Community Drug Summit Report

13 – 17 August 2001

VOLUME I

Prepared by the Community Drug Summit Office
September 2001

September 2001

The Hon Bob Kucera APM
Minister for Health
10th Floor Dumas House
2 Havelock Street
WEST PERTH WA 6005

Dear Minister

We have pleasure in providing you with the Community Drug Summit Report which consists of two volumes.

The first volume documents the development of the Summit, community consultation leading up to the Summit, presentations to the delegates and their final recommendations. Volume two consists of the corrected Record of Proceedings for the week of the Summit.

The Community Drug Summit was an historic event for Western Australia. It demonstrated that with a positive ethos, it is possible for people with very divergent views to come together and find sufficient common ground to offer guidance to the Government.

We were privileged to have chaired the Community Drug Summit and wish the Government well in determining its response.

Hon Fred Chaney	Prof Liz Harman	Jade McSherry

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CHAPTER 1

OVERVIEW

1.1 BACKGROUND

Purpose

The Community Drug Summit was held to allow the wealth of experience, knowledge and wisdom of the community to contribute to the formulation of long term and strategic policies to address the illicit drug problem in Western Australia.

Objectives

The objectives of the Summit were to:

- develop a better understanding in the Western Australia community of the causes, nature and extent of illicit drug use and its associated problems in Western Australia;
- consider the full spectrum of views of community representatives and people working in the drug field in order to inform the community about potential strategies and their application in Western Australia;
- hear and consider the views of families, young people, Aboriginal people, drug users, culturally and linguistically diverse people, professional treatment and prevention services, academics and researchers, law enforcement officers and others;
- consider new and innovative options to address illicit drug problems in Western Australia;
- examine existing strategies (laws, policies, and programs) in light of the evidence regarding what works, and consider current resource allocations;
- identify ways to improve existing strategies that work, meet any gaps in these programs and services, introduce new options and achieve continuous improvements to these strategies; and
- build community and political consensus about future directions in drug strategy in Western Australia and recommend a future course of action for the Government to follow.

1.2 SUMMIT MODEL

Consistent with the emphasis on the 'community'; community representatives were involved in all aspects of the planning for the Summit. The Summit Steering Committee comprised government, non-government and community representatives. The principles underpinning the processes were:

Inclusiveness

Involve the Western Australian community, metropolitan, rural and remote, including families, young people and other community interests in considering and developing the most appropriate drug strategies for Western Australia.

Evidence Based

Consider drug strategies based on the best available evidence in addressing the drug problem as it exists in Western Australia.

Openness

Consider all options in developing solutions for Western Australia.

1.3 DELEGATES

The Summit was held in the Legislative Assembly of the Western Australian Parliament. The venue determined the number that could attend as delegates, being one hundred in total. Consistent with some of the practices used for citizen juries and deliberate polling exercises, it was decided to advertise for the 100 delegates. Eighty places were made available for the wider community and 20 places for persons involved in illicit drug related policy, service delivery or research. Community applicants applied for a place in one of the eight categories as follows:

- the wider community;
- young people, under 30;
- people from country Western Australia;
- Aboriginal people;
- CALD people;
- people from religious organisations;
- people from local government; and
- people from the business community.

Approximately one thousand people applied for places and were selected based on the following criteria:

- the extent to which the applicant had demonstrated extensive interest and involvement in the community;
- the extent to which the applicant had demonstrated extensive interest and involvement in, or exposure to illicit drug use;
- the extent to which they reflected the range of views currently held in the community on illicit drug use; and
- age, gender, locale, occupation, race/ethnic background, religious affiliation and business or local government involvement.

Twenty-five places were reserved for country delegates, 28 were selected.

