	30.78	34.71	45.45
<b>Females</b>							
1985	96.19	73.04	65.43	65.11	45.33	54.55	67.54
1988	90.91	94.11	70.59	61.54	70.00	53.85	74.07
1991	88.37	66.67	65.96	75.00	62.22	47.62	67.43
1993	na	na	na	na	na	na	66.58
1995	92.86	75.28	78.55	65.14	47.96	37.62	65.78
<b>Persons</b>							
1985	92.36	76.90	64.00	59.17	49.41	55.89	66.86
1988	90.48	87.18	68.97	69.57	50.00	42.86	68.02
1991	81.70	64.44	60.47	59.09	57.29	46.59	61.32
1993	na	na	na	na	na	na	61.68
1995	66.68	65.95	69.41	52.02	36.93	36.12	54.77

Source: NDS Household Surveys.

• Age ranges = 14-19, 20-29, 30-39, 40-54, 55-69, 70+.

**Figure 8.2: Proportion (%) of adolescents aged 14 to 19 who have never used illicit drugs in the past 12 months, Australia, 1985 - 1995**



### 8.2.3.4. Surveys of high risk groups

#### Introduction

There is evidence of substantially higher rates of drug abuse by young people who are involved in crime, are outside the school system, or belong to socially marginal groups. There have been a limited number of surveys conducted in the metropolitan area and in country regions which have dealt with patterns of drug abuse by such 'high risk' populations of young people. These include:

- surveys of young offenders in detention (sentenced and on remand) centres and young people with drug related problems attending regional offices of the Juvenile Justice Division;<sup>415</sup>
- surveys in relation to volatile substances;<sup>416</sup> and
- surveys by youth work agencies of marginalised young people living in the metropolitan regional areas using amphetamines.<sup>417</sup>

There are few studies which have examined the relationship between crime and drug use among juvenile offenders. NSW research, which involved 247 detained young people,<sup>418</sup> indicates a significant proportion of juvenile offenders resort to crime to raise money with which to procure drugs. The following proportions of offenders claimed they had committed crime for this reason:

- 30% of those convicted for break, enter and steal;
- 16% of those convicted for shoplifting; and
- 5% of those convicted for stealing a motor vehicle.

### **Excluded and marginalised young people**

Research in Sydney has identified very high rates of illicit drug use amongst young people not attending school, with attendant problems such as unemployment, crime and poor relationships with their families. Such an example was a 1990 street intercept survey of 581 16 to 21 year old illicit drug users. While not necessarily representative of young people in other parts of Australia, nevertheless this data gives a helpful overview of the extent of drug use and some of the related health and social problems of marginalised youth.<sup>419</sup>

All respondents had used at least one illicit drug other than cannabis within the three months prior to the interview and 161 (28%) of the respondents had ever injected at least one of those drugs. Alcohol use was prevalent, with only 6% of the sample claiming that they did not drink alcohol. Drinking was characteristically frequent (40% of drinkers drank three or more times a week) and heavy (67% usually drank five or more drinks in a session and 82% had drunk five or more drinks in a row at least once in the two weeks prior to the interview).

Almost all of the respondents had smoked cannabis at least once (98%), and 93% had smoked it in the previous three months. Use of illicit drugs other than cannabis over the previous three months included 61% had used amphetamines, 40% had used hallucinogens, 36% had used ecstasy, 31% had used sedatives, 20% had used inhalants, 20% had used cocaine and 15% had used heroin.

Occasional drug use was prevalent, with 78-97% of the users of most drugs reporting that they used a number of drugs once a week or less often. More than half reported using once a month or less. The exceptions to this rule were cannabis and heroin, which were reportedly used more than once a week by about half of users. The majority of the sample had used one (41%) or two (25%) illicit drugs other than cannabis in the previous three months, while the remaining third reported using three (15%) or more (18%) drugs.

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<sup>415</sup> Watts P. *Youth in custody project - a profile of juvenile offender's drug use patterns*. Perth, Youth Suicide Steering Committee, Health Department of WA, 1992; Ministry of Justice, Juvenile Justice Division. *Survey of drug use patterns amongst young offenders in detention*. Perth, Ministry of Justice, 1995.

<sup>416</sup> Rose J, Daly A, Midford R. *Report on the usage patterns of volatile substances users in Perth*. Perth, Alcohol and Drug Authority, 1992; Baines P. *Community research project, volatile substance use among young people in the north east region of the Perth metropolitan area*. Perth, North East Region Youth Centre, 1992; German D, Skidmore M. *Young people and solvent use in the Armadale area*. (unpublished paper) 1994.

<sup>417</sup> Koondoola and Girrawheen Youth Inc. *Speeding in the northern suburbs, problems of a group of young amphetamine users*. Perth, Koondoola and Girrawheen Youth Inc, 1993

<sup>418</sup> Salmelainen, P. Money, drugs and juvenile crime. *Paper presented at the Australian and New Zealand Society of Criminology 10th Annual Conference Crime, Criminology and Public Policy*. Sydney 27-30 September 1994.

<sup>419</sup> Spooner C, Flaherty B, Homel P. *Results of a street intercept survey of young illicit drug users in Sydney*. Sydney, Directorate of the Drug Offensive, NSW Department of Health, 1992.

## **Select Committee Into Misuse of Drugs Act 1981**

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Sedative users tended to be younger; to be less well educated; to be more likely to have used cocaine, inhalants and/or heroin; and to have been interviewed in the inner city, inner western or western suburbs. Amphetamine users were older, less well educated, and more likely to have used cocaine than respondents who did not use amphetamines. Cocaine users were older and more likely to have used sedatives, amphetamines, ecstasy and heroin than respondents who did not use cocaine.

Hallucinogen users were younger, more likely to be male, to be using inhalants and to have been interviewed in the western or south western suburbs of Sydney than respondents who did not use hallucinogens. Inhalant users were younger, better educated, more likely to have used sedatives, hallucinogens or ecstasy and to have been interviewed in the western or south western suburbs than respondents who did not use inhalants. Ecstasy users were more likely to have used cocaine and inhalants and to have been interviewed in the city and less likely to have been interviewed in the western or south western suburbs than respondents who did not use ecstasy.

Heroin users were older, more likely to be female, less well educated, more likely to have used sedatives and cocaine and more likely to have been interviewed in the inner western suburbs than respondents who did not use heroin.

A minority (14%) of the sample had been arrested for using or possessing drugs. Injecting drug users were more likely than non injecting drug users to have been arrested (31% compared with 8%). Most (64%) of those who had been arrested stated that the arrest had had no effect on their subsequent use of drugs. Of the 21 respondents who stated that the arrest had some effect on their drug use, the most commonly stated effect (48%) was that the respondent was more careful not to get caught.

Few (17%) reported that they were afraid of being arrested for using or possessing drugs and only 13% thought that it was likely that they would ever be arrested for using or possessing drugs. Most (69%) of the sample did not think that their use of illegal drugs was 'wrong', mainly because 'it doesn't hurt anyone'.

The frequency of injecting was fairly evenly distributed between daily and infrequent injecting. Heroin was the most frequently injected drug (89% of heroin users had ever injected heroin), followed by amphetamines (35%) and cocaine (26%). Regular needle sharing was the exception rather than the rule, with two thirds of the injectors (66%) stating that they never shared needles, one quarter (25%) sharing occasionally and 6% sharing often or always.

Overall, sharing tended to occur with friends or others who did not look sick. Most (73%) of those who shared reported that they always cleaned a fit if they were using it after somebody else. Cleaning methods tended to be inadequate, with only 28% stating that they used the "two washes, two bleaches, two washes" method, which was popularised some years ago. More recently there has been a reconsideration of the limitations of promoting this method, as it does not encourage IDUs to recognise other sources of BBVs, such as mixing instruments, tourniquets, etc.

Knowledge of AIDS risk factors and the concepts of safe sex and safe using was quite widespread, although some misconceptions existed. More than half (57%) of non injectors, 42% of injectors who did not share needles and 23% of injectors who shared needles felt they had no chance of getting AIDS.

Nearly half (44%) of the sample claimed that they had made changes to their sexual behaviour because of the risk of AIDS. Injectors were more likely than non injectors to have changed their drug use behaviour in response to AIDS (63% compared with 11%). With regard to both sexual behaviour and drug using behaviour, a recurrent theme was that a person was not considered to be infected if they were known to the respondent or, if not known, if they did not look sick.

## 8.2.4. Risk factors and protective factors

Steinberg provides an overview of risk factors and protective factors for adolescent drug use, which are summarised as follows.<sup>420</sup>

### 8.2.4.1. Risk factors

#### **Individual**

- A prior history of personality problems, especially those related to anger, aggression, impulsively, or depression
- School failure and academic difficulties, especially if they have resulted in grade retention
- Involvement in other problem behaviours, including precocious sexual activity, truancy, or non drug criminal or delinquent behaviour

#### **Interpersonal**

- Distant or hostile relations with parents or guardians
- Familial disruption, reconstitution, and marital conflict
- Membership in a peer group or friendship group that encourages or tolerates drug use

#### **Institutional**

- School transitions that involve movement into a more impersonal, more anonymous, and less protected environment
- Involvement in the part time labour force in excess of 20 hours per week
- Lack of access to meaningful roles in the community
- Growing up in poverty

### 8.2.4.2. Protective factors

#### **Individual**

- A sense of self efficacy and personal responsibility
- Well developed social and interpersonal skills
- Adequate decision making and intellectual abilities

#### **Interpersonal**

- Having at least one close relationship with a parent, teacher, relative, or mentor who can provide both guidance and emotional support
- Membership in a peer group that actively discourages alcohol and drug use and encourages academic, athletic, or artistic accomplishment as routes to popularity and status

#### **Institutional**

- A sense of bonding to school and other societal institutions
- An acceptance of societal approved values and expectations for behaviour.

Other studies have identified similar risk factors and protective factors for adolescent drug use. A literature review compiled by Marsh<sup>421</sup> found 18 year olds who used frequently to be more alienated, emotionally distressed and impulsive than abstainers or experimenters.

Marsh found almost all young drug users say they use drugs to feel good, to escape, to seek personal identity, and to rebel against authority. However, recreational users were more likely to report using drugs out of curiosity and to have fun socially, whereas heavy users often report being motivated to relieve personal distress, cope with negative emotions or to improve self concept.

<sup>420</sup> Steinberg L. "Adolescent transitions and alcohol and other drug use prevention." In Goplerud (ed). *Preventing adolescent drug use: from theory to practice*. Washington DC, US Department of Health & Human Services, 1991.

<sup>421</sup> Marsh A. "Young people with drug problems: why some and not others?" In Wilkinson C, Saunders B (eds). *Perspective on addiction*. Perth, Montgomery, 1996.

### **Family relationships**

Other studies have found the family to play an important role in determining levels of drug use. Positive interpersonal relationships within the family have been found to reduce the risk of social problems, including drug use. Conversely, negative relationships increase the risk of drug use.<sup>422</sup> It is argued that the family, in particular the adolescent's attachment to their parents, acts as a protective factor which shields the adolescent from participation in the drug culture. A review of the literature suggests that the best buffer against drug use is an emotionally warm and affectionate family.<sup>13</sup>

Furthermore, relationships with peers were seen to be among the strongest and most consistent predictors of alcohol and other drug use. Heaven discusses several studies which found that adolescents with peers who use licit or illicit drugs are more likely to use themselves.<sup>423</sup>

### **Reputation enhancement theory**

Reputation enhancement theory suggests that individuals carefully choose the image or social identity they wish to promote in the community and will go to great lengths to develop and maintain this image. Odgers, Houghton and Douglas' study of secondary school students in Perth found significant differences between current substance users and non users.<sup>424</sup>

The findings indicate that users tend to be less confident in themselves and believe that they are less liked by their families. They did not differ significantly in aspects of peer and physical self concept. Users tend to use significantly more non productive coping strategies and less productive coping strategies than non users. There were no differences in the extent to which they refer to others for assistance in solving their problems. Furthermore, users have higher levels of admiration of drug related activities (eg making good money selling drugs) and lower levels of admiration for prosocial activities (eg being a good athlete).

Users had a greater desire to attain a non conforming reputation and subsequently portray themselves in this manner. They were found to be mean and nasty, to cause trouble and break rules and to be unreliable. In addition, communication to adults about drug related activities is carried out by users significantly less than non users thought they would be prepared to do so. Conversely, users communicate with their peers about drug related activities significantly more than non users thought that they would be prepared to do so.

Research suggests that some of the factors which predict initiation of cannabis use may also predict its continuation. A strong predictor of continuation of cannabis use appears to be the extent of involvement in drug use; people who initiate drug use when younger, were heavier users, had used other drugs, or who used for psychological reasons rather than social reasons were more likely to continue use. Factors which predict cessation of cannabis use include having fewer drug using friends, higher involvement with religion, higher self rating of health, getting married, non participation in minor delinquency, and lower deviance.<sup>425</sup>

## **8.2.5. Health Promotion Services programs**

Historically, Health Promotion Services has not conducted campaigns associated with illicit drug use, and in particular cannabis. Strategies have included a range of initiatives targeting school aged children, young people, parents, professionals and the general community. In 1996/97 the WADASO invited Health Promotion Services to assist with the development, implementation and evaluation of the Drug Aware Campaign.

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<sup>422</sup> Schaps E, Battistich "The etiology of problem behaviours." In Goplerud (ed). *Preventing adolescent drug use: from theory to practice*. Washington DC, US Department of Health & Human Services, 1991.

<sup>423</sup> Heaven PCL *Adolescent health*. London, Routledge, 1996.

<sup>424</sup> Odgers P, Houghton S, Douglas G. Reputation enhancement theory and adolescent substance use (unpublished) 1994.

<sup>425</sup> National Drug Campaign. *Report of the National Task Force on Cannabis*. Canberra, Australian Government Publishing Service, 1994.

The ***Drug aware parent education campaign*** was first launched in October 1996. The campaign aimed to provide parents with reliable and accurate information on the short and long term individual, and public health implications of illicit drug use within a harm reduction context and to encourage them to communicate with their children about drug use issues.

In 1997/98, the campaign aims to increase parents' knowledge about illicit drugs, particularly cannabis and heroin, and to encourage regular ongoing communication between parents and their children. The first phase of this campaign, focusing on communication, with a specific emphasis on heroin, was launched in September 1997. The second phase, which will continue the emphasis on communication, with a specific focus on cannabis, is proposed later in the year.

In addition, a ***Cannabis campaign***, focusing on young people who are at risk of experimenting with cannabis and those who are current users is proposed for later in the 1998/99 fiscal year. This campaign will utilise alternative media, such as targeted radio and Xpress magazine, and implement relevant support strategies. Strategies will target young people both in school, tertiary and technical institutions and those who have moved into the workforce or who are unemployed.

A range of harm reduction materials, focusing on specific drugs including cannabis, which target young people who attend late night venues and raves, are currently being produced and will be distributed in November 1997.

## **8.3. Treatment and support programs**

### **8.3.1. Overview**

The Select Committee both visited and met with representatives from the major agencies in this State who provide services to young people. Concern was indicated by a number of organisations that with the establishment of a sobering up type facility, they would be better able to provide care to young people who at present cannot otherwise be admitted to existing residential programs.

A sobering up facility would enable the police to take young people to a protected environment. The Select Committee was informed that at present police and welfare workers experience considerable difficulties in managing intoxicated young people. An issue is that a number of these young people find it difficult to be admitted to many of the support accommodation programs as their drug use can be disruptive. A comprehensive approach to establish a service to assist intoxicated young people is contained in Appendix 8, the text of Yirra's submission for funding of ***On Track, Safe Transitions Youth Project***.

#### ***Recommendation 30***

***That a 'youth friendly' sobering up facility targeted at young people be established in Perth to enable intoxicated youth to be diverted into a safe environment and to establish relationships between young people and the mainstream alcohol and other drug treatment programs, police and mainstream youth focussed welfare programs.***

#### ***Recommendation 31***

***That the Select Committee draws the State Government's attention to the apparently inadequate nature of the accommodation services for young people with serious levels of drug abuse and dependency and requests the Minister for Family and Children's Services to report to Parliament on how such accommodation services can be improved to better meet the special needs of this group.***

## **Select Committee Into Misuse of Drugs Act 1981**

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A consistent theme of most representatives was that their residential rehabilitation programs had relatively short waiting lists. However, a number of agencies indicated that the area where they were experiencing the most difficulty was in meeting the demand for community based services, especially to assist parents in crisis and young people requiring assessment and supervision under community based orders.

Residential programs are expensive and are cost effective if targeted at that relatively small number of young people with high levels of need. This means that the emphasis in resource allocation has been on providing community based programs which can assist the greatest number of young people and their families in need.

### ***Recommendation 32***

***That the WA Drug Abuse Strategy Office address the need for additional residential rehabilitation programs targeted at young people with serious levels of drug abuse and dependency.***

There was strong support by metropolitan agencies for the expansion of community based programs so that services can be provided to a greater number of young people at the earliest stage, ie at the onset of problematic behaviour and before chronic patterns of drug use and associated social dysfunction become entrenched.

Yirra has flagged that it is actively considering the feasibility of expanding of its community based programs by developing a more targeted and efficient residential program. An example of the advantages from investing in innovative community based programs that incorporate close interagency linkages is exemplified by the proposal to establish the On Track, youth transitions project.<sup>426</sup>

### ***Recommendation 33***

***That consideration be given for the funding of a project that provides a service throughout the metropolitan area that has similar objectives and outcomes as contained in the On Track proposal.***

The Select Committee is of the view that there is also the need for the development of a team of specialists in the inner city area, based on a Community Drug Service Team, which focuses on meeting the health needs of young people, particularly in relation to drugs. The Select Committee received evidence that young people present at agencies with multiple problems, such as transient housing, underlying psychiatric problems, a spectrum of anti social behaviours and offending.

A number of these young people are involved in serious levels of drug use, including high risk behaviours in relation to injecting drug use and street level employment in the sex industry. It was also pointed out that a number of these young people have a revolving door contact with the juvenile remand and custodial services, quickly becoming reinvolvement in drug use and associated social problems on release.

These concerns highlight the need for a significant investment in a youth focussed program in the inner city which is able to provide the linkages between the different organisations and sectors which are attempting to assist a most difficult treatment population with complex needs. A model which the Select Committee believes should be carefully considered is the Youth Substance Abuse Service in Melbourne, details of which are provided later in this chapter.

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<sup>426</sup> Cf Appendix 8.

**Recommendation 34**

***That high priority be given to establishing two new youth focussed Community Drug Service Teams, the first to be located in the inner Perth city area and the other, capable of being deployed on short notice to problematic areas, targeted at the whole metropolitan area and regional areas, and that these teams employ a range of medical, health, youth and welfare personnel able to assist young people who have serious levels of drug problems.***

It is true that problems by young people who are using drugs at the serious end of the spectrum are most visible in the inner city area, where often there is a need to deal with accommodation, health and legal issues. However, there are also young people in regional metropolitan centres and other areas outside the inner city with significant levels of drug abuse.<sup>427</sup>

Evidence was reported that in some instances these young people have become involved in injecting drug use and had become dependent on heroin and amphetamines. During the Select Committee's visit to Geraldton, evidence was also provided of small numbers of young people who have also become involved in 'hard' drug use. It is likely that similar difficulties are occurring in other major regional towns outside the metropolitan area.

In addition to the obvious health problems that these young people can face through injecting drug use, they are also likely to commit crime to generate income to purchase drugs, as generally they are unemployed and may have few family supports. As indicated in evidence to the Select Committee, while youth workers and other outreach programs are able to make contact with significant numbers of these young people, they may be 'invisible' to the mainstream alcohol and other drug service providers.

Accordingly, it is the Select Committee's view that in addition to services which are targeted at the inner city area, there also needs to be a mobile service which make contact with young people with serious levels of drug problems in the wider metropolitan area. This suggestion needs to be addressed in considering the recommendations above, which address a range of concerns the Select Committee has about additional services to assist young people who are seriously abusing drugs.

The Select Committee also visited Rangeview Remand and Assessment Centre and, in the course of discussions with various workers at this facility, was informed that drug use was very prevalent and was a major factor in many of these young people's offending. An impression was gained of limited resources to address this issue, and despondency by committed staff who realised that many of these young people would continue to reoffend and progressively become more entrenched in a drug using lifestyle.

## **8.3.2. Yirra**

### **8.3.2.1. Introduction**

Yirra provides a residential and non residential community based youth substance abuse service, targeted at young people aged 13 to 17 years. The services provided include:

- motivational assessment;
- a residential service involving case management, therapeutic groups, individual groups and recreational activities;
- non residential counselling and urinalysis surveillance;
- family counselling; and
- wilderness enhancement and adventure therapy programs.

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<sup>427</sup> Loxley W, Davidson P. *Forgetting to breathe: opioid overdose and young injecting drug users in Perth*. Perth, National Centre for Research Into the Prevention of Drug Abuse. Curtin University of Technology, 1998.

All services offered by Yirra are done through a systems case management model. This model requires that all referrals are firstly assessed, relevant stakeholders are identified and consulted as to what their needs may be and then offered a service appropriate to their circumstances, the level and extent of the clients substance use, legal issues, health issues and family supports. The provision of a motivational assessment as a stand alone therapeutic intervention accounts for the difference in the number of assessments conducted and the smaller number of young people who engage in other Yirra services.

A young person who is determined to be an experimental user may only require a motivational assessment and a follow up drug education or community education session.

However, if a young person is found to be using drugs to assist them through a difficult time in their life, have stable accommodation and/or are engaging in school or work, it may be appropriate to offer them assistance through extended non residential counselling sessions. If the young person's drug use is found to be extreme however, and they are motivated to address their difficulties, they may be offered a place in Yirra's residential program.

### **8.3.2.2. Motivational assessments**

A motivational assessment is provided to all referrals in order to determine the individual needs of the client and which service will be most appropriate. Motivational assessments can also be completed as a once only intervention.

The main aims of the motivational assessments are as follows:

- To impart a clear description of the residential program run by Yirra as an option to assist the young person to address their substance abuse issues.
- To clarify and gather information regarding the client's drug taking history, extent of use, usage patterns, drug of choice, periods of controlled use and periods of abstinence.
- To clarify and develop an understanding of underlying issues related to the client's drug use such as family dynamics and background, health issues, crime and legal issues, educational needs, peer relationships difficulties and unemployment.
- To develop the client's ability to consider strategies and action plans with which to address the identified issues.
- To provide relevant information to referring agencies (such as the Juvenile Justice Division) in order to assist their case management.

#### **Referral criteria**

Young people under the age of eighteen who wish to clarify issues surrounding their drug and alcohol use.

### **8.3.2.3. Non residential counselling**

Non residential counselling may be offered to a young person and their family in the following circumstances:

- When a young person's drug and alcohol use is not severe enough to warrant removal from their current environment.
- When issues within the family result in family counselling being the most useful option.
- If the young person has employment, training or schooling which excludes them from being able to participate in a structured residential treatment program.

Additionally, non residential counselling may be offered to a young person who simply wishes to consider the issues faced by them but who is not yet certain as to how they wish to address them. If appropriate, admission to Yirra's residential treatment service may be offered at a later stage. During non residential counselling, urinalysis may be requested if appropriate.

**Referral criteria**

Any young person under the age of eighteen who wishes to address their alcohol and drug use, and their families or significant others.

**8.3.2.4. Family program**

Two services are available for parents of young people with alcohol and drug issues. Individual counselling sessions with the family coordinator may be provided should parents identify a need for support.

Additionally, a family and friends group at Yirra will provide parents and caregivers with factual information about young people's issues. Parents will be provided with a forum within the group in which to explore the establishment of firm boundaries and rules which encourage support for the young person and mutual respect for all involved in recovery. Similarly, drug taking and disruptive behaviour which is not acceptable will be explored and the need to prescribe clear consequences.

**Referral criteria**

Any parent of a substance user who is under the age of eighteen.

**8.3.2.5. Residential program**

A residential treatment program is offered to young people who identify that they have a problematic substance using lifestyle. The program is delivered in a residential setting to enable a break away from the drug using lifestyle and contacts.

Young people entering the program are given the opportunity to explore the impact which drug use has had on their lives and to determine a change in their life direction. A broadening of life experiences, education options, recreational experiences, enhancement of life skills and outreach are essential aspects of the program.

The residential program operates 24 hours, seven days a week and is staffed by professional staff at all times. However, it is important to note that young people are not detained on the premises, and therefore must be 'voluntary' participants.

**Referral criteria**

Young people who have a problematic drug using lifestyle who are motivated to attend the program and are aged between 13 and 17 years.

**8.3.2.6. Wilderness adventure therapy program**

This program model is based on the south coast wilderness enhanced program which was established in 1990 by the NSW Department for Education.

Youth targeted for admission to this program have been through the 'system' and are making no response to the strategies used to encourage personal behaviour change. For these non compliant deeply entrenched young people, a significant 'turn around' experience is necessary. A ten day wilderness experience is used to create this image, using the pressures of survival and the consequences of a remote environment, to take responsibility for their behaviour and make decisions that will bring about 'real' and immediate consequences.

## **Select Committee Into Misuse of Drugs Act 1981**

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Staff use non direct intervention skills, while playing the role of participants to work the group towards identified goals and change.

Rather than a separate program, it should be seen as a catalyst for change, another 'tool' from the toolbox of therapeutic strategies currently available. The techniques of dealing with tension and disequilibrium are anticipated processes used by staff on the program. Stories are written about each participant, to be read and explored by referring agencies and staff, long after the wilderness journey is over.

The expedition usually involves up to six days of backpacking through remote bush near Walpole, 6 hours south west of Perth, followed by 3 to 4 days canoeing on the Frankland River to the Nornalup inlet. Participants should be:

- able to process the outdoor experience as something which will provide 'time out' to contemplate their family, friends or current drug using situation;
- having difficulties initiating personal change through current therapeutic strategies; and
- willing to undertake a remote wilderness experience as a 'voluntary' participant.

Anticipated outcomes of the wilderness experience include:

- The closed system provided by the wilderness experience will give each participant the opportunity to take responsibility for their own actions and accept consequences of decisions made by the group.
- Significant physical, mental and psychological challenges will need to be overcome by the participant, meeting those challenges will be accompanied by a powerful sense of personal achievement (photographs will record these challenges).
- This experience will present opportunities to identify personal difficulties (accepting blame, confronting problems) and discuss issues in an informal setting, staff will be able to identify incidents which provide appropriate metaphoric transfer for further therapeutic intervention.
- Participants will receive a certificate, journal and photographs acknowledging their wilderness experience.

### **Referral criteria**

Clients may be referred through Juvenile Justice, Education Department, Family and Children's Services or through family or friends for assessments as suitable candidates.

### **8.3.2.7. Youth outreach counsellor services**

Outreach counselling and comprehensive follow up are services offered to young people who are in detention and have identified problematic substance use, possibly linked to their offending behaviour.

The services are delivered at Banksia Hill and Rangeview and involve motivational assessment, individual counselling, and follow up counselling on release from detention.

Young people are invited to explore their drug use and the impact it has had on their lives. This counselling service may provide young people with the opportunity to address possible changes in their life direction and to examine their drug use in relation to offending behaviour.

Young people may experience problems when leaving detention and it is therefore important to assist them in negotiating services and resources where appropriate. Issues such as accommodation, education and training, and family may be addressed prior to release from detention.

### **Referral criteria**

This service is available for 13 to 17 year olds who are currently in detention or on remand with possible substance use issues.

### 8.3.2.8. Overview of services 1995/96 - 1996/97

The main target group who participate in Yirra's program are aged 15 to 19. In 1995/96 and 1996/97, about eight out of 10 of all clients were from this age group (Table 8.4). Males outnumber females, with about 4 times as many males as females seeking assistance (Table 8.5). The three most important drug groups that were the primary problem, involved opioids, cannabis and alcohol (note that the number of admissions related to alcohol dropped in 1996/97).

Yirra has experienced substantial increases in utilisation of services across all components of its programs, with a three fold increase in providing non residential services (Table 8.6).

**Table 8.4: Age trends (%) of clients attending Yirra, 1995/96 - 1996/97**

Age group	1995/96 (n = 102)			1996/97 (n = 346)		
	Male %	Female %	Persons %	Male %	Female %	Persons %
10-14	21	32	23	16	23	18
15-19	79	68	77	84	77	82

Note: The figures for 1995/96 are not complete, however for the purpose of trends they are seen as indicative.

**Table 8.5: Trends in drug taking by clients attending Yirra, 1995/96 - 1996/97**

Drug	1995/96		1996/97	
	Male (n = 80) %	Female (n = 19) %	Male (n = 252) %	Female (n = 86) %
Alcohol	22	16	17	8
Speed	9	5	6	1
Cannabis	19	21	33	30
Opioids	30	21	35	38
Poly drug	3	-	2	6
Volatile substance	5	21	2	12
Benzodiazepine	4	-	2	-
Hallucinogen	-	-	2	4
Other	8	16	1	1

Note: The figures for 1995/96 are not complete, however for the purpose of trends they are seen as indicative.

**Table 8.6: Trends in major services utilised by clients attending Yirra, 1995/96 - 1996/97**

Service	1995/96	1996/97	% change 1995/96 - 1996/97
Referrals	230	329	+43%
Assessments	176	246	+40%
Residential treatment	40	72	+80%
Non residential treatment	41	165	+302%

Note: The figures for 1995/96 are not complete, however for the purpose of trends they are seen as indicative.

### 8.3.2.9. Overview of services 1 July - 31 December 1996

The following analysis is based on an activity report provided to the WADASO by Yirra, covering the period 1 July 1996 to 31 December 1996. The information that follows illustrates the type of data that agencies are required to provide as a condition of funding. These reports would be utilised to evaluate the extent to which agencies are meeting their contracted outcomes.

In this 6 month period, the following services were provided:

- Motivational assessment.
- Residential service incorporating case management, therapeutic groups, individual counselling and recreation.
- Non residential counselling and urinalysis (individual, schedule counselling and the possibility of some day activities).
- Family counselling (individual) and family support groups.
- Wilderness enhancement/adventure therapy programs.
- Additionally, the position of youth outreach counsellor has provided Yirra with a presence in the juvenile justice detention centres. This position offers formal assessment and counselling of individuals within the centres and follow up upon release.

**(a) Motivational assessment**

**Total referrals**

In the 6 month period, a total of 167 young people were referred to or referred themselves to Yirra for motivational assessment. From the referrals received, 124 young people were actually engaged for assessment.

In this period, 6 young people were assessed on more than one occasion. The discrepancy between the number of referrals and the number of assessments can be attributed to factors such as inappropriate referrals which do not meet program criteria, or failure of clients to present for assessment.

**Gender**

The majority of assessments were provided for young males (approximately 80%), with females accounting for approximately 20% of the population. It would appear that there was an increase in the number of young women accessing the Yirra program, compared to the preceding period.

**Age**

Approximately half of all Yirra clients (69) were males aged between 15 and 17 years. Of the total population of clients, two thirds (83) were in the 15 to 17 years age group. The younger age group, 13 to 14 years, were predominantly male (31) with females accounting for 9 clients.

**Drug of choice**

Almost one third of clients identified heroin or opioids as their drug of choice. A further 28% indicated cannabis as their preferred drug, with 12% reporting alcohol as their drug of choice. Volatile substances including butane gas, lighter fluid, commercial glues and spray paints accounted for 8% of primary use amongst clients, and amphetamines 6%. Other drugs such as hallucinogens, benzodiazepines and ecstasy were reported as being the drug of choice on only a few occasions. Further, a large majority of the client population who use opioid based or amphetamine substances do so through intravenous injection.

**Ethnicity**

The vast majority were Caucasian and of English or European extraction. Approximately 8% of all males were Aboriginal and 10% of all females were Aboriginal. A small number of clients were of South East Asian heritage.

**Referral source**

The largest portion (41%) of referrals to Yirra came from the Ministry of Justice, Juvenile Justice Division. A further 14.5% of clients were referred by Family and Children's Services. Other referral sources included 14% family or friends, 12% self referral and around 3% from schools. Other non government agencies and varied sources such as Aboriginal Legal Service, NASAS, Cyrenian House, Chesterfield House, Killara and private doctors accounted for the rest of the referred client group.

On average, Yirra received approximately 6 referrals per week and conducted 4.6 assessments per week for clients.

**(b) Residential and non residential service**

**Total numbers**

After participating in motivational assessment, a total of 32 young people were engaged in the residential program at Yirra. This was a total of 639 beddays for the six month period, which resulted in a residential capacity of just under 60%.

**Length of stay**

The average length of stay for clients was approximately 14 days. Compared to earlier periods, more clients were found to be staying for a longer period of time, with about 50% staying at least 3 weeks or more.

**Non residential contact**

A total of 92 young people and their families received non residential counselling and/or family counselling. Of this number, 72 were male and 20 clients were female.

**Improvement in overall functioning<sup>428</sup>**

Young people who enter into an interactive contract with Yirra appear to experience a noted improvement in their social, psychological and physical health. Changes in lifestyle, as indicated by an improved diet, enhanced self image, development of daily routine and an increase in physical exercise, tend to point to positive outcomes for participants in the program.

Young people and their parents often see Yirra as a safe house in which clients can spend some 'time out'. It is noted that improvements in parent/child relationships can come about as a response of parents being able to relax while their child is in a safe environment. Clients are also found to unwind in the safe environment provided at Yirra.

Importantly, some clients who are offered substances outside of Yirra report that they feel far more empowered, with regard to saying no or remaining 'safe', because they have set particular goals around their stay at the centre.

The general wellbeing of clients engaging in the residential or wilderness programs is enhanced quite effectively by the activities offered. All residents are required to participate in the daily recreational component at Yirra. The activities tend to include quite energetic pursuits such as abseiling, basketball, swimming and (more recently) weight training. Once a young person begins to experience an increase in their physical health, they are far more likely to maintain a lifestyle that does not include drug use.

On completion of their stay in the residential program at Yirra, all clients are asked to participate in an 'exit interview'. This interview examines possible improvements in a young persons lifeskills development, potential to participate and gain meaningful employment, and changes in drug dependency.

**(c) Individual counselling, advocacy and referral using a case management model**

**Individual counselling sessions**

All young people who engage in Yirra's residential centre are assigned a primary and secondary counsellor and are offered individual counselling sessions. Individual counselling sessions are conducted both formally and informally, depending on the time of day/night and the location. Often youth counsellors working in a residential setting find that significant interactions with young people occur outside of a formal counselling setting.

Formal counselling sessions are offered to clients twice a week and attempt to complement group sessions. Individual sessions cover topics such as family dynamics, realistic goal setting and

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<sup>428</sup> As reported by client feedback, parents and referring agencies.

strategies for moving towards or remaining abstinent. Eleven therapeutic group sessions are conducted each week in the residential centre. All residents are expected to participate in groups, with topics ranging from safe drug and sex practices to understanding relapse and its implications. Recently, art therapy and music therapy groups have been introduced at Yirra.

**Referrals to other agencies**

Within the framework of Yirra's weekly residential program, clients engage with a number of other agencies. The Department of Social Security make fortnightly scheduled visits to Yirra, as does the Youth Legal Service. Young people are also referred to Perth City Missions 'CV' program, which assists in enhancing employment options. Accommodation issues are of significance for youth who need a safe and stable environment. Step 1 has also provided residents with skills training which may enhance employment prospects.

**Reduction in detrimental drug use**

The extent to which a client's health and welfare issues are resolved and their life stabilised cannot be measured as a single item. Consequently, these outcomes cannot be addressed individually. However, a number of issues are assessed upon 'follow up' interviews of Yirra clients, which when examined together could be said to represent the health and welfare issues and extent to which a client's life has stabilised. Follow up was successful with 34% of clients.

It should be noted that young people who access the services at Yirra are quite a transient group and consequently can be difficult to follow up.

**(d) Family counselling, mediation, support and referral**

**Family counselling sessions**

All families attending Yirra are encouraged to involve themselves in some form of counselling. Indeed it is apparent that the young people who experience family mediation tend to have a longer stay at Yirra and shift their behaviour in a positive direction.

Over the six month period, a total of 32 meetings can be attributed directly to family counselling. However, it should be noted that it is often the case that mothers or fathers will accompany their children to the centre at assessment or admission time. And, while these interactions are generally recorded as an encounter between counsellor and client, parents are involved. Some parents, on the other hand, do not wish to engage directly with Yirra or their child but counsellors may spend significant amounts of time in telephone conversations with them. Unfortunately counsellors have found it difficult to record these times with any real accuracy.

**Effectiveness of family, individual and group counselling**

The effectiveness of interactions through individual, family and group counselling is best reflected in standard questions drawn from a formal interview/questionnaire which is administered at the time a young person leaves the residential centre. Of the interviews conducted, counsellors found that the majority of residents (58%) felt that they had benefited either 'greatly' or 'somewhat' as a result of their group counselling involvement at Yirra. Only a small percentage (7%) felt that they had 'not benefited at all', through the group component of their stay at Yirra. Of the total number of residents at Yirra in this period, 35% did not complete an 'exit interview'.

### **8.3.2.10. Proposed restructure of Yirra**

**Introduction**

Perth City Mission established the Yirra program in 1992, in an effort to meet the needs of young people aged 12 to 18 who required a therapeutic program in a residential setting to address issues of problematic and detrimental substance use. Since that time, there has been a great deal of program refinement and development so that in 1998 the program has the following components:

- Motivational assessments for young people which give them, their family and significant others an indication of the young person's perception of their drug use and their willingness to change.

