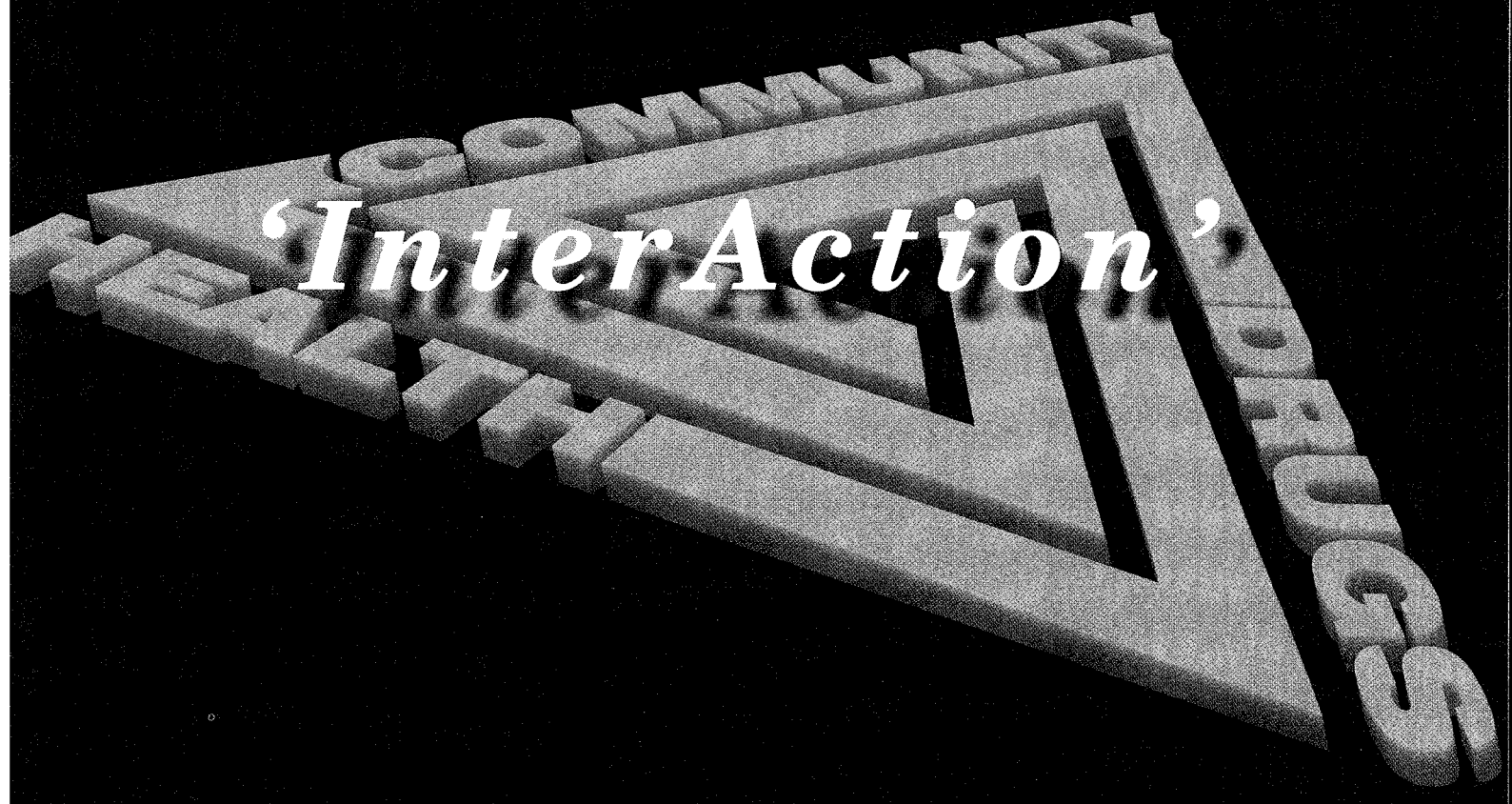
HEALTH DEPARTMENT OF WESTERN AUSTRALIA

DRUG STRATEGY 1999–2003



'InterAction'

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CONTENTS

1. Coordination

- Establish an Alcohol and Drug Policy and Planning Section within the Health Department to coordinate policy and planning.
- In collaboration with the Alcohol and Drug Policy and Planning Section, each Health Department Division will develop purchasing intentions from 1999–2000 that encompass alcohol and other drug outputs.
- Develop health service plans to provide enhanced coordination and cohesive alcohol and other drug services for the community.

2. Capacity Building

- Increase the capacity of the health sector to develop and deliver alcohol and other drugs responses, through professional training and consultancy, policy and protocol development, establishing partnerships with other sectors, and other innovative responses.
- Develop the Alcohol and Drug Authority's services into a centre for leadership, clinical excellence, education and training.
- Develop evidence-based clinical protocols for new pharmacotherapies to treat alcohol and other drug problems.
- Consolidate and strengthen undergraduate and postgraduate medical and nursing alcohol and other drug education.
- Collaborative development of evidence-based prevention, treatment and training programs by the Centre for Mental Health Service Research and the Alcohol and Drug Authority.

3. Mainstreaming

- Develop the capacity of the mental health system to assess and manage clients with substance-use problems and the capacity of alcohol and other drug services to assess and manage clients with psychiatric problems.
- Develop the potential for other priority populations (i.e. youth, Aboriginal people, women, culturally and linguistically diverse populations) to access and receive substance use treatment and assistance.
- Develop and support of general practitioners and other primary health practitioners to provide alcohol and other drug services, including: methadone maintenance and other pharmacotherapies; brief intervention and motivational interviewing for clients at risk of alcohol-related harm; and alcohol and other drug detoxification.
- Substantial devolution to general practitioners of methadone treatment by expansion of the Community-Based Methadone Program.

- Establish a statewide alcohol and other drug clinical consultancy service.
- Establish specialist alcohol and other drug services at major metropolitan hospitals.
- Develop regional alcohol and other drug services through the education of general practitioners and health service nursing staff, the development of clinical protocols and resources, and other regionally determined responses.
- Training for general practitioners in home detoxification, in-patient detoxification, new pharmacotherapies and behavioural interventions.

4. Prevention

- Further develop prevention and harm-reduction programs targeting smoking, excessive alcohol consumption and the problem use of illicit and pharmaceutical drugs.
- Collaborative planning and enhanced cooperation between regional and statewide services.
- Proactive use of the Department's statutory powers in the amendments to the Liquor Licensing Act 1988, the Poisons Act 1964, the Tobacco Control Act 1990 and the Health Act 1911 to prevent and minimise alcohol and other drug-related harm.
- Develop a statewide information system about the sources of alcohol-related harm presenting to health services, including Accident and Emergency departments that will inform direct action to prevent further harm.

1. INTRODUCTION

The purpose of this document is to present a strategy for addressing the health sector's role in managing the problems arising from the use of alcohol and other drugs*.

This strategy has been developed primarily for the government health sector but will involve the collaboration of non-government, other government, corporate and community groups. This document is intended to shape the broad activities of the Health Department of Western Australia, including these collaborations, and is therefore designed as an internal document.