1.4 ISSUES PAPERS

As the first objective was 'to develop a better understanding in the Western Australia community of the causes, nature and extent of illicit drug use and its associated problems in Western Australia', it was decided that Issues Papers would be written by Issues Groups. The Issues Groups consisted of about 10 community members with varying views and were chaired by academics with a background relevant to the topic under consideration. Provision was made to invite the Government and the opposition parties to provide two Members of Parliament (MPs) to be members of each of the Issues Groups. Seven groups had two MPs, one had a single MP, and one group had no MPs.

The Issues Groups and the topics were:

1. Young People and Illicit Drug Use.
2. Supporting Families to Deal with Illicit Drug Issues, Particularly Regarding Issues for Children of Drug Users and Parents and Siblings of Drug Users.
3. Addressing Illicit Drug Use Among Aboriginal People, Including the Provision of Treatment Programs for Drug Dependent Aboriginal People.
4. Prevention and Early Intervention Strategies, Including School, Parent and Public Education and Action in Local Communities.
5. Treatment for Drug Users and Reintegration of Drug Dependent People into the Community.
6. Broadening the Provision of Treatment for Drug Users Through Other Human Services, Including the Health, Justice, Welfare and Youth Sectors, and Its Integration With Specialist Alcohol and Drug Services.
7. Drugs and Law Enforcement, Including Consideration of the Most Appropriate Legal Framework for Illicit Drugs, Diverting Drug Users into Treatment and Treating the Most Serious Offenders in Prisons.
8. Reducing Harm to the Community and Individuals Caused by Continued Drug Use.
9. Linking Drug Strategies into Overall Social Policies to Address the Underlying Causes that Generate Other Social Problems, Such as Violence, Suicide and Crime.

These topics also constituted the basis for the working groups that delegates were divided into at the Summit. Five priority recommendations were made in relation to each topic.

In addition a paper titled, *Illicit Drug Use in WA: Facts and Figures*, was produced. It caused considerable media attention as it revealed that Western Australia had the second highest overall rate of recent illicit drug use in Australia. Furthermore, it indicated that in broad terms the economic cost to the Western Australian community is over $1 billion per annum, and the cost incurred by the State Government is $250 million per annum.

The Issues Papers served the purpose of describing the current situation in Western Australia and presented issues for consideration to stimulate thinking during the Community Consultation Process. The Issues Papers and the Facts and Figures Paper are at Appendix I.

1.5 COMMUNITY CONSULTATION

All of the main regional centres in Western Australia were visited by staff from the Community Drug Summit Office (CDSO). Community members were invited to 'have their say on the illicit drug problems in Western Australia'. An Aboriginal Forum involving 130 people was held. Approximately 350 young people aged 12-17 years participated in a process, designed to 'hear their voices', which was overseen by the Office of Youth Affairs and the School Drug Education Project. The Youth Affairs Council of Western Australia conducted a one day Forum for its members, 30 of whom participated. The WA Network on Alcohol and Other Drug Agencies (WANADA) had 100 people participate in a Forum, whilst within the prison system 64 people, including prisoners, officers, service providers and families contributed to the consultation process. A Forum involving 12 general practitioners and consumer representatives also took place. The views and proposals generated from these activities were included in the 545 submissions received by the CDSO.

When the 425 individuals making submissions are added to the individuals involved in the various youth, service provider, justice, Aboriginal and general practitioner activities, input from at least 1,127 individuals was made.

In general the submissions:

- supported a much greater emphasis on education, prevention and early intervention;
- called for more family support;
- pointed out the lack of culturally appropriate services for indigenous people;
- pointed out the inadequacy of support and services in regional and remote areas;
- identified service and treatment gaps, particularly regarding young people;
- asked for consideration to be given to the Swedish approach to dealing with illicit drug use; and
- debated the pros and cons of harm reduction and prohibition strategies.

A number of submissions emphasised the importance of moving the debate forward, concentrating on finding the common ground and getting away from divisive arguments on prohibition and harm reduction.

The majority of the submissions related to the topics (Issues Papers) under consideration. There were however, a number that supported zero tolerance and a drug free society. These 241 submissions were grouped together and consisted primarily of letters (233) from individuals supporting abstinence as the goal of drug policy, the Swedish approach to dealing with illicit drug use and compulsory treatment. They opposed safe injecting facilities, heroin trials and the liberalisation of cannabis laws.