- Residential therapeutic intervention based at premises in Beaufort Street, Mount Lawley; average length of stay four to five weeks; safe, drug free environment; intensive program of lifeskills development, recreation, employment and training, 1:1 counselling with professional counselling staff; discussion groups on drug use, relationships, relapse prevention, etc.
- Adventure therapy program incorporating ten day treks through rugged, isolated bush areas.
- Non residential and family counselling provided at Beaufort Street to individuals and groups.
- Outreach counselling to the juvenile detention centres of Rangeview and Banksia Hill.

**Proposal**

It is proposed that for the fiscal year 1998/99, Yirra will be restructured to enable the residential and non residential components of the program to operate from separate locations. The new model of care will have the following features to:

- accurately reflects the needs of young people who have problematic substance use;
- make provision for a separate, purpose built residential facility;
- continues to offer motivational assessments at a central location;
- provides an activity based “day program” accessible to both residential and non residential clients. Components to include therapeutic groups, life skills development, active and passive recreation, and professional counselling on a 1:1 basis;
- incorporate a structured program over an eight week period which includes a wilderness expedition as a “circuit breaker”; and
- involves family members and significant others such as workers from other statutory agencies.

**Rationale for changes to program**

For some time, the Yirra program has been limited in its growth and specifically in its ability to provide services to a broader range of young people because of the co location of residential and non-residential services.

Having the participants living at Beaufort St has meant that the vast majority of resources are absorbed in the running of the “hostel”. When Yirra provided residential services only, this was appropriate, but with the inclusion of new strategies such as the rapid growth of a non residential case load it has become increasingly difficult to balance competing needs.

By contrast, the demand for residential places has remained steady in the past two years, with the average occupancy of the six bed facility being four young people per week. It is clear that not all young people are willing to, or have the need to, engage in an intensive residential program. For those who are in positive living arrangements with family or friends, it may be more detrimental than advantageous to move into the Yirra residential facility.

The residential program attracts those young people with the most severe and entrenched drug use issues. Yirra has always recognised the inappropriateness of mixing this client group with those adolescents who are experimental or social drug users. The contamination issues are critical. However, the organisation has philosophical difficulty in saying to young people or their parents when they seek assistance that their problems are not severe enough to warrant our service. There is a wealth of well documented research which indicates enormous benefits for individuals and for the community if services are provided at the “point of need” to adolescents.

### **Program structure**

Based on sound research findings and indicators of best practice achieved during 1996/97, Yirra will make use of the aspects of the current program which are attractive to young people and most effective in dealing with substance abuse issues. The proposed therapeutic program will focus around a model which includes:

- preparation and completion of a wilderness journey over 10 to 12 days;
- closed group of 8 – 10 young people;<sup>429</sup>
- one team leader and two counsellors involved throughout the program; and
- provision for other personnel to deliver specific components of the program (eg art and music therapy, nutrition, education, employment and training advice).

### **Referrals**

Referrals are expected to come from the same sources as they currently do. The “one stop shop” approach may encourage additional contact from street present services such as the Police Juvenile Aid Group (JAG), Killara, Step One and more localised groups such as Koondoola and Girrawheen Youth or Drug Arm.

### **Central assessment function**

The establishment of a duty officer to undertake assessments at a central location will facilitate the provision of a more holistic service to young people and their families. Many adolescents present to helping services with a range of problems. Often substance abuse has led to the current crisis but it may be a symptom of other more entrenched problems. When dealing with the adolescent target group, it is crucial that the initial assessment opens the door to all the youth services offered by the Mission (and by other agencies as appropriate).

### **Accommodation options**

Not all young people will enter the Yirra House as part of their involvement in the program. Young people who are in satisfactory accommodation will not have to leave that to attend the therapeutic day program. Thus they could reside at home, with extended family, with friends, or in another PCM supported accommodation facility such as the newly revamped Dane House.

### **Operation of new facility**

Perth City Mission has had an offer from a well established, reputable building company to build a new residential facility on land provided by Homeswest. The land will be purchased from existing Homeswest stocks through the Community Housing project team utilising funds from the Crisis Accommodation Program (CAP). A joint equity agreement will be drawn up to ensure security of tenure for the Mission. The house will be built with the following features:

- four to five bedrooms;
- two bathrooms;
- living room(s) for the live in carers at the front of the house, separate to the rest of the house;
- a balance between communal areas and individual areas to allow for a mix of passive and active recreation options and to cater for the need for privacy of the young people living there; and
- an atmosphere that is as homely and non institutional as possible.

All residents will be participants in the Yirra day program. Transport to and from the day centre will be provided and supervised.

In order to provide a drug free and safe environment, the program will have similar house rules as the current Yirra program including therapeutic contracts between counsellors and clients, compulsory urinalysis, restrictions on unsupervised outings and visits.

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<sup>429</sup> Weekly counselling and motivational assessments will be available to clients who are waiting to access the next closed Program. Admissions will not be made once the program has commenced.

The house will be staffed by residential care workers (on split shifts) or lead tenants. Coordination of the residential service will be conducted by a senior counsellor. "On call" back up from a roster of senior staff will be available after hours and on weekends to the residential staff.

***Centre based day program***

The Yirra day program is an opportunity for a new and more focussed approach to assisting young people in the target group who wish to make changes to their drug using behaviour. Clients will be invited to join a closed group for a set number of weeks (probably around 8 to 10 weeks). They will meet at the day centre each morning for a structured program of activities. There will be a mix of compulsory activities and elective activities.

Each client will be allocated a primary counsellor, who will coordinate case management of their program and conduct 1:1 counselling on a regular basis. The day program will be a drug free environment and, to this end, compulsory urinalysis will continue to be a condition of involvement.

A core element of each program is the wilderness expedition to a remote location near Walpole for 10 to 12 days. This activity is an opportunity to build group dynamics and acts as a "circuit breaker" for young people who have developed drug using behaviours in a social setting. For many adolescents, the opportunity for "time out" from peer group, family and pressures associated with unemployment, homelessness, and/or other issues provides a catalyst for change.

Operating the program within the structure of a closed day program enables the crucial follow up from trained counsellors who can assist with the generalisation of skills learned on the wilderness to their everyday experiences. Wherever possible, all clients accessing the Yirra day program will attend a wilderness expedition.

Any young people who wish to access the program will be offered a motivational assessment. If they are deemed to be suitable for the program and wish to proceed, they will be offered counselling sessions on a regular basis until a new program group is ready to commence.

The day program will provide a source of information to young people about issues other than just substance use. Perth City Mission staff with expertise in the areas of accommodation, education (including alternatives to mainstream), employment preparation and training, parent teen conflict and income support will be either on site or will visit regularly.

Family support will remain as a key focus of the program. The primary counsellor will ensure that parents or nominated care givers are kept informed of the young person's therapeutic contract and progress where this is appropriate. Counselling for parents is available either in conjunction with the young person's involvement with the program or as a stand alone opportunity for parents to access counselling.

***Prison to parole program***

The close links already in existence between the Prison to Parole program and Yirra will be continued under the proposed restructure. The counsellor who does the outreach work to juvenile detention centres will be located at the day centre premises. Counselling appointments for clients after release from detention will be conducted at the centre.

Currently, the number of young people who attend post release counselling is low, despite their agreement to do so made whilst in detention. Few of these young people avail themselves of the residential option. Locating this service with the new day program may afford greater opportunity to engage these young people in the range of activities on offer, including the wilderness and the residential program if required.

**Adventure therapy**

The adventure therapy component of the restructured day program has always had the potential to be a “stand alone” option but has been restricted due to the need to use resources in the residential service.

With the restructure, there will be opportunities for this component to be offered to groups with special needs (eg young women, Aboriginal young people with specific problems such as solvent abuse, “at risk” young people who are attending school). There is already considerable demand for these specialised expeditions.

**Community Drug Service Teams**

There is tremendous potential for the development of supportive links between the restructured Yirra program and all the metropolitan teams. It is considered that referrals from the Community Drug Service Teams could be appropriately made to Yirra where a specialist youth service is required in residential and/or non residential.

Referrals from Yirra to the Teams would allow for post program support to clients who have been in the Yirra program and have now returned to the community. There would be some opportunity for shared case management, especially in the areas of family counselling and support where families have difficulty accessing central Yirra services. The local knowledge developed by the teams will allow them to link young people and families into corollary resources which will enhance the maintenance of their rehabilitation.

**Target group**

For the residential component, the target group are young people aged 13 to 18 who have detrimental and problematic substance use. For the day program, the same target group would be given priority but consideration will be given to extending the eligibility criteria to include young people aged 18 to 21 years. Experience indicates that these young people also have some or all of the following issues to contend with:

- relationship difficulties with family, school personnel, authority figures and sometimes peer group;
- legal issues including court orders or impending juvenile justice issues;
- accommodation issues often related to breakdown in family relationship or changes in the family of origin (eg parents with new partners, blended families);
- education difficulties such as non attendance at school or imminent suspension/ expulsion;
- unemployment, lack of suitable skills for employment, inability to keep a job due to drug use and other health problems; and
- health issues including malnutrition, sexually transmitted diseases and diseases associated with injecting drug use. Often the young people have such a fear of health issues that they avoid getting tests done or seeking assistance from doctors. This can lead to extreme anxiety and in some cases mental health issues such as depression and psychoses.

Suitability for this program would also be assessed on:

- level of motivation to change existing lifestyle; and
- commitment to complete eight week program or at least to set short term goals towards completion.

**Residential advantages**

Staff skills can be utilised more appropriately. Highly trained therapeutic staff are currently spending afternoon and night shifts in a residential care role. This has implications for program costs and for staff morale, as many staff leave the service dissatisfied at doing a domestic role after all their years of tertiary study. Advantages of this change would include:

- removal from close proximity to the city to a northern suburb on land identified by Homeswest will assist in keeping the residential clients safe from drug dealers and unwanted visitors;
- substantially reduce the costs of shifts (as afternoon and night shifts will no longer be required);
- residential carers will be put on a work place agreement or similar which will allow for benefits such as free board; and
- therapeutic counselling staff can build more effective relationships with clients if they are not also their care givers.

**Day program advantages**

- Located centrally and not in a residential area.
- Greater integration of services especially PCM’s accommodation, employment/ training, and community drug services.
- Higher visibility and greater accessibility for young people. As the centre is not the “home” of the young people in the residential service, there will be greater opportunity for signs, a reception area and more appointment times for non residential clients.
- Duty officer model to facilitate rapid referrals and assessments.
- Improved opportunities for staff skills development, as they will not spend the majority of their shift supervising domestic chores.
- “One stop shop” approach to information sources for young people.
- A broader range of opportunities to engage young people.

At present, the program can only offer non residential clients weekly one hour counselling sessions and occasional wilderness expeditions. When the day program stands apart from the residential, there will be far greater capacity to engage outpatients in other therapeutic experiences such as art and music therapy, short term positive recreation experiences, group work on drug and health related topics and activity based exposure to counselling staff.

The restructuring of the Yirra Youth Substance Abuse Service has advantages both from a program delivery perspective and a financial perspective. It has been evident for some time that the costs of operating a residential program with shifts which attract award penalties and allowances would see the Yirra budget continue to increase.

**Recommendation 35**

*That the proposed restructure of Yirra receive appropriate support from the WA Drug Abuse Strategy Office, as it provides a valuable framework to improve access by a combination of tailored programs determined by cost effective outcomes and the model be utilised to expand the provision of alcohol and other drug services to young people and their families in the metropolitan area.*

**8.3.3. Holyoake**

**8.3.3.1. Introduction**

Holyoake is a long standing agency that provides assistance to individuals and family members affected by alcohol and other drugs. It has a primary focus on providing an array of outpatient programs which address a wide spectrum of drug related issues affecting families and young people.

### **8.3.3.2. Outpatient treatment and support services**

Holyoake's outpatient programs are targeted at a number of broad groups:

- adults with alcohol and other drug related problems;
- juvenile offenders; and
- parents concerned about drug use by their children.

In this section, information will be provided about Holyoake programs which are primarily provided for young people and their families. Information about the organisation's other programs are discussed in chapter 4.

Holyoake offers a number of options for young people and their families in relation to four broad areas, which are discussed in greater detail below:

- the young peoples program;
- adolescent program;
- parent talk program; and
- parent drug awareness program.

#### **Young people's program**

The young people's program (YPP) is targeted at providing safe and supportive relationships to enable young people to talk about their thoughts and feelings regarding the use of alcohol and other drugs by an adult member of their family. The YPP involves extensive use of activities and games to help young people not only deal with the impact of alcohol and other drug use, but also other issues such as parental divorce or separation, family conflict, stress and worry. The object of the YPP is to enable young people to understand their family and develop skills to better cope with their circumstances.

#### **Adolescent program**

The adolescent program is targeted at young people aged under 18, who have appeared before the Children's Court or Juvenile Panel and where the offence involves the use of alcohol and other drugs. Participants to adolescent programs may be self referred, be referred by a parent or by a lawyer.

There is also contact with young people in juvenile detention and remand centres to provide education and life skills to reduce the likelihood of relapsed problematic drug use on release back into the community.

Young people may participate in short term counselling, either individually or as a family conference, depending on a particular stream, as follows.

#### **Yellow stream**

This program is exclusively available to young people who are referred by a Juvenile Justice Team (JJT). The interventions provided are designed to address a young person's use of alcohol and other drugs and how this is related to their offending. As this is a minimal intervention, it is targeted at the experimental drug user, who may be using drugs at low or harmful levels.

#### **Blue stream**

This program is targeted at young people with low to moderately severe problems related to the use of alcohol and other drugs with respect to their pattern and level of offending. In common with other streams, content will also involve the individual's relationship with his or her parents and self esteem issues.

#### **Green stream**

This program targets those young people with serious issues related to their use of alcohol and other drugs with respect to their pattern and level of offending. Issues that may be dealt with

include dysfunctional relationships with parents, other family members and peers, unemployment, chronic truancy and homelessness.

**Parent talk program**

Components of this program parallel a particular adolescent program and provide a number of levels of contact, including telephone and crisis counselling and family conferences, as follows.

**Yellow stream**

This program is provided in conjunction with the adolescent yellow stream program. It is an opportunity for parents to put the young person's drug use in a wider context, taking account of developmental issues. It also is a screening process for those parents facing more serious problems of drug use to be referred to more intensive interventions.

**Blue and green streams**

In the context of the parent talk program, these two streams of the adolescent program are combined into one stream, providing up to six sessions for parents.

**Parent drug awareness campaign**

This is a community based program, which has the object of empowering parents involving presentations to groups of parents at schools and community centres in the eastern metropolitan region.<sup>430</sup> Educational materials are provided to participants, including a range of currently available literature produced by the Health Department of WA and drug identification charts produced by the WA Police Service.

## **8.3.4. Palmerston**

### **8.3.4.1. Introduction**

Palmerston operates a custodial services program which is targeted at young people and provides a series of four one to one counselling sessions for detainees one month prior to their release. Once released, clients are then required to complete an additional four sessions. Clients are offered a two month period in which to complete these follow up sessions.

### **8.3.4.2. Overview**

The service has been particularly beneficial in providing substance use interventions to detainees defined by the following reasons:

- their sentence was not long enough to allow for the completion of a substance use group;
- they needed more intensive treatment due to previously having completed a group/s, or their substance use was extreme;
- they did not wish to participate in a group; and
- they have had previous contact with the Palmerston Centre and wished to continue this.

It was beneficial that the service was provided by a specifically trained and knowledgeable substance use counsellor, particularly as many of the clients referred were the more challenging youths in the centre (in terms of their substance use). The up to date knowledge of substances, blood borne diseases and current treatments for substance use was invaluable.

Another advantage of the service was the reduction of the number of professionals that each detainee has contact with. Optimally, each detainee would receive intervention from as few professionals as possible, to encourage continuity. However, it is often the case that a detainee would see several different counsellors both inside the centre and in the community for substance use and other issues.

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<sup>430</sup> In the 1996/97 year a total of 21 presentations were made, involving 475 participants.

## Select Committee Into Misuse of Drugs Act 1981

With the service provided by Palmerston, it is at least possible that one substance use counsellor can be maintained during detention and post release. A number of outcome measures for the year 1997 are presented in Table 8.7 and would suggest that about one third of clients successfully complete the program, with about another third who did not meet all requirements but did not breach the conditions imposed. It may be possible that some of the conditions were unrealistic or were unattainable.

**Table 8.7: Participation in Palmerston youth program, 1997**

	Jan-June	July-Dec
<b>Number of individual assessments pre release</b>		
Male	22	27
Female	5	3
Total	27	30
Number of drug treatment plants within parole or supervised release plans	25	20
Number of post release clients	24	21
<b>Number of individual counselling sessions</b>		
Actually attended	115	71
Did not attend	70	60
Total	185	131
<b>Percentage completing treatment component of parole or supervised release plan</b>		
Did not comply with conditions but not breached	34%	7%
Country clients unable to participate in follow up program	22%	20%
Breached and returned to custody	36%	15.5%
Not required to participate in follow up program	4%	5.5%
Initial assessment only	na	5.5%
Referred but did not participate	na	6.5%
Completed internal program, but had not been released at time of data collection	na	10%
Percentage completing parole or supervised release	36%	27%

### 8.3.5. Trinity Youth Options

#### 8.3.5.1. Introduction

Trinity Youth Options (TYO) is a detached youth work service for 'at risk' young people based in the Perth inner city and is funded by the Perth Trinity Parish of the Uniting Church in Australia. TYO operates within a detached youth work model that utilises a welfare rights approach. A feature of this model is its ability to be flexible in its response to young people. Three modes of service have been developed by TYO:

- an operational base in the Perth inner city area that young people can come to;
- a street work component where workers go out and meet young people in the inner city; and
- a mobile service that meets young people in settings that they feel safe in.

The detached role provides mobility to make contact with a young person's family and significant others, as well as networking with a variety of relevant agencies including Westrail railway guards, nightclub bouncers, vice squad and youth workers based in the suburbs.

Overall, the workers' aim is to provide young people with information on a wide range of issues, so they are able to make more informed choices and decisions regarding their life. This is done through engaging in a relationship with the young people over a period of time. Young people that frequent the TYO Centre do so on their own initiative. At the centre, young people can make phone calls, have a coffee and a chat, seek the help of the workers in advocating on their

behalf to various agencies (for example, Social Security, Homeswest, Ministry of Justice, Police, etc) or to ask a worker to attend court with them for some moral support.

### 8.3.5.2. Recent directions

In early 1996 in response to a need for TYO to develop greater consistency with their street presence in the inner city, a roster was developed for the detached youth workers and the senior youth worker cover two shifts on street per week. One shift was rostered for a weekday afternoon, and the other shift (from 7.30 pm to 11.30 pm) alternating between Friday and Saturday nights. TYO's consistent presence on the street established a greater recognition within the inner city and Northbridge by young people, nightclub doorpersons, police officers, Westrail security guards, staff from the Noongar Alcohol Substance Abuse Service, the AIDS Council mobile NSEP and Step One.

There was a large response to this initiative. As a result, the organisation has had to rationalise the continued provision of an outreach service, as it has not had sufficient resources to meet the demand. Accordingly, TYO has focussed more recently on developing the drop in centre function and the mobile service.

### 8.3.5.3. Overview of services January - December 1997

#### Number of clients

Table 8.8 summarises the number of discrete individual young people and the total contacts for the 12 month period January to December 1997. The number of individual young people who used TYO services varied from between 22 and 70 per month, with an average of 45 young people per month.

#### Number of contacts

The total number of contacts varied from month to month throughout the year, according to seasonal variations, staffing levels, and detention of regular clients. During 1997, contacts varied from a total of 57 in January to 360 in the colder month of July, when a significant number of young people were without stable accommodation for some time. There was an average of 206 contacts per month. It should also be noted that from January to April 1997, the service employed only one full time detached youth worker.

**Table 8.8: Number of individuals and contacts with young people attending Trinity Youth Options, 1997**

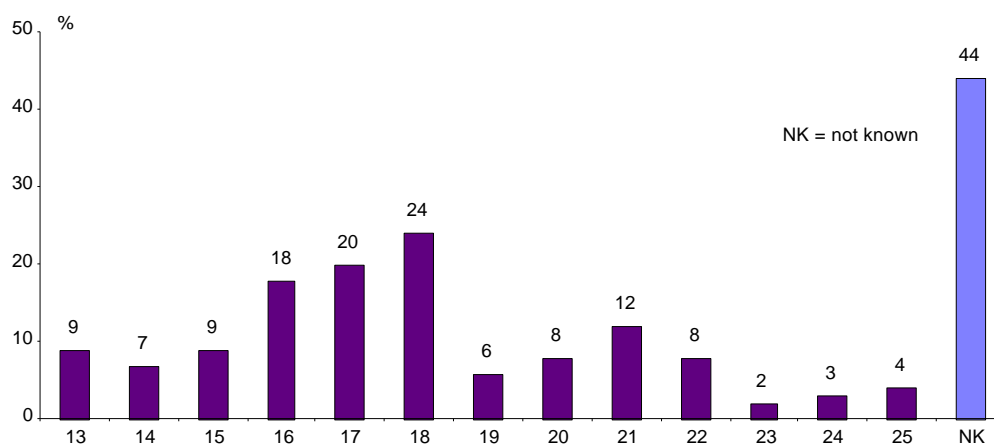
Month	Individuals	Total contacts
January	22	57
February	29	117
March	31	116
April	53	204
May	52	246
June	38	143
July	46	360
August	58	294
September	70	309
October	63	283
November	42	204
December	42	135
Total	174	2,468

#### Age

The client group attending TYO is aged between 12 and 25 years of age. Figure 8.3 indicates that in 1997 most clients were in the 16 to 18 age group, with a smaller peak of clients in the 20 to 22 age group. Of the 174 discrete individuals who attended:

- 25% were 16 years and younger;
- 25% were aged 17 or 18 years of age; and
- 22% were aged between 19 and 25 years of age.

**Figure 8.3: Age of Trinity Youth Options service users, 1997**



**Gender**

Of the 174 clients, 92 (53%) were male and 82 (47%) were female.

**Aboriginality**

In the year 1997, of the 174 clients, 30% (41) were Aboriginal and 70% (133) were non Aboriginal.

**Drug use**

The issue of drug use among young people is multifaceted, with its consequences often reaching far beyond the mere physical effects of substance use. As may be expected, the use of both legal and illegal drugs is a prominent feature of the lifestyles of many young people who had contact with TYO (Table 8.9).

**Table 8.9: Drug use by young people attending Trinity Youth Options, 1997**

	n	%
Prescription drug	55	31
Alcohol	52	30
Solvent	26	15
Heroin	83	48
Cannabis	53	30
LSD/ecstasy	4	2
Other	7	4
Total	174	100

Note: The above figures do not total 100% as a significant number of young people use several types of drugs.

### 8.3.6. Teen Challenge

Teen Challenge operates a Christian residential rehabilitation centre at Esperance for those aged 16 to 35 years experiencing problems including alcohol, tobacco and other drug problems. Esparancho Ranch is a 260 acre farm in Esperance providing a 12 week non medical detoxification program. It is a 25 bed facility with male and female accommodation, providing services to about 50 young people per year, at a total cost of about \$500,000. Assessment for admission to the residential program at Esperance is conducted at the organisation's Perth based office.

Criteria for admission are an acceptance of an interdenominational Christian treatment approach and that the person has a problem with substance abuse or other personal difficulties. The program emphasises an educational approach to problem solving, including recreation, survival courses, social skills, relationship counselling based on academic, vocational and spiritual principles.

### 8.3.7. Interstate programs

#### 8.3.7.1. Youth Substance Abuse Service

##### **Introduction**

The Select Committee met with a number of representatives of the YSAS on its visit to Melbourne in February 1998. At that time, only a number of parts of the service were operational as the organisation was finalising the appointment of key staff to enable it to provide the full range of services as planned. The need for a comprehensive approach modelled on the YSAS, to assist those young people with serious levels of problems (particularly in regard to drugs social, health, legal and accommodation issues) has been addressed earlier in this chapter with the recommendation to establish an Inner City CDST.

##### **Overview**

The Youth Substance Abuse Service (YSAS) was established in May 1997. It consists of a consortium of Jesuit Social Services, Turning Point Alcohol & Drug Centre, St Vincent's Hospital and the Centre for Adolescent Health. YSAS aims to provide services to young people aged between 12 and 21 years with complex drug related issues, via outreach work and a short term residential care facility.

It will also provide training and support services to youth workers, health workers and other practitioners who work with young people. The services will operate within a multidisciplinary, psychosocial health framework, focusing on strategies to reduce drug related risks and harms and engaging young people in opportunities for a healthy and meaningful lifestyle that does not require the need for drugs. A funding resource pool is provided to maximise the capacity of YSAS to respond to the identified needs of young people in a timely manner.

##### **Service development**

The service had by early 1998 engaged 23 full time staff, including an Executive Officer with extensive experience in services for chronically disadvantaged youth and young adults, the homeless, and in organisational management and development and a Coordinator of Training and Support.

##### **YSAS board of directors**

The board comprises two representatives each from St Vincent's Hospital, Turning Point Alcohol and Drug Centre, Jesuit Social Services and the Centre for Adolescent Health. This arrangement provides YSAS with directors who have a range of skills, including financial management experience, expertise in implementation of State and Federal Government health policy, commitment to community based care and an understanding of the interrelationships and connections between health and welfare services.

### **Advisory groups**

The overall development of YSAS is supported by two advisory groups, an Implementation advisory group (IAG), and a Resource funding pool reference group (RFPRG).

The first, the IAG, is comprised of representatives from each of the sectors anticipated to have close relationships with the YSAS. These include law enforcement, juvenile justice, drug treatment, youth, adolescent health and protection and care services. The role of the IAG is to provide guidance and support in ensuring that YSAS service delivery will be integrated and responsive to the needs of all sectors engaged with young substance users.

The role of the second advisory group, the RFPRG, is to advise and assist in the development of operational guidelines for the use and management of the flexible funding pool. Its membership combines expertise in fund management and the experience of direct care workers.

### **Practice principles**

YSAS supports three practice principles concerning the delivery of services for young people with alcohol and drug problems.

- Any intervention directed at young people with alcohol or other drug issues need to be attractive, relevant and engaging to the young person.
- Young people's drug use takes different forms, and hence interventions must reflect the context of the individual, reflecting developmental stage and impact of drug use on development.
- Interventions need to be flexible, aimed to minimise harm and that services need to be prepared to be in for the long haul. This reflects an understanding that improvement in an individual's quality of life may require long term or repeated intervention.

The key features of the YSAS model are:

- A relationship based approach.
- Provision of after hours response.
- Targeting the most marginalised and problematic drug/alcohol using young person.
- Provision of responsive, practical and useful support.
- An emphasis on coordination and collaboration with other agencies.
- An evolving and developmental approach to operation.
- The development of expertise and leadership in training concerning alcohol and drug interventions for young people.
- The development of expertise and leadership in the direct provision of alcohol and drug services for young people.

### **Development methodology**

The YSAS approach to the development of programs and services is based on a methodology which involves three ongoing activities:

- a review of the relevant literature, in particular treatment outcome studies;
- a survey of relevant treatment and care services currently in use; and
- extensive consultation with key stakeholders (including prospective service users) and individuals with recognised expertise in the treatment and care of young people with drug and other intercurrent problems.

Within an action research framework, existing intervention techniques, as well as new and innovative responses, will be implemented and trialed. Selection of service models and interventions will be based upon evidence of their efficacy. The development of an evaluation model for YSAS will include key performance indicators and methodology for data collection.

### **Service integration**

A central goal of the YSAS is to cooperate with existing services in the development of an integrated service system for young people with drug use problems. The aim is to draw upon the strengths of the individual service providers to ensure a holistic approach to the issues that arise for this highly marginalised sector of the community. YSAS comprises three integrated components: an outreach service, a residential service and a training and support team.

### **Outreach service**

The outreach service will operate with teams of two or three members, each supervised by a senior practitioner, in seven locations. Each team will provide services to complement, rather than duplicate, the existing services in each area. Therefore, the precise role of the outreach workers will vary according to identified local needs.

The first services have commenced in the central business district of Melbourne and in Bendigo. The remaining services will be established in the following order: Dandenong/Springvale, Western suburbs, Latrobe Valley, northern suburbs and Ringwood.

### **Residential service**

The residential service provides short term respite accommodation with a limited capacity for pharmacotherapy. Access to the residential service is achieved via referral to the local outreach team. Residential service users have case management services provided by the outreach teams before, during and after their period of residence.

### **Training and support team**

The training and support team comprises three members who perform a range of training and support functions. These include the identification of local and agency specific training needs; the development and implementation of training services including post training support programs; and the development of ongoing service improvement initiatives. The team plays a coordinating role in YSAS service integration efforts.

## **8.3.7.2. Mirikai**

In 1971, a group of citizens concerned about the absence of alcohol and drug services in the Gold Coast area banded together to form the Drug Referral Centre, to run a drug awareness and a volunteer training course, and to provide a basic counselling and referral service. The organisation changed its name to the Gold Coast Drug Council in 1981. A non medical detoxification program was established to complement the education and prevention activity of the organisation.

In 1985, a Queensland health grant enabled employment of a full time professional worker. The program at this time included a rudimentary residential program providing living skills, group therapy sessions and support for clients who required more than simple detoxification.

Over recent years Mirikai has specialised in the treatment of persons with a dual diagnosis of substance abuse and psychiatric disorder. Currently, the majority of Mirikai's clients are under 25 and a significant proportion under 18. Persons over the age of 25 are admitted only under exceptional circumstances.

The organisation maintains two broad streams of activities: a range of staged treatment services targeted at young people who are experiencing psychiatric, behavioural, drug and/or related problems; and activities targeted at the wider community

Mirikai operates a number of levels in the treatment stream of its service, from a 24 hour telephone information service (largely operated outside of business hours by volunteers), assessment, referral, outpatient counselling and support, a staged intensive residential program and an aftercare service.

The Mirikai treatment includes, in common with other comparable programs, negotiated treatment plans, ongoing case management and incorporation of the principles of harm minimisation.

The residential program consists of four components:

- a safety net program, of six weeks duration, targeted at those not wanting or needing to participate in a lengthier and more intensive treatment;
- a transition program, of two weeks duration, to prepare residents for reentry to the community or progression to the next phase;
- a treatment program, of up to eight weeks duration, which builds on principles followed in other similar residential programs, such as increasing levels of responsibility, intensive counselling and relapse prevention; and
- a reentry phase, to enable a full return to living in the community through establishing accommodation, employment, development of support networks, etc.

The organisation's community programs have a preventive and educational emphasis, to increase awareness and knowledge of issues related to the use of alcohol and other drugs to reduce drug related personal harms and social costs within the community.

## **8.4. Services for women**

### **8.4.1. Introduction**

The section provides an overview of the utilisation by females of a number of alcohol and other drug treatment programs in Perth. As indicated in chapter 5, the excessive consumption of CNS acting drugs has been a major factor in the development of programs tailored to women. More recently the growth in the number of heroin dependent younger women has also stimulated the development of ante natal services tailored to the needs of women during pregnancy and following the birth of their babies. These programs are:

- an outpatient program based at WA's only dedicated women's hospital, King Edward Memorial Hospital (KEMH);
- a short stay inpatient detoxification service, at the Central Drug Unit (CDU); and
- a community based non government organisation, Perth Women's Centre (PWC), which provides counselling and ancillary services, including a creche for women with young children.

Because of inadequacies in the data available with respect to the program conducted by the PWC, it has not been possible to provide a complete analysis of the utilisation of community based programs which target women with alcohol and other drug problems.

#### **8.4.1.1. Antenatal Chemical Dependence Clinic**

Specialised help is available at the Antenatal Chemical Dependency Clinic (ACDC) at KEMH, where women can be referred by GPs and other health providers for treatment and counselling. This service was established in 1994 following a recommendation from the Ministerial Task Force into Obstetric, Neonatal and Gynaecological Services in WA.

The ACDC is designed to minimise the risks of childbirth for both the mother and baby. To help ensure healthy early parenting, clinic staff encourage a woman, her family and her partner to seek assistance from other support services in the community. The antenatal clinic is staffed by health professionals from the hospital and the ADA. As can be seen in Table 8.10, relatively small numbers of women attend the Antenatal chemical dependence clinic.

The ACDC is a free and confidential service and operates as a team with an obstetrician, nurse and social worker to provide:

- assessment of a woman's needs for herself, baby and family;
- support and care throughout her pregnancy and confinement;
- discharge planning with referral to appropriate support agencies; and
- counselling.

**Table 8.10: Attendances at Antenatal Chemical Dependence Clinic, (KEMH) 1994 - 1997**

Year	New cases	Average no. seen each week	Average non-attenders per week
1994	32	8	3
1995	52	6	3
1996	52	5	5
1997	45	5	2

### 8.4.1.2. Perth Women's Centre

NGOs have traditionally provided integrated services, and like the ADA, usually only differentiate between client groups according to whether the primary drug problem involved alcohol or illicit drugs. In contrast, programs run by the PWC emphasise that treatment should include services that address the causative underlying emotional issues and familial and environmental factors often associated with women who become dependent on prescription drugs.

In recognition of the need especially for community based gender sensitive services for women because of their special needs, an agreement was reached in November 1989 to establish a female only non residential drug treatment service in Perth under the auspices of the Women's Health Care Association. The impetus for the development of a specialist drug education, information and treatment service at the PWC, which commenced in March 1990, stemmed from activities by a community based non government organisation, Women for Women with Dependencies (WWD).

The Select Committee received evidence from representatives of the Perth Women's Centre about the specific needs of women who have health and social problems due to drug abuse by themselves or other members of their family. This service focuses on assisting those with problems due to the use of alcohol and benzodiazepines. It was noted that

*"(i)t is an area where women are over represented. In alcohol and drug issues, women are under represented compared to men, but women are over represented in the benzodiazepines and prescription medication area, and in caring for significant others using drugs... some women have different patterns of substance taking and shame is attached to that consumption."*<sup>431</sup>

The special needs of women with drug related problems emphasises the need for a different approach to assist this group compared to the approach adopted by mainstream alcohol and other drug service providers. Additional information on this issue was provided in evidence to the Select Committee from the Perth Women's Centre.

*"Ms Heath: When setting up community drug service teams through the tender process, we had the idea that it would be great to have a drug education worker based at women's health centres who could work with local community people and schools, start dealing with matters at the local level and provide specialised care in a general setting. That works well because people do not have to go to the drug and alcohol service where only junkies go; they can go to the women's health centres. Very ordinary women go to health centres. We see women from*

<sup>431</sup> Evidence to the Committee by Trish Heath, Education Officer, Perth Women's Centre, 9 October 1997, 2.

## Select Committee Into Misuse of Drugs Act 1981

*a broad section of the community, and it works well for mental health women to be part of a mainstream service but to receive the specialised care they need.”<sup>432</sup>*

An adequate level of statistical information on admissions to Perth Women’s Centre was only available for some of the periods from 1994 to 1997. An evaluation of trends and comparison of characteristics of the treatment population were not possible because of changes in definitions and reporting categories.

It would appear that about two thirds of the clients who attend PWC have a primary problem related to alcohol abuse, or attend for non drug reasons (Table 8.11). It is to be noted that relatively few clients who attend the PWC are involved in illicit drugs. For instance in the July – December 1996 period, 13% of the 92 admissions involved benzodiazepines and 21.7% involved alcohol.

**Table 8.11: Number of admissions to Perth Women’s Centre by drug group 1994 – 1997**

	1994		1995		1996		1997	
	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec	Jan-Jun	Jul-Dec
Alcohol	57	15	na	16	17	20	na	40
Amphetamines	8	5	na	1	-	-	na	1
Barbiturates	-	-	na	-	-	-	na	-
Benzodiazepines	9	3	na	4	1	12	na	3
Cannabis	3	1	na	1	3	9	na	4
Opioids	2	5	na	1	-	6	na	2
Poly drug	9	3	na	1	2	3	na	11
Antidepressants	1	4	na	2	-	4	na	7
Tobacco	-	-	na	-	-	1	na	2
Other (non drug)	53	20	na	35	44	37	na	37
<b>Total</b>	<b>142</b>	<b>56</b>	<b>na</b>	<b>61</b>	<b>67</b>	<b>92</b>	<b>na</b>	<b>107</b>

Source: Health Department of WA, WA Drug Abuse Strategy Office (based on agency activity reports)  
Note: na = not available

### 8.4.1.3. Alcohol and Drug Authority

Since the mid 1970s, the ADA has provided a wide range of programs designed to meet a wide spectrum of needs, such as a State wide information service, as well as conventional treatment services, such as individual and family counselling, controlled provision of medication and short stay detoxification programs.

As the ADA’s treatment programs have not usually differentiated between the treatment needs of males and females who abuse alcohol and other drugs, the provision of female exclusive programs has not usually been provided.

The ADA has maintained a comprehensive client data system of admissions to the CDU and its other programs since 1988. However, as comparable data from the PWC was only from the last quarter 1993 until the end of 1994, information in relation to both programs has been aggregated to provide a comparative summary of the characteristics of females who attended the CDU and the PWC over the 15 month period October 1993 to December 1994.