Priority Health Department activities are in prevention, early intervention, treatment, continuing care, research and coordination. The strategy is informed by an evidence-based approach to each of these issues, and expert sector development is provided by specialist services located within the Health Department.

The Health Department WA Drug Strategy 1999–2003 has been developed within the context of the Western Australian Strategy Against Drug Abuse, titled *Together Against Drugs*, and gives action to key health sector strategies identified within this strategy.

Together Against Drugs sets out a comprehensive, across-government plan including responses through public education, health services, community support services, law enforcement and community action. Implementation of this strategy is coordinated by the Western Australian Drug Abuse Strategy Office (WADASO).

The Health Department of Western Australia introduced a new program model in 1997 which integrates the related dimensions of health conditions, the resources invested in their management, the interventions aimed at their prevention, treatment and care, and specific measurable outcomes. The Health Department WA Drug Strategy 1999–2003 has been developed to be consistent with this new program model.

In 1998, the Ministerial Council on Drugs Strategy released the draft National Drug Strategic Framework 1998–2002. The priorities identified in this document include partnerships, linkages with other strategies, prevention, treatment services, Police and Customs services, professional education and training, research and evaluation.

The implementation of the National Drug Strategy 1998–2002 will be coordinated by an Inter-governmental Committee, including Health Department of WA representation. This committee is also informed by expert advisory groups.

The Health Department WA Drug Strategy 1999–2003 is in accord with the draft National Drug Strategy.

Coordination of alcohol and other drug policy in the Health Department is provided by the Health Department Alcohol and Drug Policy and Planning Section. This section is located in the Mental Health Division and has an across-health role facilitated through collaborative, intra-departmental coordination.

* For the purpose of this document alcohol and other drugs will refer to alcohol, tobacco, illicit drugs, and illicit use of pharmaceuticals and inhalants.

2. MISSION

To reduce the health problems arising from the use of alcohol, tobacco and other drugs in the West Australian community.

3. PRINCIPLES

The purchasing of alcohol and other drug services will be guided by a set of strategic principles. These principles are consistent with the Health Department's *Foundations for a Healthier Future*, the draft National Drug Strategy and the WA Strategy Against Drug Abuse. These principles are:

Evidence-based practice
Evidence-based practice and a commitment to continual improvement will ensure the effective and efficient use of resources.

Best use of resources
Ensuring that resources are invested in alcohol and other drug services that meet community needs and achieve the best health outcome for all West Australians.

Social justice
Improving access to alcohol and other drug services for all West Australians and ensuring services are culturally sensitive, delivered in the best setting and as locally as possible.

Continuity of care
Treatment outcomes will be improved by service coordination and the better linking of people with service providers.

Working in partnership
Involving people, both individually and collectively, to determine service needs and establishing partnerships with health and community service providers to ensure complete management of people's alcohol and other drug problems.

Accountability
Accountability to government and the people of this State will be achieved through monitoring, evaluation and the development of performance measures that focus on outputs and outcomes.

Comprehensive approach
Strategies focus on preventing and reducing problem drug use, as well as reducing harm where use is continuing.

4. DRUG-RELATED HARM IN WESTERN AUSTRALIA

Problem alcohol, tobacco and other drug use has a major impact on the health of West Australians and results in a significant demand for health services. The main drug-related conditions for which people are admitted to hospital in Western Australia are shown in Table 1.

Table 1. The main drug-related conditions causing hospitalisation

Tobacco	Alcohol	Illicit, Pharmaceutical and Other Drug-related Conditions
Ischaemic heart disease	Fall injuries	Suicide attempts
Chronic obstructive pulmonary disease	Assault	Dependence
Atherosclerosis	Road injuries	Drug psychoses
Lung cancer	Alcohol dependence	Drug use disorders
Peptic ulcer	Alcohol abuse	Complications of pregnancy/infancy
Stroke	Alcohol psychosis	Accidental poisoning
Cardiac dysrhythmia	Stroke	Conditions relating to injecting drug use
Pneumonia	Alcoholic liver cirrhosis	Undetermined cause
Heart failure	Suicide	
Bladder cancer	Epilepsy	

Note: Data in this table was derived from references 2–4 (see page 20).

Table 2 summarises the impact of alcohol, tobacco and other drugs on mortality, morbidity and cost, as a factor of overall mortality and morbidity. Figures 1a–c break these figures down by contributing drug type. More details about the major drug categories and their health effects are given in Appendix 2 on page 25.

Table 2. Average number of hospital admissions, bed days and deaths per year (percentages of admissions, bed days and deaths from all causes)

	Admissions	Bed days	Deaths	Cost of bed days per year
Tobacco	11 746 (2.5%) *1993–95*	82 415 (4.2%) *1993–95*	1502 (15.0%) *1985–96*	$36 million (4.2%) *1993–95*
Alcohol	8548 (1.8%) *1993–95*	58 627 (3.0%) *1993–95*	330 (3.3%) *1985–96*	$26 million (3.0%) *1993–95*
Other Drugs	2315 (0.5%) *1991–95*	10 557 (0.5%) *1991–95*	72 (0.7%) *1985–96*	$4.6 million (0.5%) *1993–95*

Note: Data for admissions and bed days comes from references 2–5, and data for costs and deaths from reference 1–5 (see page 20).

Figures 1a, 1b and 1c: percentage Alcohol and Other Drug conditions

Figure 1a: percentage breakdown, drug-caused deaths (1986–96)

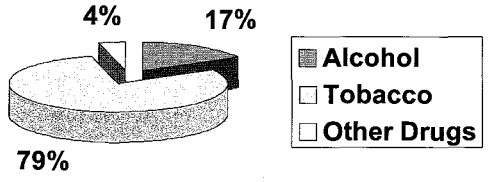


Figure 1b: percentage breakdown, drug-caused admission (1993–95)

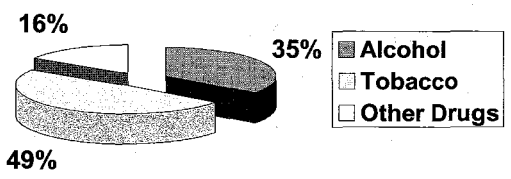
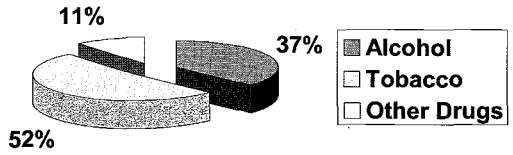


Figure 1c: percentage breakdown, drug-caused bed days (1993–95)



Note: Data in these figures comes from references 2–5 (see page 20)

Costs

The cost of problem alcohol and other drugs use is much greater for health than any other portfolio. Over 43 per cent of the costs associated with alcohol and other drugs are incurred by the health sector.[1]

In 1993 it was conservatively estimated that the problem use of alcohol, tobacco and other drugs in Western Australia cost the health sector in excess of $115 million.[1] In-patient hospital stays were estimated to cost approximately $67 million or 30 per cent of total government funds spent on drug-related problems.[1-5]

In 1997/98, Public Health Services spent some $4.5 million on prevention and harm reduction strategies. Specialist treatment services provided principally by the Alcohol and Drug Authority amounted to some $9 million. Alcohol and other drug services purchased by the Office of Aboriginal Health for aboriginal people amounted to some $0.75 million.[6]

5. PRIORITY AREAS FOR ACTION

Alcohol and other drug-related harm is amenable to intervention. The health sector offers the opportunity to minimise this harm by implementing a comprehensive range of prevention, early intervention, treatment, research, and coordination strategies.