Another 77 submissions were classified as 'general' as they addressed a variety of matters.

1.6 THE MEDIA

The ability of the media to sensationalise and polarise illicit drug issues was recognised as a potential risk to the effective running of the Summit. The media players were approached

early in the process and asked if they were interested in making a constructive contribution to the Community Drug Summit. Overall the media coverage of the Summit was balanced and comprehensive and contributed to the process.

1.7 CHAIRING

Due to the nature and scope of the views held about illicit drug use and its associated problems, it was agreed that it was important to have co-chairs that were totally independent. In addition, it was agreed that a youth assistant chair should represent young people in Western Australia and provide a contact point for them, if they were inhibited by the process or the older players. The chairing team of the Honorable Fred Chaney, Professor Liz Harman and Ms Jade McSherry proved to be a powerful combination. Procedural Rules were developed for the Summit, however the approach of the Chairs was one of flexibility and the Rules were modified, with the agreement of the delegates, as the need arose. For example, the recommendation amendment process and the method of voting on recommendations were modified. With the approval of the delegates a secret ballot voting process was utilised.

1.8 ETHOS

Given that the recent history of the illicit drug debate in Western Australia had been characterised by significant polarisation between those supporting zero tolerance and harm minimisation approaches, it was decided that it was important to try and develop a positive and constructive ethos. To this end, the emphasis was on finding common ground. The Honorable Fred Chaney expressed the views of the Chairs in emphasising that the Community Drug Summit was not about winners and losers and it was important to make sure that all points of view were understood. At the opening of the Summit, the Honorable Bob Kucera, Minister for Health, said that the Government was 'asking the community for a way forward on one of the most emotive, divisive and complex social problems facing us today'. He asked the delegates to have 'a bold and open minded approach' (Record of Proceedings, 13/08/2001, page 3).

1.9 BRIEF FOR THE COMMUNITY DRUG SUMMIT

Principles

Within the agreed national strategy of supply, demand and harm reduction the Summit Chairs, in conjunction with the Government, presented the Summit with a number of principles for consideration as the basis of the Summit deliberations. The principles were:

1. A commitment to finding as much common ground about developing government strategies to tackle illicit drug use.
2. Recognition of the range and complexity of the causes of illicit drug use and therefore the need to take education, prevention, treatment and law enforcement into consideration.

3. An acceptance of the fundamental importance of promoting children's health and wellbeing and therefore supporting families in preventing or minimising the impact of illicit drug use.
4. A recognition of the particular needs of young people in dealing with illicit drug use.
5. A recognition of the particular challenge that illicit drug use poses for indigenous people and the need for culturally appropriate services.
6. A recognition of the special needs of regional and remote communities in dealing with illicit drug use.
7. A commitment to protecting all sections of the community from the adverse impact of illicit drug use.
8. An acknowledgment of the particular difficulties that illicit drug use contributes to and creates for the prison population.
9. Recognition of the necessity for policy-making to be evidence based and for all programs and services to be properly evaluated.
10. A commitment to ensuring that the best value is obtained from the resources utilised in addressing illicit drug use.

Mr John Harris (Record of Proceedings, 15/08/2001, page 2) on behalf of group *Addressing Illicit Drug Use Among Aboriginal People* proposed a small number of changes with the intent of emphasising the severity of the impact of illicit drug use on Aboriginal communities.