#### **Age related trends**

There were a total of 1,016 female admissions to the CDU over the 5 year period from 1993 to 1997. When broken down by age group, these admissions involved the following age groups (Tables 8.12 and 8.13):

<sup>432</sup> Id 11.

- 20.4% were in the 15 to 24 age group;
- 38.0% were in the 25 to 34 age group;
- 27.6% were in the 35 to 44 age group;
- 10.5% were in the 45 to 54 age group and
- 3.4% were in the 55 and over age group.

Trends and age related admissions to the ADA program indicate there has been a growth in the number of admissions in the 15 to 24 and the 25 to 34 age groups from 1993 up to the present (Figure 8.4).

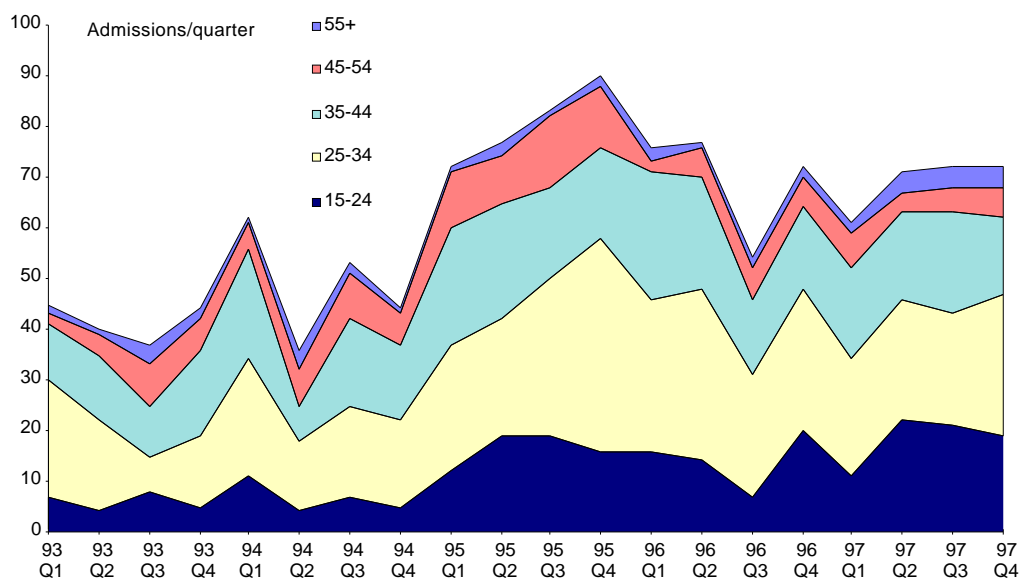
**Table 8.12: Quarterly female admissions to Central Drug Unit by age group, 1993 - 1995**

	1993				1994				1995			
	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
<15	0	0	0	0	0	0	0	0	0	0	0	0
15-24	7	4	8	5	11	4	7	5	2	8	19	16
25-34	23	18	7	14	23	14	18	17	7	7	31	42
35-44	11	13	10	17	22	7	17	15	10	8	18	18
45-54	2	4	8	6	5	7	9	6	4	2	14	12
55+	2	1	4	2	1	4	2	1	0	0	1	2
<b>Total</b>	<b>45</b>	<b>40</b>	<b>37</b>	<b>44</b>	<b>62</b>	<b>36</b>	<b>53</b>	<b>44</b>	<b>23</b>	<b>25</b>	<b>83</b>	<b>90</b>

**Table 8.13: Quarterly female admissions to Central Drug Unit by age group, 1996 - 1997**

Age group	1996				1997				1993-1997	
	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Total	%
<15	1	0	0	0	0	0	0	0	1	0.1
15-24	16	14	7	20	11	22	21	19	207	20.4
25-34	30	34	24	28	23	24	22	28	386	38.0
35-44	25	22	15	16	18	17	20	15	280	27.6
45-54	2	6	6	6	7	4	5	6	107	10.5
55+	3	1	2	2	2	4	4	4	35	3.4
<b>Total</b>	<b>77</b>	<b>77</b>	<b>54</b>	<b>72</b>	<b>61</b>	<b>71</b>	<b>72</b>	<b>72</b>	<b>1,016</b>	<b>100.0</b>

Figure 8.4: Quarterly female admissions to Central Drug Unit by age group, 1993 - 1997



**Drug related trends**

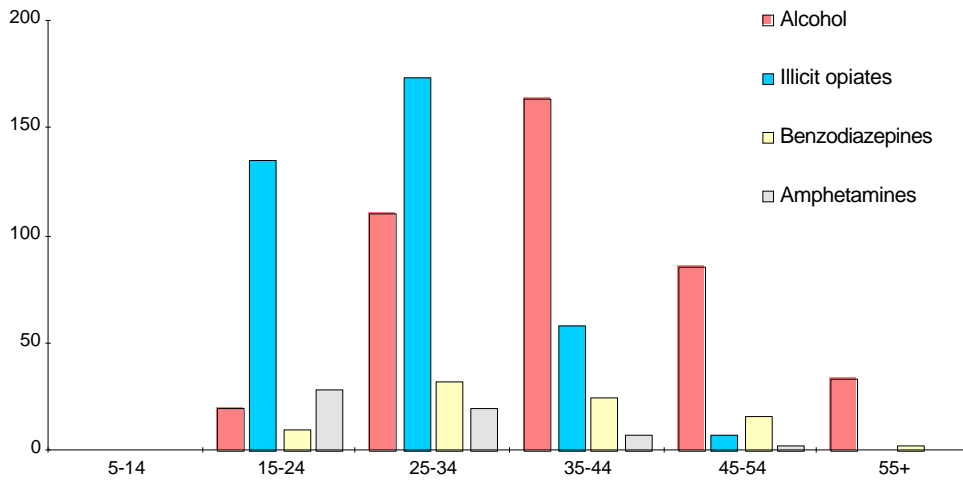
There were a number of features by age and primary drug problem over the five year period (Figure 8.5):

- the greatest number of amphetamine abusers involved the youngest age group (15 to 24 years);
- the number of illicit opioid abusers peaked in the 25 to 34 age group, with the treatment population spread across the 15 to 44 age range;
- the number of admissions of alcohol abusers peaked in the 35 to 44 age group, with admissions spread across females in the age range 15 to 44; and
- the number of benzodiazepine abusers peaked in the 25 to 34 age group, with smaller numbers of admissions involving the 35 to 44 and 45 to 54 age groups.

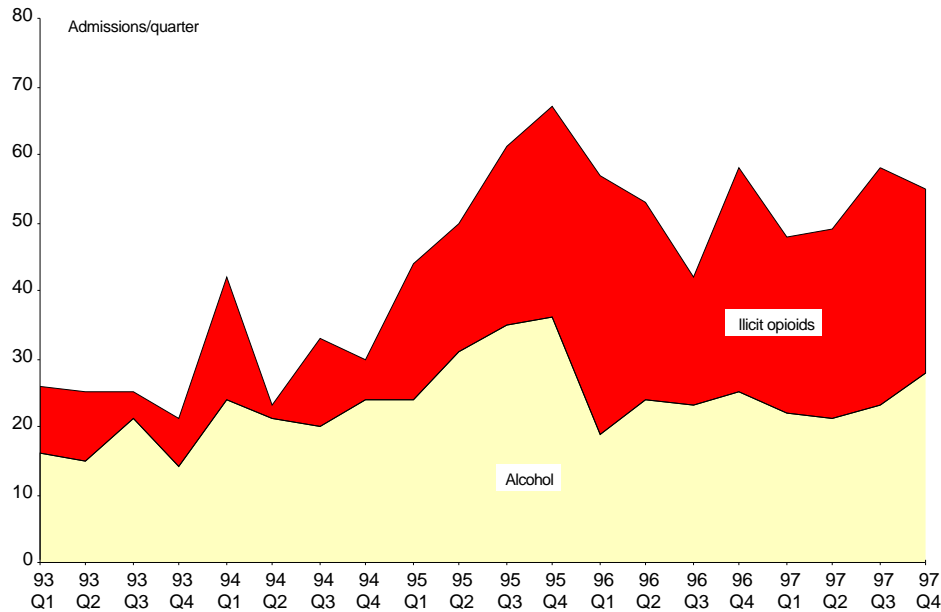
It should be emphasised that the abuse of amphetamines and illicit opioids poses particular health problems in relation to these younger women, especially in relation to the risks of the transmission of blood borne viral infections, such as Hepatitis B (HBV), Hepatitis C (HCV), and the human immunodeficiency virus (HIV) as these drugs are typically used intravenously.

From 1993 up to the end of 1995, the majority of admissions were related to problems caused by alcohol. However, it can be seen that over the last three years there have been an increased number of admissions due to problems associated with the abuse of illicit opioids (Figure 8.6).

**Figure 8.5: All female admissions to Central Drug Unit by drug group and age group, 1993 - 1997**



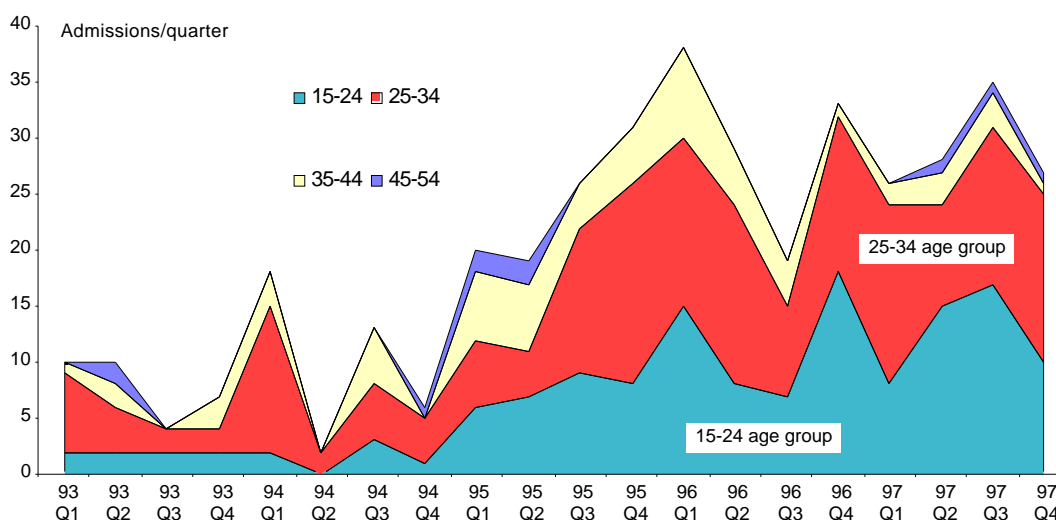
**Figure 8.6: Quarterly female illicit opioid and alcohol admissions to Central Drug Unit, 1993 - 1997**



**Illicit opioids**

Just under half of illicit opioid abusers involved women in the 25 to 34 age group, with about another third who came from the 15 to 24 age group (Tables 8.14 and 8.15). The impact of illicit opioids as a major cause of admissions to the CDU is well illustrated in the marked increase in the number of admissions that occurred in the first quarter of 1995. The number of admissions have increased about seven fold from the first quarter 1995 to the first quarter of 1996 and have since fluctuated at around 25 admissions per quarter up to the present (Figure 8.7).

**Figure 8.7: Quarterly female illicit opioid admissions to Central Drug Unit by age group, 1993 - 1997**



**Table 8.14: Female illicit opioid admissions to Central Drug Unit by age group, 1993 - 1995**

Age group	1993				1994				1995			
	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4
<15	-	-	-	-	-	-	-	-	-	-	-	-
15-24	2	2	2	2	2	-	3	1	1	2	9	8
25-34	7	4	2	2	13	2	5	4	1	1	13	18
35-44	1	2	-	3	3	-	5	-	4	3	4	5
45-54	-	2	-	-	-	-	-	1	-	-	-	-
55+	-	-	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>10</b>	<b>10</b>	<b>4</b>	<b>7</b>	<b>18</b>	<b>2</b>	<b>13</b>	<b>6</b>	<b>6</b>	<b>6</b>	<b>26</b>	<b>31</b>

**Table 8.15: Female illicit opioid admissions to Central Drug Unit by age group, 1996 - 1997**

Age group	1996				1997				1993-1997	
	Qtr1	Qtr2	Qtr3	Qtr4	Qtr1	Qtr2	Qtr3	Qtr4	Total	%
<15	-	-	-	-	-	-	-	-	-	-
15-24	15	8	7	18	14	26	28	18	162	37.7
25-34	15	16	8	14	26	17	18	27	200	46.5
35-44	8	5	4	1	3	6	5	2	61	14.2
45-54	-	-	-	-	-	2	2	2	7	1.6
55+	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>38</b>	<b>29</b>	<b>19</b>	<b>33</b>	<b>43</b>	<b>51</b>	<b>53</b>	<b>49</b>	<b>430</b>	<b>100.-</b>

**New admissions all ADA programs**

Analysis of the number of annual new admissions of females to all ADA programs over the period 1988 to 1997 by type of drug group indicates that (Table 8.16):

- there was an overall increase from 109 admissions in 1988 to 127 admissions in 1997 of alcohol abusers. (However, it is to be noted that since a total of 250 admissions were recorded in 1995, admissions have dropped by nearly half to 127 in 1997);
- the number of admissions of abusers of illicit opioids remained relatively constant from 1988 to 1994 and then have increased by nearly three and a half times from 75 admissions in 1994 to 262 in 1997;
- the annual number of admissions of licit opioid abusers remained at a low level for the period 1988 to 1994, and then have increased by nearly three times from 1994 to 1997;
- there was a decrease of more than half in the number of benzodiazepine abusers, from 33 (1988) to 14 (1997);
- there was a peak in admissions of amphetamine abusers up to 1994 when 94 admissions were recorded, which has since dropped with 30 recorded in 1997; and
- the number of cannabis related admissions has increased four fold from 8 in 1988 to 33 in 1997.

**Table 8.16: New females to all ADA programs, 1988 - 1997**

	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	Total	%
Alcohol	109	157	122	139	143	156	178	254	188	127	1,573	35.1
Illicit opioids	82	69	58	61	62	67	75	173	244	262	1,153	25.7
Prescribed opiates	9	6	4	10	7	17	14	71	56	35	229	5.1
Barbiturates	4	-	-	-	-	-	-	-	-	-	4	-.1
Benzodiazepines	33	31	20	25	18	16	18	36	23	14	234	5.2
Amphetamines	4	14	22	51	52	66	94	80	27	30	440	9.8
Cocaine	2	-	-	-	-	1	-	-	-	-	3	-.1
Cannabis	8	14	2	11	23	17	20	37	33	33	198	4.4
Other drugs	14	16	12	21	10	3	5	11	9	16	117	2.6
Not available	74	63	72	98	77	101	46	4	1	-	536	11.9
<b>Total</b>	<b>339</b>	<b>370</b>	<b>312</b>	<b>416</b>	<b>392</b>	<b>444</b>	<b>450</b>	<b>666</b>	<b>581</b>	<b>517</b>	<b>4,487</b>	<b>100.-</b>

## **8.5. Blood borne viruses**

### **8.5.1. HIV**

#### **8.5.1.1. Introduction**

The human immunodeficiency virus (HIV) has three main modes of transmission:

- the exchange of HIV infected body fluids during unprotected sex;
- the use of HIV contaminated injecting equipment; and
- being passed on from mother to child during pregnancy or birth, and possibly via breast milk during feeding.

Injecting drug users (IDUs) are potential transmitters of HIV through sexual contact or use of non sterile injecting equipment. As there is no cure for HIV/AIDS, the only way to curb its rapid spread is by eliminating or modifying the risk behaviours involved in its transmission.

For IDUs, changes may include abstinence, or if this is not feasible, either changing the route of administration of the drug (for instance oral ingestion or smoking) or by adopting safer injecting practices, namely:

- not sharing injecting equipment; or
- if sharing, properly cleaning the equipment by either sterilising or rinsing with bleach.

A number of treatment programs have over recent years included information about HIV risks by providing educational materials and practical assistance that includes:

- warning about the risks of needle sharing;
- needle and syringe cleaning techniques;
- the availability of clean needles and syringes or needle exchange programs;
- safer sexual practices; and
- the availability of free condoms.

New and irregular IDUs are at high risk of contracting HIV infection through the use of contaminated injecting equipment. For new users, this occurs because they may be initiated by using an experienced user's injecting equipment, while for irregular users their drug use is often unplanned and thus more likely to share needles because they do not have sterile injection equipment.

Injecting drug use by populations of incarcerated prisoners occurs raises serious concerns about the potential for the transmission of infectious diseases such as HBV, HCV and HIV. Recent NSW research into drug use in prisons has highlighted the need for a much greater effort to reduce injecting drug use, with about 25 percent of prisoners injecting drugs.<sup>433</sup> This research shows that provision of methadone treatment in NSW jails has had a significant impact on reducing injecting drug use by prisoners.<sup>434</sup>

Alcohol intoxication among IDUs and the effects of other drugs may also contribute to the risk of HIV infection, as the disinhibition resulting from the use of these drugs may increase the likelihood of unsafe sexual practices.

The development of AIDS takes on average about a decade from the time of infection. In countries where substantial proportions of IDUs have become infected with HIV, the majority of children with AIDS have been found to have drug using parents.

In most Western countries during the early years of the HIV/AIDS epidemic, homosexual/bisexual males were the highest risk group, whereas in recent years cases involving IDUs have become more common in North America and Western Europe. Subsequently, the incidence of AIDS has increased among children and non drug using heterosexuals.

IDUs are regarded as the most likely conduit for HIV infection to reach the general community through heterosexual contact. This is a particular concern in relation to drug dependent IDUs who work in the sex industry. As drug abusing sex workers are likely to be excluded from working in establishments regulated under the State's containment policy, these individuals will tend to operate in more high risk areas, such as street prostitution.

### 8.5.1.2. Prevalence

As indicated below, in this State over the period 1983 to 1997 there was a total of 59 (5.5%) of notifications involving cases where injecting drug use was the sole risk factor, with a further 66 (6.1%) notifications involving injecting drug use as a multiple risk factor. The low prevalence of HIV infection due to injecting drug use in this State is consistent with the low rates found in other Australian jurisdictions.

However, there is quite a different picture in a number of overseas countries, with much higher rates of HIV involving IDUs. For instance, in most European countries, between 20 and 30 percent of IDUs are HIV positive, with higher rates of between 50 to 60 percent reported in Spain and Italy respectively. The low Australian rates may be attributed to the adoption of a national harm minimisation approach soon after the HIV epidemic was first noted in this country in the early 1980s.

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<sup>433</sup> Interview with Dr Kate Dolan "Heroin prescription and needle exchange in prison." The Health Report, ABC Radio National transcript 10 August 1998.

<sup>434</sup> Dolan K, Wodak A, Hall WD. "Methadone maintenance treatment reduces heroin injection in New South Wales Prisons." (1998), 17 *Drug and Alcohol Review* 153-158.

*“The effects of a harm minimisation approach are evidence in North America where the HIV epidemic is now being driven by infections among IDU and their sexual partners and children. In the US, where there are approximately 1.5 million IDUs in the 96 metropolitan areas with populations greater than 500,000, an estimated 14 percent of IDUs are infected with HIV. The proportion of annual AIDS cases attributable to IDUs increased from 12 percent in 1981 to 32 percent in 1994. More than half of all new HIV infections are IDU related and HIV infection is now the leading cause of death among Americans aged 25 to 44. In Australia, where there are approximately 100,000 regular heroin users (most of whom are intravenous users), HIV seroprevalence has consistently been less than five percent. The annual incidence of HIV infection has been declining in Australia since 1984 and 81 percent of reported infections to 1994 were attributed to homosexual and bisexual contact.”<sup>435</sup>*

The rapid spread of HIV infection has been widely reported in American and European populations of IDUs since the early 1980s, and more recently in Asian countries. For instance, the seroprevalence of IDUs attending treatment programs in Thailand rose from 2% in 1987 to 46% in 1988, the cumulative percentage of seropositive cases of IDUs increased from 5% in 1985 to 30% in 1990 in Europe and in New York the proportion of heterosexual seropositive IDUs rose from 18% in 1982 to 46% in 1990.<sup>436</sup>

However, much higher prevalence rates of HCV have been reported in populations of IDUs. For instance, in a Victorian study, a seroprevalence of 68% has been reported,<sup>437</sup> and it has been reported that more than 80% of patients attending the ADA’s methadone program tested for HCV were found to be seropositive.<sup>438</sup>

In January 1993 in Australia, 7.7% of all people diagnosed with HIV and 3.9% of people living with AIDS were identified as having a risk factor of injecting drug use. While these figures appear relatively low compared with some Western countries (eg Italy or Spain, where IDUs constitute the majority of HIV/AIDS cases), HIV has the potential to spread rapidly among the population of IDUs in Australia unless precautions are taken.

### 8.5.1.3. Trends in HIV notifications

#### **Risk groups**

From 1983 to 1997, there were a total of 1,077 notifications of HIV and AIDS in WA (Table 8.17). The majority of notifications over the 15 year period involved four sole risk groups: 692 (64.2%) homosexual risk group; 136 (12.7%) heterosexual risk group; 61 (5.7%) bisexual risk group; and 59 (5.5%) IDU risk group.

There were a further 66 (6.1%) notifications that had multiple risk factors (ie homosexual sex and injecting drug use). While it is impossible to determine what the risk factor was in these cases, it should be noted that male to male sex is a greater risk than injecting drug use.

#### **Trends**

Over the 15 year period, the total number of HIV notifications for all risk groups peaked in 1986, when 107 cases were recorded. It is to be noted that whereas between 1985 and 1991 the total of number of notifications fluctuated between about 75 and 100 per year, since 1992 the number has fluctuated between about 60 and 70 per year (Table 8.18)

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<sup>435</sup> Maher L, Dixon D, Lynskey M, Hall W. *Running the risks: heroin, health and harm in South West Sydney*. National Drug and Alcohol Research Centre, University of New South Wales, 1998, 125.

<sup>436</sup> Des Jarlais DC, Friedman SR, Choopanya K, et al. “International epidemiology of HIV and AIDS among injecting drug users.” (1992) 6 *AIDS* 1053; Darke S. “Injecting drug users and the Human Immunodeficiency Virus what do we know?” (1992) 11 *Drug and Alcohol Review* 153.

<sup>437</sup> Crofts N, Hopper JL, Bowden DS, Breschkin AM, Milner R, Locarnin SA. “Hepatitis C virus infection among a cohort of Victorian injecting drug users.” (1993) 159 *Medical Journal of Australia* 237.

<sup>438</sup> Alcohol and Drug Authority. *Annual Report 1993/94*, 11.

### Gender

There are marked differences between males and females in relation to risk group. For instance, the heterosexual risk group was a significant risk factor for females, accounting for 61 (70.9%) of all female notifications, whereas for males only 75 (7.6%) of all male notifications involved this risk group (Table 8.19; Table 8.20). There were a total of two notifications for the gender transsexual, in 1991 and 1995, both of whom were from the homosexual risk group.

With respect to the total of 59 notifications for the risk group where injecting drug use was the sole risk factor, 16 (27.1%) involved females and 43 (72.9%) involved males. It is to be noted that surveillance of HIV seroprevalence in adolescent and adult women is a valuable indicator of trends in HIV transmission through heterosexual contact in the population as a whole.<sup>439</sup>

There has been a different pattern of exposure to HIV among women in Australia compared to women in the United Kingdom and France. For instance, of the 4,300 cases of HIV infection in the UK that have been diagnosed by 31 December 1996, 68% reported a history of heterosexual contact only and 22% reported a history of injecting drug use. There has also been differences in the pattern of HIV exposure between Australian women with AIDS and women with AIDS in Europe and the United States.

*“In the United States, 34% of women diagnosed with AIDS in 1996 attributed their exposure to HIV to injecting drug use and, of the 40% of women who reported a history of heterosexual contact only 35% reported heterosexual contact with an injecting drug user.”<sup>440</sup>*

**Table 8.17: All HIV/AIDS notifications by risk group, WA, 1983 - 1997**

	1983 - 1997	
	n	%
Homosexual	692	64.2
Bisexual	61	5.7
Heterosexual	136	12.7
IDU	59	5.5
Homosexual/bisexual + IDU	66	6.1
Blood products	33	3.1
Vertical (prenatal)	4	0.4
Unknown	26	2.4
All categories	1,077	100.0

Source: Disease Control Service, Health Department of WA

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<sup>439</sup> McDonald A, Cui J. “The pattern of diagnosed HIV infection and AIDS in women in Australia, 1984-1996.” (1997) 13 (2) *Australian HIV Surveillance Report* 1-6.

<sup>440</sup> Id 6.

**Table 8.18: Annual HIV/AIDS notifications by risk group and year of first diagnosis, WA, 1983 - 1997**

	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Homosexual	2	8	77	84	56	43	58	65	76	43	43	41	39	31	40
Bisexual	-	-	6	4	10	11	6	-	5	1	1	5	3	3	6
Heterosexual	-	-	4	1	5	4	6	9	9	11	13	17	24	18	15
IDU	-	-	1	6	5	3	9	5	8	4	3	3	6	2	4
Homosexual/bisexual + IDU	-	-	5	6	6	8	8	6	4	3	5	3	5	2	5
Blood products	-	7	8	5	1	3	2	3	1	2	-	1	-	-	-
Vertical (prenatal)	-	-	-	-	1	-	-	-	-	1	1	-	-	1	-
Unknown	-	-	-	1	-	1	2	2	2	1	3	4	3	5	2
<b>All categories</b>	<b>2</b>	<b>15</b>	<b>101</b>	<b>107</b>	<b>84</b>	<b>73</b>	<b>91</b>	<b>90</b>	<b>105</b>	<b>66</b>	<b>67</b>	<b>71</b>	<b>73</b>	<b>71</b>	<b>61</b>

Source: Disease Control Service, Health Department of WA

Note: Two notifications classified as transsexual, in 1991 and 1995 for homosexual risk group.

**Table 8.19: Annual male HIV/AIDS notifications by risk group and year of first diagnosis, WA, 1983 - 1997**

	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Homosexual	2	8	77	84	56	43	58	65	75	43	41	38	31	40	29
Bisexual	-	-	6	4	10	11	6	-	5	1	1	5	3	3	6
Heterosexual	-	-	3	1	3	1	4	5	6	2	11	8	13	10	8
IDU	-	-	1	2	1	2	7	4	8	4	2	2	4	2	4
Homosexual/bisexual + IDU	-	-	5	6	6	8	8	6	4	3	5	3	5	2	5
Blood products	-	7	8	4	1	1	2	3	1	1	-	1	-	-	-
Vertical (prenatal)	-	-	-	-	1	-	-	-	-	-	-	-	-	1	-
Unknown	-	-	-	1	-	1	2	2	2	1	3	4	2	3	2
<b>All males</b>	<b>2</b>	<b>15</b>	<b>100</b>	<b>102</b>	<b>78</b>	<b>67</b>	<b>87</b>	<b>85</b>	<b>101</b>	<b>55</b>	<b>63</b>	<b>61</b>	<b>58</b>	<b>61</b>	<b>54</b>

Source: Disease Control Service, Health Department of WA

**Table 8.20: Annual female HIV/AIDS notifications by risk group and year of first diagnosis, WA, 1983 - 1997**

	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Homosexual	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Bisexual	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Heterosexual	-	-	1	-	2	3	2	4	3	9	2	9	11	8	7
IDU	-	-	-	4	4	1	2	1	-	-	1	1	2	-	-
Homosexual/bisexual + IDU	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Blood products	-	-	-	1	-	2	-	-	-	1	-	-	-	-	-
Vertical (prenatal)	-	-	-	-	-	-	-	-	-	1	1	-	-	-	-
Unknown	-	-	-	-	-	-	-	-	-	-	-	-	1	2	-
<b>All females</b>	<b>-</b>	<b>-</b>	<b>1</b>	<b>5</b>	<b>6</b>	<b>6</b>	<b>4</b>	<b>5</b>	<b>3</b>	<b>11</b>	<b>4</b>	<b>10</b>	<b>14</b>	<b>10</b>	<b>7</b>

Source: Disease Control Service, Health Department of WA

**IDU risk group**

It can be seen that IDU notifications for the risk group where injecting drug use was the sole risk factor peaked in 1989 (9 cases). Over the 8 year period 1990 to 1997, the number of notifications where injecting drug use was the sole risk factor has remained relatively static, with a mean of about 4 cases per year.

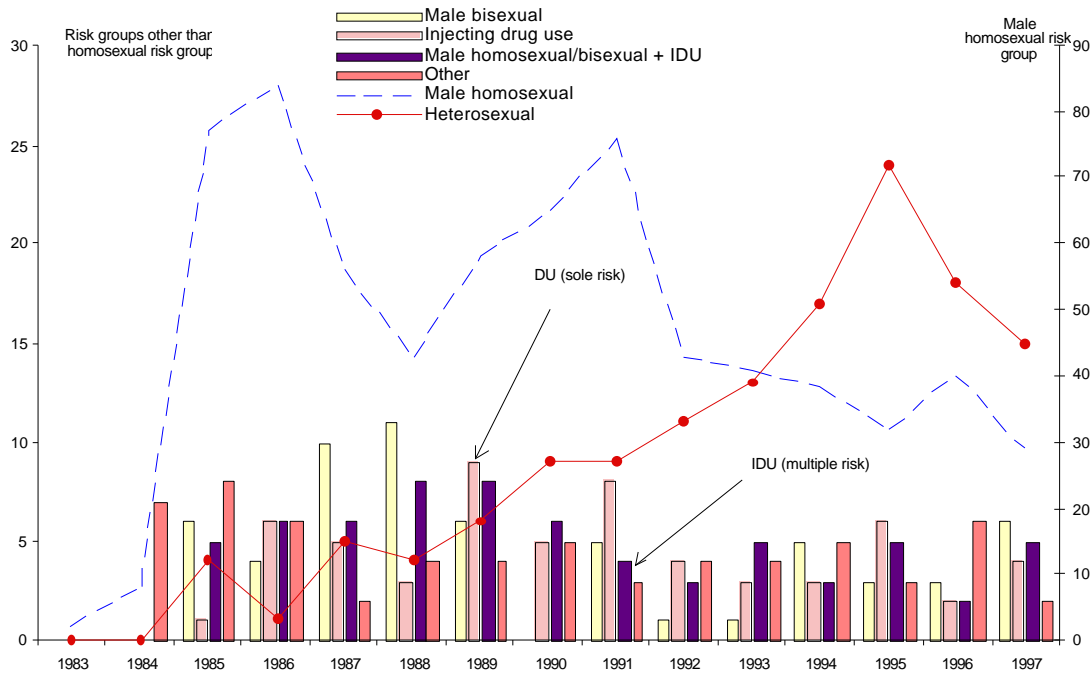
In relation to where IDU was either the sole or a multiple risk factor, such notifications peaked in 1989 (when they accounted for 18.7% of all notifications (Figure 8.9)). The number of notifications for combined IDU risk groups dropped to 5.6% of all notifications in 1996. A small

**Select Committee Into Misuse of Drugs Act 1981**

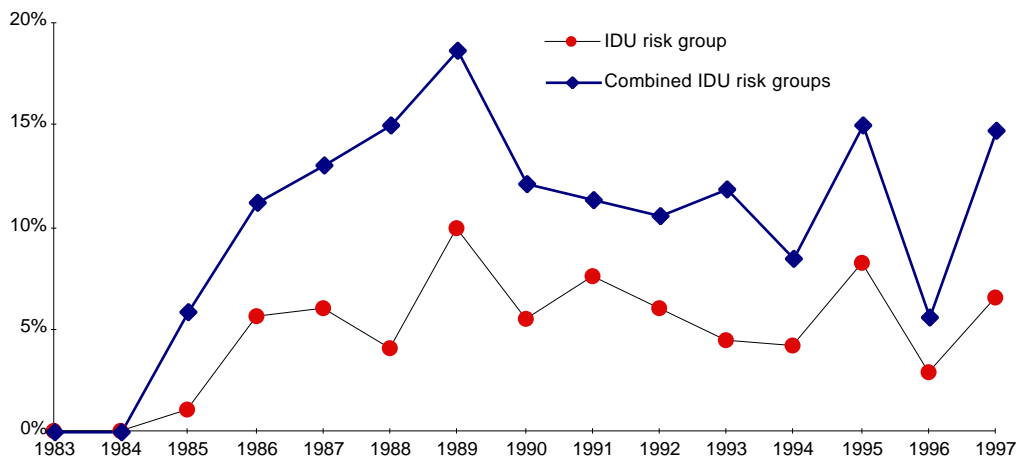
increase was recorded in 1997, when there were 9 (14.8%) notifications which involved injecting drug use was the sole or a multiple risk factor.

Compared to the IDU risk group, the number of notifications for the heterosexual risk group increased until 1995, when a total of 24 notifications were recorded. Since 1995 there has been a decrease of 37.5% (to 15 in 1997) in notifications for this risk group (Table 8.18; Figure 8.8).

**Figure 8.8: Annual HIV/AIDS notifications by risk group and year of first diagnosis, WA, 1983 - 1997**



**Figure 8.9: Annual proportion (%) of IDU risk groups of all HIV/AIDS notifications, WA, 1983 - 1997**



### 8.5.1.4. Trends in HIV in treatment populations

Testing of IDUs in treatment programs is potentially an effective approach to maintaining awareness about high risk practices among clientele attending D&A treatment programs.<sup>441</sup> The concept of sentinel surveillance of high risk populations, such as IDUs attending treatment programs, has been suggested by the National Centre in HIV Epidemiology and Clinical Research. If implemented this would mean, for instance, that treatment programs test clients at the time of admission, at readmission and on a regular ongoing basis for clients remaining in long term treatment (eg on a six monthly basis).

There is very limited data on the rates of testing of IDUs in treatment programs in this State. The number of detected HIV positive IDUs in treatment programs is only available in relation to the ADA's methadone program, which attempts to systematically screen all patients, with their consent, at the time of admission to an episode of treatment.

Over the period 1986 to 1997, a total of 4,313 HIV screening tests were undertaken of patients attending the ADA methadone program (Tables 8.21 and 8.22). This was an average of 392 tests per year. It is to be noted that there were higher rates of testing over the period 1988 to 1991. More recently, from 1992 to 1997, the number of tests declined by 23.8%, from 369 in 1992 to 281 in 1997.

**Table 8.21: Quarterly HIV testing, ADA methadone program, 1986 - 1991**

Year	Quarter	Tests/quarter	HIV positive individuals	
			n	%
1986	January-March	-	3	0.9
	April-June	2	3	1.0
	July-September	1	3	1.1
	October-December	2	2	0.7
1987	January-March	73	4	1.5
	April-June	49	3	1.1
	July-September	122	6	2.0
	October-December	111	7	2.2
1988	January-March	92	7	2.0
	April-June	116	8	2.2
	July-September	89	8	2.0
	October-December	124	9	2.0
1989	January-March	90	6	1.3
	April-June	112	6	1.3
	July-September	89	7	1.6
	October-December	154	8	1.9
1990	January-March	200	9	2.0
	April-June	141	8	1.8
	July-September	140	3	0.6
	October-December	131	5	1.1
1991	January-March	115	7	1.5
	April-June	119	8	1.6
	July-September	126	7	1.4
	October-December	103	8	1.6

Source: Alcohol & Drug Authority.

Note: Testing data not available in the first quarter of 1986.

<sup>441</sup> Brown BS, Needle RH. "Modifying the process of treatment to meet the threat of AIDS." (1994) 29 *International Journal of Addictions* 1739; Wodak A, Des Jarlais DC. "Strategies for the prevention of HIV infection among and from injecting drug users." (1993) 45(1) *Bulletin on Narcotics* 47.

## Select Committee Into Misuse of Drugs Act 1981

The total number of HIV tests is likely to be somewhat higher than this figure, as additional testing of IDUs would also have been undertaken by other health providers and general practitioners. The number of confirmed HIV positive IDUs per quarter in methadone treatment increased from 3 in the March 1986 quarter (when testing commenced) to a peak of 11 in the June 1992 quarter. Since 1992, the number of HIV positive patients has gradually declined to about 4 per quarter (Table 8.22).

**Table 8.22: Quarterly HIV testing, ADA methadone program, 1992 - 1997**

Year	Quarter	Tests/quarter	HIV positive individuals		Ever tested currently on program	
		n	n	% all	n	% all
1992	January-March	110	8	1.6	na	-
	April-June	69	11	2.2	na	-
	July-September	102	10	1.9	355	68.7
	October-December	88	8	1.5	362	67.7
1993	January-March	83	4	0.7	368	66.7
	April-June	109	4	0.7	387	67.4
	July-September	124	4	0.7	394	65.6
	October-December	52	5	0.8	388	63.5
1994	January-March	56	5	0.8	374	60.6
	April-June	98	3	0.5	423	65.6
	July-September	107	3	0.4	447	67.0
	October-December	109	2	0.3	460	66.8
1995	January-March	60	2	0.3	451	64.7
	April-June	59	2	0.3	455	61.9
	July-September	116	3	0.4	490	61.5
	October-December	80	3	0.4	509	62.9
1996	January-March	84	2	0.2	527	63.0
	April-June	98	2	0.2	563	66.3
	July-September	65	4	0.5	556	64.3
	October-December	62	3	0.3	566	62.0
1997	January-March	76	3	0.3	583	58.5
	April-June	73	4	0.4	597	57.0
	July-September	74	4	0.4	598	55.2
	October-December	58	4	0.4	582	52.2

Source: Alcohol & Drug Authority.