Effectiveness in implementation relies on statewide and community-based strategies that will, at times, engage government and non-government health sector agencies, community groups and other government agencies.

This section states a range of alcohol and other drug strategies that should be implemented by 2003.

Each strategy also identifies the Health Department division that is responsible for its purchase.

5.1 Prevention and Early Intervention

Significant improvements in the health status of the community can be attributed to prevention and early intervention strategies.

Strategies that prevent or intervene early in practices that cause alcohol or other drug-related harm are a primary responsibility of the health sector.

These strategies, when targeted at at-risk and high-risk populations, can reduce the overall incidence of alcohol and other drug-related harm.

This comprehensive range of strategies will include public education, structural change, community action and organisational initiatives, many of which have already been implemented.

However, there are strategies for development within communities that require a reorientation for some public health and other primary health service providers.

To enable greater cohesion and service effectiveness, an emphasis on collaborative planning and practice is imperative. This includes greater cooperation between statewide and regional service providers to enable forward planning. Collaborative projects between government and non-government sectors will also be necessary to deliver the contracted outputs.

Key Strategies for Development

The priority for strategy development by 2003 differs for each drug category. This section states the strategies for priority development in all drug categories. Appendix 1 on page 21 provides a summary of these strategies by drug category.

- Continuing support will be provided for public education strategies, based on the use of mass media, for smoking prevention (Quit) and alcohol harm reduction (Respect Yourself and 100% Control). These campaigns will target high-risk groups. See Appendix 1 for further detail.

- Structural and organisational reform strategies will be further developed for smoking prevention and harm reduction for alcohol, illicit drugs and pharmaceuticals. See Appendix 1 for further detail. A special emphasis will be given to the capacity of the Health Department to plan strategically for structural change through the use of its statutory powers in the amendments to the Liquor Licensing Act 1988, the Poisons Act 1964, the Health Act 1911 and Tobacco Control Act 1990.

- Monitoring and enforcement of the Tobacco Control Act 1990 will be further developed throughout Western Australia with the assistance of health services. The Executive Director of Public Health's statutory right to intervene in liquor licensing will be further developed to reduce alcohol-related harm in West Australian communities.

- Monitoring of alcohol and other drugs mortality, morbidity and consumption will be maintained. See Appendix 1 for further detail.

- Accident and Emergency departments will collect information about alcohol-related harm, including place of last drink. This data will be analysed and used to inform local harm-reduction strategies, including liquor-licensing actions by the Executive Director of Public Health.

- Priority will be given to continuing the monitoring of drug-use patterns amongst adults and school students.

- Priority will be given to supporting general practitioners and primary care providers to conduct early interventions for clients who smoke or whose alcohol consumption places them at risk. This strategy will include the establishment of a project in the Alcohol and Drug Authority to support general practitioners and other primary care providers.

- To enable more effective action, an emphasis on collaborative planning and practice will be introduced. This will involve greater cooperation between statewide and regional service providers. Regional Health Services will be assisted in the development of regional health drug plans that will complement the strategies outlined in this strategy and other divisional plans.

- Blood-borne virus (BBV) prevention programs will continue to be supported through the Needle and Syringe Exchange Program, peer education programs and other innovative responses.

Divisional Responsibility

The Public Health Division will be responsible for the purchasing of these strategies, with the exception of:

- The early intervention strategies will be purchased by the Alcohol and Drug Policy and Purchasing Section (Mental Health Division)
- Public education about illicit drugs. This strategy is a collaborative initiative with the WA Drug Abuse Strategy Office providing funds to the Public Health Division for the development of the campaigns
- Morbidity/mortality and consumption data research, which is currently provided by the Health Information Centre
- Development of regional plans, for which funding support will be provided by the Alcohol and Drug Policy and Planning Section
- The Accident and Emergency Department Alcohol Project, collecting information about alcohol-related harm. This strategy will be a collaborative initiative involving Operations Division (Accident and Emergency Department data collection), Public Health Division (analysing and coordinating action) and the Alcohol and Drug Policy and Planning Section providing funds for data analysis.

5.2 Treatment

Specialist alcohol and other drug services should be accessible to people living in the metropolitan area and the country regions. These services should include assessment, in-patient and outpatient detoxification, pharmacological interventions and counselling.

In rural and remote communities there is limited access to alcohol and other drug services. Detoxification services are frequently not available, despite the presence of general practitioners, hospitals and community alcohol and other drug services. Provision of service and effective management of clients is possible with adequate training and supporting policy.

While alcohol and other drug use may be the cause of, or a significant contributor towards, many presenting conditions, this relationship often goes unidentified with no intervention applied. Frequently the condition requiring hospitalisation is treated and the client subsequently represents again.

Intervention within the hospital and other primary care settings presents a two-fold opportunity for improvement. Firstly, research indicates a substantial health improvement opportunity resulting from diagnosis and management of the client's alcohol or drug use. Secondly, there is a substantial cost saving to the health sector if clients do not re-present as a result of minimal or other intervention, or avoid hospitalisation altogether as a result of preventative activities undertaken in the primary care setting.

Emergency departments are an important point of contact for people experiencing drug-related harm. While this site is possibly inappropriate for further intervention, an innovative project providing follow-up support for overdose cases presenting to emergency departments has been commenced in 1998.

Priority is to be given to the development of alcohol and other drug treatment services in health care settings. Specialist alcohol and other drug services will be made available through the general health care services.

Collaboration between community drug services, primary health care providers and hospitals will be encouraged to provide better-managed care for clients with alcohol and other drug problems.

Key Strategies for Development

General Health Services

- Specialist alcohol and other drug services should be established at major metropolitan hospitals. These services would be responsible for establishing a simple and uniform approach to the identification and management of patients presenting to the hospital with alcohol and other drug problems as either a primary or secondary diagnosis. These specialist medical services will include in-patient clinical consultancy and liaison, minimal intervention, in-patient detoxification and out-patient assessment and follow up. Patients' alcohol and other drug problems will be identified by the introduction of simple screening as part of routine medical and nursing admission protocols. Patients identified as having problems will be provided with minimal intervention or be reviewed by the specialist liaison service. Support will be given to people treated in Accident and Emergency departments for drug overdose.

- Where contracted to provide services to the public health system, private hospitals will be required to include as part of patient care the assessment and management of alcohol and other drug problems.

- The ability of primary health care providers and the regional hospitals to provide specialist alcohol and other drug services will be increased through specific education and training programs, the development of clinical protocols and resource materials, and through the establishment of an alcohol and other drug telelinked clinical consultancy service. Brief intervention will be developed within primary care settings. Primary health care providers will be supported to screen and provide brief intervention for excessive drinking and smokers.