The changes were:

1. A commitment to finding as much common ground about developing government strategies to tackle illicit drug use.
2. Recognition of the range and complexity of the causes of illicit and licit drug use and therefore the needs for early identification and for the need to take education, prevention, intervention, treatment and law enforcement into consideration.
3. An acceptance of the need to involve the extended family in preventing or minimising the impact of illicit and licit drug use and therefore promote the health and wellbeing of children.
4. A recognition of the particular needs of young people in dealing with illicit and licit drug use.
5. A recognition of:
   - the exclusion and related disadvantage of Aboriginal communities caused by colonisation and its impacts;
   - the particular severity of illicit and licit drug use in Aboriginal and Torres Strait Islander communities; and
   - the need for culturally appropriate services and for effective cultural skills in the general health and addictions workforce.
6. A recognition of the special needs of regional and remote communities in dealing with illicit and licit drug use.
7. A commitment to protecting all sections of the community from the adverse impact of illicit drug use.
8. An acknowledgment of the particular difficulties that illicit drug use contributes to and creates for the prison population.

9. A recognition of the necessity for policy makers to use and expand the evidence base on illicit and licit drug use and for all programs and services to be properly evaluated.
10. A commitment to ensuring that the best value is obtained from the resources utilised in addressing illicit drug use.

The Minister indicated his willingness to accept these changes but the changes were not considered by the Summit therefore the original Principles stand.

Matters for Consideration

Consistent with the Government's election policies the Matters for Consideration were addressed by the Minister for Health and distributed to the delegates in the following form:

The Government acknowledges that the deliberations of the Summit and the development of strategies need to occur in the context of the agreed National strategy of supply, demand and harm reduction.

The Government views illicit drug use primarily as a health issue but it wishes to break the cycle of drug abuse and crime. The Community Drug Summit has been established to develop recommendations that can provide the basis of a framework for effective and comprehensive strategies regarding illicit drug use.

The Government has a genuinely open mind on a number of matters but consistent with its policies on Health, Civil Rights, Law Reform and Crime it asks delegates to give consideration to, and make recommendations regarding:

- the value of different early intervention and education strategies, particularly those directed towards young people in different age groups socio-economic, cultural and regional settings;
- the criteria to be used in assessing the desirability or otherwise of emerging treatment and rehabilitation initiatives;
- the value of a heroin prescription trial;

- the value of supervised injecting facilities in the Western Australian context;
- the desirability of reviewing the existing illicit drug law enforcement framework in Western Australia, specifically the *Misuse of Drugs Act 1981*;
- changes to the State's cannabis laws involving decriminalisation of:
  - the cultivation of up to 2 plants;
  - possession of up to 50 grams;
  - use by adults on private property; whilst
  - the trade of cannabis would remain illegal;
- the value of Drug Courts and whether diversionary options should be expanded; and
- the need for a secure and separate drug-free treatment centre or prison for drug dependent offenders.

A bold and open minded approach needs to be adopted in combination with a tough but smart approach to law enforcement. We need to maximise the benefits we get from State

Government expenditure of $51 million and Commonwealth expenditure of $7 million on programs and services for illicit drug use. These figures do not account for the vast indirect cost of illicit drug use to the Government and the community, the estimated total annual cost to the whole community being in excess of $1 billion per year.

1.10 RAPPORTEURS' SUMMARY

Prior to the delegates considering the draft recommendations from each of the Summit working group and voting, the Rapporteurs provided an overview of the Summit to that point. Professor David Hawks observed that:

- neither the supply or demand for drugs can be eliminated, therefore harm minimisation is necessary;
- we have the second highest prevalence of drug use in Australia. There are many good programs which should not be discontinued in restructuring, however the present structure has failed to achieve the 1995 Task Force aim to achieve the lowest level of drug use in Australia;
- the need to reconcile the two apparent contradictory messages of abstinence and harm minimisation. They are not contradictory;
- a commitment is needed to pragmatism, not dogmatism. Evaluation is vital;
- alcohol and tobacco are the gateways to illicit drug use and themselves constitute the greatest harm;
- not including these two in drug policies will only reduce credibility, particularly from young people;
- effective policies to reduce problematic drug use must involve listening to drug users;
- compulsory forms of treatment, although not seen as the therapeutic ideal, have their place; and that
- drug policies need to be coherent. Inconsistencies reduce their credibility and hence, their effectiveness.