Note: Ever testing data only available from September quarter 1992.

### 8.5.2. Hepatitis B

Risk behaviour statistics are not routinely recorded for Hepatitis B. However, in 1995 a survey was undertaken to review risk factors of those cases notified in the metropolitan area. Of 320 cases notified, 299 questionnaires were returned and only 9 of these were acute cases.

As three of these cases were due to injecting drug use, this route of transmission counts for a very small number of Hepatitis B cases. Obviously most cases are in fact chronic carriers and by far the vast majority of these come from countries where there are high endemic rates of this disease. It is a recommendation of the Health Department that intravenous drug users are offered vaccination against Hepatitis B.

### 8.5.3. Hepatitis C

#### 8.5.3.1. Australian perspective

##### *Introduction*

It has been estimated that there are at present between 50,000 to 200,000 people infected with Hepatitis C (HCV) in Australia.<sup>442</sup> The only population based information which estimates the prevalence of HCV infection in Australia is that which is available from potential blood donors. This indicates that 0.2 - 0.4% of this section of the community have been infected. However, this is a selected population and risk behaviour screening prior to blood even being collected for testing could make this percentage unreliably low.

The infection rate is much higher amongst people participating in high risk behaviours.<sup>443</sup> Amongst IDUs one study showed that 40% are infected after 4 years and this approaches 100% after 10 years of injecting drug use. The Victorian Drugs and Crime Prevention Committee has pointed out the extremely high rates of HCV amongst IDUs, noting that overall it is estimated that two thirds of IDUs are infected.

*“An extensive 1994 study showed that more than 80 per cent of those who have injected for over eight years are infected, and about 15 per cent of those injecting for less than two years are infected. This compares with an estimated prevalence rate in the wider Australian community of about 0.45 per cent.”<sup>444</sup>*

Male and female workers in the sex industry have a higher prevalence than the general population, with 5 - 8% having been infected. It is thought this is more likely to be caused by concomitant injecting drug use rather than by sexual transmission.

Regular recipients of pooled blood products (eg Factor VIII) before 1990, had a substantial risk of being infected with HCV. These infections were acquired before heat treatment procedures were introduced. In Australia, a retrospective analysis of the prevalence of antibodies to HCV (and HIV & HBV) revealed that infection generally occurred in this group at an early age, with 68% of children below the age of ten having anti HCV.

It is now estimated that 85 - 90% of people with haemophilia have been infected with HCV. A New Zealand study showed 65% of people with haemophilia tested positive for HCV. Other uncommon but recognised risks of transmission include organ transplantation and renal dialysis patients.

People who were born overseas have a greater prevalence of HCV antibodies than those born in Australia. One possible route of infection for such people was the use of unsterilised non disposable needles in medical clinics in their countries of origin. Other cultural practices which may also contribute to higher prevalence include unsterile tattooing and scarification. The prevalence is higher in those from Mediterranean and Eastern European countries, Asia, South America, Africa and the Middle East.

Studies investigating the risk of infection from an accidental needle stick injury in health care workers, estimate the risk to range between 2.5 - 10% when the donor is HCV positive. Another group at particular risk are people who have been incarcerated and have a history of injecting drug use.

<sup>442</sup> National Health & Medical Research Council. *Draft report on a strategy for the detection and management of hepatitis C in Australia*. Canberra, National Health & Medical Research Council, 1996.

<sup>443</sup> Coutinho RA. “HIV and hepatitis C among injecting drug users.” (1998) *British Medical Journal* 424-425; Van Beek I, Dwyer R, Dore GJ, Luo K, Kaldor JM. “Infection with HIV and hepatitis C among injecting drug users in a prevention setting: retrospective cohort study.” (1998) *British Medical Journal* 433-437.

<sup>444</sup> Victoria, Parliament, Drugs and Crime Prevention Committee. *Interim report of the inquiry into the Victorian government’s drug reform strategy*. Melbourne, Victorian Parliament, 1997, 179.

**Acute infection**

It is unusual to develop any significant illness at the time of infection with HCV. Many active infections are asymptomatic and some people remain healthy. However, some people develop a flu like illness in which nausea may be the predominant symptom. Other common symptoms are extreme tiredness, abdominal and back pain and headache. Jaundice may develop, but it is not common. In symptomatic patients, the incubation period usually ranges from 6 to 10 weeks.

**Chronic infection**

It is believed that at least 50% and up to 80% of individuals who are exposed to the HCV virus become chronically infected and are able to transmit the virus. For the majority of patients, such chronic HCV infection is asymptomatic. Even in those who do have symptoms, they are generally non specific and include general malaise and right upper quadrant abdominal discomfort and anorexia. Spontaneous viral cure in chronic patients is thought to be rare.

Cirrhosis will develop in about 20% of those with chronic HCV infection and this generally occurs at least 20 years after the time of infection. Even if cirrhosis develops, it may run an indolent course. Some patients will develop liver failure. A proportion of those who develop cirrhosis due to chronic HCV infection ultimately develop hepatocellular carcinoma. This generally seems to occur at least 5 to 10 years after the development of cirrhosis. Overseas studies indicate that 5 - 10% of those affected with chronic HCV will ultimately develop this carcinoma.

**History**

The identification of diagnostic markers for hepatitis A and hepatitis B infection in the early 1970s led to the realisation that there were a group of patients, particularly after transfusion, who developed hepatitis which was not caused by either of these agents. The specific infective agent for non A non B hepatitis, as it came to be known, was not identified until 1988. In 1990 it became possible to test for the presence of HCV antibodies. As soon as this test was commercially available, it was incorporated as a screening test for healthy blood donors, and a positive rate of 0.5 - 1% was found. Subsequent refinements to the tests have decreased the false positive rate and a rate of 0.2 - 0.4% is currently detected in apparently healthy blood donors.

**Description of virus**

Hepatitis C virus is a single stranded RNA virus of the family flaviviridae, and bears genomic resemblances to the genus, pestivirus. Other members of the flaviviridae known to infect man are the aetiological agents of yellow fever, dengue fever, Japanese encephalitis and Australian encephalitis. At least six and probably greater than nine HCV genotypes exist. Concurrent infection with different genotypes is possible, as is infection on different occasions with the same genotype.

It is possible for reinfection to occur after complete resolution of a previous infection with the same genotype. Genotypic variations may play a role in the differences in disease progression and response to interferon therapy, although data are inconclusive at this stage. Humans are thought to be the only natural host, although non human primates have been infected experimentally.

**8.5.3.2. Western Australia**

The Disease Control Services of the Health Department of WA is presently consulting with key stakeholders to develop a framework, the *Hepatitis C Education and Prevention Strategy for WA*, to reduce the transmission of HCV in WA.<sup>445</sup> As it is known that as approximately half of those currently infected with HCV are past or current IDUs, strategies to reduce the incidence of HCV make injecting drug use the primary target for prevention and education programs. Other priority groups include people who participate in tattooing and other skin penetration activities, health care workers, correctional services institution clients, the general community, and people affected by HCV.

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<sup>445</sup> Due to be released in the third quarter of 1998.

**Goals**

- To reduce the incidence of Hepatitis C in those at risk.
- To reduce the social and personal impact of Hepatitis C infection on those infected and affected.
- To reduce the uptake of, and participation in, risk behaviour.

**Broad objectives**

- To improve knowledge of the transmission routes of HCV and reduce risk behaviours.
- To provide a comprehensive range of education and prevention services which facilitate the minimisation of the transmission of HCV in identified target groups.

**Broad strategies**

- Enhance and improve education and prevention services to injecting drug users and those contemplating injecting drugs.
- Provide information and education to health care workers and others working with specific target groups.
- Enhance existing infection control programs targeting health care workers and providers of skin penetration services.
- Provide information and education regarding HCV and its available treatments to people infected and affected by the virus.

**Target groups**

- People who inject drugs.
- Non injecting drug users who are contemplating injecting drugs.
- People who participate in skin penetration/tattooing activities.
- Health care workers.
- Correctional services.
- People affected by HCV.
- General community.

**People who inject drugs**

Of the existing pool of past HCV infections, it is estimated that 75% have a history of injecting drug use. Studies show that with increasing years of injecting drug use, rates of HCV in IDUs increase to nearly 70% by 6 years and 100% by 8 years of use. This indicates that efficient and continuing transmission is occurring in this group despite past and current education and prevention programs.

In WA, an analysis of a detailed surveillance of 556 cases of a group of people tested for HCV through particular laboratories over an 18 months period showed that 72% of this group reported IDU as a risk factor and of those designated as acute cases 85% reported IDU as a risk factor.<sup>446</sup>

Education strategies need to maintain a harm reduction approach that is comprehensive. This includes the reduction of sharing of any injecting equipment in people who inject drugs currently, and an increase in their awareness and knowledge about transmission of HCV in the injecting environment, alternative routes of administration, safe disposal, drug treatment and rehabilitation programs and abstinence from drug use. Different strategies aimed at the differing subpopulations who inject drugs are required. Peer education, opportunistic education in which IDUs are in contact with health professionals and targeted advertising and information strategies will enhance current activities.

**Aim**

To promote harm reduction practices among those people who already inject drugs and therefore reduce unsafe injecting behaviour among people who inject drugs.

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<sup>446</sup> Health Department of WA, 1997, unpublished data.

### **People who participate in tattooing/skin penetration activities**

Tattooing has been shown to be a risk factor for HCV transmission while a similar risk exists with other skin and body piercing activities if equipment is not sterile.<sup>447</sup> Apart from “formal settings” (ie tattoo studios), tattooing and skin penetration activities occur in WA in “informal” situations such as custodial institutions and “backyard” operations in people’s homes.

Prevention of infection in skin penetration activities and tattooing is dependent on those people carrying out the procedure in a manner which meets minimum standards of infection control. These include a clean and safe working environment, use of appliances which are clean and sterile and aseptic operating techniques. Training, education and regulations and standards are the strategies proposed to guide and assist those people who participate in tattooing and skin penetration activities in WA.

### **Aims**

- To ensure adequate control of skin penetration procedures through updating of the *Health (Skin Penetration) Regulations 1987* and development and distribution of a Code of Practice.
- To increase community awareness regarding the risks of transmission of HCV and other blood borne viruses associated with tattooing, body piercing and other skin penetrative procedures.
- To increase the ability of people who practice skin penetration to meet minimum standards of infection control.

### **Correctional services**

Experience from other countries indicates that custodial institutions are potentially important settings for transmission of blood borne viruses, particularly where there are high rates of infection upon entry combined with the ongoing practice of syringe sharing among demographically dissimilar injectors.<sup>448</sup>

Strategies developed to reduce the level of drug use and the prevalence of HCV in the wider population will impact on the problems encountered in this population. However, the large numbers of IDUs entering the custodial system, and the particular nature of the prison culture, means that different prevention strategies must be developed for this group. The custodial setting may lead to unsafe drug use behaviours as well as unsterile tattooing. In this setting, warnings regarding the use of clean equipment and safe techniques are likely to be ineffective.

The development and implementation of an innovative plan through the leadership of the Ministry of Justice, in collaboration with key agencies, may address some of the issues necessary to tackle the reduction of transmission of HCV in the custodial setting.

### **Aims**

- To decrease the frequency of unsafe injecting and unsterile tattooing in correctional services institutions.
- To increase knowledge and prevention skills regarding HCV transmission among correctional services staff and offenders in custody.

In 1993, HCV became notifiable in this State. From 1993 to 1997, there was a total of 5,925 notifications. The number of annual notifications is as follows (Table 8.23):

- in 1993 there were 1,107 cases;
- in 1994 there were 1,319 cases;
- in 1995 there were 1,180 cases;
- in 1996 there were 1,229 cases; and
- in 1997 there were 1,090 cases.

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<sup>447</sup> National Health & Medical Research Council (NH&MRC) Hepatitis C Working Party, 1996. *Draft report on a strategy for the detection and management of Hepatitis C in Australia*, unpublished.

<sup>448</sup> Des Jarlais DC, Friedman SR, Hagan H. “Studies of HIV/AIDS and injecting drug use.” (1992) 4 *AIDS Care*, 481.

For HCV there were less cases identified in 1997 than in any previous year. Based on 80% of cases for which there is data, the following risk factors have been identified for 1997:

- injecting drug use (78%);
- tattoo or skin piercing (10%); and
- blood transfusion (11%).

While the exact cause of transmission cannot be determined, it does seem injecting drug use is by far the most common route of transmission for HCV in WA. Nine percent of the cases were deemed to be acute cases, and of these, 81% gave injecting drug use as their risk behaviour. While these numbers are still small, it would seem that injecting drug use is the most important route of transmission of this virus in WA.

**Table 8.23: Number of HCV notifications, WA, 1993 - 1997**

	Male		Female		Persons		MF rate ratio
	Cases	Rate	Cases	Rate	Cases	Rate	
1993	737	72.0	370	37.8	1,107	56.3	1.99
1994	828	79.3	491	49.2	1,319	66.1	1.69
1995	760	71.7	420	40.7	1,180	57.8	1.81
1996	777	74.9	452	44.7	1,229	59.9	1.72
1997	670	63.8	416	41.1	1,090	52.6	1.61
<b>1993 - 1997</b>	<b>3,772</b>	<b>-</b>	<b>2,149</b>	<b>-</b>	<b>5,925</b>	<b>-</b>	<b>-</b>

Source: Disease Control Service, Sexual Health Program, Health Department of WA.

### 8.5.3.3. United States response

In the United States, studies have estimated that 1.8 percent of the population (nearly 4 million Americans) carry the virus HCV which causes hepatitis C. In March 1997, the National Institute of Health (NIH) held a Consensus Conference, where it was estimated that 30,000 acute new infections occur each year in the United States, of which only 25-30% are diagnosed. Current data sources indicate that 8,000 to 10,000 Americans die from hepatitis C disease each year. The President of American Liver Foundation, Dr William Harrison made the following comment about HCV in October 1997.

*“We call hepatitis C a silent killer because people may carry the virus for years and not know it, while it slowly destroys their livers and potentially their lives. Education and increased community screening for hepatitis C is crucial to public health. The death toll from hepatitis C is expected to triple over the next 10 to 20 years, resulting in a higher death rate from this virus than HIV, the virus which causes AIDS.”*

As a result of the NIH Consensus Conference a number of objectives have been identified in a campaign to prevent the spread of HCV, as follows:

- HCV awareness must be increased among the general public and the medical community;
- screening and diagnosis should be available to those who need it;
- information pertaining to treatment options should be available to those who need it;
- effective hepatitis C treatment should be available to those who need it; and
- more research is needed to effectively prevent, treat and cure this disease.

According to a study published in the September edition of the journal Hepatology, approximately 20 to 30 percent of individuals who are chronically infected with HCV will develop liver cirrhosis and/or hepatocellular carcinoma. It has been noted that complications from HCV are the leading reason in the United States for liver transplants.

## 8.5.4. Needle and syringe program

### 8.5.4.1. Introduction

Injecting drug use has been recognised as a major factor in the spread of HIV, HBV and HCV through the reuse of unsterile injection equipment. HIV rates have remained low in Australia, and in 1993 only 4.9% of cumulative cases of HIV infection were attributable to injecting drug use.

Since the late 1980s, joint Commonwealth and State funded programs have been undertaken in all jurisdictions to increase knowledge by IDUs about lower risk injection practices, to increase the frequency of use of sterile injection equipment and to expand access to new needles and syringes (N&S).

Arising from these policies, in WA (as in most other jurisdictions) the provision of new N&S has become an established component of the strategy to deal with the risk posed by blood borne viruses to both IDUs, and through them the wider community.

It has been noted that an approach of severely restricting N&S in the belief that limits on access to sterile injection equipment in conjunction with vigorous law enforcement and abstinence oriented treatment programs would ‘deter’ injecting drug use was a major factor in serious epidemics of HIV among populations of IDUs in the United Kingdom.<sup>449</sup>

A 1985 Home Office report, *Tackling Drug Misuse*, criticises the former policy as being seriously flawed, as it “concentrated hard on control and had little to say or recommend to comfort the individual with an addiction problem. It was largely about a non medical approach to a problem which was seen as a problem of control and public order.”<sup>450</sup> More recently, the 1995 White Paper has recognised the vital role of N&S programs in the United Kingdom, as having a primary role of reducing harm from injecting drug use.

Over the past 10 years, measures have been developed in WA to encourage chemists and health care providers to distribute new N&S to IDUs. There has also been a more limited funding of outreach services and needle and syringe exchange programs (NSEPs) to engage hard to reach groups. The impetus for bringing about this change stems from public health concerns about the need to develop programs that are attractive to IDUs.

*“Injecting drug users provide the greatest opportunity for HIV to be transmitted into the wider community, and while Australia currently has a relatively low rate of HIV infection amongst injecting drug users, treatment services will play an important role in maintaining this low rate.... Not to provide treatment to this group would greatly enhance the risk of spread of HIV both within the injecting drug using community and, through sexual contacts, to the wider population.”*<sup>451</sup>

The approach has also brought about some change in the priorities of treatment programs.

*“In the treatment context the harm minimisation approach maintains abstinence as a desirable goal, but it is acknowledged that a reduction in the harm associated with drug use is also a valuable outcome. Further, focussing on the narrower concept of HIV risk reduction, the goals of treatment can be conceived of as a hierarchy of desirable outcomes with*

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<sup>449</sup> Drummond DC, Taylor JA, Mullin PJ. “Replacement of a prescribing service by an opiate-free day program in a Glasgow drug clinic.” (1986) 81 *British Journal of Addiction* 559; Lenton S, Donoghoe M, Loxley W, Ovenden C, Carruthers S. *IDUs, needle and syringe provision and harm reduction: the English and WA experience*. Perth, National Centre for Research Into the Prevention of Drug Abuse, Curtin University of Technology, 1994.

<sup>450</sup> Robertson R. “The Edinburgh epidemic a case study.” In Strang J, Stimson G (eds). *AIDS and drug misuse*. London, Routledge, 1990, 101.

<sup>451</sup> Ali R, Miller M, Cormack S. *Future directions for alcohol and other drug treatment in Australia*. Canberra, Australian Government Publishing Service, 1992, 13.

*abstinence from illicit drug use at the top followed by a number of less desirable outcomes.”<sup>452</sup>*

### 8.5.4.2. Western Australian approach

#### **Introduction**

In this State, two approaches have been implemented to maximise access by IDUs to sterile injection equipment:

- the sale of new N&S by retail pharmacies, a collaborative initiative between the Pharmaceutical Council of Western Australia and the Health Department of Western Australia (HDWA); and
- an outreach Needle and Syringe Exchange Program (NSEP), established by the West Australian AIDS Council (WAAC), to sell clean injection equipment in the Perth metropolitan area and to collect used N&S for disposal.

In WA, the NSEP is largely based on a user pays system with the majority of needles and syringes sold through 427 pharmacies across the state. Other outlets include two mobile NSEPs based in the metropolitan area, and a vending machine located in the inner city area. A fixed site NSEP also operates in Perth, and provides peer based education and referral services.

Approximately 80 other health services such as rural hospitals, bush nursing posts and community and public health centres are also approved to provide needles and syringes to IDUs. The enabling legislation for the licensing of NSEPs is contained in the *Poisons Act Regulations 1994*.<sup>453</sup> A number of intervention strategies are supported by the needle and syringe program to reduce risk behaviours, examples of which are listed below.

#### **Legislation**

- Amendments to specific legislative acts to create a defence for persons operating approved needle and syringe programs.
- Review of skin penetration regulations.

#### **Risk reduction strategies**

- Promotion of and improved access to sterile injecting equipment.
- Coordination and monitoring of needle and syringe availability programs.
- Encouragement of establishment of needle and syringe programs in areas where there are gaps in access and availability.
- Provision of safer sex information and equipment through needle and syringe exchanges.

#### **Education of injecting drug users**

- Support and funding of community based organisations to provide specific educational services, support and referral services.
- Accessing injecting drug users that may not be in contact with other treatment or health services through needle and syringe distribution and exchange programs, which provide a point of contact for disseminating preventative, referral and educational materials.
- Production of materials promoting harm reduction practices among those people who already inject drugs.

#### **Community education**

- Education of the general public (including children) regarding needle and syringe disposal issues, through collaboration with other agencies.
- Provision of information and referral to the general community.

<sup>452</sup> Bell M. “Treatment.” In Wardlaw G, Strang H, Bull M, MacDowell D, Norberry J. *Comparative analysis of illicit drug strategy*. Canberra, Australian Government Publishing Service, 1992.

<sup>453</sup> Poisons Amendment Regulations 1994. *Government Gazette*. 26 May 1994, 2197.

## **Select Committee Into Misuse of Drugs Act 1981**

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### **Research and evaluation**

- Routine monitoring of trends relating to distribution of needles and syringes.
- Routine monitoring of notifiable diseases including HIV, hepatitis C and B.
- Needs assessments of target groups.
- Collaborative research projects undertaken with other organisations.

### **Policy and strategy development**

- Development of strategies to address needle and syringe disposal issues with local government authorities.
- Participation in national committees addressing education about, and prevention of, blood borne viral infections.
- Development of a hepatitis C strategy for Western Australia.
- Input into policies regarding other groups at risk of blood borne viral infections (for example, people in custodial institutions and skin penetration practices such as piercing and tattooing).

### **Professional education**

Provision of information and education to health care workers and others working with specific target groups to minimise the transmission of blood borne viruses and to minimise the social and personal impact for those already infected.

### **Legislative framework**

Retail pharmacies in WA had for a number of years sold new N&S to IDUs. It is to be noted that until 1994 the provision of injecting equipment to IDUs was illegal in this State. Those who provided N&S to IDUs, could as the law stood, have been charged with offences under the *Criminal Code*. Pharmacists and other services provided sterile injection equipment to IDUs as a critical public health strategy to prevent the further transmission of HIV in this State. The relevant provisions for establishing a NSEP are contained in the *Poisons Act 1964* and the *Poisons Regulations 1965*, as follows.

### **Poisons Act 1964**

5. (1) In this Act unless the context requires otherwise –

...

“bloodborne infectious disease” means Human Immunodeficiency Virus (HIV) infection, Hepatitis B, Hepatitis C or any other infectious disease that is carried in the blood;

...

“needle and syringe program” means a program to do one or more of the following –

- (a) to supply persons with sterile hypodermic syringes or sterile hypodermic needles;
- (b) to facilitate the safe disposal of used hypodermic syringes or used hypodermic needles; or
- (c) to advise, counsel or disseminate information to persons,

principally for the purpose of preventing the spread of bloodborne infectious diseases.

### **Poisons Regulations 1965**

12A. (1) A person may apply to the Commissioner of Health for the approval of a needle and syringe program.<sup>454</sup>

(2) An application referred to in subregulation (1) shall –

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<sup>454</sup> Regulation 12A inserted in Gazette 26 May 1994, 2197-8.

- (a) be in the form of Form 14 in Appendix A; and
  - (b) nominate a person to be the coordinator of the program.
- (3) The Commissioner of Health may by notice in writing require an applicant to provide further information with respect to the application.
- (4) An approval of a needle and syringe program shall –
- (a) be given by instrument in writing signed by the Commissioner of Health;
  - (b) clearly identify the program that is being approved by reference to the activity or activities, and the persons or class of persons engaging in the activity or activities, that constitute the program; and
  - (c) specify the period during which the program is approved.
- (5) The Commissioner of Health is not to approve a needle and syringe program unless the Commissioner of Health is satisfied that the coordinator of the program –
- (a) has attained the age of 18 years;
  - (b) is a person of good character and repute and is a fit and proper person to coordinate the needle and syringe program; and
  - (c) understands his or her duties as the coordinator of the program.

The effect of these provisions is those who are involved in running NSEPs are provided with a defence if the NSEP is approved by the Commissioner of Health. It is considered that the introduction of this amendment lead to a marked expansion in the number of pharmacists who were willing to provide sterile injection equipment.

#### **Rationale for NSEPs**

By the late 1980s, it was appreciated that without substantially expanded access to sterile injection equipment, there was a real risk that HIV and other BBVs would rapidly spread in IDUs in this State. There was particular concern that, as infected IDUs had readily transmitted HIV and other BBVs via heterosexual contact with non IDU sexual partners in many other jurisdictions, this issue raised significant public health problems.

#### **Role of pharmacies**

In July 1987, more than 400 pharmacies throughout the metropolitan area and in regional centres were approached to sell N&S as a kit, incorporating both sterile N&S and HIV preventive materials. The use of a self contained pre packaged container of new N&S was developed, which also had a dual function of a storage container to retain N&S after use, to effect safe disposal without the attendant risk of infection. The first version, known as the SS5 Pack, contained literature on how HIV was spread through reuse of N&S, a swab, five sterile 1 ml syringes and needles, a condom and lubricant, and a rigid disposal container. The SS5 Pack was sold by retail pharmacies throughout the state between June 1987 and June 1992.<sup>455</sup>

The SS5 Pack was extensively promoted, and to maximise the participation of pharmacies, was supplied at no cost by the HDWA's former AIDS Bureau. In conjunction with the SS5 Pack, participating pharmacies displayed a standardised logo near their entrance, and seminars and workshops were held in the metropolitan area as well as in a number of regional areas. A key factor in obtaining such a high participation by retail pharmacies, particularly in the Perth metropolitan area, was the principle that IDUs should obtain injection equipment without

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<sup>455</sup> Swensen G, Westlund G, Baker MR. *Sales of needles and syringes in WA - the SS5 pack project 1987-1990*. Perth, Health Services Statistics and Epidemiology Branch, Health Department of WA, 1992.

## **Select Committee Into Misuse of Drugs Act 1981**

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stigmatisation and that N&S should be purchased like any other health care product through pharmacies.

In July 1992, the HDWA discontinued subsidisation of SS5 Packs, and transferred the distribution of N&S to the two major pharmaceutical wholesale suppliers, Sigma and Fauldings. As part of the change in distribution a new plastic container, the FitPack, was introduced which had previously been used in the Eastern State. This consisted of a compartment with five new N&S and an adjoining compartment with five self locking slots for IDUs to retain used N&S. The FitPack did not contain the additional HIV preventive items previously provided with the SS5 Pack, and was sold by pharmacies for about \$4 to 5.

Since July 1992, the FitPack scheme has been fully funded by consumers (IDUs). Outreach N&S programs are partially subsidised by joint funds from the Commonwealth/State HIV/AIDS program.

### **Needle and syringe exchange programs**

In July 1987, the WA AIDS Council (WAAC), in conjunction with the Beaufort 565 Sauna, started the first NSEP in WA, whereby IDUs were able at no cost to exchange used injection equipment for new injection equipment. Since July 1992, the WAAC programs have charged a low cost for new N&S provided to IDUs who do not have used injection equipment to exchange for N&S.

In June 1988, the WAAC started a Drug Outreach Program targeted at a range of IDUs, particularly recreational drug users. This is a NSEP run from a van, providing a mobile NSEP that incorporates one to one contact with IDUs, distributes preventive literature, condoms and information about HIV assessment and makes referrals to appropriate agencies. The van operates at scheduled times at discreet locations in the Perth metropolitan area, with most of the N&S being distributed from locations in the inner city.

The Perth Aboriginal Medical Services (PAMS) has operated a mobile NSEP since July 1996. The PAMS mobile NSEP operates in close collaboration with the WAAC mobile NSEP, so both programs complement one another's opening times and sites. In November 1997, a fixed site NSEP operated by the Western Australian Substance Users Association (WASUA) commenced in Northbridge. This program also provides peer education and outreach services.

Features of the mobile NSEPs is that they provide a comprehensive range of educational and preventive literature and will provide new N&S in exchange for used N&S without cost. If a used N&S is not returned, injection equipment is sold at a low cost. It is understood that the WAAC mobile NSEP achieves return rates of at least 90 - 95%. The WASUA program provides additional service which is targeted at IDUs who seek out one to one support and advice about their drug use and for options to change their lifestyle.

Due to changes in the outsourcing of the incineration disposal of this type of waste, which previously had been done at no cost through the Royal Perth Hospital incineration facility, WAAC and the PAMS are required to pay \$20 per bucket for the incineration of used N&S. This is a significant cost burden on these organisations. In the case of WAAC, it is now paying at least \$1,000 per month for the cost of having used N&S disposed of at a private incinerator. This additional cost has had to be met through reductions in other services provided by the NSEP.

### **Vending machines**

The only authorised vending machine is at the ADA's Central Drug Unit (CDU), with the object of providing after hours access to N&S in Perth. This is the only 24 hour source of new N&S in the Perth metropolitan area. This service does not provide new N&S in exchange or on condition of the return of used N&S, although a disposal bin is located at the boundary of the CDU to receive used N&S.<sup>456</sup> The close association of this vending machine with a health facility which is

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<sup>456</sup> A number of metropolitan and non-metropolitan local authorities have established N&S disposal bins in public toilets in specific localities.

not located on a main thoroughfare, compares with the location of a N&S vending machine close to the entrance of Kirketon Clinic,<sup>457</sup> which was noted by the Select Committee during the course of its visit to Sydney.

### 8.5.4.3. State overview

A total of 10.1 million new needles and syringes were distributed over the period 1987 to 1997 in this State (Table 8.24), as follows:

- 6,573,245 (65.0%) through chemists;
- 3,015,855 (29.8%) through NSEPs;
- 225,430 (2.2%) through hospitals;
- 19,905 (0.2%) through community health centres,
- 258,170 (2.6%) through vending machines;
- 2,230 (<0.1%) through nursing posts; and
- 18,116 (<0.1%) through other outlets.

It is to be noted that a total of 4,305 N&S were sold in 1991 and 1992 through an experimental vending machine at the WAAC's former premises in Northbridge. A more reliable and closely supervised vending machine (thus precluding vandalism) has been operated by the ADA since mid 1994 at the CDU.

From 1987 up to the early 1990s, there was a steady increase in the number of N&S distributed per year in this State. Then from 1993 to 1994 the number of N&S distributed increased by nearly 400,000. After peaking in 1994, when a total of nearly 1.6 million N&S were distributed, there was small decrease in the number of N&S distributed in 1995 and 1996. More recently, from 1996 to 1997 the number of N&S distributed increased by 21.5% (Figure 8.10; Table 8.24).

It has not been determined whether there is a correspondence between the distribution of N&S and prevalence, as local factors can play a significant impact on utilisation of N&S. For instance, the higher rates of distribution of N&S in some areas can be explained by a greater willingness of pharmacies to provide N&S, whereas low rates in other areas can be attributed to the limited availability of N&S. This may mean that IDUs from areas with limited availability will distort sales of N&S from nearby areas with greater availability.

It is speculated that recent trends in the distribution of N&S does reflect changes in prevalence of the two major illicit drug groups: amphetamines and heroin.<sup>458</sup> The peak of nearly 1.6 million N&S in 1994 coincides with the documented peak in amphetamine related problems that occurred at that time. It is possible the recent increase in N&S distribution, with nearly 1.9 million N&S for 1997, may reflect some of the recent increase in heroin prevalence that has occurred in this State.

The growth in the importance of chemists as a source of N&S for IDUs over the period 1987 to 1997 is illustrated in a quarterly breakdown by type of outlet (Table 8.25; Table 8.26; Figure 8.11). Since the first quarter of 1992, the number of N&S through chemists has exceeded the number of N&S distributed through NSEPs.

<sup>457</sup> Located in inner Sydney city area close to Kings Cross.

<sup>458</sup> Cf data on trends in ADIS calls and admissions to ADA treatment programs elsewhere in this report.

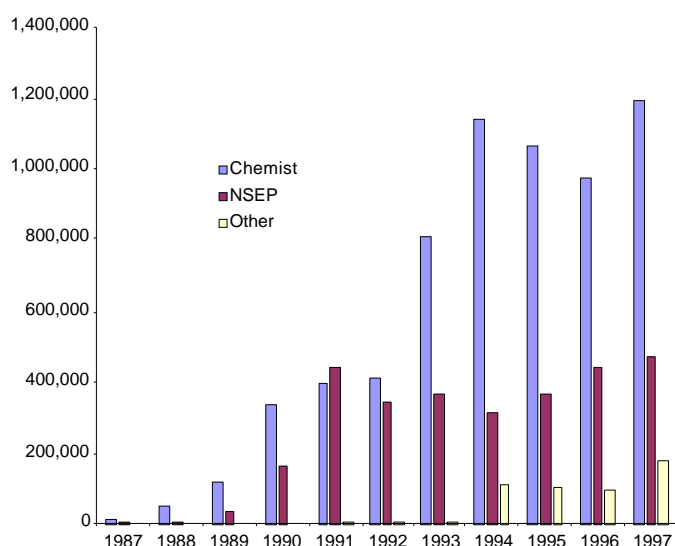
## Select Committee Into Misuse of Drugs Act 1981

**Table 8.24: Annual distribution of needles and syringes by type of outlet, WA, 1987 - 1997**

	Type of outlet							Total
	Chemist	NSEP	Hospital	Community Health Centre	Vending Machine	Nursing Post	Other	
1987	23,990	6,000	-	-	-	-	-	29,990
1988	59,380	12,000	-	-	-	-	-	71,380
1989	120,260	42,648	-	-	-	-	-	162,908
1990	340,355	171,031	-	250	-	-	-	511,636
1991	394,820	444,225	2,560	1,000	2,385	200	-	845,190
1992	420,150	349,806	7,400	-	1,920	-	-	779,276
1993	817,025	372,234	3,570	750	-	30	500	1,194,109
1994	1,144,710	322,983	39,985	6,605	63,535	1,250	1,250	1,580,318
1995	1,070,550	369,671	36,960	3,000	61,030	500	2,270	1,543,981
1996	983,325	447,750	45,775	4,500	45,960	250	4,290	1,531,850
1997	1,198,680	477,507	89,180	3,800	83,340	-	9,806	1,862,313
<b>1987-1997</b>	<b>6,573,245</b>	<b>3,015,855</b>	<b>225,430</b>	<b>19,905</b>	<b>258,170</b>	<b>2,230</b>	<b>18,116</b>	<b>10,112,951</b>

Source: Disease Control Service, Health Department of WA.

**Figure 8.10: Annual distribution of needles and syringes by type of outlet, WA, 1987 - 1997**



The success in the program in this State to maximise IDUs' access to sterile injection equipment is illustrated by the increase in the mean daily number of N&S distributed from 1988 (the first full year of data) up to 1997 were as follows:

- in 1988 there were 195;
- in 1989 there were 446;
- in 1990 there were 1,402;
- in 1992 there were 2,316;
- in 1992 there were 2,129;
- in 1993 there were 3,270;
- in 1994 there were 4,330;
- in 1995 there were 4,230;
- in 1996 there were 4,185; and
- in 1997 there were 5,102.

**Table 8.25: Quarterly distribution of needles and syringes by type of outlet, WA, 1987 - 1992**

Year	Quarter	NSEP	Chemist	Other	Total
1987	2	-	11,670	-	11,670
	3	3,000	4,080	-	7,080
	4	3,000	8,240	-	11,240
1988	1	3,000	3,430	-	6,430
	2	3,000	14,220	-	17,220
	3	3,000	15,190	-	18,190
1989	4	3,000	26,540	-	29,540
	1	3,000	28,210	-	31,210
	2	3,000	21,370	-	24,370
1990	3	16,587	30,500	-	47,087
	4	20,061	40,180	-	60,241
	1	24,610	60,975	250	85,835
1991	2	36,117	64,930	-	101,047
	3	42,894	104,700	-	147,594
	4	67,410	109,750	-	177,160
1992	1	91,945	97,530	-	189,475
	2	101,970	88,210	1,400	191,580
	3	124,677	108,780	1,960	235,417
1992	4	128,018	100,300	400	228,718
	1	98,729	112,160	2,000	212,889
	2	81,720	108,000	1,750	191,470
1992	3	85,179	93,150	2,050	180,379
	4	86,098	106,840	1,600	194,538

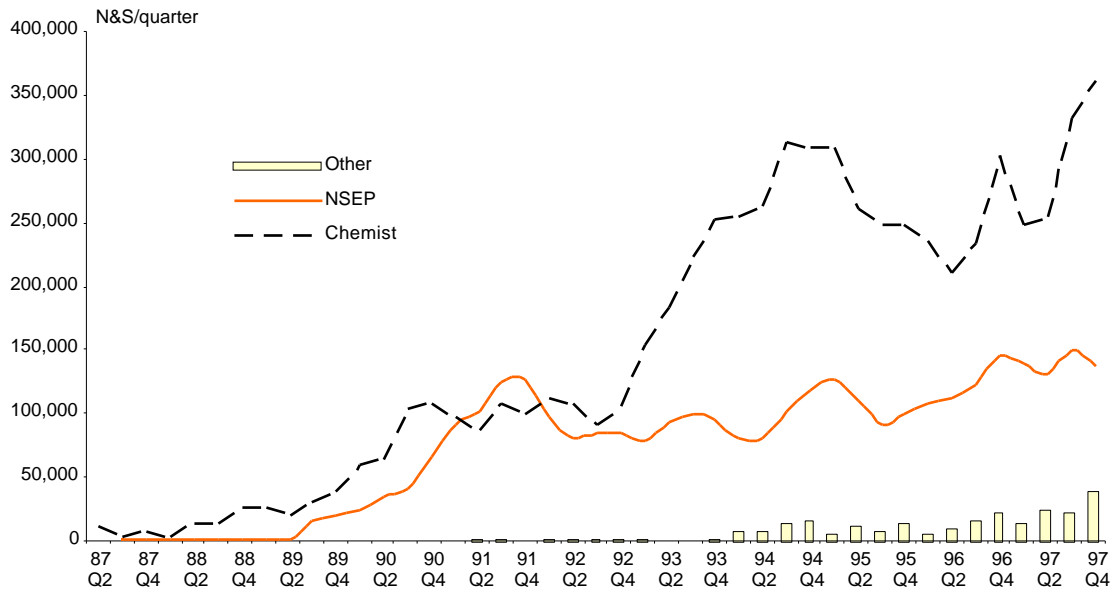
Source: Disease Control Service, Health Department of WA.