- Priority will be given to the development of general practitioners' skills, as providers of alcohol and other drug services, providing both home and in-patient detoxification and methadone treatment. The recently introduced Community-Based Methadone Program will see general practitioners as the main providers of methadone treatment. Through continuing education and clinical protocol development, the role of general practitioners will be expanded to include behavioural interventions, new pharmacological approaches (for example, naltrexone, buprenorphine and LAAM) to treatment and home- and outpatient-based detoxification.

Specialist Drug and Alcohol Services

- The WA Alcohol and Drug Authority (WAADA) is to be developed as a centre for best practice, research and clinical leadership.

- This specialist health service will provide specialist in-patient and outpatient assessment, detoxification and counselling services. A specialist methadone dispensary and a statewide clinical advisory service supporting the Community-Based Methadone Program will be located at this site. The clinical services unit will undertake applied clinical research to enable the development of clinical protocols reflecting best practice. Priority will be given to facilitating the introduction to the health system of new pharmacotherapies (for example, naltrexone, buprenorphine and LAAM) for the treatment of alcohol and other drug-related problems.

- Clinical and treatment services will be further developed to enhance their role in managing clients with complex and special needs. Service delivery will link with research, clinical policy development and the training role of this specialist agency. The purpose being to develop better practice that will support and inform the general health system.

- This specialist service will contribute to the education of the health workforce. This will be achieved through direct input into undergraduate medical and nursing education; support for postgraduate alcohol and other drug studies; and the development and delivery of continuing education and in-service programs. Specialist clinical placements for postgraduate medical, nursing and allied health workers will also be available.

- The specialist service will also establish a project to develop and support general practitioner alcohol and other drug service practice. Priority will be given to brief intervention and motivational interviewing for clients at risk of alcohol-related harm, alternative pharmacotherapies and detoxification.

Divisional Responsibility

The Operations Division, in collaboration with the Alcohol and Drug Policy and Purchasing Section, Mental Health Division will be responsible for the contracting and purchasing of these strategies, with the exception of:

- Specialist Alcohol and Drug Services, which will be purchased by the Alcohol and Drug Policy and Planning Section (Mental Health Division)

- The training of general practitioners and primary care providers, which will be purchased by the Alcohol and Drug Policy and Planning Section.

5.3 Research

In Australia there are two nationally funded alcohol and other drug research centres – a prevention research centre located in Western Australia, and a treatment research centre in New South Wales.

There is a need to complement the work of these centres by funding applied prevention and treatment research.

Research in the Health Department is currently undertaken by a number of sections, including the Public Health Division's Research and Evaluation unit, the Health Information Centre and WAADA. Many research projects have also been undertaken by individual health workers and services. Some strategies with regard to research are outlined in other sections of this document (for example, 'Prevention' on page 11, 'Mental health' on page 18 and 'Treatment' sections on page 13).

There is a need to ensure that research is performed in a coordinated and well-disseminated manner, and that such research can form the basis of continuing practice and program development.

Key Strategies for Development

- The recently established Centre for Mental Health Service Research will have a special alcohol and other drug program stream on applied research projects studying effective alcohol and other drug prevention, treatment and training services.

- The Mental Health Department will act as a 'clearing house' for drug research projects undertaken in health, and provide advice on new proposals. This will involve the establishment of a database of health-based research, and referral to relevant sections within health for specialist program expertise.

Divisional Responsibility

The Mental Health Division will be responsible for the purchase of this strategy.

5.4 Coordination

There is a need to coordinate Health Department alcohol and other drug policy, planning and purchasing. Improved coordination can enable the sharing of expertise and existing resources, the allocation of resources to areas of greatest need and impact, a minimisation of service duplications and an enhanced consistency of approaches and 'best practice' adhesion.

Alcohol and other drug services are purchased by the Health Department Divisions of Mental Health, Public Health, Operations and Office of Aboriginal Health.

Services are delivered by primary care providers, specialist treatment services, general hospitals, mental health services, public health providers and some non-government agencies.

Within the geographical boundaries of the government health services there is a need for coordination of alcohol and other drug services provided by the health sector. 'Coordination' is a descriptor term of a broad range of activities, including the facilitation of collaborative intradepartmental planning and programming. The role of the Alcohol and Drug Policy and Planning section will be to coordinate Health Department activities in this regard, not to duplicate or take over the activities of other divisions. This will entail the development of innovative communication and planning mechanisms.

Key Strategies for Development

- An Alcohol and Drug Policy and Planning Section will be established in the Health Department to provide policy advice to the department and the Minister for Health, coordinate planning within the Health Department and across the health sector, and identify and articulate priorities for service development and purchasing.

- In 1999–2000 and 2000–2001, assistance will be provided to government health services to develop integrated and comprehensive regional alcohol and other drug plans. These plans will reflect regional alcohol and other drug priorities within the

context of this overall Health Department Alcohol and Other Drug Strategy. A pilot project will be conducted in 1998–99 to inform the statewide development of this strategy.

- An emphasis on developing community partnerships will be fostered and driven by the Alcohol and Drug Policy and Planning Section, involving enhanced collaboration between general practitioners, health services, specialist alcohol and other drug services, and other community sectors.

Divisional Responsibility

- The Health Department Alcohol and Drug Policy and Planning Section will be located in the Mental Health Division but maintain a whole-of-health role. Funding for the section will be the responsibility of the Mental Health Division.

- The Health Department Alcohol and Drug Policy and Planning Section will support and facilitate health services and the broader health sector to develop alcohol and other drug plans.

5.5 Aboriginal Health

Problems associated with the use of alcohol and other drugs impact very significantly on Aboriginal people.

In 1994, a Western Australian Aboriginal Alcohol Action Program resulted from a State Summit and 17 regional consultative workshops. This program has guided the Office of Aboriginal Health's approach to alcohol and other drug service provision.

Aboriginal alcohol and other drug services are purchased through the Office of Aboriginal Health. These include prevention, harm reduction and treatment services. A statewide solvents project is also located in the Office of Aboriginal Health.

While specialist alcohol and other drug services and general health services are also utilised by Aboriginal people, these services need to be more culturally sensitive.

Key Strategies for Development

- Priority will be given to the continued implementation of the health-related components of the WA Aboriginal Alcohol Action Program's five major streams of action:
  - demonstration service projects
  - support for community action and organisation
  - industry liaison and cooperation
  - information and public relations
  - policing.

- In collaboration with regional interest groups, the Office of Aboriginal Health will facilitate the development of regional health plans that include strategies addressing alcohol and other drug-related problems.

Divisional Responsibility

The Office of Aboriginal Health will be responsible for the purchasing of these strategies.

5.6 Mental Health

The reported prevalence of substance use disorders in psychiatric populations varies but has been reported in some studies to be up to 66 per cent. Psychiatric services should have the capacity to assess and manage patients who have a major psychiatric illness and a substance-use disorder.

A significant number of patients presenting to alcohol and other drug services have personality, anxiety or depressive disorders. Most of these patients can be managed within the existing specialist alcohol and other drug services with some specialist psychiatric advice. A small number of patients have an acute or chronic psychosis and require specialist psychiatric assessment and ongoing care.