Associate Professor Richard Mattick observed that:

- the National Drug Strategy was non-partisan, balanced and evidence based, but it did not stretch the boundaries;
- it was important not to copy drug policy from one country to another;
- heroin prescribing and supervised injecting facilities were not the same; and
- a range of treatments were needed.

He told the delegates to beware of magic bullets and drug wars.

Associate Professor Mattick said that:

> We need to stretch the boundaries and think what we can do that is different. We should not just restructure what is already there… Tell the Government that you want to know what the changes are and that you want it monitored carefully, but be practical and compassionate and I think you will have the opportunity to show national leadership (Record of Proceedings, Thursday 16 August 2001, page 31).

1.11 RECOMMENDATIONS

The working groups were asked to have their draft recommendations ready by lunch time on day four. These were distributed to all delegates and times set for the receipt of proposed amendments. The proposed amendments were provided to the relevant working group. Each working group was asked to sit at the bar table in the Chamber, present its rationale for its draft recommendations and its position on the proposed amendments. The amendments were presented on the large screen in the Chamber and the final recommendations constructed on the basis of the debate and the associated show of hands.

As some working groups incorporated proposed amendments into the original recommendations, unfortunately, there is not a complete record of all the original recommendations.

1.12 EVALUATION

All the delegates were asked to complete a feedback form before leaving the Summit. Sixty of the 100 delegates did so with the following results:

SUMMARY OF DELEGATE EVALUATION

	Highly Dissatisfied %	Dissatisfied %	Satisfied %	Highly Satisfied %
1. Pre Summit	1	3	37	59
2. Working Groups	5	2	28	65
3. Plenary Reviews	1	4	59	36
4. Keynote Speakers		9	53	38
5. Question Times	2	7	49	42
6. Recommendations		14	37	49
7. Overall	2		32	66

The wide representation, diversity and balance of the delegates was much commended, as was the chairing and the willingness of delegates to listen to each other and to work together. The facilitators were praised as were the scientific advisers and, notwithstanding some discomfort with the seating, the use of the Parliament was seen as giving the Summit a status and a tone that reinforced the importance of its deliberations. The secret ballot was also commended as it gave delegates, particularly those who had changed their views, the freedom to vote as they wished without repercussion. The major complaint was time; many delegates would have liked more time for debate, for working groups and the ability to work after hours. Some thought there were too many speakers, some of whom had not geared their presentations to an audience consisting primarily of community members. Overall, however, the satisfaction rating was high with 98% being satisfied with the process.

1.13 THE STRUCTURE OF THIS REPORT

This Report consists of two volumes. Volume I summarises the development, consultation phase and recommendations of the Community Drug Summit with a separate chapter devoted to each topic. Each chapter summarises input to the Community Drug Summit for that particular topic, that is, input from the Community Consultation process, and presentations given to the Summit. The recommendations passed by the Summit relating to the topic are then listed. A list of all those who made submissions is included at Appendix II.

Volume II consists of the corrected Record of Proceedings of the Community Drug Summit held from 13 – 17 August 2001. All references referred to in the following chapters are to be found in the relevant Issues Papers.

1.14 REFERENCING

Within Volume I of this Report references to original research papers have been made. As these references have been drawn directly from the Community Drug Summit Issues Papers (Issues Papers 1-9 and *Illicit Drug Use in WA:Facts and Figures*), these references have not been listed individually at the end of each chapter in this Report.

A comprehensive reference list can be found at the conclusion of each of the relevant Issues Papers.

CHAPTER 2

LINKING DRUG STRATEGIES INTO OVERALL SOCIAL POLICIES TO ADDRESS THE UNDERLYING CAUSES THAT GENERATE OTHER SOCIAL PROBLEMS, SUCH AS VIOLENCE, SUICIDE AND CRIME

2.1 WESTERN AUSTRALIAN CONTEXT

Issues Paper 9 addressed *Linking Drug Strategies into Overall Social Policies to Address the Underlying Causes that Generate other Social Problems, such as Violence, Suicide and Crime.* This Issues Paper proved to be the most problematic to write as the Issues Group members dealing with this topic had diverse opinions of what social policy is and its capacity to address the underlying causes of problematic drug use.