**Table 8.26: Quarterly distribution of needles and syringes by type of outlet, WA, 1993 - 1997**

Year	Quarter	NSEP	Chemist	Other	Total
1993	1	80,390	155,945	1,620	237,955
	2	95,212	183,705	630	279,547
	3	100,201	223,545	450	324,196
	4	96,431	253,830	2,150	352,411
1994	1	82,358	256,340	9,100	347,798
	2	82,144	264,760	9,400	356,304
	3	102,466	314,070	14,705	431,241
	4	119,550	309,540	15,885	444,975
1995	1	127,764	309,575	6,650	443,989
	2	110,203	261,860	13,290	385,353
	3	92,794	249,500	8,760	351,054
	4	99,940	249,615	14,030	363,585
1996	1	108,828	236,045	5,500	350,373
	2	113,817	210,500	9,840	334,157
	3	123,880	233,975	15,850	373,705
	4	147,185	302,805	23,625	473,615
1997	1	140,478	249,790	14,830	435,898
	2	132,526	254,875	24,655	412,056
	3	150,410	332,200	23,500	506,110
	4	137,433	361,815	39,801	571,579

Source: Disease Control Service, Health Department of WA.

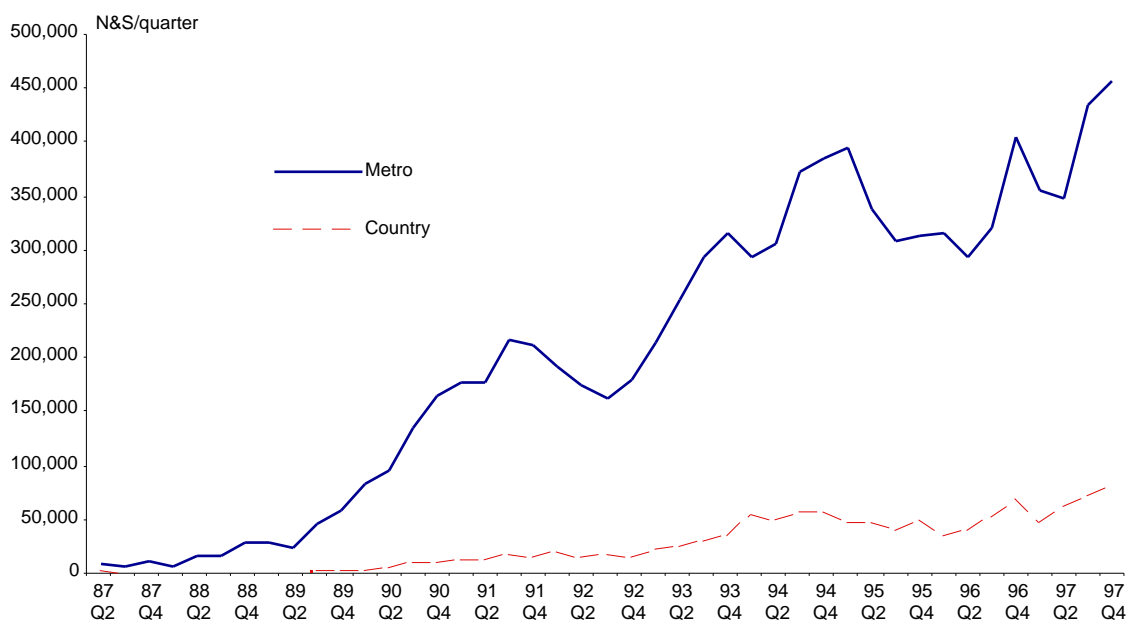
Figure 8.11: Quarterly distribution of needles and syringes by type of outlet, WA, 1993 - 1997



#### 8.5.4.4. Metropolitan and country areas

Just over one quarter of WA’s population live in the country. Over the period 1987 to 1997, a total of 8,978,886 N&S were distributed in the metropolitan area (Table 8.27). Over this same period, a total of 1,134,065 N&S distributed in the country areas (Table 8.28). This means that about nine out of every 10 bought by IDUs in this State were distributed in the metropolitan area.

Figure 8.12: Quarterly distribution of needles and syringes by metropolitan and country areas, WA, 1987 - 1997



The number of N&S provided per quarter to IDUs living outside the metropolitan area has gradually increased (Table 8.29; Table 8.30; Figure 8.12). Since December 1993, the proportion of N&S provided to IDUs in non metropolitan areas has remained above 10% of the total N&S each quarter, reaching about 15% in December quarter 1997 (Table 8.30). Overall, apart from the second quarter of 1987 (which was part of a trial distribution to all chemists, when 16.1% of N&S distributed went to country areas), relatively few N&S were distributed in country areas until about 1994.

**Table 8.27: Annual distribution of needles and syringes by type of outlet, metropolitan area, WA, 1987 - 1997**

	Chemist	NSEP	Other	Total
1987	21,915	6,000	-	27,915
1988	58,580	12,000	-	70,580
1989	116,760	42,648	-	159,408
1990	311,130	171,031	-	482,161
1991	339,750	446,610	-	786,360
1992	361,115	351,726	500	713,341
1993	707,275	372,234	750	1,080,759
1994	971,445	386,518	5,750	1,363,713
1995	919,140	430,701	9,285	1,359,126
1996	829,715	493,710	15,040	1,338,465
1997	1,007,405	560,847	29,306	1,597,558
<b>1987-1997</b>	<b>5,644,230</b>	<b>3,274,025</b>	<b>60,631</b>	<b>8,978,886</b>

Source: Disease Control Service, Health Department of WA.

**Table 8.28: Annual distribution of needles and syringes by type of outlet, country areas, WA, 1987 - 1997**

	Chemist	NSEP	Other	Total
1987	2,075	-	-	2,075
1988	800	-	-	800
1989	3,500	-	-	3,500
1990	29,225	-	250	29,475
1991	55,070	-	3,760	58,830
1992	59,035	-	6,900	65,935
1993	109,750	-	4,100	113,850
1994	173,265	-	43,340	216,605
1995	151,410	-	33,445	184,855
1996	153,610	-	39,775	193,385
1997	191,275	-	73,480	264,755
<b>1987-1997</b>	<b>929,015</b>	<b>-</b>	<b>204,550</b>	<b>1,134,065</b>

Source: Disease Control Service, Health Department of WA.

## Select Committee Into Misuse of Drugs Act 1981

**Table 8.29: Quarterly distribution of needles and syringes by metropolitan and country areas, WA, 1987 - 1992**

Year	Qtr	Metro	Country	Total
1987	2	9,645	2,025	11,670
	3	7,030	50	7,080
	4	11,240	-	11,240
1988	1	6,430	-	6,430
	2	17,220	-	17,220
	3	18,190	-	18,190
	4	28,740	800	29,540
1989	1	30,460	750	31,210
	2	24,370	-	24,370
	3	45,837	1,250	47,087
	4	58,741	1,500	60,241
1990	1	83,585	2,250	85,835
	2	95,822	5,225	101,047
	3	136,594	11,000	147,594
	4	166,160	11,000	177,160
1991	1	177,695	11,780	189,475
	2	178,420	13,160	191,580
	3	217,427	17,990	235,417
	4	212,818	15,900	228,718
1992	1	193,639	19,250	212,889
	2	175,720	15,750	191,470
	3	163,424	16,955	180,379
	4	180,558	13,980	194,538

Source: Disease Control Service, Health Department of WA.

**Table 8.30: Quarterly distribution of needles and syringes by metropolitan and country areas, WA, 1993 - 1997**

Year	Qtr	Metropolitan	Country	Total
1993	1	216,465	21,490	237,955
	2	253,867	25,680	279,547
	3	293,821	30,375	324,196
	4	316,606	35,805	352,411
1994	1	294,408	53,390	347,798
	2	307,864	48,440	356,304
	3	374,461	56,780	431,241
	4	386,980	57,995	444,975
1995	1	395,784	48,205	443,989
	2	337,873	47,480	385,353
	3	310,594	40,460	351,054
	4	314,875	48,710	363,585
1996	1	316,618	33,755	350,373
	2	294,067	40,090	334,157
	3	322,740	50,965	373,705
	4	405,040	68,575	473,615
1997	1	357,003	48,095	405,098
	2	349,256	62,800	412,056
	3	434,530	71,580	506,110
	4	456,769	82,280	539,049
<b>1987 - 1997</b>		<b>8,979,386</b>	<b>1,133,565</b>	<b>10,112,951</b>

Source: Disease Control Service, Health Department of WA.

### 8.5.4.5. Selected country areas

The Select Committee has been provided with results of analysis undertaken by the WADASO who were provided with a copy of the updated copy of the N&S database managed by the Disease Control Service, Public Health Division of the HDWA. The following analysis deals with those major country areas by postcode which have been involved in distributing N&S over the period 1993 to 1997. It should be noted that regional totals may be unreliable, as in some areas where N&S are not available, IDUs may purchase them from areas where supplies are available.

The areas included are those where more than 2,000 N&S were purchased. Five areas (by postcode) accounted for the majority of the sales of N&S in 1997 in this State as follows (Table 8.31):

- a total of 108,415 N&S were purchased in the Kalgoorlie-Boulder area (6430 - 6432);
- a total of 44,285 N&S were purchased in the Mandurah area (6210);
- a total of 31,840 N&S were purchased in the Bunbury area (6230);
- a total of 18,220 N&S were purchased in the Geraldton area (6530); and
- a total of 15,025 N&S were purchased in the Busselton-Margaret River area (6280 - 6285).

A more detailed understanding of trends in quarterly totals from 1993 to 1997 is contained in Table 8.33. It can be seen that over the 5 year period, the greatest number of N&S each quarter has been purchased in the Kalgoorlie-Boulder area. Over the period, there has been an overall increase in the number of N&S purchased in three areas (Bunbury, Mandurah and Busselton-Margaret River), whereas decreases have occurred both in Geraldton and Albany.

From 1993 to 1997, these changes have been as follows:

- a more than three fold increase for the Kalgoorlie-Boulder area (6430 - 6432);
- nearly doubling for the Mandurah area (6210);
- an increase of nearly four and a half times for the Bunbury area (6230);
- a decrease of nearly one fifth for the Geraldton area (6530);
- an increase of nearly three and a half times for the Busselton-Margaret River area (6280 - 6285); and
- a decrease of just over one third for the Albany area (6330).

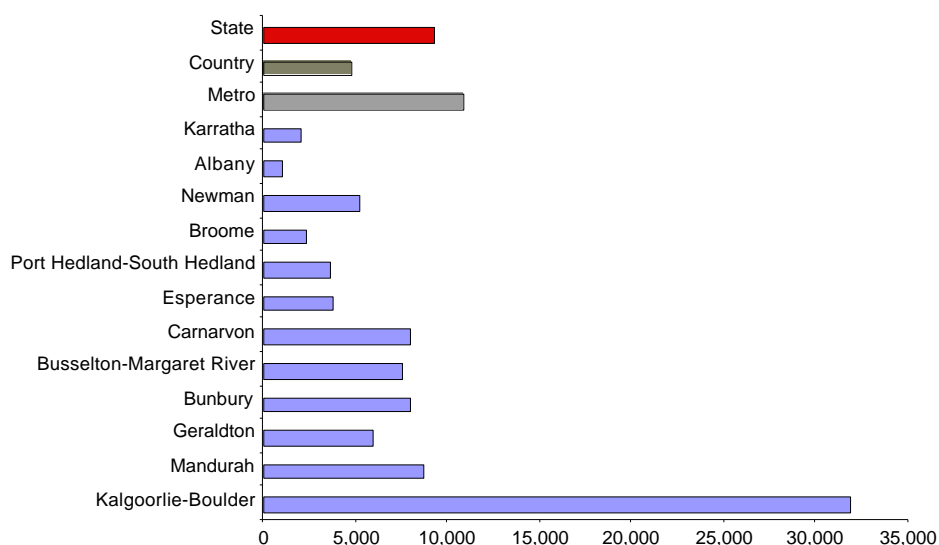
Trends in the 5 year period of purchases of N&S for each area are provided in Figures 8.14 to 8.19.

**Table 8.31: Annual distribution of needles and syringes by selected country areas, WA, 1993 - 1997**

Locality	Postcode	1993	1994	1995	1996	1997
Kalgoorlie-Boulder	6430-6432	32,375	77,590	59,310	64,710	108,415
Geraldton	6530	21,830	30,330	18,745	19,635	18,220
Mandurah	6210	22,215	29,800	32,675	34,095	44,285
Busselton-Margaret River	6280-6285	4,555	10,270	8,820	10,020	15,025
Bunbury	6230	7,085	25,610	18,855	21,450	31,840
Carnarvon	6701	3,700	5,500	2,940	6,080	7,020
Broome	6725	3,270	4,560	3,545	3,740	4,220
Esperance	6450	2,955	3,280	4,950	5,010	6,865
Albany	6330	4,625	7,085	3,900	3,120	2,930
Karratha	6714	1,680	3,140	3,510	4,130	2,110
Port Hedland-South Hedland	6721-6722	2,360	4,970	13,615	12,525	13,105
Newman	6753	845	1,350	1,250	1,340	2,885

Source: Disease Control Service, Health Department of WA.

**Figure 8.13: Crude rates of distribution of needles and syringes by selected non metropolitan areas, WA, 1997**



An overview of variations between these areas by the crude rates for 1997 is provided in Figure 8.13. This analysis indicates a rate for the Kalgoorlie-Boulder area of 37,392 N&S per 10,000 population,<sup>459</sup> which is 3.5 times the mean State crude rate of 10,550 N&S per 10,000 population.

It is to be noted that the Kalgoorlie-Boulder and Mandurah areas were the only non metropolitan areas which had crude rates which were above the *mean State crude rate* (10,550 N&S per 10,000 population). A number of non metropolitan areas had crude rates above the *mean country crude rate* (5,631 N&S per 10,000 population), as indicated in Table 8.32.

**Table 8.32: Number and crude rates of distribution of needles and syringes by selected non metropolitan areas, WA, 1997**

Area	Postcode	N&S	Population	Crude rate	Rate ratio (area:State)
Kalgoorlie-Boulder	6430-6432	108,415	28,994	37,392	3.5
Mandurah	6210	44,285	40,717	10,876	1.0
Geraldton	6530	18,220	30,061	6,061	0.6
Bunbury	6230	31,840	39,619	8,037	0.8
Busselton-Margaret River	6280-6285	15,025	19,804	7,587	0.7
Carnarvon	6701	7,020	8,786	7,990	0.8
Esperance	6450	6,865	11,809	5,813	0.6
Port Hedland-South Hedland	6721-6722	13,105	13,168	9,952	0.9
Broome	6725	4,220	13,455	3,136	0.3
Newman	6753	2,885	5,476	5,268	0.5
Albany	6330	2,930	26,167	1,120	0.1
Karratha	6714	2,110	10,333	2,042	0.2
Metro		1,597,558	1,295,092	12,335	1.2
Country		264,755	470,164	5,631	0.5
<b>State</b>		<b>1,862,313</b>	<b>1,765,256</b>	<b>10,550</b>	<b>1.0</b>

Note: Rate per 10,000 population based on 1996 Census data by postcode

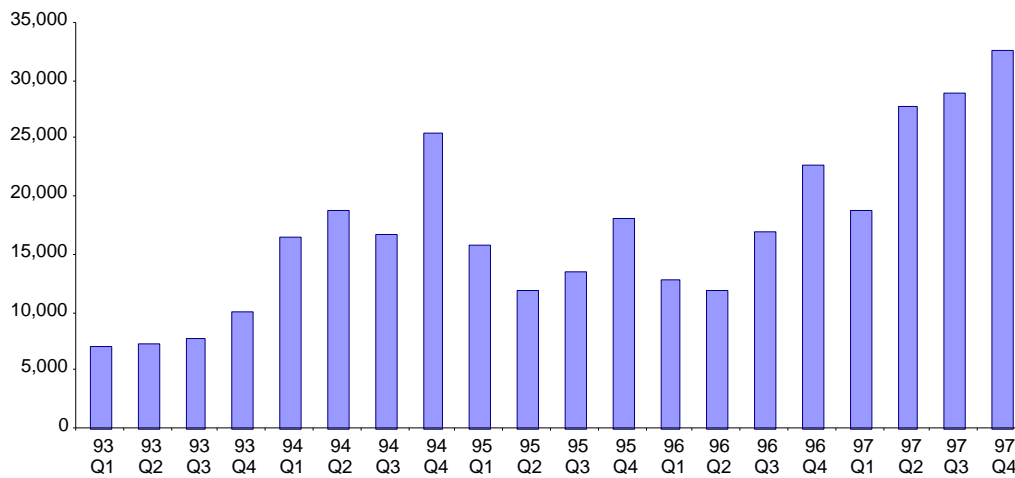
<sup>459</sup> Based on 1996 postcode data.

**Table 8.33: Annual distribution of needles and syringes ranked by 6 non metropolitan areas, WA, 1993 - 1997**

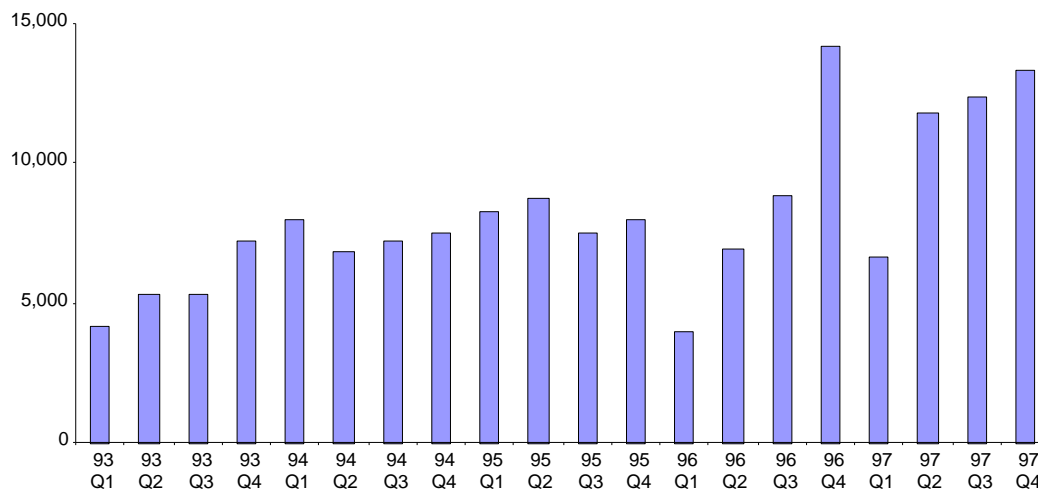
	Kalgoorlie- Boulder 6430-6432	Mandurah 6210	Bunbury 6230	Geraldton 6530	Busselton- Margaret River 6280-6285	Albany 6330
<b>1993</b>						
Qtr 1	7,100	4,225	1,200	4,265	660	840
Qtr 2	7,345	5,375	1,555	5,365	1,155	810
Qtr 3	7,885	5,370	1,530	5,900	1,375	1,555
Qtr 4	10,045	7,245	2,800	6,300	1,365	1,420
<b>Total</b>	<b>32,375</b>	<b>22,215</b>	<b>7,085</b>	<b>21,830</b>	<b>4,555</b>	<b>4,625</b>
<b>1994</b>						
Qtr 1	16,500	8,025	7,230	8,310	2,570	1,910
Qtr 2	18,790	6,915	6,695	5,815	2,420	1,390
Qtr 3	16,720	7,285	6,705	10,665	2,890	2,635
Qtr 4	25,580	7,575	4,980	5,540	2,390	1,150
<b>Total</b>	<b>77,590</b>	<b>29,800</b>	<b>25,610</b>	<b>30,330</b>	<b>10,270</b>	<b>7,085</b>
<b>1995</b>						
Qtr 1	15,810	8,320	5,875	5,110	1,890	1,450
Qtr 2	11,870	8,775	5,055	4,420	3,100	645
Qtr 3	13,485	7,570	3,425	4,430	1,790	780
Qtr 4	18,145	8,010	4,500	4,785	2,040	1,025
<b>Total</b>	<b>59,310</b>	<b>32,675</b>	<b>18,855</b>	<b>18,745</b>	<b>8,820</b>	<b>3,900</b>
<b>1996</b>						
Qtr 1	12,995	4,050	3,715	3,595	2,080	705
Qtr 2	11,880	6,950	4,440	5,110	2,335	455
Qtr 3	16,985	8,860	4,970	5,515	2,885	395
Qtr 4	22,850	14,235	8,325	5,415	2,720	1,565
<b>Total</b>	<b>64,710</b>	<b>34,095</b>	<b>21,450</b>	<b>19,635</b>	<b>10,020</b>	<b>3,120</b>
<b>1997</b>						
Qtr 1	18,970	6,685	5,480	4,290	3,200	670
Qtr 2	27,850	11,845	6,590	4,695	3,135	745
Qtr 3	28,925	12,400	8,745	5,225	4,655	450
Qtr 4	32,670	13,355	11,025	4,010	4,035	1,065
<b>Total</b>	<b>108,415</b>	<b>44,285</b>	<b>31,840</b>	<b>18,220</b>	<b>15,025</b>	<b>2,930</b>

Source: Disease Control Service, Health Department of WA.

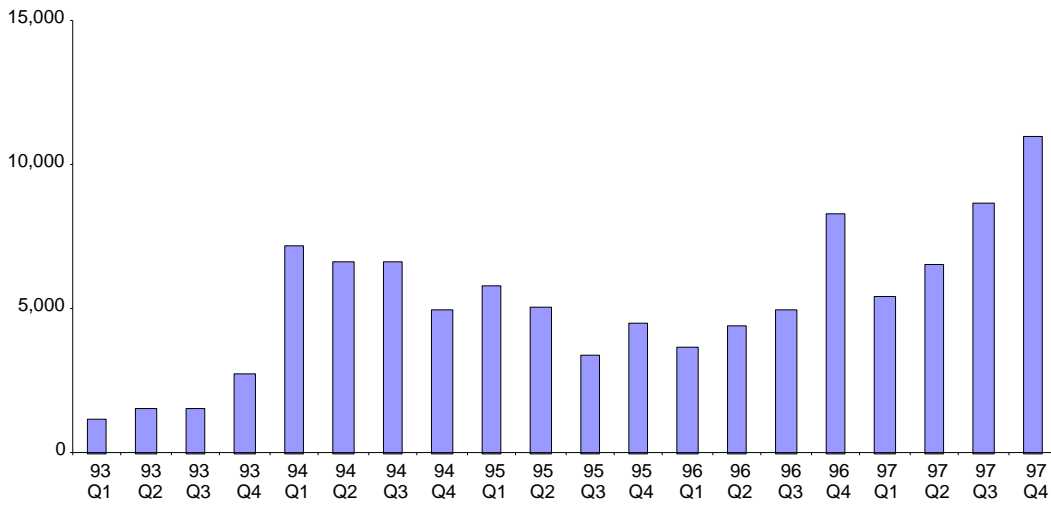
**Figure 8.14: Quarterly distribution of needles and syringes, 1993 - 1997  
Kalgoorlie - Boulder postcode area**



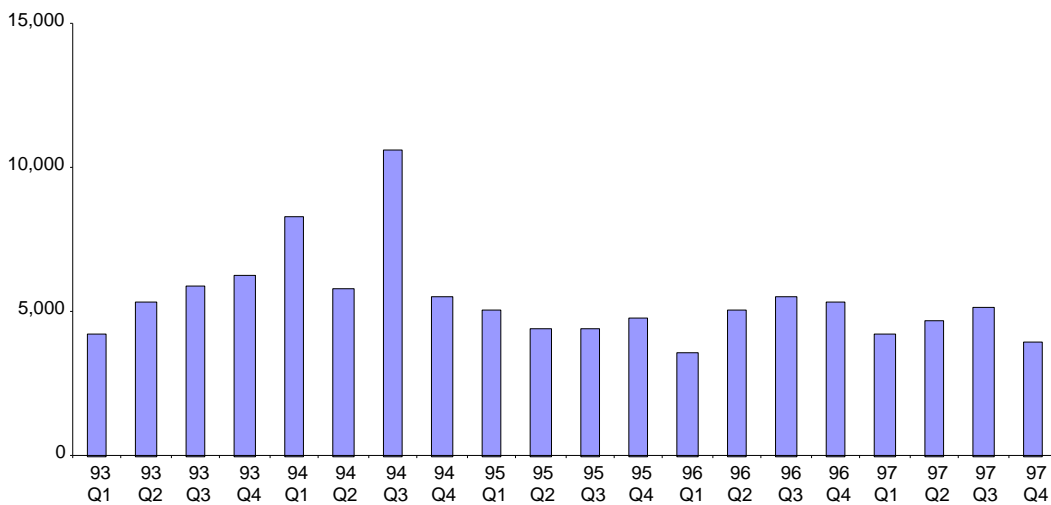
**Figure 8.15: Quarterly distribution of needles and syringes, 1993 - 1997  
Mandurah postcode area**



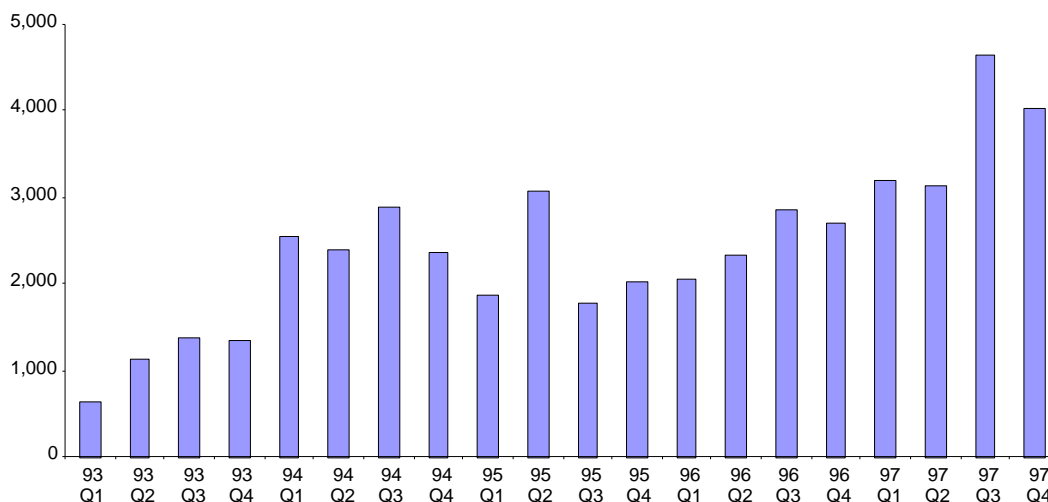
**Figure 8.16: Quarterly distribution of needles and syringes, 1993 - 1997  
Bunbury postcode area**



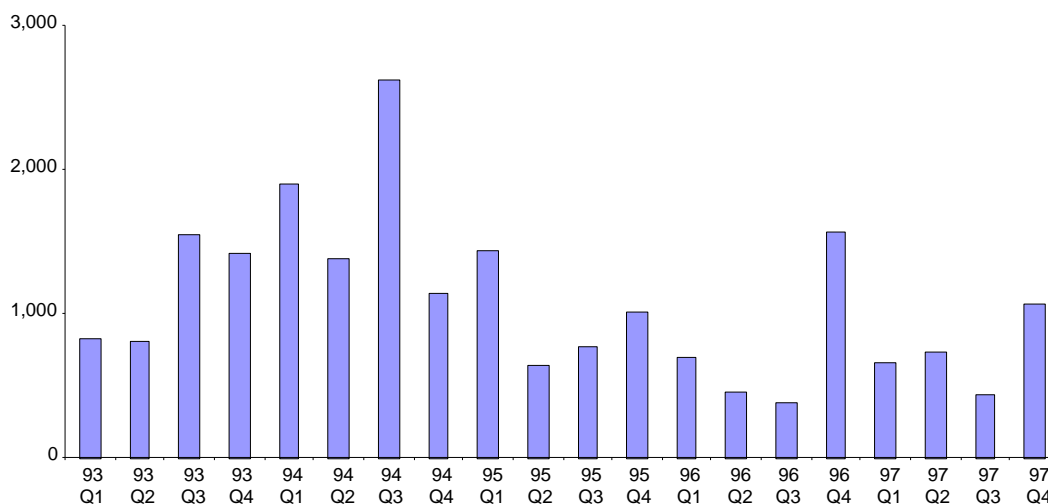
**Figure 8.17: Quarterly distribution of needles and syringes, 1993 - 1997  
Geraldton postcode area**



**Figure 8.18: Quarterly distribution of needles and syringes, 1993 - 1997  
Busselton - Margaret River postcode area**



**Figure 8.19: Quarterly distribution of needles and syringes, 1993 - 1997  
Albany postcode area**



## 8.6. Indigenous people

### 8.6.1. Introduction

Illicit drug use, in particular injecting drug use, is an important and emotive issue in many indigenous communities. The health and social effects of illicit drug use are diverse and complex in nature. Communicable diseases, infectious and parasitic diseases including pneumonia, influenza, meningitis, kidney infections and HIV/AIDS show the largest differentials in indigenous:non indigenous mortality.<sup>460</sup>

<sup>460</sup> Anderson et al *Mortality of indigenous Australians*. Cat No. 3315.0. Canberra, Australian Bureau of Statistics, 1996.

## 8.6.2. Injecting drug use

Indigenous mortality rates for these diseases are about 12 times higher than in the total Australian population. The main way of transmitting HCV is by the sharing of contaminated equipment through injecting drug use. A national survey found HCV prevalence among indigenous IDUs to be 72% (34 out of 47) in 1995 and 70% (46 out of 66) in 1996.<sup>461</sup> This data has important implications for unsafe injecting drug use practices, in particular, for people in custodial settings.

The Select Committee was assisted in investigation of the special needs of Aboriginal peoples in relation to illicit drug from evidence provided at a hearing by representatives who were involved in the management of the mobile NSEP operated by the Perth Aboriginal Medical Service. This testimony confirmed the Aboriginal community has identified that illicit drugs are of deep concern, particularly in relation to injecting drug use. To the credit of PAMS and other organisations, measures have been implemented to try to reduce the serious health problems that could arise through failure to use non sterile injecting equipment.

These problems are not confined to the metropolitan area, as on its visits to both Geraldton and Kalgoorlie, the Select Committee met with health care workers from the Aboriginal medical services in both towns. While it was apparent that volatile substance abuse was of particular concern in Kalgoorlie, there is evidence that the abuse of other illicit drugs, such as amphetamines, is closely related to offending. As noted earlier, the Select Committee was informed by staff on its visit to Rangeview Remand Centre of similar concerns about the extensive abuse of alcohol and illicit substances.

## 8.6.3. National surveys

Given the difficulties of being able to obtain sufficient information with the time frame and limited resources available to the Select Committee, data from a recent national survey has been utilised to develop a picture of the nature of problems. In 1989, the National Aboriginal Health Strategy (NAHS) identified the misuse of psychoactive drugs, in particular heroin, as a major emerging concern in Australia's indigenous population.<sup>462</sup> The NAHS documented that heroin use was a significant problem in the indigenous community in Sydney from as early as 1982 and information, at that time, suggested that heroin use was becoming a problem in other indigenous communities, especially urban, outside of New South Wales.

In 1994, the National Drug Strategy Household Survey (NDSHS) Urban Aboriginal and Torres Strait Island Supplement found that for the Aboriginal population:

- 51% have tried at least one illicit drug (24% being current users) compared with 38% of the general population;
- 19% have tried at least one illicit drug other than cannabis (6% being current users); and
- 12% have tried at least one "hard" drug (3% - 4% being current users) - this was similar in both populations. The only exception to this was for prescription drugs, for which females were either likely or more likely to be current users.

The extent of poly drug use is also an increasing concern for illicit drug use within the indigenous community. While not specifically considered by the NDHS, this issue was dealt with in the Nu Hit Report, a regional study of injecting drug use among the Nunga community in South Australia.<sup>463</sup> This data suggests that amphetamines and other designer drugs are likely to be used in

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<sup>461</sup> ANCARD Working Party. *The national indigenous Australian's sexual health strategy, 1996-97 to 1998-99*. Canberra, Department of Human Services and Health, 1997.

<sup>462</sup> This section draws on information published in Office for Aboriginal and Torres Strait Islander Health Services. *Review of the Commonwealth's Aboriginal and Torres Strait Islander substance misuse program*. Canberra, Department of Health & Family Services, 1998.

<sup>463</sup> Lane J. Nu-Hit. *Nunga users HIV intervention team. A report for the AIDS Council of South Australia*. Adelaide, AIDS Council of South Australia, 1992-93.

## Select Committee Into Misuse of Drugs Act 1981

combination. However, it should be noted that reliable data on illicit drug use is difficult to collect given the very small sample numbers and the illegal nature of this type of drug use.

Table 8.34 indicates the differential mean ages that indigenous and non indigenous peoples first tried different illicit drugs. For every drug, with the exception of amphetamines (ie speed), indigenous peoples reported use at an earlier age. The available data also suggests that approximately half of all indigenous Australians who have ever tried illicit drugs, are current consumers of an illicit drug.

**Table 8.34: Mean age first used illicit drugs, indigenous and non indigenous peoples, Australia, 1994**

	Indigenous peoples (1994)	Non indigenous people (1994)
Cannabis	18.2	19.4
Sleeping tablets	19.3	21.0
Pain killers	17.4	17.7
Petrol sniffing	14.4	not collected in 1993
Glue, other sniffing	14.1	not collected in 1993
Inhalants generally	see petrol, glue	16.9
Speed	19.5	19.0
Cocaine	18.5	21.6
Heroin	17.5	20.2
Hallucinogens	17.8	19.2
Designer drugs	18.0	22.3

Source: NDS Household Survey Urban Aboriginal and Torres Strait Islander Peoples Supplement 1994.  
NDS Household Survey 1993.

### **Cannabis**

However, statistically significant prevalence data on the use of cannabis is available. The 1994 NDS indicated that prevalence of cannabis use is more widespread in the indigenous community than in the non indigenous community, with nearly double the proportion of current users, and nearly triple the proportion of those using it at least weekly.<sup>464</sup>

This data suggests that just over one in five of the urban indigenous community currently use cannabis. As with the non indigenous community, indigenous males were more likely to have tried an illicit drug and to be current users than were indigenous females. The only exception to this was for prescription drugs, for which females were either as likely or more likely to be current users. When regional differences are taken into consideration, NSW residents (58%) had the highest proportion of illicit drug use compared with 49% in the Northern Territory and WA, and 45% in Queensland.

## **8.7. Indo Chinese community**

The WA Drug Abuse Strategy Office has commenced consultation and program development with the Vietnamese community. This will provide a model for program development with other ethnic communities.

The prevalence and incidence of drug abuse in the Vietnamese community is assessed as being a little greater than in the general community. Vietnamese people are subject to the same availability of alcohol and illegal drugs as others, but are also subject to the pressures affecting a recently established ethnic group, such as refugee trauma, cultural adaptation and pronounced generational conflict. Problems extend from alcohol abuse, through cannabis and other drugs to heroin abuse.

<sup>464</sup> National Drug Strategy Household Survey. *Urban Aboriginal and Torres Strait Islander Peoples Supplement*. Canberra, Department of Human Services & Health, 1994.

It is not likely that the Vietnamese community will use existing specialist alcohol and drug services to any great extent. The primary reason is the potential loss of face and subsequent shame upon exposure of the problem. Low usage of existing services is compounded by language and cultural gaps. With respect to parents concerned about drug use by young people, they are most reluctant to contact any services, particularly non Vietnamese services.

Up until now, a similar market in heroin as that which has occurred in recent years in Cabramatta and other suburbs in Sydney, and in Melbourne, has not developed in Perth, on the information provided to the Select Committee. However, to avoid such problems developing here, it is vital that a range of community based policing, education and outreach programs are developed to assist the Vietnamese community to prevent young people becoming involved in heroin.

The WADASO has attempted to address these concerns based on the experience in Melbourne and Sydney through education and treatment provided through existing Vietnamese community services, as follows.

***Education to prevent drug abuse***

Education as currently provided for parents to increase their knowledge about drugs and their capacity to deal with the issues needs to be available through Vietnamese language publications and outlets. This information is being sought from existing translated material available interstate and will be disseminated through community centres and ethnic media.

***Education to reduce harm among drug users***

Education as currently provided for drug users needs to be available in Vietnamese. This information is being sought from existing translated material available interstate and will be available through community service providers.

Up to five Vietnamese agencies have been identified which can be engaged in a program of education to enhance their skills to provide intervention to treat alcohol and other drug problems. This approach needs to be supported by ongoing education, consultation and shared care arrangements with CDSTs.