In recent years, the term 'dual diagnosis' has been used to describe patients who have both a psychiatric disorder and a substance-use disorder. While this term has some utility, there is the danger that it will create a new type of patient needing their own specialist service, whereas the priority should be to develop the 'in-house' capacity of the existing alcohol and other drug and mental health services.

Key Strategies for Development

- Priority will be given to developing the capacity of the mental health system to assess and manage clients with substance-use problems. This capacity will be developed for in-patients, outpatients and community-based services.
- Specialist alcohol and other drug services will be provided with specialist psychiatric support.
- Agreed protocols for the assessment, referral and management of patients with psychiatric and substance-use disorders will be developed to guide service providers.

Divisional Responsibility

The Mental Health Division will be responsible for the purchase of these strategies.

5.7 Tertiary Education

Considerable progress has been made in developing alcohol and other drug studies within the universities' health workforce curricula. Doctors, nurses and allied health professionals are now better able to identify and respond to alcohol and other drug problems.

Key Strategy for Development

Consolidate and strengthen undergraduate and postgraduate medical and nursing alcohol and other drug education.

Divisional Responsibility

The Health Department Alcohol and Drug Policy and Planning Section in collaboration with the Mental Health Division will be responsible for the purchase of this strategy.

6. PLANNING AND PURCHASING RESPONSIBILITIES

There are four Health Department Divisions which purchase alcohol and other drug services. These are the divisions of Mental Health, Public Health, Operations and Office of Aboriginal Health.

It is the function of these divisions to strategically plan the development of health services at a statewide level, develop policy that is consistent with this planning and to purchase these services from providers. It is the responsibility of these service providers to plan how best to deliver these services within contract conditions.

The previous section identified the divisions responsible for implementation of the key alcohol and other drug strategies.

These divisions will develop plans for the implementation of the key strategies to form part of their purchasing intentions from 1999/2000 to 2002/2003.

The Health Department Alcohol and Drug Policy and Planning Section will coordinate the development of this strategy and assist the development of division implementation plans.

7. ACCOUNTABILITY

It is critical to the successful implementation of a better health sector alcohol and other drug service that comprehensive and reliable performance indicators are in place for monitoring the effectiveness of interventions and resources.

In many cases, the necessary monitoring practices for these indicators are in place. However, in other cases they will need to be developed and data collected. This is a task that will be coordinated by the Health Department Alcohol and Drug Policy and Planning Section. It will take the form of a further action plan specifically developed to reflect the outcomes stated in this document.

The indicators will include the obligations the Health Department has in reporting about alcohol and other drugs to the Western Australian Government, through the facility of the whole-of-health key performance indicators reported to Treasury. Other Health Department reporting responsibilities include the Western Australian Ministerial Council for the Strategy Against Drug Abuse and agreements with the Commonwealth including the Public Health Partnership.

Accountability will be achieved through an annual reporting mechanism to the Minister for Health for presentation to the Ministerial Council for the Strategy Against Drug Abuse.

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Prevention and Early Intervention Strategies

S denotes statewide initiatives
C denotes community-based initiatives
S,C denotes collaborative initiative between statewide, regional and community-based providers

STRATEGY	ALCOHOL	TOBACCO	ILLICIT DRUGS	PHARMACEUTICALS
Public education	• provide mass-media public education campaigns targeting at-risk groups with messages about moderate alcohol consumption, the risks of excessive alcohol consumption and host responsibility (S,C) • provide publications and self-help materials (S) • develop culturally appropriate intervention strategies and resource materials (S,C) • provide referral for at-risk drinkers wishing to reduce their hazardous and harmful consumption (S) • facilitate moderate alcohol consumption sponsorships (S)	• provide mass-media public education campaigns targeting the general population and at-risk groups with non-smoking messages (S,C) • provide publications and self-help material (S) • provide assistance and referral for smokers wanting to quit (S,C) • develop culturally appropriate intervention strategies and resource materials (S,C) • facilitate non-smoking sponsorships (S)	• provide targeted public education about illicit drug use where appropriate (S,C) • provide publications and self-help materials (S)	• provide publications and self-help materials (S,C) • use unpaid media advising about appropriate levels of use (S,C) • provide information for general practitioners, pharmacists and primary care providers about non-drug alternatives to tranquillisers • special emphasis be directed to the elderly and aboriginal people (S,C)

STRATEGY	ALCOHOL	TOBACCO	ILLICIT DRUGS	PHARMACEUTICALS
Structural and organisational	• develop alcohol policies in sporting clubs and local government (S,C) • support community-specific restrictions on availability of alcohol in response to demand (C) • develop responsible server policies with licensed and non-licensed hosts (S,C) • support community advocacy to minimise alcohol promotions that lead to excessive consumption; drink driving initiatives; alcohol-free night time activities for young people; random breath testing; price differential for alcohol (to encourage consumption of non- and low-alcohol alternatives (C) • support community action groups addressing alcohol problems in communities. Activity should target media advocacy; liquor licence density and attendant harm; responsible beverage service; risk of drink driving (C)	• support and encourage the implementation of smoke-free policies (S,C) • develop smoke-free workplace policies (S,C) • develop public place clean air legislation (S,C) • encourage broad community support and involvement in tobacco control interventions (S,C) • liaison with, and involvement of, primary health care providers to promote opportunistic health promotion at health visits (S,C) • support smoking cessation services (S,C)	• support local community-based action groups to promote understanding of illicit drugs and their use (C) • provide training for community-based drug awareness course providers (S,C)	• provide of monitoring and early warning systems for Schedule 8 prescriptions (S) • assist the Health Insurance Commission to address the practice of 'doctor shopping' (S)

STRATEGY	ALCOHOL	TOBACCO	ILLICIT DRUGS	PHARMACEUTICALS
Enforcement	• support public health advocacy for liquor licensing practices that support the minimisation of harm and ill-health (S,C)	• monitoring and enforcement of the Tobacco Control Act 1990 (S,C)	• approve and monitor needle and syringe programs under the Poisons Act 1964 (S,C)	
Monitoring	• maintain routine collection of trends in morbidity and mortality from major alcohol-related conditions (S) • maintain routine collection of statewide population data on drinking behaviours (S) • maintain routine collection of community-based data on alcohol-related injury and other health and social harm indicators (S,C) • evaluate the impact of funded projects for future planning (S)	• routinely monitor trends in morbidity and mortality from major tobacco-caused disease in Australia (S) • maintain routine collection of community-wide data on smoking behaviours, attitudes and beliefs (S) • evaluate the impact of funded projects for future planning (S,C)	• maintain routine collection of data on illicit drug-related morbidity and mortality (S) • maintain data on needle and syringe distribution trends (S) • maintain routine collection of statewide population data on illicit drug use (S) • evaluate the impact of funded projects for future planning (S)	• maintain routine collection of data on pharmaceutical-related morbidity and mortality (S) • maintain routine collection of statewide population data on pharmaceutical use (S) • evaluate the impact of funded projects for future planning (S)

STRATEGY	ALCOHOL	TOBACCO	ILLICIT DRUGS	PHARMACEUTICALS
Early intervention	• general practitioner and other primary care provider brief intervention for clients at risk of alcohol-related harm (S)	• general practitioner and other primary care provider brief intervention for smokers (S)	• targeted education interventions for at-risk groups, e.g. Opiate Overdose Prevention Project and blood-borne virus programs (S,C) • develop community-based harm reduction policies with night-time venues (S) • promote and support needle and syringe distribution programs (S,C)	

ALCOHOL

Mortality and Morbidity

The Health Department reports that over the period 1985 to 1996 there was an average of 330 deaths per year representing 17 per cent of all drug-related deaths,[1] 8548 hospital admissions and 58627 bed days (1993–1995) caused by alcohol each year in Western Australia.[2] This represents approximately 3.3 per cent of all deaths, 1.8 per cent of all hospital admissions, and 3 per cent of all hospital bed days over these periods. Twice as many males died and 1.5 times as many were admitted to hospital because of alcohol-caused conditions as females. The age standardised rates for both deaths and hospital admissions were significantly higher for males compared to females.