The Issues Paper suggested that social policy is pivotal to society's response to drugs. Among other things it establishes the distinction between legal and illegal usage of drugs, defines what is considered 'abuse' of drugs and determines society's response to drug related harm. It is also through social policy that issues associated with drug abuse, such as homelessness, crime, prostitution and suicide are considered.

The Issues Paper canvassed the following issues for community consideration:

- the need to see drug use in a global and historical context;
  - is it reasonable to suggest that a drug free society is a reasonable goal? and
  - what factors should determine whether a drug is legal or illegal?
- the need to view drug use in a social and cultural context;
- the need to acknowledge that society has always tolerated the 'recreational' use of drugs;
  - noting that not all legal drug use is tolerated, is all currently illegal drug use unacceptable? and
  - how can drug use be managed or regulated in a way that renders it more acceptable.
- drug use is a dynamic phenomenon and hence public policy and legislative control must be flexible enough to keep abreast of changing forms of drugs and patterns of use;
- no single policy is enough to address problematic drug use and its consequences; and
- governments do not have the whole responsibility in solving the problems associated with drug use.

The Issues Paper indicated that it is rare for people to become habitual users of illegal drugs if they have not had a history of use of legal drugs (especially alcohol) at an early age. To the extent that there is a 'gateway' to illegal drugs, its footbridge is most often the legal drugs alcohol and tobacco.

The Issues Paper concluded by stating:

> There are many reasons for drug use and it should always be viewed in its social and cultural context. Narrowly focussed policies will inevitably fail. Drug policy can only be effective if it is multi-faceted and very much part of a comprehensive, consistent, broader social policy framework. (Issues Paper 9, Community Drug Summit, June 2001, page 7).

2.2 COMMUNITY CONSULTATION

There were 19 public submissions received under the category of overall social policy. Five of the nineteen submissions received suggested that prohibitionist policies had failed and indicated that drug regulation and harm minimisation strategies should be tried. One submission was against further liberalisation of drug policy. Another detailed submission critically examined Swedish drug policy and its applicability to Australia.

The balance of the submissions dealt with specific issues such as homelessness, disconnectedness of youth, rights of the individual versus collective rights, and the negative impact of the media on youth. Although these submissions identified a wide range of problems, none identified any tangible solutions. Most listed the problems and identified that the Government had a responsibility to find and implement solutions.

The detailed submission by Dace Tomsons and David Wray (Submission No 402) examined the Swedish experience of linking overall social policy (inclusive of housing, employment, income support etc) in reducing drug use in the 1970s and 1980s. The success has been attributed to the multifaceted social approach to the problem highlighted by principles of social inclusiveness, social capital and State welfare expenditure. Restrictive measures aimed at incarcerating drug users for the purpose of treatment were implemented in parallel with comprehensive social policies that were based on principles of genuine care for those affected.

The submission highlighted that Sweden's increased focus on restrictive measures during the 1990s at the same time as State expenditure on welfare was decreasing due to the deteriorating Swedish economy. It is pointed out that there has been erosion of the success of Swedish drug policy that has shadowed the lesser investment in overall social policy.

A detailed submission prepared by the Office of the Inspector of Custodial Services (Submission No 129) proposed that an opportunity exists to convert an existing Western Australian prison for the treatment of drug addicted serious offenders. The submission suggests that there is clear evidence from the experience of other prison systems that carefully structured, intensive programs can show excellent success rates in terms of both health and crime outcomes.

The submission outlined that as the criminal justice system deals with a large proportion of chronic drug abusers, this system is an ideal place to organise and maintain drug treatment services. It is however noted that despite the positive steps in the introduction of the Drug Court, the level of commitment to prison-based treatment programs has been deficient.