A well publicised heroin related death of a 17 year old Vietnamese young man occurred in Perth's northern suburbs in 1997. The Select Committee also received evidence from witnesses working in the youth area of concern about the abuse of Rohypnol, other sedatives and benzodiazepines obtained on prescription among Vietnamese young people. It is possible some of this prescribing is in response to heroin use, with medication being provided through GPs and/or diverted to the black market, to provide symptomatic relief for heroin withdrawal. This apparent reluctance by those who are experiencing problematic drug use may suggest there is a reluctance to attend mainstream services.

The Select Committee notes that in Victoria funding formulae specify targets for providers to provide services to prevent and treat alcohol and other drug problems in the NESB population. The inclusion of a condition in one or more CDST contracts would be an option to ensure that a spectrum of programs are implemented to develop close relationships with the Vietnamese community, develop treatment expertise and through outreach work target hard to reach young people.

***Recommendation 36***

***That there needs to be a range of measures which specifically target the Vietnamese community to address treatment and preventive aspects. These measures need to be developed at a number of levels, including NSEB stipulations in contracts with designated service providers, engagement of local networks and community groups, and the employment of workers from the community, especially those able to engage young people.***

## 8.8. Harm minimisation

### 8.8.1. Introduction

In recent years, and particularly the last decade, the concept of harm minimisation<sup>465</sup> has been regarded as the principle that should underpin all drugs policy. Harm minimisation has been variously described, but the approach was perhaps best summarised by the then Federal Minister for Health, Dr Neal Blewett, at an early stage of the National Campaign Against Drug Abuse.

*“The National Campaign has as its aim to minimise the harmful effects of drugs on Australian society: its ambition is thus moderate and circumscribed. No utopian claims to eliminate drugs, or drug abuse, or remove entirely the harmful effect of drugs, merely ‘to minimise’ the effect of drug abuse on a society permeated by drugs.”<sup>466</sup>*

The ACT Drug Strategy notes that its strategy is based on a concept of harm minimisation:

*“Integral to this concept is the recognition that drug use occurs along a continuum and that abstinence is not an acceptable or desirable goal for all people. As such any drug policies and programs should strive to minimise the actual and potential harms associated with alcohol and other drug use, not just aim to eliminate use. In some cases, this may mean encouraging people to not start, or to stop the use of specific drugs, in other cases to use the drugs in a different manner or in different circumstances. For example, young people are discouraged from using alcohol, and adults, when they use alcohol, are encouraged to do this in a manner which will not increase the risks of immediate harm (such as road crashes, violence) and the longer term harm (such as alcohol related brain damage, alcohol dependency syndrome).”*

In some ways there is little new about harm minimisation. It can be argued that it has always been a generally accepted strategy for both individuals and the community: most individuals have aimed to keep their alcohol intake below harmful levels and/or avoid driving after drinking; the community has long accepted harm minimisation measures ranging from liquor licensing laws to reduction of cigarette tar, nicotine and carbon monoxide yield.

With the advent of HIV/AIDS since the late 1980s harm minimisation has led to acceptance of a number of strategies designed to reduce the risks for those people who continue to use illicit drugs, including activities such as needle and syringe exchange schemes. A leading British medical historian writing on historical perspectives on harm reduction, commented that:

*“Some commentators have argued that AIDS has changed the direction of drug policy. The only examples of AIDS overriding established policy objectives have been in the field of drugs. The Government had abandoned its previous stance of augmenting its restrictive and punitive policies on drugs now that AIDS had come to be seen as the greater danger.”<sup>467</sup>*

A Commonwealth draft discussion document released in May 1998 provides a helpful overview of the significance of harm minimisation across health and law enforcement strategies. The following extract from this report is reproduced below.<sup>468</sup>

*“Both licit and illicit drugs are the focus of Australia’s harm minimisation strategy. Harm minimisation includes preventing anticipated harm and reducing actual harm. Harm minimisation is therefore consistent with a comprehensive approach to drug related problems,*

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<sup>465</sup> Also referred to by the term harm reduction.

<sup>466</sup> NCADA: *Assumptions, arguments and aspirations*. Canberra, Australian Government Publishing Service, 1987.

<sup>467</sup> Berridge V. “Harm reduction: an historical perspective.” (1992) *National AIDS Bulletin*.

<sup>468</sup> Intergovernmental Committee on Drugs. *National drug strategic framework 1998 – 2002. A community partnership on drugs. Draft discussion document for public comment*. Canberra, Department of Health and Family Services, May 1998. [<http://www.health.gov.au/pubhlth/strateg/drugs/ndsfi/index.htm>]

*involving a balance between demand reduction, supply reduction and harm reduction strategies.*

*Harm minimisation has been the philosophy underpinning Australia's drug strategy since 1985 and was identified by Single and Rohl<sup>469</sup> as one of the strengths of the NDS. Harm minimisation is an approach that aims to reduce the adverse health, social and economic consequences of alcohol and other drugs by minimising harms associated with drug use for both the community and the individual. Harm minimisation recognises the need to provide a wide range of approaches for dealing with drug problems including initiatives aimed at preventing uptake of drug use through education and law enforcement abstinence oriented interventions aimed at reducing drug use interventions aimed at reducing the supply of illicit drugs and a variety of strategies aimed at reducing the harmful consequences of drug misuse.*

*Where drug use has already commenced, harm minimisation strategies include a range of messages such as cessation of drug use, reducing consumption, drug substitution programs, for example methadone treatment and other pharmacotherapies, the provision of sterile injecting equipment through needle and syringe exchange programs to prevent infections such as hepatitis and HIV/AIDS; and education about safer administration/use practices. Such strategies also provide a means for establishing contact with drug users and an opportunity to provide education, counselling or advice on access to treatment. The philosophy of harm minimisation also applies in the context of treatment and care, by encouraging individuals to modify their lifestyles and to maximise their wellbeing.*

*Harm minimisation strategies in the area of law enforcement include the implementation of initiatives to reduce the supply of illegal drugs and the enforcement of laws that reduce drug related harm, such as random breath testing. Law enforcement agencies also conduct primary prevention programs through the national police community drug education programs.*

*Under the harm minimisation philosophy, governments do not support illegal or risky behaviours such as injecting drug use. Rather, governments acknowledge that where these risky behaviours continue to occur, they have a responsibility to develop and implement public health and law enforcement measures designed to minimise the harm that such behaviours can cause, both to individuals and the community.*

*A comprehensive approach must take into account three interacting components: the individuals involved, their social, cultural, physical and economic environment, and the drug itself. Approaches for reducing harm will, therefore, differ across target groups, time and location. For example, strategies for reducing harm to underage drinkers will be entirely different from strategies targeting an older smoker. Similarly, different strategies may be required to access injecting drug users in rural Queensland from those in metropolitan Sydney."*

## **8.8.2. West Australian approach**

### **8.8.2.1. Introduction**

Certainly over time, and perhaps partly due to the seriousness of the HIV/AIDS crisis, harm minimisation has come to be associated with the view that it is more important to reduce the risk to continuing users (particularly of illicit drugs) and the broad community, than to achieve a reduction in use per se. A problem arises, however, when the aim of harm minimisation is interpreted as being to reduce some or all of the consequences of drug use without a commitment to reducing use. This view was recently summed up in the following terms.

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<sup>469</sup> Single E, Rohl T. *The National Drug Strategy: mapping the future. An evaluation of the National Drug Strategy 1993-97.* Canberra, Australian Government Publishing Service, 1997.

*“(T)he essential feature of harm reduction is that it involves an attempt to ameliorate the adverse health, social and economic consequences of mind altering substances without necessarily requiring a reduction in the consumption of these substances.”<sup>470</sup>*

In WA, there has been a modification to the broad national consensus that had developed under the National Drug Strategy about the weight given to the principles of harm minimisation. This perspective attempts to take account of concerns articulated by some that some harm reduction strategies carried out in isolation may assist in normalising drug use. If young people learn about safer ways of using illegal drugs without also learning about the importance of avoiding such use, they may draw the conclusion that it is quite acceptable for them to use such drugs. Similarly, while NSEPs are entirely appropriate as a means of reducing the risks of HIV/AIDS and other diseases, if they occur in the absence of strategies aimed at reducing use of illicit drugs and intravenous drug use they may be seen as encouraging continued use.

These concerns were outlined by the Task Force on Drug Abuse, as follows.

*“The reason for acting on drugs, whether legal or illegal, is not moral fervour. It is because these drugs can be dangerous both to individuals and to the community as a whole. Those at risk are not only the people who abuse drugs but also their families and the many others affected by the criminal and other consequences of drug abuse.*

*Society has a right to be protected from such harm, and accordingly this must be the first priority of an effective drugs control strategy ... The most fundamental objective of drug abuse control policy is taken to be protection of the community.”<sup>471</sup>*

### 8.8.2.2. Rational harm reduction

Accordingly the WA approach, referred to as rational harm reduction, is that the first priority is to achieve the lowest possible level of use, followed by the need to reduce harm for continuing users and the community. Rational harm reduction is seen as an important component of the overall approach, but not as the primary objective. This means recognising the importance of harm reduction, but also placing it in context. It should also be recognised that approaches to harm reduction will vary from substance to substance.

Rational harm reduction is intended to complement the primary objective of maintaining drug abuse at the lowest possible levels. It is not intended to be seen as an argument against programs or activities designed to reduce the spread of blood borne viruses such as HIV/AIDS, Hepatitis B and Hepatitis C. This approach is not intended to cast doubt on the importance of preventing the spread of HIV/AIDS. It is vital that these programs continue, alongside and in partnership with an effective drug control strategy.

Rational harm reduction is also an attempt to rebut criticism of those who warn against any use of illicit drugs, to imply that they are naive and to mock the concept of total abstinence from illicit drug use as utterly unrealistic. The fundamental premise is that both government policy and educational strategies should start from the position that illicit drug use is wrong, harmful, and to be avoided.

### 8.8.2.3. Together Against Drugs

The revised West Australian perspective is outlined in *Together Against Drugs*. The following harm minimisation principles underpin *Together Against Drugs*.

#### **Principle 1 - Protecting the community**

This means that the Government will seek to protect the community and individuals from drug abuse and its consequences.

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<sup>470</sup> Heather N et al (eds). *Psychoactive drugs and harm reduction: from faith to science*. 1993

<sup>471</sup> Western Australia, Task Force on Drug Abuse. *Protecting the community: the report of the Task Force on Drug Abuse. Vol 1*. Perth, Ministry of Premier & Cabinet, 1995 48-49.

**Principle 2 - Opposing drug abuse**

This means that the Government will continue to take a strong line in opposing any form of drug abuse, will resolutely maintain its absolute opposition to illegal drug use, and will ensure that clear and unequivocal messages are provided on all aspects of the drug control strategy.

**Principle 3 - Rational harm reduction**

This means recognising the need to take such action as is necessary to reduce the risks and harm to those continuing to use drugs and to the wider community, while ensuring that this does not encourage or normalise drug abuse.

**Principle 4 - Comprehensive approach**

This means that the Government will seek to tackle drug issues on all fronts, coordinate activity on drugs both within government agencies and in partnership with non-government organisations and the community at large.

### 8.8.2.4. Opposition to legalisation

There is much conjecture as to the possible impact of taking a softer line on illicit drugs, but no solid evidence to indicate that this would reduce the levels of drug use or consequent harm. Accordingly, the WA Government has emphasised its concern that proposals to decriminalise or sanction the use of illegal drugs might be taken to indicate support for normalisation. It follows that if some forms of illicit drugs became more acceptable, young people wanting to take risks might move on to experiment with more dangerous drugs.

Some commentators nevertheless assert that the simplest and most effective way to ‘solve’ illicit drug problems would be to legalise all such drugs. This, they argue, would result in an immediate end to the need for any government activity aimed at control, together with the costs attached, particularly in the areas of law enforcement and justice.

It is appropriate to draw comparisons between the consequences of tobacco use and those of an illicit drug such as heroin. Both are harmful to the user. Both are addictive. Tobacco has been available without constraint (other than legislation on sale to minors) since its discovery several centuries ago. After the introduction of mass produced cigarettes in the 1880s, its use became widespread; its health consequences make it the largest preventable form of death and disease in the community. There can be little doubt that if introduced now, its use would not be permitted.

Heroin is illegal; the number of heroin users is still far outweighed by the number of tobacco users; any government that moved towards legalising heroin or in any other way making it more accessible would be flying in the face of commonsense, and failing in its responsibility to the community.

One of the arguments most frequently used to oppose a firm line on illicit drug use is that the US experience shows such an approach to be doomed to failure. A number of arguments are articulated by proponents of this view.

- There is doubt about the evidence on the harmful consequences of some illicit drugs, particularly cannabis.
- The highly publicised War on Drugs approach in the United States has led to enormous expenditures with virtually no benefits, but many adverse consequences.
- Illicit drug use in the US is out of control.
- In Australia we already spend substantial sums on seeking to control illicit drug use.
- Australia should learn from the US experience by taking a more radical view: this would entail at the least decriminalisation of some illicit drugs, with a consequent reduction in law enforcement activity and costs (the positions argued range from decriminalisation of cannabis to total legalisation of all drugs).

It is grossly oversimplistic, however, to argue that legalisation would lead to a reduction in the problems associated with drug use. Some form of relaxation of prohibition might lead to a reduced need for law enforcement activity in the short term. However, in the longer term, this but would inevitably have a number of adverse consequences:

- increased levels of use;
- increases in the known harmful consequences from drug taking;
- an increased interest by those who promote illicit drugs in developing and promoting further products;
- a need for a specialised control system; and
- an increase in the associated costs to the community.

In addition to earlier concerns about illicit drug use, the advent of HIV/AIDS and recognition of the contribution made by illicit drug users to the spread of other diseases such as Hepatitis C means that we should be more rather than less vigilant to control intravenous drug use.

If illicit drugs were to be made available in a controlled manner, it would be necessary to develop all the apparatus of a licensing and control system: this in itself would (as in the case of alcohol) prove expensive, and inevitably entail costs related to effective enforcement and policing.

All this is not to argue that maintaining a firm approach on illegal drugs should occur in isolation or blindly. It should be clearly prioritised and accompanied by rational harm reduction strategies by a concern to ensure that penalties are appropriate to the scale of the offence, and by action on licit as well as illicit drugs. But the primary focus should be on discouraging use.

### **8.8.2.5. Comprehensive approach**

Strategies that are primarily aimed at reducing the risks and harm of drug abuse, both to those who are continuing to use drugs and to the wider community, are appropriate within the context of a comprehensive approach to tackling drug abuse.

It is essential that such strategies should be undertaken in a way that does not encourage or normalise drug abuse. This may affect the design of the strategies or involve the implementation of complementary strategies to offset any covert normalisation.

There are a range of harm reduction strategies that have been implemented in WA. These include the promotion of safe limits for drinking, laws restricting the sale of alcohol under certain circumstances such as to intoxicated persons, the provision of methadone maintenance treatment for heroin addiction, education on ways to reduce the risks associated with various forms of illicit drug use, and the provision of clean needles and syringes.

Complementary strategies to combat normalisation include comprehensive legislative frameworks for the regulation of alcohol supply and the prohibition of certain drugs, the provision of counselling opportunities for those accessing harm reduction treatments and interventions, and the inclusion of strong health warnings on packaging for clean needles and syringes.

The WA position on harm minimisation shares common ground but also has significant differences from the current policy of harm minimisation that underpins the National Drug Strategy.

Harm minimisation is presented as an overarching philosophy that has as its primary aim the minimisation of harm associated with drug abuse rather than a reduction in drug abuse per se. Harm minimisation nevertheless is defined as encompassing a range of strategies, from abstinence to safer drug using practices, that may be appropriate depending upon the particular circumstances. In contrast, the WA position recognises the legitimacy of harm reduction strategies but has as its first and foremost policy principle opposition to drug abuse.

## Chapter 9: School based drug education

“...the major health problems facing us are largely preventable, acquired in youth and attributed to a few types of behaviours, including those that lead to injuries, drug and alcohol abuse, poor nutrition and insufficient physical activity.”<sup>472</sup>

### 9.1. Introduction

The introduction of drug education programs in WA schools over the past decade has occurred through an incremental process that has involved the development of curriculum materials, training of teachers, and the incorporation of materials and delivery of content through the health curriculum. A hallmark of the process that has occurred since 1986 is the careful piloting, testing and evaluation of programs provided. This process has culminated in the formalisation of the School Drug Education Project (SDEP) in 1997, a key aspect of which is the participation of State schools, the Catholic school system and independent schools.<sup>473</sup>

The contents of this chapter mainly relate to the recent history of drug education in WA schools. Prior to 1986, drug education was fragmented and largely developed by individual schools (as there was no State program in drug education). It is worth noting that prior to 1986, as each school developed its own drug education program, the content and format varied, according to resources and the skills and interests of teachers within each school, consistent with the period. The approach followed in these type of programs was largely knowledge based.

### 9.2. History

#### 9.2.1. Health Education K-10 Syllabus

In 1986, the Education Department of WA (EDWA) developed the Health Education K-10 (ie kindergarten to year 10) syllabus. Compared to the earlier programs, the K-10 syllabus incorporated knowledge, attitudes and skills such as decision making, goal setting and enhancing self esteem. The syllabus was structured with gradated content, to match the development capabilities and needs of student according to their year level.<sup>474</sup> The major health skills developed through the K-10 health syllabus incorporate interpersonal and self management skills, as follows.

- *Self esteem maintenance.* This is regarded as a preventative strategy for a host of health compromising behaviours.
- *Communication skills.* This is developed within the context of a family and through peer relationships.
- *Group maintenance and process skills.* This component is to enhance interpersonal relationships.
- *Decision making skills,* encompassing lifestyle and life choice
- *Assertiveness skills.* Examples of these would be for a young person to refuse a drug or pressure to be sexually active.
- *Goal setting* as related to fitness, diet, lifestyle change and other health related issues.
- *Coping and stress management.* The purpose of this being for students to acquire relevant skills for health enhancement.
- *Self monitoring.* This would include a wide range of health behaviours and skills, for issues such as cancer and other diseases.

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<sup>472</sup> Jackson SA

<sup>473</sup> Information in this chapter draws upon a range of information provided to the Select Committee in submissions and other written materials about the development and the operation of the SDEP.

<sup>474</sup> The K-10 syllabus was adopted by 92% of State schools ACHPER/NHF 1993

In the early 1990s the drug education curriculum benefited from a number of studies which evaluated the impact of teacher training and development of resources and curriculum materials.<sup>475</sup> Examples of research included Commonwealth funding for the school development in health education project in 1991, which involved seven pilot schools in this State and a large scale project funded by Healthway.

### 9.2.2. WA school health project

The Healthway funding of about \$468,000 (for the period 1992 to 1996) enabled the participation of 120 West Australian schools in the WA School Health (WASH) project.<sup>476</sup> The WASH project involved the concept of the health promoting school, being a concordance between a school and its community. Key activities of the project involved intensive teacher training, policy development, school planning and the use of existing curriculum and resources. WASH also coincided with work at a national level to develop a national curriculum, which incorporated a statement of health and physical objectives for schools.<sup>477</sup> The national statement was customised for use in WA in 1993.

Drug education has also been shaped by developments in approaches to teaching. Such an example is the influence of outcomes based education, which focuses on describing what students have achieved and can do. Student outcome statements have been developed by EDWA and provide teachers with a tool which conceptualise the learning process as consisting of learning continuums.

In practice this means, as in the case of drug education, that the focus of teaching is on how to progress a student from their present level of achievement, to the next level. In the 1994/95 period the EDWA trialed outcomes for the health and physical education curriculum in more than 40 schools. Government schools in WA are currently planning for the implementation of student outcome statements over the next few years.

### 9.2.3. Other influences

Two recent influences on the direction of the drug education to be taught in WA schools, stimulated by a recommendation of the Task Force on Drug Abuse for the development of drug education as part of the mandatory curriculum, have been the formation in 1996 of the National Initiatives in Drug Education (NIDE) and the School Drug Education Task Force (SDETF).

The approach followed by both the NIDE and SDETF was to consolidate the school and community approach to drug education of the WASH project as part of a strategic plan to implement drug education across all sectors of the school system. The principles for the drug education curriculum have been consolidated in the draft West Australian Health and Physical Education Learning Area Statement (HPELAS) adopted by the Curriculum Council of WA.

These principles set out the minimum set of attitudes, knowledge and skills that should be taught in all schools in this State, with an explicit recognition that drug education is to be an integral component of the school curriculum. Major outcomes of HPELAS developed by the Curriculum Council are as follows.

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<sup>475</sup> Bremberg S. "Does school health education affect the health of students?" *Youth health promotion*.

<sup>476</sup> Cameron I, McBride N. "Creating health promoting schools: lessons from the Western Australian school health project." (1995) 5 *Health Promotion Journal of Australia* 4-10; Stafford K. "Implementing best practice in drug education: examples from the Western Australian school health project." In *Reshaping the future: drugs and young people*. Proceedings of a conference 29 September – 1 October 1996, University of Sydney; McBride N, Midford R, James R. "Structural and management changes that encourage schools to adopt comprehensive health promotion programs." (1995) 5 *Health Promotion Journal of Australia* 17-23; ; McBride N, Cameron I, Midford R, James R. "Facilitating health promotion in Western Australian schools: key factors for success." (1995) 5 *Health Promotion Journal of Australia* 11-16.

<sup>477</sup> Shilton T, McBride S, Cameron I, Hall M. "Advocacy for school health: the power of data." (1995) 5 *Health Promotion Journal of Australia* 24-29.

- Students know and understand health and physical activity concepts that enable informed decisions to be made in relation to health and physical activity.
- Students exhibit attitudes and values that promote personal and community health and participation in physical activity.
- Students demonstrate the movement skills and strategies for confident participation in physical activity.
- Students demonstrate self management skills which enable them to make informed decisions about health and physical activity.
- Students demonstrate the interpersonal skills necessary for effective relationships and healthy active lifestyles.

## **9.2.4. School Drug Education Project**

### **9.2.4.1. Introduction**

The School Drug Education Project (SDEP) was established in 1997 by the SDETF, providing goals and targets for the period 1997 - 2000, and is as such part of *Together Against Drugs*. The SDEP has been developed to ensure effective drug education is provided in all Western Australian schools, and embraces the 12 principles of best practice in school drug education.<sup>478</sup>

The SDETF has developed:

- principles of best practice for school drug education based on current national and international best practice, and consistent with the WA Strategy Against Drug Abuse policy framework; and
- a three year strategic plan (1997 - 2000) for drug education in the State.

The SDEP is a project of the Association of Independent Schools of Western Australia (AISWA), the Catholic Education Office and the Education Department of Western Australia. The implementation of the SDEP is being undertaken in a planned fashion, as provided in a strategic plan dealing with the period 1997 - 2000.<sup>479</sup>

There are a number of features of the SDEP, including:

- whole school drug policies and procedures to support classroom prevention programs;
- that school pastoral care services link with appropriate agencies to support students who have drug problems;
- the concept of a whole of school approach; and
- ongoing training of teachers.

### **9.2.4.2. Curriculum**

All school sectors are committed to the Curriculum Council's curriculum framework. Drug education is reflected in the HPELAS. The curriculum framework is currently being reviewed by the Curriculum Council as part of the 1997 school and community consultation phase. Preliminary feedback indicates that drug education is still represented strongly within the curriculum framework.

A review of effective primary school and secondary school drug education resources has occurred and all schools have received a drug education resource focus, a compendium of drug education materials. The aim of the drug education resource focus is to ensure that teachers have access to quality drug education support materials. This compendium supports teacher selection of materials appropriate to the age and background of the students. The reviewed resources range from full

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<sup>478</sup> School Drug Education Task Force. *Strategic plan 1997-2000*. Perth, Education Department of WA, 1997.

<sup>479</sup> School Drug Education Task Force. *Drug education: principles of best practice*. Perth, Education Department of WA, 1997.

## **Select Committee Into Misuse of Drugs Act 1981**

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programs to specific information sources. There are 25 primary, 77 secondary and 9 parent resources included in the compendium, as well as a selection of internet sites.

A teacher support curriculum document for years K-12 reflects the new outcome based approach to drug education. This draft document includes comprehensive lesson plans and strategies to assist teachers to plan and implement effective drug education. It is being piloted from Term one 1998 for introduction into all schools in 1999.

This document links directly to the Curriculum Council's curriculum framework and reflects current "best practice" in drug education. It is the first new outcomes based curriculum support material developed under the curriculum council framework.

### **9.2.4.3. Professional development**

The project has been designed so that schools can choose their level of professional development support. There are three models of support:

#### ***Health promoting schools for drug education (option A)***

This is targeted at school communities which have a priority in drug education. It provides an intensive, whole of school approach including teacher development, program development, policy development and the enhancement of supportive school community links.

During 1997 a total of 23 schools participated in this component of the project. During 1998, 90 schools are participating. It is expected that another 90 schools will become involved in 1999.

#### ***Teacher training in drug education (train the trainer) (option B)***

This provides professional development for metropolitan and regional teachers nominated by their schools throughout the state. Teachers receive specialist training that enables them to support other teachers in their school. They are also available to provide support for teachers from other schools in their region. Trainers attend 3 day professional development, and two 1 day network meetings.

In 1997, a total of 69 teachers were trained, with 102 teachers currently being trained in 1998. It is anticipated that another 90 teachers will be trained in 1999.

#### ***Regional drug education networks (option C)***

Regional management groups will be established and funded in all areas of the State in Semester 2 1998. Trained teachers who have undertaken professional development with the SDEP will form regional networks to provide ongoing training and support for schools in their regions. The role of regional management groups will be to consult with school staff to determine the drug education training needs of teachers in the region, collaborate with the regional networks to develop a professional development action plan, manage funding and implement training.

#### ***1997 program***

Option A: 23 schools (approx. 138 school based staff trained)  
Country cluster: Broome

Option B: 70 schools (70 trainers)

Total school year 1997 – Teacher professional development:	\$214,557
Total school year 1997 – Teacher PD – Option A:	\$103,673
Total school year 1997 – Teacher PD – Option B:	\$110,884

**1998 (Semester 1)**

Option A: 68 schools (approx. 408 school based staff trained)  
Country clusters: Albany and Bunbury

Option B: 108 schools (108 trainers)  
54 metropolitan trainers  
54 country trainers

**1998 (Semester 2)**

Option A: Approx. 15 schools (approx. 90 teachers)  
Lands schools (Aboriginal community schools – Kalgoorlie district)  
Initiative: 10 schools

Option C: Currently planning.

Teacher relief can be estimated at approximately \$160 per day. Other costs include travel and accommodation (which vary depending on where schools are located) and workshop costs (catering, venue hire, etc). Other miscellaneous costs (such as the purchase of resources) should also be included in a final estimate.

**Other projects currently in progress**

- Newsletter to all WA schools (4 times per year);
- School drug policy document (to all WA schools) – Semester 2 1998: Teacher support curriculum document (K-12) to all WA schools – term 1 1999;
- Home pack (developed in conjunction with the teacher support curriculum document) – to all WA schools – term 1 1999;
- Evaluation of SDEP; and
- Parent and community support.

#### 9.2.4.4. Drug policy and guidelines

Through the SDEP professional development strategies, schools are supported to develop a school drug policy to address the needs of their school community. These policies, once a part of school operations, serve to ensure ongoing commitment by the school to drug education, consistent approaches to dealing with drug use incidents and clarification of roles for school staff.<sup>480</sup>

It is estimated that the number of schools in WA that currently have a formal school drug/health policy is approximately 30%. The estimated number of SDEP schools who are currently developing or have in place drug policies is 85 - 95%.

A guide for the development of a school drug education policy and a manual (that provides direction to staff with regard to the referral of students for the appropriate counselling on drug issues) will be distributed and promoted to all schools in Term 3 1998.

#### 9.2.4.5. Parent and community participation

The SDEP has established, maintained and sought direction from a school drug education reference group. This group provides advice on issues relating to the project's strategic plan and has representatives from all school sectors, community groups, and key agencies and parent groups.

Materials are being developed for parents that link with the draft school curriculum resources. The aim of these parent materials is to involve parents in school drug education programs, and to encourage them to communicate with their children and school about drug issues. Parent materials are currently being trialed by 100 teachers in 69 schools.

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<sup>480</sup> Copies of a model school drug policy, and policies from two schools are contained in Appendix 1.

The professional development models of the project encourage school and community interaction to support drug education. Schools choosing the intensive health promoting schools for drug education model include the involvement of community members on school health promotion or drug education committees. This involvement keeps the community informed of school initiatives and allows for community impact on the school program.

Community drug service teams provide professional support to schools and local drug action groups (of which there are currently 37 around the State). These community groups are developing relationships with their local schools to provide input and encouragement for school drug education and policies.

### **9.2.4.6. Evaluation and monitoring**

The SDEP has established a comprehensive external evaluation plan, which includes both impact and process evaluation. This is currently out for tender.

All training sessions conducted by SDEP staff are being evaluated at the completion of each course to provide qualitative and quantitative information. Feedback is consistently very positive.

For example, results for the health promoting schools for drug education workshops (1997) indicated that:

- 87% considered that this program has increased or greatly increased their expertise in drug/health education;
- 90% of committee members (ie teachers, health coordinators, parents, administration staff and support staff) learnt new information from the workshops;
- 100% thought the presenters were organised and interesting; and
- 93% indicated that they had the opportunity to ask questions and clarify information.

Results from the evaluation of the initial teacher training in drug education workshop (1997) indicated that, on a scale of 1 to 5:

- learning new information from the workshop rated an average of 4.3;
- presenters organised and interesting – 4.8; and
- participants perceived an increase in drug education expertise – 4.1.

In 1998, the SDEP will develop additional materials to assist school communities in the internal monitoring of their drug education processes and outcomes.

### **9.2.4.7. Innovations**

An interesting aspect of the SDEP, consistent with the approach that drug education needs to extend beyond the confines of the classroom, is the provision of take home drug education materials for parents. This ensures that the content program provided through the school is complemented and reinforced outside the school context, particularly in the family. It is expected there may be important secondary gains from transmittal of preventive concepts to the wider community in the long term.

Another innovation of the SDEP is to develop regional training and support networks so that school based drug education programs can be complemented and supported by services from agencies and the wider community. A key concern for the long term viability of SDEP is to sustain an ongoing maintenance program that provides regular opportunities for teachers to receive training, revision of curriculum materials and support for drug education priorities as they arise in schools.

The Select Committee received evidence from a number of witnesses from the SDEP who indicated that it was essential that the SDEP receive adequate resources to achieve its goals. The

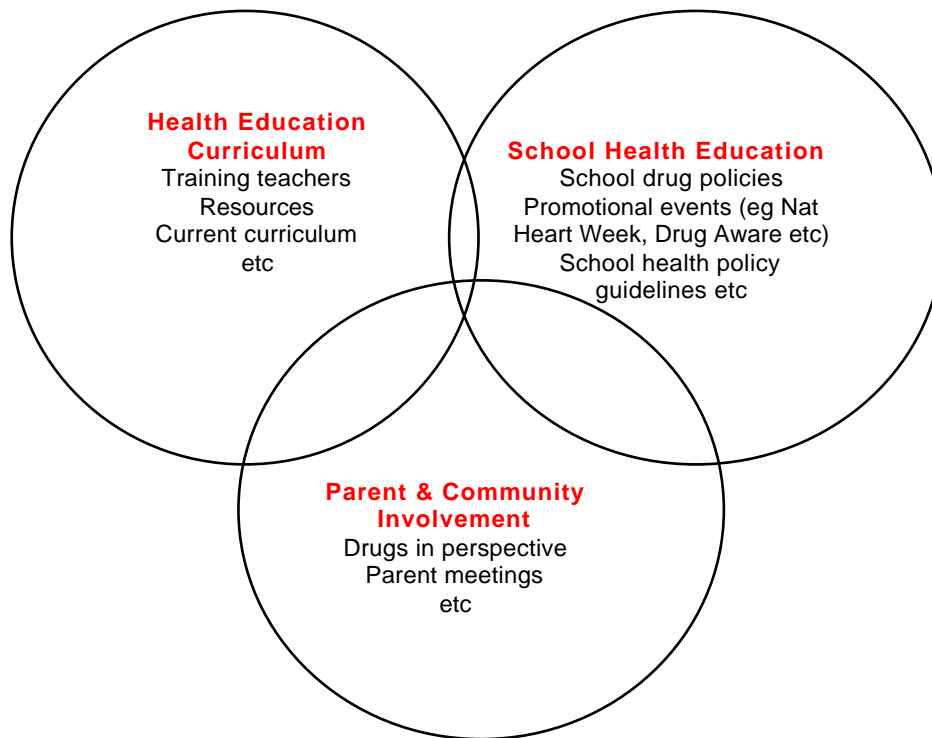
concept of the health promoting school relies on maintaining partnerships with the community and supporting agencies. The relationships between schools, parents, the community, the health education curriculum and school health education are detailed in Figure 9.1.

It was indicated that some of the resources that Life Education has been able to attract could be utilised to develop complementary activities in the community, rather than necessarily in the classroom. For instance, it was suggested that

*“we should look at other areas of the comprehensive school approach and get them (ie Life Education) working with school communities, engaging the local retailers not to sell to kids, and teaching people about not supplying alcohol to kids. We should use their energy and enthusiasm in areas where we need it. Something extra needs to be done.”<sup>481</sup>*

It is believed that Life Education has been actively engaged in discussions to broaden its role. While the van will still come to schools, it will remain on site so that it can be utilised to involve parents in evening discussions. The Life Education van has a high appeal with children and these arrangements will ensure that this aspect is maximised in order to support the broader role of regular teachers in teaching the drug education curriculum.

Figure 9.1: Model of health promoting schools



Another example of the way in which schools can develop partnerships with agencies is with the development of the icon Gurd being undertaken by the WA Police Service. The emphasis in this instance is to relate this resource to the school drug education curriculum in a way which supports the role of teachers. The primacy of the role of teachers was described to the Select Committee in the following terms.

*“Good drug education is good health education. In health education, students learn and practice skills to help them lead a healthy lifestyle. The skills they learn in health education include assertive communication, decision making, stress management, conflict resolution, self*

<sup>481</sup> Evidence to the Select Committee by Shelley Beatty. Transcript 15 April 1998, 41.

*esteem maintenance, goal setting, self monitoring etc. There is a wide range of health skills, and when children learn health education they apply these health skills to nutrition, safety, exercise and sexuality issues. Students need to learn these same skills with regard to their drug use. Therefore, drug education is best taught by the teacher who is already teaching children these skills. We need to be very careful when using outside resources and agencies. Teaching requires highly developed skills. Teachers train for a minimum of four years and someone cannot be given two days or two weeks' training and then be sent to a school to do drug education.*"<sup>482</sup>

Guidelines have been developed by the School Health Coalition to assist schools when they use guest speakers. The School Health Coalition is an organisation formed by agencies (such as the National Heart Foundation, Life Education and the HDWA), which are involved in the school health education curriculum.

#### **9.2.4.8. Regional relationships and linkages**

The SDEP will operate through a system of 16 school drug education regional management groups and corresponding school drug education teacher networks throughout WA. The relationship between these regional management groups and other regional structures are being implemented as part of *Together Against Drugs*. In the second term 1998, with the employment of a project officer, these relationships will be created through a number of structures and processes that include:

- development of regional management groups, in liaison with the SDEP management group, to ensure representation from all education systems and sectors, and both primary and secondary schools;
- establishing an operational framework to provide accountability processes to ensure that regional funding is spent according to best practice guidelines;
- the establishment and maintenance of corresponding regional school drug education teacher networks utilising previously SDEP trained teachers; and
- coordination of drug education professional development exemplars (half day/one day/two day) by other SDEP staff.

It is expected that management groups and corresponding drug education networks will be established for the start of Semester 2 1998 in the following regions:

##### **Metropolitan regions**

Cannington  
Fremantle  
Perth  
Swan

##### **Outer metro regions**

Peel  
Joondalup

##### **Country regions**

Albany  
Bunbury  
Esperance  
Goldfields  
Kimberley  
Midlands  
Midwest  
Narrogin  
Pilbara

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<sup>482</sup> Evidence to the Select Committee by Shelley Beatty. Transcript 15 April 1998, 17.

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### **Regional management group role**

The role of the regional management group is to consult with school staff to determine the drug education training needs of teachers in the region, collaboratively develop a professional development action plan, manage funding and implementation of the training. The plan will include the establishment and maintenance of a drug education teacher network. A key function of the regional management group is to ensure accountability of SDEP regional funding allocations to the SDEPMG.

### **Regional drug education teacher networks**

Teachers trained by SDEP will form the core of these networks and will provide local drug education training to others through network forums. The network should also include relevant agencies and community groups who can support school drug education.

### **Principles of regional management group**

The operations of the regional management group are to be based upon the SDETF Principles of Best Practice and within the context of the SDEP Strategic Plan (1997 - 2000), as well as consistent with the policy framework of *Together Against Drugs*.

#### **Finding 5**

*That the School Drug Education Project is a very sound and well researched program, which when implemented in its entirety will undoubtedly make a significant contribution in providing children and their families with the requisite skills, insights and attitudes to be able to make appropriate choices about using drugs. The Select Committee commends the Education Department of WA, the Catholic Education Office and the Association of Independent Schools of WA for formulating and promoting the School Drug Education Project.*

## **9.3. Developing a school drug policy**

### **9.3.1. Introduction**

Drug use by students is an issue that confronts the majority of schools in some manner at some stage. Guidelines were developed in 1996 by the Health Promotion Services to assist schools to develop and implement a school drug policy.<sup>483</sup> These guidelines were revised by the SDEP and were released in August 1998. These set out in some detail many of the issues to be considered in developing a school drug policy (SDP) and should be consulted for more information about the process of developing a drug policy and of its implementation.<sup>484</sup> The following discussion draws upon these sources of information.