The impact of alcohol use by young people is a major cause of injury. Nearly a third of deaths from alcohol-caused injuries and over a quarter of such hospital admissions are in those aged less than 25 years. Overall, there are three times as many male deaths and 1.2 times as many male hospital admissions due to alcohol-caused injuries compared to females. In contrast to young people, the substantial impact of alcohol on the elderly can mainly be attributed to long-term alcohol use, which causes chronic illness.

In 1995, the health services with the highest crude rates of alcohol-caused hospital admissions were the East and West Kimberley and Gascoyne. These health services were joined by the Northern Goldfields having the highest crude rates for alcohol-caused deaths. High proportions of Aboriginal people could be associated with these high levels of alcohol-caused mortality and morbidity.[2]

Prevalence of Use

Data on prevalence in Western Australia is collected every three years by the Health Promotion Services and clearly indicate that use of alcohol increases with age. A 1996 survey of school students aged 12 to 17 years found that approximately seven in ten (76 per cent males; 73 per cent females) had consumed alcohol in the past year and a third (34 per cent males; 32 per cent females) reported consuming alcohol in the week preceding the survey. 'At-risk' drinking behaviour was reported by 10 per cent of male and 15 per cent of female students.[3] With respect to adults aged 18 years and over, 15 per cent of males and 15 per cent of females are considered to be hazardous drinkers and 36 per cent of males and 24 per cent of females are considered to be harmful drinkers.[4] Drinking behaviour was calculated on the amount of alcohol consumed on the heaviest day of consumption in the previous week. See notes on terminology below.

Alcohol, when combined with an illicit drug or some pharmaceuticals, presents the greatest risk for harm. Cannabis and alcohol, and cannabis and tobacco, are the most commonly reported combinations involving an illicit drug.

At-risk Groups

Young men aged 18 to 25 years and Aboriginal people are over-represented in alcohol-related harm data. Data suggests young women, aged 18 to 25 years, are consuming alcohol at levels that will place them at increasing risk of harm. In addition, low education, unemployment and divorce are risk factors in excessive consumption of alcohol.[5]

Costs to the Health System

In 1993–95, the estimated annual bed day cost for alcohol-caused hospitalisation was nearly $26 million – an average of $15 per head of population. The East Kimberley Health Service had the highest annual cost of alcohol-caused hospitalisation per head of population ($46 per person) while Wanneroo Health Service had the lowest ($7).[2]

Terminology

The National Health and Medical Research Council (NHMRC) recommended that consuming up to four standard drinks of alcohol per day was considered as posing a low risk to the health of an average-sized, healthy, adult male. Up to two standard drinks per day were recommended for women. Consumption of five to six standard drinks per day or between 28 and 42 standard drinks per week for men, and three or four per day (or 18 to 28 per week) for women, is considered to be hazardous to health. Drinking in excess of these amounts is considered to be harmful to health.[6]

These terms ('low risk', 'hazardous', 'harmful') are meaningless to much of the population and the recommended levels are also largely disregarded as irrelevant, not reflecting existing consumption patterns. The NHMRC standards for Australia were established in 1992 and are currently in the process of being reviewed.

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TOBACCO

Mortality and Morbidity

The Health Department reports that over the period 1985 to 1996 there was an average of 1502 deaths per year representing nearly 80 per cent of all drug-related deaths,[1] 11 746 hospital admissions and 82 415 bed days (1993–1995)[2] caused by tobacco each year in Western Australia. This represents approximately 15 per cent of all deaths, 2.5 per cent of all hospital admissions, and 4.2 per cent of all hospital bed days over this period.

Three times as many males die and twice as many are admitted to hospital because of smoking-caused conditions compared to females. People 60 years and over account for 81 per cent of deaths, 58 per cent of admissions, and 68 per cent of bed days caused by smoking, reflecting the preponderance of deaths from chronic conditions with long latent periods that are related to long-term smoking.[2]

More Aboriginal than non-Aboriginal males and females die from tobacco-caused conditions. Between 1989 and 1991 the rate of death from smoking-caused diseases was 2.4 times higher for Aboriginal males than for non-Aboriginal males, and 3.7 times higher for Aboriginal females than for non-Aboriginal females.[3] Tobacco-caused hospital admissions for Aboriginal males was 2.6 times the rate for non-Aboriginal males and the rate for Aboriginal females was 4.7 times the rate for non-Aboriginal females. For each of the main tobacco-related causes of death and hospitalisation – ischaemic heart disease, chronic bronchitis, lung cancer and pneumonia – Aboriginal rates were much higher than non-Aboriginal rates.[4]

The Inner City Health Service had the highest crude rate for both tobacco-caused deaths and admissions. West Pilbara Health Service had the lowest crude rate for tobacco-caused deaths, while Harvey–Yarloop Health Service had the lowest crude rate for tobacco-caused admissions.[2]

Prevalence of Use

In 1997, 28 per cent of adult men and 22 per cent of adult women were 'regular' smokers (smoke daily, and have for a month or more). The prevalence of regular smoking among the adult population in Western Australia has fallen from 32 per cent in 1984 to 25 per cent in 1997.[3]

The prevalence of smoking among the sub-population groups of Aboriginal people, young men and women (18 to 29 years), and adults of lower socio-economic status, however, remain higher than for the general adult population. Recent West Australian surveys found that 48 per cent of Aboriginal adults,[4] 36 per cent of young men, 30 per cent of young women and 37 per cent of adults of lower socio-economic status smoke.[3]

A 1996 survey of school students aged 12 to 17 years in Western Australia found that approximately one in three 12-year-olds had tried smoking.[5] Experience with smoking increased to 67 per cent of males and 69 per cent of females by age 15 and continued to increase to approximately three in four students at age 17. The proportion of students who had smoked in the 12 months prior to the 1996 survey increased from 22 per cent of males and 17 per cent of females at age 12, to reach a peak prevalence of 44 per cent of males and 53 per cent of females at age 16 years.

The proportion of students who were 'current' smokers (smoked on at least one day in the past week) increased from 7 per cent of males and 9 per cent of females at age 12 to 26 per cent of males and 28 per cent of females at age 17. Overall one in ten students (11 per cent) aged 12 to 17 smoked on three or more days of the week. This represents 65 per cent of female and 58 per cent of male current smokers.

Comparison of findings between 1984 and 1996 showed that while there was a significant decrease in overall involvement in smoking among 12 to 15-year-old school students, this trend was not evident in the period between 1993 and 1996. The picture is somewhat different for 16 and 17-year-old students; for them there was no significant change in smoking between 1984 and 1996. In addition, there was a significant increase in the proportion of 16 to 17-year-old school students who had smoked in the last week (from 22 per cent to 27 per cent in 1993 and 1996).[5]

People who start smoking in their teen years are more likely to become regular smokers, to smoke more heavily, and to have more difficulty quitting as well as being at greater risk of developing smoking-related diseases.[6] The majority of adult smokers say they would like to stop.[7] In fact 80 per cent of Australian smokers have made attempts to quit.[6]

At-risk Groups

The prevalence of smoking is higher among specific groups such as people from lower socio-economic backgrounds, young men and women (18 to 29 years)[3] and Aboriginal people.[4] More Aboriginal than non-Aboriginal males and females die from tobacco-caused conditions.

Youth smoking is a priority area as almost all adult smokers begin smoking in adolescence. While the prevalence of smoking among adults has steadily declined in the past decade, there has been relatively little change overall in the prevalence of smoking among young people. Smoking by pregnant women also continues to be a concern because of the health consequences of maternal smoking to the unborn child.[6]

Costs to the Health System

Tobacco smoking places a substantial financial burden on the community. Health economists Collins and Lapsley estimate that in 1992 the direct and indirect costs of smoking to Australia were $12 736 million.[8]

The direct costs refer to the total combined cost of health care expenditure, loss of human productivity, welfare costs of victims, and costs related to the treatment and prevention of tobacco addictions. The indirect costs refer to the loss of consumption (of goods and services) by the deceased, suffering imposed on the rest of the community, and the cost benefit (to the deceased) of living that is lost due to premature death. Costs which are not quantifiable (which could not be included in the figures above) include welfare, absenteeism, property costs of accidental fires, ambulance services, passive smoking, pain and suffering of the sick, and the suffering of others.[8]

The direct and indirect cost of smoking to Western Australia in 1992 was estimated to be $1300 million. The Health Department of Western Australia estimates that the annual cost of smoking-caused hospitalisation alone between 1993 and 1995 was over $36 million – an average of $21 per head of population. The Inner City Health Service had the highest annual cost of tobacco-caused hospitalisation per head of population ($46 per person) while Wanneroo Health Service had the lowest ($13).[2]

Terminology

The Health Department of Western Australia uses the following definitions to describe the smoking status of adolescents and adults.

Adolescent smoking status

These definitions are used in the Australian School Student Alcohol and Drugs Survey. This survey is a national survey, and is conducted on school children in Years 7 to 12.

- 'Current' smoker: those who have smoked cigarettes on at least one day in the past week.
- 'Committed' smoker: those who have smoked cigarettes on at least three days in the past week.

Adult smoking status

These definitions were developed for the Tobacco and Alcohol Consumption Surveys. This survey is a statewide survey conducted on people aged 18 years or above.

- 'Ever smoked': those who have ever smoked cigarettes, cigars or a pipe once a day for a month or more.
- 'Regular Smokers': those who currently smoke cigarettes, cigars or a pipe once a day and have done so for a month or more.
- 'Ex-smokers': those who used to smoke cigarettes, cigars or a pipe once a day for a month or more, but no longer do so.
- 'Never smoked': those who have never smoked cigarettes, cigars or a pipe once a day for a month or more.

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ILLICIT DRUGS

Mortality and Morbidity

The most recent review of illicit drug-caused deaths in Western Australia was provided by the Task Force on Drug Abuse. It was reported that in 1993, 1885 deaths were attributable to drug use in Western Australia. Of these, 32 (1 per cent) were caused by illicit drugs and the mean number of years of life lost per death was 36 years.[1]

Typically, illicit drug use is most prevalent in the 18 to 24 years age range, and involves greater numbers of males compared to females. This gendered tendency in illicit use is reflected in the greater male mortality attributed to illicit drugs.

Opiate deaths in Western Australia averaged 22 over the decade 1984–1993. In 1995 there were 81 opiate deaths (62 due to heroin), and in 1996 there were 65 opiate deaths (38 heroin). In 1996 there were 88 suspected opioid related deaths, which was adjusted to 65 following coronial reports.[2] In 1997 there were 83 suspected deaths that await coronial confirmation.

Cannabis accounted for 57 hospital admissions between 1991 and 1995,[3] and no deaths between 1985 and 1996. Very few fatalities were recorded as being due to amphetamines and psychostimulants (five deaths) or hallucinogens (three deaths) between 1985 and 1996.[4] There is a growing body of knowledge that cannabis alone or in combination with alcohol and other drugs is implicated in much road trauma.[5]

Of the more than 46 000 admissions to West Australian hospitals wholly attributable to drug use – including tobacco and alcohol – between 1982 and 1992, 3 per cent were due to hallucinogens, psychostimulants, cocaine and volatile substances; a possible further 2 per cent of admissions were due to opioid use. The two age groups 20 to 29 and 30 to 39 years also accounted for the greatest numbers of admissions with more than 11 000 from each group, totalling 48.8 per cent of all such admissions.[1]

Prevalence of Use

Typically, illicit drug use in Australia[1] and Western Australia[11] is most prevalent in the 18 to 24 years age range and involves greater number of males compared to females.

Opioid use, including heroin, differs slightly from the use patterns of other illicit drugs. Regular use continues, albeit from a small base, in the 30 to 40 years age group. The average age for overdose fatalities reflects this phenomenon. In 1997, this average age was approximately 27 years of age. The prevalence of injecting drug use peaks in the 18 to 24 years age group.[1]

Polyuse of depressant drugs like alcohol and benzodiazepines is a regular feature of illicit opioid use, increasing the likelihood of respiratory failure.[2]

Recent Health Department surveys carried out in Western Australia indicate that cannabis is the most commonly and recently used illicit drug among 12 to 17-year-old school students with 39 per cent of males and 34 per cent of females reporting that they had used it in the last 12 months. This is followed by use of inhalants (16 per cent males; 17 per cent females), then LSD and other hallucinogens (10 per cent males; 8 per cent females), amphetamines (6 per cent males; 4 per cent females), ecstasy (4 per cent males; 3 per cent females), heroin and cocaine (2 per cent each males and females).[6]

The most widely used illicit drug among adults aged 18 years or more is cannabis, with 20 per cent of males and 11 per cent of females reporting use in the last 12 months. This is followed by use of LSD (5 per cent males; 2 per cent females), amphetamines (4 per cent males; 2 per cent females), ecstasy (3 per cent males; 1 per cent females), cocaine (1 per cent males; 0.1 per cent females) and heroin (0.8 per cent males; 0.5 per cent females).[7]

At-risk Groups

Overdose and other acute harm increases with period of use. This places regular users, including dependent users, at greater risk of harm.