A SDP should be incorporated into the school's overall policy on student health and welfare. Such an approach is consistent with the Education Department's performance indicators for all schools, which includes 'a concern for, and understanding of, how to achieve physical health and wellbeing', as one of the outcomes it seeks to achieve for all students. The development of a SDP is one strategy schools could implement to achieve this outcome. The SDP can also be linked to the school's management of student behaviour and/or pastoral care programs.

The merits of a comprehensive school drug policy cannot be overstated, regardless of whether the school perceives it has a problem with drug use (licit or illicit) among students. In addition to

<sup>483</sup> Health Promotion Services, Alcohol and Other Drugs Program. *Guidelines for developing a school drug policy*. 2nd ed. Perth, Health Department of WA, 1996.

<sup>484</sup> School Drug Education Project. *Developing a drug policy to promote health in your school: guidelines for implementation*. Perth, Education Department of WA 1998.

reinforcing other aspects of a comprehensive program, the development of a school drug policy ensures a proactive approach that can often prevent drug use issues from arising.

### **9.3.2. Principles**

A key principle is that school based drug education should address issues of drug use in context, acknowledging that students are most likely to experiment with and/or regularly use alcohol, tobacco and, for older students, cannabis.

The following information draws on material contained in the 2nd edition of the guidelines, published in 1996. The guidelines adopt the approach that a school drug policy needs to:

- be relevant to a school's local needs;
- include both prevention and intervention in regard to drug use issues;
- conform with the administrative requirements of the Education Department of WA; and
- be consistent with State and Federal laws.

### **9.3.3. Definition of a drug**

The guidelines provide a broad definition of what is regarded as a drug (eg analgesics, alcohol, tobacco, cannabis, amphetamines, etc). A drug is defined in the 1998 guidelines as being *“any substance, with the exception of food and water which, when taken into the body, alters its function physically and psychologically. Includes all legal and illegal drugs (World Health Organisation).”*<sup>485</sup>

An example that arises with the process of adequately defining a ‘drug’ is illustrated in relation to the abuse of volatile substances, such as glue and toluene. While these substances are not drugs as such, they need to be treated as drugs so that they can be included in a school drug policy (SDP). The 1998 guidelines point out that

*“(a)s with all drug use issues, education programs concerning solvents require sensitivity to avoid ‘normalising’ or ‘popularising’ their use or providing students with an inducement to experiment. However, if solvent use is not a problem in the school community, the implementation of such programs is not recommended. It is important to get a clear indication of the extent of the actual problem not what is suspected. If there is a small group of students involved in solvent use, direct (one to one) intervention is most appropriate.”*<sup>486</sup>

### **9.3.4. A comprehensive approach**

The role of the school in the prevention of drug use problems is complex. Although schools play an important role in addressing drug use issues, they are not the only organisation responsible. These issues are complex and require a whole community based approach. This requires a comprehensive approach which utilises a wide range of strategies, as follows.

#### ***Implementing a health education program for students which addresses drug related issues in a non judgmental way***

A SDP should provide students with accurate information, opportunities to clarify and challenge values, and a chance to practise the personal and interpersonal skills that will assist them to make informed decisions and choose healthy behaviours. The program should adopt a rational harm reduction approach to drug education. The WA Health Education K-10 Syllabus incorporates drug education within the wider framework of health education. This has been adopted in this State as the most effective way of providing drug education for students.

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<sup>485</sup> Ibid 10.

<sup>486</sup> Id 24.

### **Securing support from the local community**

Providing opportunities for parents to learn about and discuss drug use and related issues helps ensure students receive messages about drug use that are accurate and reinforced consistently. The active involvement and support of parents contributes to the success of other school based drug education initiatives.

### **Supporting the role of school health services**

School health services include programs that promote health on a one on one basis, through prevention, intervention and remediation of specific health problems. School health services staff include the school health nurse, school psychologist, school based police officer, school chaplain and other relevant staff members.

These staff can often provide health counselling and instruction for staff and students, organise parent education and provide support for other school based activities (for example, school health days and Quit smoking programs for staff and students).

## **9.3.5. Prevention and intervention**

The main role of the school is to prevent the occurrence of drug use problems by providing drug education within the health education curriculum. An effective SDP should address the prevention of drug use problems by:

- identifying the content of the Health Education K-10 Syllabus that the staff, parents and students perceive as important;
- identifying the appropriate student outcome statements;
- ensuring that health education is adequately resourced;
- providing, where necessary, professional development for health education teachers;
- ensuring that health education has adequate time on the school timetable; and
- adopting a rational harm reduction approach to drug education.<sup>487</sup>

At the same time as providing adequate health/drug education for students, schools should acknowledge that incidents of drug use may occur at school and require a response from the school. School drug policy and procedures which address intervention as well as prevention ensure that the school's response to such incidents is planned and clearly understood by everyone.

The SDP should give a clear message that particular types of drug use are not acceptable in the school and also outline what assistance will be provided for students or staff with drug related problems.

## **9.3.6. Advantages of an effective school drug policy**

There are a number of advantages in having a standardised response to incidents of drug use, and of documenting and implementing school drug policy based on a wide and thorough consultation process.<sup>488</sup> These advantages include:

- reinforcing the school's role in prevention of alcohol, tobacco and other drug related problems;
- standardising and documenting the school community's agreed position on, and accepted procedure for dealing with, drug related incidents and problems;
- demonstrating the school's responsiveness to issues of school and community concern;

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<sup>487</sup> Rational harm reduction means recognising the need to take the action necessary to reduce the risks and harm faced by those using drugs and by the wider community, while ensuring this does not encourage or normalise drug use.

<sup>488</sup> School Drug Education Project. *Developing a drug policy to promote health in your school: guidelines for implementation*. Perth, Education Department of WA 1998, 11.

- clarifying roles, rights and responsibilities of all school community members in relation to alcohol, tobacco and other drug use problems;
- providing a planned and coordinated response to alcohol, tobacco and other drug related problems to ensure the efficient school community resources and a better outcome for all parties involved;
- setting guidelines for students, staff and visitors on what are acceptable and unacceptable alcohol, tobacco and other drug use behaviours on school premises;
- ensuring that school staff are not placed at risk by their actions, through a clear statement of the school's legal and procedural responsibilities;
- identifying a sequence of events that will be followed when an incident of prohibited drug use occurs and incorporates appropriate disciplinary measures, which stipulates when parents and police are to be notified; and
- supporting staff by providing clear guidelines to follow if alcohol, tobacco and other drug related problems occur.

### **9.3.7. Steps in developing a school drug policy**

The process used to develop the SDP is as important as the policy itself. It is essential that all staff, parents and students or their representatives who will be required to adhere to the policy are consulted during its development and provided with opportunities to comment on the content.

#### **Committee**

A school health committee should be formed, consisting of six to eight volunteers representing the school community. The committee may include the following:

- principal and/or deputy principal;
- student services staff member/s (eg school health nurse, school based policy officer, etc);
- members of the parents' representative group;
- student representatives;
- health education coordinator;
- union representative; and
- other staff as required.

#### **Function of the committee**

The role of the committee is to act on behalf of the school community, to make recommendations about the content of the policy, establish a standardised school response to alcohol, tobacco and other drug related incidents, develop and circulate a draft version and prepare the final document. The tasks of the policy committee include:

- appointing a chairperson and a minutes secretary;
- establishing how and when the committee will report to the school staff, parents and students; and
- deciding whether to approach an outside agency or district education office for assistance.

#### **Workshop**

A workshop should be organised to provide committee members with up to date information about alcohol, tobacco and other drug use issues relevant to school aged children. This workshop may be repeated for the whole school staff to ensure that all members approach the issues from an informed perspective.

#### **Needs analysis**

A needs analysis should be conducted to identify any existing (or most likely potential) drug use problems in the school and to identify local resources available to the school for education support or intervention purposes.

## 9.3.8. Development of policy and response to drug use incidents

### **First draft**

A draft needs to be written, detailing the prevention initiatives that the school will introduce (or continue) and the procedures to follow in the event of improper drug use. In many instances, this is simply a matter of documenting existing procedures. The policy should be as brief as possible, in plain language and easy to read. The procedures should be clear and easy to follow.

It is suggested the entire document should be:

- no longer than two A4 pages;
- include a short rationale;
- contain three to four general policy statements followed by guidelines; and
- be incorporated into the school health policy.

Circulation of the draft document should involve a number of steps, including:

- circulation to staff members and relevant workplace representatives;
- indicate the deadline for receipt of feedback;
- hold a meeting to discuss the contents of the proposed policy; and
- make the draft available to parents for comment.

### **Second draft**

Feedback from the school community needs to be incorporated and prepared as a second draft. This draft should be circulated in the same manner as the first.

### **Third version or final working of the draft revision**

A third version of the policy is then prepared, which should then be presented by the principal (or nominee) to the school decision making group and the parent representative group. This group may require further modification before endorsing the document.

### **Final version**

The final version can then be published under the school name and logo.

## 9.3.9. Making the policy work

### 9.3.9.1. Implementation

The success of a good school drug policy can hinge on how it is implemented. Schools may wish to launch the policy and develop a one page outline for distribution to students, parents and school staff. This outline can be added to student information booklets. Local media may be able to assist by publishing an article which outlines the main points. Discussion and interest raises public awareness. It is important to ensure that the policy is understood and used. All new staff, students and parents should be made aware of the policy.

### 9.3.9.2. Evaluation

After the policy has been implemented for six to 12 months, the committee should reconvene to assess its effectiveness. A school development day may provide an opportunity for the committee to meet and consult staff. Information could be collected by conducting a brief survey or by asking for verbal or written comments from a range of school community representatives.

### **9.3.9.3. Responding to incidents of drug use**

It is important that each school, as an integral part of its drug policy, develop procedures to address the following issues that arise when incidents of drug use occur at a school.<sup>489</sup>

- Does the proposed procedure protect the welfare and confidentiality of the student/s while being consistent with the school's operation and ethos?
- When and how will parents be informed about incidents of drug use and who will be responsible for contacting them?
- Will police be notified of possession, or incidents of illicit drug use, and what procedures will be required for interviews and/or arrests of students or staff?
- Will liaison be established with local retailers to prevent the sale of cigarettes and alcohol to children under the age of 18 years and control the sale of solvents?
- What roles will personnel from supporting community agencies play?
- What will be the referral and communication processes and who will coordinate referrals to outside agencies?
- What welfare and counselling services will be made available to students experiencing drug related problems?
- How will the school deal with the media?

### **9.3.9.4. Other considerations**

Schools were advised in the Education Department guidelines for developing a school drug policy to consider a number of other issues which they should take into account in developing their SDP. These issues are outlined below.

- For what reasons should a school develop a SDP?
- What is the difference between prevention (before behaviours occur), and intervention (after behaviours occur) and will the SDP address both?
- Since role models regarding drug use have a significant impact on school aged children's drug use behaviour, will the SDP apply equally to staff and students?
- Will the SDP apply to school visitors?
- Will the SDP cover drug use (for example, alcohol and tobacco consumption) at functions that are held on the school premises and at school functions held off the school premises at which students are present?
- What other policies and regulations should this policy comply with? For example, does the SDP comply with the:
  - *Misuse of Drugs Act 1981*
  - *Occupational Health Safety and Welfare Act 1987*
  - Education Department administrative circulars<sup>490</sup>
  - Managing student behaviour guidelines

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<sup>489</sup> Id 14.

<sup>490</sup> For example Circular No. 205: *Administration of Medication*; Circular No. 214: *Smoking in the Workplace*.

- *Tobacco Control Act 1990*
  - *Liquor Licensing Act 1988*
  - Controversial issues statement<sup>491</sup>
- Does this policy cover all types of drug use, both licit and illicit?
  - Will all staff members be offered an opportunity to attend a short meeting or seminar about the final document and, if so, when will this happen?
  - How will students and parents be informed about the policy?
  - How will staff, students and parents who are new to the school be informed about the policy?
  - Will the policy be reviewed in the future and, if so, who will be responsible for this?

## 9.4. Issues

### 9.4.1. Students' possession of illicit drugs

Principals usually consider a range of factors when deciding whether to involve the police. These may include the possible repercussions for the students and the school community, the usual behaviour of the students, and whether the students have previously been involved in a similar situation. Advice from the Crown Solicitor's Office has been sought to clarify the legal issues associated with students in possession of drugs. This advice has been incorporated in the text of the revised guidelines for implementing a school drug policy, which are reproduced below.<sup>492</sup>

In accordance with the *Misuse of Drugs Act 1981* (MDA), schools are under no legal obligation to report possession of an illicit drug to the police. The Crown Solicitor's Office advises that there is no principle of the criminal law, either in the MDA or otherwise, requiring a person who becomes aware of an offence against the MDA to report that offence to the police. This decision lies with the school principal.

If principals confiscate an illicit drug, they are then considered to be in possession of it. However, principals may have the drug in their possession for the purpose of delivering it to a person who is authorised to be in possession, eg a police officer.

The Crown Solicitor's Office advises that a person who comes into physical possession of an illicit drug and retains it solely for the purpose of disposing of it by conveying to the police or some other person authorised to receive it, would not have unlawful possession of the drug under the MDA. The drug should not be retained for longer than is absolutely necessary, otherwise an inference of intention to possess the drug, rather than simply deliver it, may be drawn.

### 9.4.2. Students' possession of cigarettes

In accordance with the *Tobacco Control Act 1990*, it is illegal for retailers to sell cigarettes to persons under the age of 18 years. It is not illegal for persons under the age of 18 years to smoke tobacco.

Schools can become active in helping to restrict the supply of tobacco to students by encouraging retailers to refuse to sell cigarettes to anyone under the age of 18 years. Reinforcement should also be given to those retailers who are known to support this law. If retailers continue to sell cigarettes to students, schools should consider informing a Tobacco Control Officer at the HDWA.

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<sup>491</sup> Dealt with in the Health Education K-10 syllabus

<sup>492</sup> School Drug Education Project. *Developing a drug policy to promote health in your school: guidelines for implementation*. Perth, Education Department of WA 1998, 23.

### 9.4.3. Students' possession and consumption of alcohol

In accordance with the *Liquor Licensing Act 1988*, it is illegal for any person to consume liquor on unlicensed premises without the consent of the occupier or of the person or authority having control of those premises. In the case of licensed premises, it is illegal for a person under the age of 18 years to consume liquor on those premises and for a licensee, and any other person by whom liquor is sold or supplied on those premises, to permit a person under the age of 18 years to consume liquor. It is also illegal to sell or supply liquor to persons under the age of 18 years on licensed premises. If retailers sell alcohol to students, consideration should be given to informing local police.

### 9.4.4. Students' use of solvents

Substances 'sniffed' are readily available and cheap. There is no law against selling, buying or possessing these substances in WA, with the exception of those products classified as a Schedule 6 of the *Poisons Act 1964*. It is illegal to sell or supply a Schedule 6 poison to persons aged under 16 years. If there are signs that a young person is in 'moral danger', the police can act under Section 138B of the *Child Welfare Act 1947*.

### 9.4.5. Search of students' possessions

There are a number of provisions in the *Education Regulations 1960* for government schools which relate to the searching of students' possessions.<sup>493</sup>

Regulation 28 provides that "a teacher has authority to secure the good behaviour of his pupils within the school and in the school playground and when a child comes to or returns from the school".

Regulation 30 requires proper provisions for the supervision of students.

Regulation 33 authorises a teacher to take "such physical action as is appropriate to prevent or restrain a child from acting in a manner which places at risk the safety of the child, or any other child or a member of the staff".

The Crown Law Department suggests that the Regulations, in combination, justify teachers taking possession of hazardous objects brought to school by students and this includes searching bags or lockers when there is a **reasonable suspicion** that such objects are in the possession of students. It is pointed out in the revised guidelines that

*"(t)he preferred approach at all times is for teachers to request the consent of students to search their property. Random or periodical searches, which are simply inquisitive in origin, need more to justify them. Teachers are not invested with the powers and protections of the police. It is not part of their role to become involved in general law enforcement."*<sup>494</sup>

### 9.4.6. Police and schools

The Select Committee was made aware of measures implemented in a number of schools in Victoria and New South Wales which were designed to improve security and to monitor anti social behaviour. These measures also involve instances where surveillance systems have detected students using and selling drugs. It has been reported that up to 80 Victorian schools have now installed security cameras and that at least six Victorian schools have used sniffer dogs to detect drugs in schools.<sup>495</sup>

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<sup>493</sup> Id 25.

<sup>494</sup> Ibid.

<sup>495</sup> Gibson R. "Schools come under surveillance." *The Age* 4 July 1998.

There has been a growing concern about the increasing use of measures to detect drugs at school. For instance, a newspaper article on this issue reports the comments of a Relationships Australia counsellor that the use of sniffer dogs “would start an endless game where children increased their secrecy to match their parents’ detective work.” In the same article, Professor Margaret Hamilton, the Director of Turning Point (a Victorian drug treatment organisation) was quoted as saying that “using sniffer dogs on teenagers was destructive. ‘Parents should talk to their children instead of policing them,’ Prof Margaret Hamilton said.”<sup>496</sup>

A well publicised case occurred in Sydney 1997 at the Glen Eira Secondary College, where boys using heroin in the school toilets were filmed by CCTV.<sup>497</sup> While it is recognised that these instances are rare, nevertheless they are a cause of concern to schools and other students and parents.<sup>498</sup>

West Australian police have been involved for a number of years in providing input in school based drug education programs. It is understandable that police wish to become involved in school programs, as they may frequently see those who have become harmed from drug abuse. Earlier this year, the Fremantle police expressed their desire to play a more positive role in this area. An example of such a view was contained in a report published in a community newspaper in February this year.

In the interview for this article, Constable Barbara Olney stated “Drug education should be positive and start before children are at risk. It is too late to leave education or important drug issues until they are in their high school years.” It was stated in the same article that the proposed drug education program would involve selected and trained uniformed officers, who would teach children the risks involved with drug use.<sup>499</sup>

However, as was outlined to the Select Committee, the emphasis of the SDEP is that wherever possible the primary responsibility for delivering drug educational materials to the students rests with trained teachers who are part of the school’s complement of teaching staff. The appropriateness of uniformed police officers to deliver school based drug education needs to be questioned.

During the course of the Select Committee’s investigations, there were a number of searches of school students and their belongings by police in a number of high schools throughout the State. In Kalgoorlie during June 1998, a 15 year old boy was observed selling drugs and subsequently charged with a cannabis related offence. It is believed that in 1997 the police had conducted a raid at the Goldfields High School in response to concerns about drug use at the school.<sup>500</sup>

In July and August 1998, there were a number of publicised searches by police of high schools in the Fremantle and Manjimup areas. In early July, police with sniffer dogs searched the South Fremantle and Hamilton Senior High Schools and Christian Brothers College. These searches involved police randomly searching students and their belongings for cannabis, smoking implements and weapons.<sup>501</sup> It was reported that police had confiscated a small amount of cannabis, smoking implements and a knife, with 11 students being cautioned. These intensive searches were described by the police as being

*“not drug raids but were designed to deter students from bringing drugs to school. ‘We are not coming here acting on a tip off,’ (Inspector Mitchell said) ‘We want to show students that if you bring drugs to school there is a good chance that you are going to get caught.’”*<sup>502</sup>

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<sup>496</sup> Hewitt S. “Dog on scent of drug teens.” *Sunday Herald* 5 July 1998.

<sup>497</sup> Webb C. “Anger as schools call in sniffer dogs to fight drug abuse.” *The Age* 2 July 1998.

<sup>498</sup> Pennells S. “School suspends two boys, 10, for dealing.” *The West Australian* 20 June 1998.

<sup>499</sup> Fremantle Gazette. “Drug plan for schools.” 17 February 1998.

<sup>500</sup> Kalgoorlie Miner. “Principal continues tough stand on drugs.” 13 June 1998.

<sup>501</sup> Fremantle Gazette. “Checks dispel drug myths: principal.” 10 July 1998; Maclean S. “Drugs shock. students caught with cannabis in school raids.” *Cockburn Community Gazette* 3 July 1998.

<sup>502</sup> Fang G, Ashworth K. “School drug blitz widens.” *The West Australian* 3 July 1998.

While it is reported that there was support by students and parents for these searches, there has also been criticism.<sup>503</sup> Perhaps the greatest criticism has involved searches in early August of two high schools in Manjimup, the Manjimup Senior High School and the Catholic Kearnan College. While it is reported that only a small number of students were charged with cannabis offences, in one instance four male and four female students aged between 14 and 16 had been strip searched. The search was conducted at a house apparently frequented by students which was adjacent to the high school.<sup>504</sup>

The revised guidelines for schools to develop a drug policy were released on 17 August 1998.<sup>505</sup> These guidelines address a variety of issues for schools to consider when identifying alcohol, tobacco and other drug related problems. It is pointed out in the guidelines that “(s)trategies such as the use of sniffer dogs or locker and bag searches are options. Timing and appropriateness need to be considered carefully, as they may impede further attempts to communicate about the issue.”<sup>506</sup> There has been some concern, however, about this particular strategy for searching students and their possessions.

*“WA’s major parent group said it was worried the authorisation of searches of student property was an infringement of children’s rights and invaded their privacy. WA Council of State School Organisations president Dianne Guise said: ‘We want to do everything in our power to keep drugs out of schools but we must be mindful that kids have rights.’”<sup>507</sup>*

Random searching of school bags and lockers in the school environment may amount to trespass against the individuals personal and private property. Action such as this has the potential to embarrass and cause civil action against the police involved.

Before police can conduct a search in these circumstances, they must first have reasonable grounds for doing so. That is, they must be in possession of information in relation to a particular drug or drugs and the precise location where it may be found within the school setting. To allow the dogs to randomly search school bags or lockers is likely to be unlawful and any evidence so obtained may be ruled inadmissible in court.

The Crown Solicitor’s Office has provided a legal opinion on this issue as follows.<sup>508</sup>

*“A principal has the right to permit police to enter school premises to attend to official business pursuant to Regulation 3(2)(c) of the School Premises Regulations 1981. However, there are no provisions in the Education Act, Education Regulations or School Premises Regulations which authorise police to search school premises and, in particular, the bags or lockers of students.*

*Rather, police powers of search have their origin in a number of other statutes such as the Police Act, the Criminal Code, the Firearms Act and, relevantly to this opinion, the Misuse of Drugs Act. For example, sections 14 and 24 of the Misuse of Drugs Act authorise a justice of the peace to issue to a police officer a search warrant in respect of specified property if he is satisfied by information that there are reasonable grounds to suspect that such property may be on the premises. A search warrant will authorise a police officer to search the premises using such force as is reasonable (sic) necessary and with such assistance as the police officer considers necessary.*

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<sup>503</sup> Melville-Fremantle Community. “Support, criticism for police searches.” 14-20 July 1998; Campbell B. “School’s no place for men in black.” *Fremantle Herald* 1 August 1998; Fremantle Gazette. “Students approve police presence.” 3 July 1998.

<sup>504</sup> Rechichi V. “Students strip searched.” *The West Australian* 1 August 1998.

<sup>505</sup> Ashworth K. “Search for drugs, schools told.” *The West Australian* 17 August 1998.

<sup>506</sup> School Drug Education Project. *Developing a drug policy to promote health in your school: guidelines for implementation*. Perth, Education Department of WA, 1998, 21.

<sup>507</sup> Ashworth K. “Search for drugs, schools told.” *The West Australian* 17 August 1998.

<sup>508</sup> Provided 8 May 1996 by Assistant Crown Solicitor, Linda Pettit to Charles Smits, Acting Senior Policy Officer, Policy and Planning Branch (Legislative Services), Education Department of WA.

*While the consent of students to search their property would avoid the need for a search warrant, the obtaining of such consent would be impractical, if not impossible, in view of the scale of the search contemplated.*

*In the circumstances, a principal should permit police officers to enter school premises for the purpose of conducting a search of school lockers and school bags only under the authority of a valid search warrant."*

The Select Committee believes that there is a need for guidelines to be issued dealing with police searches at schools. Such guidelines would enable schools, parents and students to be aware of responsibilities and appropriate conduct.

**Recommendation 37**

***That the Education Department develop, in conjunction with the Police Service, independent schools and the Catholic school system a set of legally sanctioned guidelines for police to follow when they undertake searches for drugs at schools.***

## **9.5. Drug education in current health curriculum**

### **9.5.1. K-10 drug education**

Drug education is currently a component of the health education K-10 syllabus. Drug education skills and content are progressively and developmentally introduced at each year level, appropriate to the needs of students. The syllabus is used by teachers in over 90% of schools (National Heart Foundation Survey 1993) to plan and implement health education programs. The K-10 syllabus will continue to provide curriculum support for teachers in drug education.

The recently produced draft drug education curriculum materials complement the K-10 health syllabus.

### **9.5.2. Year 11 & 12 drug education**

Health studies is an accredited subject available to Year 11 and Year 12 students and is currently implemented in 26 senior high schools. These courses contain course outcomes relating to drug abuse. A range of additional strategies is being developed by the school drug education project to meet the needs of Year 11 and 12 students. The health studies subject is being examined during 1998 - 1999 as part of the curriculum council's review of all post compulsory subjects.

### **9.5.3. Drug education for Aboriginal students**

The Aboriginal school health project has recently distributed to schools a new resource called Staying Healthy, which complements the health education K-10 syllabus with the aim of being more relevant for students in schools attended predominantly by Aboriginal students.

### **9.5.4. Details of K-10 drug education**

The following outlines areas in the unit curriculum where drug education is the principal content of lessons. There are some other areas in the curriculum where drug education can be indirectly taught.

### **9.5.4.1.    Preschool**

#### **Community and environmental health**

- Students discuss safety rules at home
  - recognise poison warnings

#### **Societal health issues**

- Students describe alternative ways to obtain pain relief
  - recognition of medicines
  - awareness that only adults should handle medicine
  - safety rules for medicine
- Students discuss the dangers of sidestream smoke
  - ways to improve health
  - dangers of sidestream smoke
  - recognising no smoking signs

### **9.5.4.2.    Year 1**

#### **Physical health**

- Students identify the importance of positive health practices in minimising disease
  - disease prevention
  - ways to control disease
  - immunisation

#### **Societal health issues**

- Students identify medications and state that they should only be given by an adult after alternative methods have been unsuccessful
  - alternatives to taking medicines
  - dangers of incorrect dosages of medicines

### **9.5.4.3.    Year 2**

#### **Community and environmental health**

- Students identify hazardous products around the house
  - instructions on bottles
- Students identify the places where various health products may be purchased and discuss the skills required when selecting any health product
  - role of pharmacies
  - care when selecting health products

#### **Societal health issues**

- Students identify medications and understand that they should be used only when given by an adult after alternative methods have been unsuccessful
  - management of medication
  - alternative methods of pain relief
  - power of advertising

### **9.5.4.4.    Year 3**

#### **Community and environmental health**

- Students read and discuss labels of products concerned with personal health practices
  - labelling of health products
  - influence of advertising on selection of health products

**Physical health**

- Students describe the management of disease and disability
  - control and/or cure of various diseases by medication

**Societal health issues**

- Students identify the ways of coping in situations where they are affected by tobacco smoke
  - influence of tobacco smoke on non smokers
- Students define how medicines can have both positive and negative effects on health
  - incorrect use of medicines
  - role of pharmacist

**9.5.4.5. Year 4**

**Community and environmental health**

- Students list the reasons and rules for the correct use and storage of medications
  - correct use and storage of medications

**Societal health issues**

- Students identify and discuss advertisements about products that may affect their health
  - role of advertising
  - advertising health products
  - tobacco advertising
- Students identify and practice alternative methods of achieving mild pain relief
  - past methods of pain relief
  - current alternative methods of mild pain relief

**9.5.4.6. Year 5**

**Community and environmental health**

- Students describe the local government and community involvement in maintaining health in the environment
  - local government health services
  - community responsibility for using and supporting the local government services

**Societal health issues**

- Students describe the reasons why people smoke
  - reasons why adults and students may smoke

**9.5.4.7. Year 6**

**Physical health**

- Students discuss factors that affect the health of the circulatory system
  - effects of high blood pressure, smoking, high blood fats, excessive body weight, lack of exercise, excessive consumption of alcohol, stress and behaviour types
- Students discuss the occurrence and prevention of life style diseases in society
  - nature of life style disease
  - effects of life style disease
  - role of the individual and society in preventing life style disease
- Students discuss the short term effects of smoking upon the smoker and the non smoker
  - short term effects of smoking on the smoker
  - short term effects of smoking on the non smoker

**Societal health issues**

- Students discuss the cost of life style diseases to society
  - identifying life style diseases
  - personal and financial cost of life style diseases
- Students discuss the current attitudes towards health issues
  - current attitudes towards health issues in society
  - possible solutions to health issues in society

**9.5.4.8. Year 7**

**Community and environmental health**

- Students discuss the manufacturers responsibility for the correct labelling of consumer goods
  - purpose of labelling goods
  - legal requirements for labelling goods
  - motives of manufacturers
- Students discuss their legal responsibilities which, when combined with existing government legislation, improve the health and safety of the community
  - individual responsibility and health
  - legislation affecting health and safety
  - agencies responsible for administering health and safety legislation

**9.5.4.9. Year 8**

**Community and environmental health**

- Students analyse the agencies and services in the community that provide assistance for the health concerns of adolescents
  - health, medical, community and service agencies available for adolescents
  - developing a directory of health services

**Societal health issues**

- Students appraise the common meanings and images associated with drugs and drug use and analyse the nature of drug use in Australia
  - define drug, drug misuse and drug abuse
  - common images associated with drug use in Australia
  - drug use in Australia
- Students describe both the immediate and short term effects of cigarette smoking and relate these to the long term health consequences
  - immediate effects of smoking a cigarette
  - relationships between the immediate effects and the long term health consequences
- Students state the reasons why people begin to smoke, continue to smoke or are non smokers
  - reasons why people take up smoking
  - number of people who are smokers
  - reasons why people continue to smoke
  - reasons for non smoking
- Students state that both smokers and non smokers have rights that need to be considered and discuss the advantages and value of non smoking
  - rights of smokers and non smokers
  - non smoking as an attractive life style

### 9.5.4.10. Year 9

#### **Community and environmental health**

- Students describe and apply realistic criteria to be used when selecting health products
  - claims of manufacturers and advertisers
  - evaluating and selecting health products

#### **Physical health**

- Students appraise the common meanings and images associated with cancer and describe the incidence, type, possible causes and prevention of cancer
  - cancer and its associated images
  - incidence and types of cancer
  - factors predisposing to cancer
  - reducing the risk of cancer
- Students identify the major life style related diseases in Australia and analyse the ways to prevent and minimise these conditions
  - major life style diseases
  - preventing and minimising life style diseases

#### **Societal health issues**

- Students appraise situations in which they might be offered drugs and consider ways of responding to those offers
  - situations in which drugs may be offered
  - pressures to use a variety of drugs
  - responding to a drug offer
- Students describe the nature of alcohol and discuss its effects on the body
  - alcohol as a drug
  - source and production of alcohol
  - different alcoholic beverages
  - misconceptions about alcohol and its effects
- Students analyse the prevalence of and major reasons for alcohol use in Australia
  - prevalence of alcohol use
  - drinking patterns
  - alcohol and road use
  - blood alcohol levels and the law

### 9.5.4.11. Year 10

#### **Community and environmental health**

- Students analyse legislation and regulations that are relevant to health and determine the extent to which laws influence health
  - legislation relevant to health
  - legislation relevant to manufacturers and employers
- Students identify and consider the major factors contributing to the road toll
  - road toll statistics
  - factors contributing to the road toll
  - minimising the road toll

#### **Societal health issues**

- Students discuss the nature and value of alternative forms of health care and life style
  - alternative in medicine, diet and life style
  - reasons why people pursue the alternatives
  - advantages and disadvantages of each method

- Students evaluate the health services and facilities offered by private enterprise
  - nature of private enterprise facilities and services
  - value of the services provided
- Students appraise the nature and the extent of the drug problem in Australia and discuss possible solutions
  - incidence of drug use
  - drug problems in Australia
  - possible solutions to the drug problem
- Students analyse the significance of abstinence or moderation in the use of legal drugs and discuss alternatives to drug use
  - abstinence from drug use
  - moderation in drug use
  - alternatives to drug use
- Students analyse the nature of the illegal drug use in Australia and discuss the social, legal and personal implications
  - types and nature of illegal drug use in Australia
  - incidence of illegal drug use
  - personal, legal and social implications of illegal drug use
- Students analyse the extent to which individuals have control over their health and discuss the personal and social implications
  - individual responsibilities for health
  - factors that influence health and are beyond an individual's control
- Students survey and discuss current health issues
  - current health issues

### 9.5.5. Interstate perspectives

#### 9.5.5.1. Introduction

The Select Committee has not compared the SDEP with approaches being undertaken to provide school based drug education programs in the other Australian jurisdictions. However, a number of developments with the role of police in Victorian schools, and the recent Commonwealth announcements on developing a national approach to school based education require some comment.

#### 9.5.5.2. Police role in Victorian schools

In Victoria, police have a broad role in schools, which extends beyond drug issues, to assist with the empowerment process of young people through skill development, information and personal development.<sup>509</sup> The Select Committee believes that police can provide input in the school environment which can complement school based education programs. The Victorian Police Schools Involvement Program (PSIP) illustrates possibilities for young people to learn a range of skills to assist them confronting risky situations, including drugs.

The PSIP is a proactive policing program which works in close collaboration with school communities in order to enable young people to develop skills to enhance their ability to make positive life choices. In turn, this contributes to the individual's personal safety and the community's safety.

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<sup>509</sup> This section draws upon information provided by Manager Police/Schools Involvement Program, Victoria Police.

In itself, PSIP is not drug education, and drug education is not PSIP. Rather the two concepts share a similar underpinning philosophy and approach; problem prevention and early intervention. In 1988, the then Chief Commissioner of Police in Victoria identified a number of problems, such as rising crime rates and perceived lack of opportunity for young people to learn the basics of being a law abiding citizen. Accordingly, a decision was taken to develop a proactive policing program that involved police in schools which would emphasise people valuing other people, being non judgmental and encouraging working through issues in which we all have vested interest.

In 1997, the PSIP was involved with 222,778 young people in a total of 530 primary and 125 secondary schools in Victoria. It was delivered by a total of 85 operational police statewide, each of whom are known as a school resource officer (SRO).

Each SRO has a total of up to 10 schools which they visit on a regular basis throughout the school year. The program is structured so that the same group of young people have contact with the SRO on a fortnightly basis. In this way, a positive and trusted relationship can be built up with the officer concerned.

Once the SRO is working within the school system, ongoing professional development is provided in order to maintain and develop professional skills and maintain the relevance of the program to the school environment.

In 1995, much of the professional development was in the area of drug education with an emphasis on the harm minimisation approach. Course content was age appropriate and recognised the principles of drug education including harm minimisation, the social competency model and the public health model.

The aims of the PSIP are:

- to reduce the incidence of crime in society;
- to develop a better relationship between police and youth in the community;
- to create in young people an understanding of the police role in the structure of society;
- to extend the concept of the crime prevention into the Victorian school system; and
- to equip young people with the necessary skills to avoid dangerous and threatening situations.

Along with these specific aims, behavioural objectives are set, and it is hoped that after participation in the program, young people will be able to:

- demonstrate the values, responsibilities and obligations current society deems valuable;
- state the consequences of a person's actions regarding unlawful behaviour;
- demonstrate sufficient self esteem and skill to reduce and delay the uptake of drugs and resist engaging in antisocial behaviour;
- engage in positive interactions and consultation with police members; and
- state the basic role of police and the legal system in Victoria.

In order to achieve the above aims and objectives, the program is delivered around a core structure of seven themes:

- the role of police in society;
- the legal system;
- rights, rules and responsibilities;
- consequence of our actions;
- keeping ourselves and others safe;
- drug and alcohol education; and
- personal development.

## **Select Committee Into Misuse of Drugs Act 1981**

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All of these seven themes closely interlink with the school curriculum thus enhancing the relevance to the school community and the learning of the young people concerned.

### **Example of how PSIP works**

In one of the police districts in the south eastern suburbs of Melbourne, there are eight school resource officers involved in PSIP. These members are spread over the district at various police stations. In 1995, one of the SROs identified the need for drug education in one of the secondary schools she was attending on a regular basis. The school had expressed a desire to be involved in drug education and the young people concerned also had views about which aspects they felt would be most useful. This experience was common to several schools in the area.

After working through a number of options with the schools concerned, the SROs designed workshops on issues relevant to young people understanding more about responsible alcohol consumption. The issues that appeared relevant for this situation were those of understanding about standard drinks, the effect of alcohol on the body, the impact on driving ability and the potential personal consequences of over indulging.