Age and gender are strongly associated with the use of illicit drugs and young, unattached and unemployed males are more likely to use illicit drugs. Illicit drug use is highest among persons aged less than 35 years and males are more likely to experiment and continue using illicit drugs.[8]

The prevalence of volatile substance use occurs primarily in young people between eight and 14 years of age. Morbidity is primarily associated with chronic use, which is not a common pattern of use for the majority of young people inhaling volatile substances.[9] However, young Aboriginal people are at greater proportional risk for use than non-Aboriginal people and there are some communities where chronic solvent use is a significant problem.[1]

The major risk associated with injecting drugs is the transmission of blood-borne viruses (BBV). The risk of contracting a BBV is proportional to the period of use. While contracting a BBV can occur through any one episode of using a syringe containing an infected product, the likelihood of infection increases over a period of use. From 1995–1998 there were twenty-three males and two females diagnosed with HIV which was contracted through the injection of drugs.[10] Other risks from injecting drug use include overdose, septicemia, collapsed veins and ulceration.

Costs to the Health System

In Western Australia, the estimated average cost for all other (licit and illicit) drugs other than alcohol and tobacco was over $5.1 million per year, or $3 per head of population. This is lower than tobacco ($21 per person) and alcohol ($15 per person).[3]

During 1991–1995, the estimated average annual cost of opioid-caused hospitalisation was $510 000.[3]

Terminology

Illicit drugs tracked under the National Drug Survey include cannabis, amphetamines, hallucinogens, cocaine, heroin, ecstasy and other designer drugs. Particular concern is with the intravenous use of illicit drugs (mainly involving heroin, cocaine and amphetamines) due to the higher potential for spreading infectious diseases. Cannabis is the most widely used illicit drug. The least frequently used illicit drugs are heroin, cocaine and ecstasy. Volatile substances are not illegal to either purchase or possess, and are therefore usually classified generically within the category 'other drugs', which often also includes illicit drugs.

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PHARMACEUTICALS and 'OTHER DRUGS'

Mortality and Morbidity

The Task Force Report on Drug Abuse, while recognising that pharmaceutical drugs deliver many benefits to people, also states that as with any drug, there are problems associated with their use, misuse and abuse. High consumption of medication has been associated with an increased risk of adverse reactions, the over-prescription of some classes of medication, sub-optimal choice of medicines within therapeutic categories by prescribers and the use of multiple medications by many people.

Figures provided by the Task Force indicate that there were 35 deaths in Western Australia in 1993 caused by pharmaceuticals, representing 2 per cent of the total number of deaths attributable to drug abuse. The mean number of years of life lost per death was 36 years. This is identical to the mean number of years lost through the use of illicit drugs, as compared to alcohol (18 years) and tobacco (5.2 years).[1]

Hospitalisation data available for all drugs (licit and illicit) other than tobacco and alcohol indicates that in Western Australia over the five-year period 1991 to 1995 an estimated 0.5 per cent of all hospital admissions and bed days were due to all other drugs. The drug groups responsible for the most admissions were tranquillisers (24 per cent) followed by unclassified drugs (22 per cent), anti-depressants (13 per cent) and opioids (11 per cent).[2] Task Force figures indicate that hospital admissions due to other drugs increased by more than 20 per cent during the 11-year period from 1982 to 1993.[1]

Prevalence of Use

Estimates by the Task Force indicate that prescribed and/or over-the-counter medication was used by 76 per cent of women and 65 per cent of men at some time in the two weeks preceding the 1989–90 Australian National Health Survey. Specifically, the survey indicated that approximately 50 per cent of the population used analgesics, 30 per cent used vitamins and minerals, 5 per cent used sleeping medications and 2 per cent used tranquillisers and sedatives. Estimates of licit drug use in Western Australia in 1993, indicate that 77 per cent of males and 89 per cent of females have used analgesics, 25 per cent of males and 47 per cent of females have used tranquillisers, and 3 per cent of males and 4 per cent of females have used barbiturates.[1]

The use of sleeping medication, tranquillisers and sedatives increases with age, particularly among females.

At-risk Groups

Patients most at risk of an adverse drug reaction are elderly patients with multiple medical problems. In particular, residents of nursing homes and hostels are very high users of medicines and therefore at greater risk. The Task Force estimates that 90 per cent of people over 65 years of age are currently using medication.[1] In a representative sample of people aged 65 years or older, it was found that 81 per cent were taking at least two medications and 44 per cent were taking at least four medicines concurrently. Predictors of multiple medication use were recent hospitalisation, increasing age, female sex and increasing depression.

Overall the incidence of morbidity and mortality of poisoning in children is low, but preventable. Childhood poisoning accounted for 0.5 per cent of all admissions to a major children's hospital and 66 per cent of these were due to medication, the most common being benzodiazepines, iron preparations, paracetamol and anti-convulsants.[1]

Costs to the Health System

Risks with pharmaceutical misuse can include short-term mild side-effects, longer-term dependency, overdoses and accidents. In 1995, 5 per cent of all people in drug treatment programs in Australia had a principal drug problem related to benzodiazepines, sleeping pills and tranquillisers or barbiturates. The economic cost to the Australian community of pharmaceutical misuse relating to, for example, medical services and lost productivity, is presently not quantifiable.[2]

The use of legal psychostimulants, such as ephedrine, by heavy transport and shift workers, is an issue of public concern. In recent years there have been a number of motor vehicle crashes involving heavy transport vehicles in which some of the drivers had taken excessive amounts of the stimulant ephedrine. Australian research has reported that 30 to 46 per cent of long-distance truck drivers take stimulants to keep awake at least some of the time.[2]

The Task Force on Drug Abuse Report stated, 'compared to the benefits, the adverse consequences of inappropriate use or abuse of pharmaceutical products are relatively minor'. The report also went on to comment about the use of analgesics and associated harm. It was stated that, 'the evidence suggesting paracetamol misuse is occurring and leading to substantial illness is weak.'[1]

Terminology

The term 'other drugs' has been used by Unwin et al. (1997) with respect to data available on hospital admissions in an attempt to overcome the limitations of the terms 'illicit' and 'licit'.[3] Hospital admissions attributed to illicit drug use often involve combinations of pharmaceutical and non-pharmaceutical drugs and even where licit drugs are thought to be responsible, it is difficult to determine whether they were obtained by prescription or other means.

The Task Force on Drug Abuse reports on five major groups of drugs in their chapter on 'Other Drugs' which include cannabis, opioids, psychostimulants, volatile substances and pharmaceutical drugs. As the data on morbidity and mortality for drugs other than tobacco and alcohol is often confounded as noted above, it is difficult to present data solely for pharmaceuticals.

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DRUG-RELATED ATTEMPTED SUICIDE

The drug group most commonly responsible for hospitalisation due to drug-caused suicide attempts was tranquillisers, associated with 35 per cent of such admissions.

The age-standardised rate for female hospital admissions due to drug-caused suicide attempts was significantly higher than the male rate.

People aged between 15 and 34 years old accounted for 61 per cent of hospital admissions for drug-caused suicide attempts and 48 per cent of bed days.

The female age-specific admission rates for drug-caused suicide attempts showed a higher and earlier peak in females compared with males.

Over the period 1991 to 1995, the age-standardised rates for hospital admissions due to drug-caused suicide attempts increased significantly. The admission rate for opioids, in particular, showed a dramatic increase, by an average of 65 per cent per year.

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