A package of three workshops were designed using a variety of curriculum materials and innovative techniques that could be used flexibly according to need. The workshops were designed to be complimentary to the health curriculum and to target Years 10 to 12 who are in the position of obtaining learners' permits and drivers' licences and experimenting with alcohol. Three workshops were planned to run simultaneously, with the young people concerned rotating through the workshops. A variety of resources and techniques were used during the workshops, with a great deal of flexibility of approach built in so that the differing needs and interests of the young people could be accommodated.

**Workshop 1 or The standard drink** involved the use of a number of resources including "Choices" which is produced by Vicroads, an exercise which is part of the "Rethinking Drinking" Package and information resources designed by the SROs themselves.

**Workshop 2 or Your System and their machine** involved the breathalyser and the effects of alcohol on the driver. Students were encouraged to explore myth and reality about the breathalyser, understand how it works, discuss the law as related to alcohol and driving, discuss several scenarios of alcohol effected drivers (including the notion that various amounts of alcohol effect people differently in different situations) and develop an understanding of the absorption, distribution and elimination of alcohol from the body.

**Workshop 3 or The party**, was named after the video of the same name taken from the "Rethinking Drinking" package.

### **9.5.5.3. Expert national committee**

In April 1998, the Commonwealth announced the establishment of an expert national committee to develop and promote a national strategy on schools drug education. The role of the committee, appointed by the Commonwealth Minister for Schools, Vocational Education and Training, will be to provide expert advice on schools drug education matters to the Australian National Council on Drugs (ANCD).

The ANCD was announced by the Federal Government as the vehicle to implement projects to be funded through the Prime Minister's Tough on Drugs National Illicit Drugs Strategy (NIDS). The expert committee is to be chaired by Ms Karyn Hart<sup>510</sup>, and is made of representatives from all jurisdictions except Tasmania. The two members of the committee from this State are Mr Richard Crane (Coordinator of the SDEP) and Mr Peter Collier (a teacher from Scotch college and a member of the State Youth Advisory Committee).

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<sup>510</sup> Principal Rochedale High School, Brisbane; and President of the Australian Secondary Principals Association

Some elements of the national strategy, which is intended to complement programs in each jurisdiction, include:

- identification of national best practice in drug education;
- improvement of access to drug education best practice models;
- enhancing the range of suitable curriculum material;
- professional development for teachers; and
- identifying and addressing areas of particular need.

The Select Committee commends the Commonwealth for establishing an expert national committee to develop a national approach to school based drug education. At this time, it is not possible to determine the impact on the SDEP as a result of the development of a national framework for drug education in Australian schools.

It would be of concern to the Select Committee if the planned careful expansion of the SDEP, which is widely supported by students, parents and participating schools, was delayed or forced to be remodelled if the Commonwealth supported national guidelines which contradicted the principles of the SDEP.

It is understood at this stage that the Expert National Committee will support a flexible approach by the Commonwealth. Whilst funding is yet to be determined, it is likely that it will use a similar criteria as applied under the NIDE funding when WA received 10% of the national allocation.

An area of need to this State, which would require additional resources, is being able to develop specific Aboriginal education for training teachers working in community schools throughout the State. There is also the need for additional resources to expand undergraduate level training of teachers at universities to equip them to provide drug education.

The annual cost of the SDEP is about \$1.5 million per year. This level of funding will be required up to and including the 1999 school year. Thereafter, it is likely that the annual cost of the SDEP will drop to about \$700,000 per annum to adequately maintain the program through schools in WA. The high initial costs for the SDEP reflect the need to develop a large amount of curriculum materials (which is a one off cost). Therefore, it is important that if additional Commonwealth funds become available that they be utilised to maintain the SDEP which at this time is still being expanded and consolidated.



## Chapter 10: Matters arising from Interim Report

### 10.1. Introduction

Following the tabling of its Interim Report, the Select Committee undertook travel to Sydney (in February 1998) where it met with a number of key staff involved with the New South Wales Crimes Commission. Evidence was obtained from presentations at this meeting about the role and function of the Commission, the operation of its asset investigation and forfeiture responsibilities, the impact of the Wood Royal Commission on drug law enforcement in NSW and the relationship between the Commission and the Police Integrity Commission. The Select Committee also received an overview of the illicit drug education programs within the NSW Police Service.

The Select Committee also met with representatives of the New South Wales Department of Corrective Services. Presentations by this department's representatives dealt with a number of areas, including the management of security and drug surveillance in NSW prisons, and of the provision of comprehensive education and treatment services targeted at those prisoners who are assessed as having substance abuse problems.

Information in this Chapter discusses the approach in New South Wales of establishing mechanisms to identify and seize assets obtained by individuals and groups involved in serious organised drug related crime, its framework to maintain police standards and integrity measures (especially in the context of drug law enforcement) and the issue of the need for prison programs to prevent the spread of blood borne viruses caused by injecting drug use in prisons.

### 10.2. NSW Crime Commission

The major New South Wales confiscation legislation in respect of serious crime is the NSW *Criminal Assets Recovery Act 1990* (CARA), which replaced the NSW *Drug Trafficking (Civil Proceedings) Act 1990* (DT(CP)). CARA was proclaimed on 3 August 1990 (in respect of drug related crime) and on 25 July 1997 (in respect of other serious crime) and is administered by the New South Wales Crime Commission (NSWCC). The key provisions under the legislation, enabling the confiscation of assets and for proceeds assessment orders to be made in the civil jurisdiction of the Supreme Court of New South Wales, are outlined below.

#### 10.2.1. Forfeiture of assets of a serious crime offender

A restraining order can be obtained to prevent a person dealing with his/her property by satisfying the Supreme Court that there are reasonable grounds to suspect that a person has been engaged in a serious crime related activity.<sup>511</sup>

An assets forfeiture order must be applied for within 48 hours of the making of a restraining order if the restraining order is to be preserved. The Supreme Court must make an assets forfeiture order if it finds on the balance of probabilities that the person, whose suspected serious crime related activity or activities formed the basis of the restraining order, was engaged in a serious crime related activity (drug related activity involving an indictable quantity of prohibited drugs) during the six years prior to the commencement of proceedings.<sup>512</sup>

A person can successfully exclude property from the making of such an order if he/she can show that the property was not illegally acquired property.<sup>513</sup>

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<sup>511</sup> S 10.

<sup>512</sup> S 22.

<sup>513</sup> S 25.

**Recommendation 38**

***That the Select Committee reaffirms Recommendation 40 in its Interim Report concerning the need for non conviction based forfeiture legislation and urges the Attorney General to expedite the drafting and passage of the same into law.***

## **10.2.2. Effective control provisions**

CARA allows the lifting of the “corporate veil” and permits a court to look behind the legal and equitable interests in property, to determine whether the interests in property ought to be regarded as that of the defendant.<sup>514</sup>

## **10.2.3. Illegally acquired property**

In the case of the *Cth DPP v Jeffery* in the NSW Supreme Court on 15 January 1992, Hunt CJ held inter alia that property acquired by the use of funds made available to the applicant by reason of taxation offences, such as failing to furnish returns or understating income, are deemed to be indirectly derived from an unlawful activity.

## **10.2.4. Serious criminal activity**

Serious criminal activity includes, in addition to drug related offences, offences punishable by imprisonment for five years or more and which involve theft, fraud, obtaining financial benefit from the crime of another, money laundering, extortion, violence, bribery, corruption, harbouring criminals, blackmail, obtaining or offering a secret commission, perverting the course of justice, tax or revenue evasion, illegal gambling, forgery and homicide.

## **10.2.5. Forfeiture of serious crime derived property**

A restraining order can be obtained to prevent a person dealing with his/her property if there are reasonable grounds to suspect that the property is serious crime derived property.<sup>515</sup>

An interest in property is serious crime derived property if:<sup>516</sup>

- it is all or part of the proceeds of a serious crime related activity;
- it is all or part of the proceeds of the disposal of or other dealings in serious crime derived property; or
- it was wholly or partly acquired using serious crime related property.

An assets forfeiture order must be applied for within 48 hours of the restraining order if the restraining order is to be preserved. The Supreme Court must make an assets forfeiture order if it finds on the balance of probabilities that the person whose suspected serious crime related activity or activities formed the basis of the restraining order was engaged in a serious crime related activity (drug related activity involving an indictable quantity of prohibited drugs) during the six years prior to the commencement of proceedings.<sup>517</sup> A person can successfully exclude property from the making of such an order if he/she can show that the property was not illegally acquired property.<sup>518</sup>

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<sup>514</sup> Ss 7, 8.

<sup>515</sup> S 10.

<sup>516</sup> Section 9 of CARA

<sup>517</sup> S 22.

<sup>518</sup> S 25.

### 10.2.6. Proceeds assessment order

If a restraining order has been obtained as described above and a forfeiture order has not been applied for, a proceeds assessment order (PAO) must be applied for within 48 hours of the making of a restraining order if the restraining order is to be preserved.

The Supreme Court must make a proceeds assessment order where it finds on the balance of probabilities that a person has engaged in a serious crime related activity in respect of drug related activity involving an indictable quantity of prohibited drugs.<sup>519</sup>

The amount a person is required to pay under a PAO is a debt payable by the person to the Crown and is recoverable as such.

### 10.2.7. Calculation of amount of Proceeds Assessment Order

The legislation does provide methods to assist in calculating the amount of the PAO. However, it does not include all methods. It is to be noted that the legislation refers to proceeds, not profit. Section 28(4)(a) of CARA provides that in making an assessment of proceeds, expenses or outgoings incurred by the defendant in relation to the drug activity are not to be deducted.

Monies received by a person as agent for another are also not to be deducted. If (for example) a person is paid money in exchange for drugs (whether controlled buy money or not) as an agent for a drug supplier, the full amount is considered to be the proceeds of serious crime activity of the person acting as agent. In the calculation by the Court, no deduction from the total of monies received can be made of monies paid by the agent to the drug supplier.<sup>520</sup>

If evidence is given at a hearing for a proceeds assessment order of the amount of a defendant's expenditure during the period of six years before the making of the application for the order, the Supreme Court is to treat any such amount as proceeds derived by the defendant from an illegal activity or activities, except to the extent the Supreme Court is satisfied that the expenditure was funded from legitimate funds.<sup>521</sup>

### 10.2.8. Control and seizure orders

The Supreme Court may (if it considers that the circumstances so require) order the Public Trustee to take control of some or all of interests in property to which the restraining order relates.<sup>522</sup> The Supreme Court may make an order requiring or authorising the seizure or taking possession of property.<sup>523</sup>

### 10.2.9. Hardship provision

CARA provides for the relief from hardship for spouses and dependants of the person who will forfeit an interest in property under any asset forfeiture order. The Court will not make an order in respect of hardship in favour of the dependant of a person whose serious crime related activity formed the basis for the assets forfeiture order concerned unless the Court is satisfied that the dependant (this does not apply to dependants under 18 years of age) had no knowledge of any serious crime related activity.<sup>524</sup>

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<sup>519</sup> S 27.

<sup>520</sup> S 28(4)(b).

<sup>521</sup> S 28(3).

<sup>522</sup> S 10(4).

<sup>523</sup> S 12(1)(e).

<sup>524</sup> S 34.

### **10.2.10. Reasonable living expenses**

Section 10(5)(a) provides for reasonable living expenses of any person (including dependants of the person) whose interest in property is subject to the restraining order.

Whether the NSWCC will consent to any application for orders for reasonable living expenses will depend on the facts. In instances where the restraining order restrains interests in property acquired after the order was made, it is likely the NSWCC will consent. It would be unreasonable to restrain the future legitimate income of a person without providing for reasonable living expenses.

### **10.2.11. Reasonable legal expenses**

Section 10(5)(b) provides for reasonable legal expenses of any person whose interest in property is subject to the restraining order, being expenses incurred in connection with the application for the restraining order or an application for a confiscation order, or incurred in defending a criminal charge.

Section 16A sets out restrictions on payment of legal expenses from restrained property. In essence this Section provides that:

- no provision is to be made unless the Supreme Court is satisfied the person cannot meet the expenses out of the person's unrestrained property;
- no provision is to be made in relation to any particular interest in property if the Supreme Court is satisfied that the interest is illegally acquired property;
- no provision is to be made unless a Statement of Affairs disclosing all the person's interests in property and liabilities and verified on oath by the person has been filed with the Supreme Court;
- no provision is to be made unless the Supreme Court is satisfied that the person has taken all reasonable steps to bring all of the person's interests in property within the jurisdiction of the Court; and
- any such provision must specify the particular interest in property out of which the expenses concerned may be met.

### **10.2.12. Confiscated funds**

Section 32 of CARA provides for the establishment by the Treasurer of an account called the "Confiscated Proceeds Account". Forfeited monies, proceeds from the sale of forfeited property and amounts recovered from proceeds assessment orders are credited to the Proceeds Account.

Section 32(3) sets out how the funds in the Proceed Account can be used:

From the Proceeds Account there is to be paid:

- to the Treasurer - the amounts from time to time determined by the Treasurer in consultation with the Minister as payable for the purpose of administering this Act;
- any amount required to be paid in accordance with an order of the Supreme Court under this Act;
- to the credit of the Victims Compensation Fund established under the Victims Compensation Act 1987 - such amounts as are determined by the Treasurer in consultation with the Minister; and
- other amounts in aid of law enforcement, drug rehabilitation or drug education as directed by the Treasurer in consultation with the Minister.

The values of realisable confiscation orders (including legal costs recovered) for the period 1990/91 to 1996/97 are set out in Table 10.1.

**Table 10.1: Realisable values of confiscation orders under CARA 1990/91 - 1996/97**

Year	Value (\$)
1990/91	118,515
1991/92	650,500
1992/93	3,123,528
1993/94	1,528,000
1994/95	3,376,639
1995/96	5,196,108
1996/97	4,000,345
<b>Total</b>	<b>17,993,635</b>

### 10.2.13. Examinations

The Supreme Court may order the examination on oath before the Court of the owner of an interest in property that is subject to a restraining order or another person concerning the affairs of the owner, including the nature and location of property in which the owner has an interest.<sup>525</sup> A spouse or defacto spouse of the owner of restrained property can also be examined.<sup>526</sup>

Section 13 provides that a person being examined is not excused from answering any question, or from producing any documents, on the grounds that the answer or production might incriminate the person, or on the ground that the production of the document would be in breach of an obligation of the person not to disclose. Any statement or disclosure made by a person in answer to a question put in the course of an examination is not admissible (with some exceptions) against the person in any civil or criminal proceedings.<sup>527</sup>

### 10.2.14. Production orders

Section 33 provides for an authorised officer to apply to the Supreme Court for a production order which requires a person to produce property - tracking documents.

The decision in respect of legal professional privilege in *NSWCC v Larssen* on 10 May 1991 is noteworthy.<sup>528</sup> Justice Newman in the Supreme Court considered sections 33 and 35 of the DT(CP) Act and legal professional privilege following an application from two firms of solicitors who resisted the order claiming legal professional privilege. He held inter alia that:

- a person is not excused from complying with an order for production on the ground of breach of obligation imposed by legal professional privilege; and
- the legal professional privilege belongs to the client, not his legal adviser. However, it places an ethical obligation upon the legal adviser not to disclose certain documents without his client's consent. Section 35(1)(b) of the DT(CP) Act abrogates this obligation.

### 10.2.15. Search warrants

CARA provides for applications to be made by authorised officers for search warrants.<sup>529</sup>

In the case of serious crime derived property, illegally acquired property of a person suspected of serious crime related activities, evidence of a serious crime related activity or property subject to

<sup>525</sup> S 12 (1)(b1).

<sup>526</sup> S 12 (1)(b1).

<sup>527</sup> S 13(2).

<sup>528</sup> 53 A Crim R 131.

<sup>529</sup> NSW Police Officers are included under the definition of “authorised officer”.

a restraining order believed to be on premises, a search warrant can be applied for under Section 38 to seize such items.

In the case of property suspected of being in or on any premises, a search warrant can be applied for under Section 44 of CARA. In the case of tracking documents suspected of being in or on any premises, a search warrant can be applied for under Section 45 of CARA.

### **10.2.16. Monitoring orders**

Section 48 provides that on application by an authorised officer the Court may make a monitoring order which directs a financial institution to give to the NSWCC information about transactions conducted by a particular person with the institution.

### **10.2.17. Communications of information by financial institutions to the NSWCC**

If a financial institution has reasonable grounds for believing that information it has about a transaction with the institution:

- might be relevant to an investigation of a serious crime related activity or the making of a confiscation order; or
- might otherwise be of assistance in the enforcement of CARA and the regulations,

the institution may give the information to the NSWCC.<sup>530</sup>

### **10.2.18. Management of the confiscation function within the NSWCC**

The confiscation function within the NSWCC relates to serious crime. The commencement of proceedings is undertaken by the Financial Investigation Team (FI Team), which assesses all matters referred to the NSWCC for confiscation consideration. The FI Team will prepare all documentation for the matter and solicitors attached to NSWCC investigation teams will (on a rostered basis) attend before a Supreme Court Judge and make an *ex parte* application for the restraining and other orders sought.

The FI Team has a manager and 11 other staff, consisting of five senior financial investigators (who conduct the financial investigation and manage the litigation of matters in which confiscation proceedings have commenced), two financial investigators, analyst (legal) and seven support staff.

### **10.2.19. Source of matters for consideration**

NSW Police, pursuant to an instruction from the NSW Police Commissioner, must report to the NSWCC details of each drug arrest in NSW which involves an indictable quantity of a prohibited drug (5 grams of heroin, cocaine, amphetamine; 1 kilogram of cannabis leaf, 50 cannabis plants, 90 grams of cannabis resin, 25 discrete dosage units of LSD, etc).

New instructions will be issued concerning other serious crime but can still be reported to the NSWCC. Each matter reported by police is reviewed by the FI Team. Arresting police will forward to the NSWCC a facts sheet and a completed “Suspects Financial Profile Questionnaire”. This form can be used also for all serious crime offences until a new form has been prepared and issued. The information provided is reviewed and a decision made as to whether the matter warrants confiscation proceedings, whether no further action is to be taken or whether further investigation is required.

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<sup>530</sup> S 51.

Where no further action has been approved in relation to a matter, the NSWCC advises the police officer involved by letter of the reasons for such decision. If the officer believes all the facts have not been taken into account, he can (and should) advise the NSWCC and the matter will be reassessed.

Other sources include THE Australian Federal Police and the National Crime Authority, in respect of investigations by them where a decision has been made not to use the Federal confiscation legislation.

The NSWCC has also commenced a money laundering reference, which is concentrating on the investigation of persons with assets who have been involved in serious crime related activities or who are believed to have been so involved. A principal aim of the investigation is to confiscate assets from career criminals who in the past may have avoided prosecution or confiscation action. A number of confiscation proceedings have been commenced from this source.

### **10.2.20. Criteria for assessing whether to commence proceedings**

Before the NSWCC commences confiscation proceedings in the NSW Supreme Court, assessments need to be made of:

- The evidence available to establish on the civil onus that a person has engaged in a serious crime related activity (involving an indictable quantity in respect of drug related activity).
- CARA has a six year relation back provision which in effect makes conduct in the six years prior to the commencement of proceedings a possible target of the Act.
- CARA catches serious crime related activity whether or not a conviction has been recorded.
- The evidence available to establish on the civil onus that a person has obtained a benefit from his involvement in a serious crime related activity. This assessment is linked to a consideration of a person's acquisition of assets over time, as the increase in value of assets over a relevant period may be deemed to be the benefit obtained by a person from his serious crime related activity.
- Whether the value of the person's property is sufficient to satisfy any confiscation orders made, ie. evidence of the net worth of the property of the relevant person. This will include property over which the person is capable of exercising control even if the property is not recorded as owned by the person.
- The ability of any person to exclude property under sections 25 or 26 of the Act by proving that the property or a part of it was acquired with funds from a lawful source. Additionally, an assessment is made of the availability of evidence as to the illegal source of the monies used by the person to acquire his property.
- Whether the action will be profitable given the right of a person to make an application under S 10(5)(a) and (b) of CARA for the release of restrained property to enable him or her to meet reasonable legal and living expenses.
- Whether there will be anything left to satisfy the confiscation orders after his/her legal representatives have been paid. Even where the person under consideration initially has a valuable estate, the court usually allows him or her access to it for the purpose of defending the criminal and confiscation proceedings.
- The effect of a hardship application made by the person's dependants under Section 24 of the Act.

### **10.2.21. Commencement of proceedings**

When confiscation proceedings have been commenced in the Supreme Court in respect of a matter, it is allocated to a senior financial investigator to conduct a financial investigation. In many cases, a detailed financial investigation is undertaken. The NSWCC currently has seven senior financial investigators conducting these investigations.

### **10.2.22. Financial investigation**

Police can assist the confiscation function by ensuring that information concerning the financial affairs of the suspected serious crime offender is collated from the beginning of an investigation. Financial information including evidence of proceeds earned from serious criminal activity can be gathered by the investigation team from:

- informants (should be questioned about financial affairs of suspect as well as about criminal activities);
- telephone intercepts and/or listening devices surveillance reports;
- Lands and Titles Office, Roads and Traffic, Austrac, Australian Securities Commission and other basic searches;
- documentation seized upon execution of search warrant;
- questioning of offender upon arrest;
- questioning of spouse and family members upon arrest of offender; and
- further inquiries following arrest.

### **10.2.23. Main purpose of financial investigation**

The main purpose of a financial investigation is to identify assets and the sources of funds used to acquire those assets. The financial evidence collected may also provide evidence which will assist the criminal prosecution.

Other financial information or evidence required includes details of:

- legitimate income of offender, spouse and family over the last 6 years (at least);
- all illegally acquired income; and
- proceeds of drug activity.

### **10.2.24. Timing of referral to the NSWCC**

When it becomes evident during a serious crime investigation that suspects have assets, the sooner the FI Team of the NSWCC can be briefed on the situation the better. The FI Team can provide advice and assistance in relation to the financial side of the investigation.

In practise, when the NSWCC is involved in the matter prior to arrests, profiles have been prepared and presented at a briefing for the operation. These have enabled the police interviewing the alleged offender to ask relevant questions concerning assets. Admissions of proceeds of serious crime activity being used to purchase real estate have been obtained in the past by asking such questions. This enabled swift confiscation proceedings to be commenced.

Speed is also of the essence when a large amount of money is discovered in a bank account. As soon as documents are seen or information is received concerning large sums of money in bank accounts or otherwise invested, the FI Team should be advised. Unless swift action in these cases is taken and the accounts restrained, the money can easily be lost.

In other cases, confiscation proceedings can be commenced to coincide with arrests. Orders to restrain assets or to seize certain assets (such as motor vehicles, motor cycles or other valuable assets) can be obtained prior to arrest.

### **10.2.25. Basic financial checks**

When the NSWCC receives information of a serious crime arrest (in respect of drug related crime involving an indictable quantity of prohibited drugs) and there is an indication of assets, a number of basic checks are carried out (LTO, Austrac, ASC and RTA).

If these checks have already been done by the investigation team, copies of these searches would be appreciated.

Generally, the result of these checks are collated on to a proforma document headed “Confiscation Suspect Profile”. The document makes easier reading than the computer print outs. It clearly sets out the search criteria, the date checks were made or the date of the microfiche used for checking.

A separate section is available for “previously owned real estate” and “previously owned motor vehicles”. Details of previously owned assets are required because, in all probability, the proceeds of the sale of these assets will have funded the purchase of currently owned property or assets.

### **10.2.26. Limitations to basic checks**

Limitations to basic checks are self evident. More people dealing in drugs or committing other serious crimes hide their assets from the start. This will never be discovered relying on basic checks. Many assets are also not on the public record (for example, works of art, antique furniture and investments in financial institutions).

If the NSWCC is to rely only on the basic checks, there will be many matters in which it will not find significant assets. This means that it is vital that the gathering of financial evidence and information must begin at the same time the criminal investigation commences.

Prior to arrest, it would be ideal if the “Confiscation Suspect Profile” could be completed and also a chronology of all financial/serious crime evidence prepared.

### **10.2.27. Search warrants for financial documentation**

In a number of matters commenced by the NSWCC, the documents seized pursuant to search warrants have been invaluable. One recent matter commenced involved a number of properties in false names. Documents seized by police included numerous false drivers licences, birth certificates and marriage certificates, which enabled the properties to be identified.

A warrant for “property tracking documents” can be obtained under the Act. However, if police wish to use warrants under the NSW *Search Warrants Act*, the offence of money laundering under the COPOC Act may be an offence to rely on to enable relevant documentation to be seized.

### **10.2.28. Assistance available to police from the NSWCC**

The NSWCC can provide advice and, in instances where a person being investigated does have significant assets, may be willing to conduct covert inquiries and work with investigating police with a view to considering commencement of confiscation proceedings at the same time as the arrest. The extent of the NSWCC's ability to provide such assistance in any particular case will depend on the NSWCC's current workload.

## **10.3. Police Integrity Commission**

### **10.3.1. Introduction**

Law enforcement misconduct covers a broad spectrum of activity, from minor transgressions of rules and procedures to significant misconduct. There are three broad types of law enforcement

## Select Committee Into Misuse of Drugs Act 1981

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misconduct: excessive use of force, corruption and ‘process corruption’. The public perception is that complaints and corruption are about law enforcement, agencies and officers doing the wrong thing. Both of these are misconduct.

In the course of an inquiry by the Australian Law Reform Commission into the issue of dealing with complaints in relation to the Australian Federal Police, corruption was defined as

*“law enforcement behaviour that results in private gains at public expense ... (and can also) involve the misuse of authority by law enforcement officers so as to produce personal gain for themselves or others. There can also be ‘process corruption’ where law enforcement officers fabricate evidence, act illegally in the course of investigations or in other ways subvert or obstruct the administration of justice”.*<sup>531</sup>

### 10.3.2. Integrity procedures and drug law enforcement

In NSW, the need for adequate procedures to maintain police standards and to address misconduct in relation to drug matters was highlighted during the Wood Royal Commission. The Wood Royal Commission revealed the inadequacies in the NSW system to deal with complaints against police. It found that

*“the existing system was widely regarded as cumbersome, slow and inflexible; insufficiently responsive to corruption; unproductive in terms of the resources and managerial time involved; lacking in credibility; and counter productive in terms of overall operational effectiveness.”*<sup>532</sup>

In its Interim Report, the Select Committee specifically endorsed recommendations of the Wood Royal Commission with reference to the detection, investigation and prosecution of illicit drug offences by WA police (Recommendation 52).

### 10.3.3. NSW Police Integrity Commission

The Police Integrity Commission (PIC) was set up as a result of the Royal Commission into the NSW Police Service. The legislation establishing the PIC was passed in June 1996, with the machinery and administrative provisions of the Act proclaimed so it could commence operations on 1 July 1996.<sup>533</sup> The PIC commenced its principal functions on 1 January 1997 following proclamation of the other parts of its Act.

The principal functions of the PIC are to prevent, detect and investigate serious police misconduct.<sup>534</sup> One of its other functions is to assemble evidence for the prosecution of persons, including police officers, for criminal offences or disciplinary offences.<sup>535</sup> One of the products of the Commission, and a significant measure of its success, will be the extent to which the evidence and information it acquires is able to be used in such prosecutions.

The success of prosecutions has implications for the way in which the PIC operates. The gathering of admissible evidence is not always best carried out by public hearings, particularly since answers given or material produced at such hearings are not generally admissible in evidence against the witness in civil or criminal proceedings (although they are admissible in disciplinary proceedings).

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<sup>531</sup> Australian Law Reform Commission. *Integrity: but not by trust alone – AFP and NCA complaints and disciplinary systems*. Sydney. Australian Law Reform Commission 1996, para 2.16.

<sup>532</sup> Police Integrity Commission Annual Report 1996/97, 7.

<sup>533</sup> Police Integrity Commission Act 1996.

<sup>534</sup> S 13.

<sup>535</sup> S 15.

The NSW *Police Integrity Commission Act 1996*<sup>536</sup> provides that the NSW *Drug Trafficking (Civil Proceedings) Act 1990*<sup>537</sup> (DT(CP)A) applies to the Commission in the same way as it applies to the NSW Crime Commission (NSWCC). This means that the functions that may be exercised by the NSWCC may also be exercised by the PIC. The Act specifically states that it is intended that the PIC will exercise a function under the DT(CP)A only in connection with matters arising during or out of its own investigations. The PIC may only do this after it has consulted with the NSWCC.

### 10.3.4. Category 1 complaints

Category 1 complaints are the most serious class of complaints made against police officers. The NSW *Police Integrity Commission Act 1996*<sup>538</sup> and Part 8A of the NSW *Police Service Act 1990* confer functions on the PIC with regard to making decisions on Category 1 complaints made against serving or former police officers.

On 15 January 1998, the PIC Commissioner and the Ombudsman signed a new agreement defining Category 1 complaints as follows:

- A complaint that a police officer has or may have sought or may seek to pervert the course of justice by giving false evidence, by destroying or interfering with evidence, by withholding or refraining from giving evidence, by fabricating evidence or by influencing another so to act.
- A complaint that a police officer has or may have committed or may commit
  - an assault which has caused or may cause a serious injury and which could lead to a charge of maliciously wounding or inflicting grievous bodily harm upon a person pursuant to section 35 of the NSW *Crimes Act 1900*;
  - an offence (including larceny) relating to property where the value exceeds \$5,000; or
  - any offence (other than assault occasioning actual bodily harm) punishable on conviction on indictment by a maximum sentence of imprisonment or penal servitude for five years or more.
- A complaint that a police officer has or may have solicited or accepted, or may solicit or accept, a benefit for himself/herself or for another in return for failing to carry out his/her duties.
- A complaint that a police officer has or may have sought or may seek to interfere improperly in the investigation by another police officer of an alleged offence.
- A complaint that a police officer investigating an offence alleged to have been committed by another police officer has or may have improperly failed to carry out, or may improperly fail to carry out, his/her duties in the course of that investigation.
- A complaint that a police officer has or may have manufactured, or may manufacture, a prohibited drug, cultivated or may cultivate a prohibited plant, or supplied or may supply a prohibited drug or a prohibited plant, unless the amount or number of such drug or plant is less than the indictable quantity therefore as specified in the NSW *Drug Misuse and Trafficking Act 1985*.

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<sup>536</sup> S 19.

<sup>537</sup> *Drug Trafficking (Civil Proceedings) Act 1990* has since been amended and renamed the *Criminal Assets Recovery Act 1997*.

<sup>538</sup> *Police Integrity Commission Act 1996*, Part 4.

## **10.4. Drug use in prisons**

### **10.4.1. Introduction**

*“In theory the community is entitled to believe that once offenders are placed into custody, they are secured in a controlled environment which should make drug abuse, trafficking or continued criminal activity extremely difficult to exist.”<sup>539</sup>*

In its Interim Report, the Select Committee proposed a range of measures to deal with the serious problem of illicit drug use in prisons, ranging from improved detection systems to dedicated drug treatment/rehabilitation centres within prisons. In the course of its interstate visits, the Select Committee met with a number of officials from the NSW Department of Corrective Services. The Select Committee was impressed with the focus by the NSW prison system on interdiction of drugs (such as the development of Task Force STED) and other measures to limit opportunities for drugs to be brought into prisons. As with Western Australian prisons, NSW experience also confirmed that one of the most common methods of drugs entering prisons is via contact visits.

### **10.4.2. Use of drugs in NSW prisons**

To deal with this problem, Task Force STED has instituted comprehensive measures. These include a corrections and intelligence group supported by intelligence officers at correctional centres, the use of active and passive drug detection dogs, a mobile fan assisted drug detection unit, search programs and the power to place restrictions or ban visitors known or suspected to have been involved in bringing drugs into prisons. A feature of the NSW system is the display of prominent messages at all entry points to the correctional centres, warning visitors of the legislation and applicable penalties if they are convicted of bringing in drugs and injection equipment into a prison.

The comprehensive approach also includes developing relationships with other agencies. For instance, when a person is found to have brought prescription drugs into a NSW prison, attempts are made to establish the identity of the prescribing doctor. Once established, the doctor is notified of the diversion of the prescription. A list of these doctors is provided to the NSW Health Department, while the identity of the person to whom the drugs were prescribed is provided to the Health Insurance Commission.

It has been noted that in NSW about 8 out of 10 prisoners have been imprisoned as a result of a conviction for a drug related offence or are drug dependent. This concentration of individuals with drug problems at the time of incarceration is conducive to creating an environment of intense demand for drugs and a willingness to offend that is more marked than in the broader community. It has been noted that this results in a large number of complex problems that prison administrators have to deal with.

*“Drug trafficking in correctional centres leads to stand over tactics, an underground economy, violence, assaults on both inmates and staff, inmate power bases, continuation of the recidivist cycle, the spread of communicable diseases, needle stick injuries, deaths in custody, murders, corruption and a constant threat to the security, good order and discipline of correctional centres.”<sup>540</sup>*

Similar problems have been noted in many other jurisdictions, as a great number of prisoners have serious drug and other health problems. For instance, in the United States it has been found that about three quarters of prisoners had a history of drug abuse and that more than half were under the influence of alcohol or other drugs when they committed an offence.<sup>541</sup> In NSW, it has been

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<sup>539</sup> Kelly B “Drugs in prison – Part 1”. *ABCI Intelligence Digest*, July 1996, 29.

<sup>540</sup> *Ibid.*

<sup>541</sup> Cited in Incorvaia D, Baldwin S. “Drugs behind bars (part 1): a multi-dimensional approach to correctional services settings.” (1997) 2 *Journal of Substance Misuse* 69-76.

found that two thirds of prisoners were under the influence of a drug at the time of their arrest. Furthermore, two thirds of prisoners said their offence was related to alcohol or other drugs.<sup>542</sup>

### 10.4.3. Prisoners and blood borne viruses

Another issue of concern is that, following release from prison, IDUs have a much higher risk of death from overdose. A recently published Scottish study of a large sample of prisoners has estimated that there is a relative risk of about 8:1 from death of overdose in the first 2 weeks after release.

*“Prison may not markedly increase the overall risk of injecting drug users dying from an overdose, but the time immediately after release is one of intensified risk, probably caused by a decrease in tolerance to drugs as a result of less frequent injecting while in prison or the lower purity of drugs found in prison.”<sup>543</sup>*

In the UK, a recent survey of more than 500 adult male remand prisoners found that two thirds had used illicit drugs at the time of reception, 24% had injected drugs and a third had shared needles. Of concern, only a small proportion of those abusing drugs were assessed by prison doctors and only 5% who needed detoxification actually received it.<sup>544</sup>

The issue of drug use in prisons is of particular concern because of the high proportion of prisoners who have been injecting drug users (IDUs). For instance, in NSW research has found that 50% of the prison population have been IDUs prior to their imprisonment and that half of these IDUs continue to inject whilst in jail.<sup>545</sup>

There has been great concern in this State, as in many other jurisdictions, for measures to reduce demand for drugs in prisons, particularly to avoid the great risk to the community (particularly their sexual partners) from the transmission of blood borne viruses (BBVs) from released prisoners who have become infected through sharing injection equipment whilst they have been incarcerated. The concern about BBVs includes HIV, but more recently there has been growing awareness about how readily Hepatitis C (HCV) can be spread and of the high morbidity associated with this illness. It needs to be understood that prisons are heterogenous populations with sub groups who have high risks based on gender, sex, ethnicity, etc.

*“HIV infection is more prevalent in prison populations than in the corresponding community because of the increased prevalence of HIV infection in IDUs and the high proportion of IDUs in prison populations. As early as 1988, about half of the inmates in Madrid and 20% of prisoners in New York City tested HIV positive. Within prison populations, certain groups have higher levels. In 10 US correctional systems, infection levels were higher among women (15%) than men (8%), among younger women (5%) than younger men (2%) and among non Caucasians (5%) than Caucasian (3%). It was estimated that in New York state prisons in 1988, there were 2,200 male and 200 female HIV positive entrants, making HIV the leading medical problem among inmates.”<sup>546</sup>*

As indicated in the Interim Report, the Select Committee believes that the implementation of more comprehensive drug and alcohol assessment procedures will assist in the long term management of prisoners over the term of their incarceration. There is clearly a need for a significant amount of resources to be made available to the Ministry of Justice to implement demand reduction measures. Given the public health issues involved, it is essential that adequate

<sup>542</sup> Kevin M. *Drug and alcohol exit survey. Part one: drug and alcohol background of inmates.* Sydney, Department of Corrective Services, 1992.

<sup>543</sup> Seaman SR, Brett RP, Gore SM. “Mortality from overdose among injecting drug users recently released from prison: database linkage study.” (1998) 316 *British Medical Journal* 426-428.

<sup>544</sup> Mason D, Birmingham, Grubin D. “Substance use in remand prisoners: a consecutive case study.” (1997) 315 *British Medical Journal* 18-21.

<sup>545</sup> The Health Report. “HIV-AIDS in prisons.” Radio National Transcripts 18 November 1996.

<sup>546</sup> Dolan K. “AIDS, drugs and risk behaviour in prison: state of the art.” (1977) 8 *International Journal of Drug Policy* 7.

## **Select Committee Into Misuse of Drugs Act 1981**

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treatment procedures be developed. In chapter 2 of our report, the Select Committee makes a number of recommendations in regard to the Ministry of Justice.

### ***Recommendation 39***

***That the Ministry of Justice gives priority to implementing innovative educational and appropriate treatment programs which give the highest priority to the prevention of blood borne viruses in the prison population associated with the use of drugs in West Australian prisons and that appropriate legal coercions be used to assist in achieving realistic outcomes in all such programs.***