> At present non-intensive programs (ie. two weeks or less in duration) are available in most WA prisons, but there are no intensive programs. Overseas experience suggests that, if a well-constructed program is to be effective, its duration needs to be six months or longer (Submission No 129, page 1).

The submission argued for the establishment of a *therapeutic prison* and not merely a therapeutic community within a prison. Moreover, the submission details why therapeutic communities within prisons have failed in other countries and provides evidence to support the establishment of a best practice and properly evaluated single purpose custodial centre.

Accordingly the submission proposed that:

- Riverbank Prison should be identified as a suitable venue for the establishment of a therapeutic prison and the necessary funds committed to refurbish and redevelop the site;
- the Department of Health, in conjunction with the Department of Justice, should conceptualise a best practice drug treatment program, to be offered to appropriate offenders within a therapeutic prison environment at Riverbank;
- prison staff, both uniformed and program, should be specially selected and trained to deliver such a program, and Department of Health personnel should also be actively involved;
- the elements of the program should include education, treatment and detection;
- the programs should be effectively linked to through-care arrangements involving program reinforcement in a community setting;
- that being so, the program should be timed so that offenders do not upon completion return to another (non-therapeutic) prison;
- the funding arrangements should recognise that during the start-up period of two or three years the payback is unlikely to be clear cut, so initial funding should be for a period of at least five years; and
- evaluation protocols should be put in place from the outset.

2.3 PRESENTATIONS TO THE SUMMIT

The presentations made by the two international speakers at the Summit are relevant to the subject of this chapter. The presentation by Mr Torgny Peterson on Monday 13 August titled *The Swedish Approach to Illicit Drugs: Benefits and Limitations* gave an overview of Swedish drug policy.

Mr Petersen indicated that the overriding aim of Swedish drug policy was to create a society free from drugs. The aim conveys the message that drugs will never be permitted to become an integral part of Swedish society, and that drug abuse must remain unacceptable behaviour. Accordingly, anything involving the use of illicit drugs is a criminal offence.

Notwithstanding the above, Mr Petersen stated that does not mean that drug users in Sweden are put into prison. He indicated that the emphasis in Sweden was on treatment that can be initiated through coercion or on a voluntary basis. The primary aim is to get drug users into treatment rather than incarcerating them.

Mr Petersen went on to explain how young people can be coerced into treatment if they have a serious drug abuse problem. He indicated that under the Swedish social welfare system a young person with problematic drug use could be coerced into institutional treatment for a period of up to six months. If the young person responds well to treatment in the first few months then treatment can revert to a voluntary arrangement. This arrangement can be initiated regardless of whether the young person has committed a criminal offence.

The same arrangements do not extend to adults. An adult must have committed a criminal offence before they can be coerced into compulsory treatment in the Swedish prison system.

Mr Martin Hosek from the Swiss Federal Office of Public Health also spoke at the Summit on Monday 13 August 2001. The title of Mr Hosek's talk was *The Swiss Experience in Drug Strategies: An Evaluation of Practice.* Mr Hosek explained that in 1991 the Swiss Government adopted a fourfold approach to drug policy: prevention, therapy and rehabilitation, harm reduction and repression. This policy framework has broad national consensus having being agreed to by a national referendum.

Approximately half of the total funds spent on drug issues at all levels are spent on repression (police forces and control measures). The balance of funds is spent on a combination of prevention, therapy and rehabilitation, and harm reduction. The most significant harm reduction measure has been the establishment and operation of 11 safe injecting rooms in five Swiss cities. This measure was introduced in response to open drug scenes in the major Swiss cities.

In 1999, the Swiss Government approved the introduction of heroin assisted treatment following an extensive trial period. Mr Hosek stated that heroin is used as a form of bait for addicts who, for 10 to 15 years could not sustain other forms of treatment, and through the provision of state supplied heroin can be placed into a treatment plan. The number of heroin assisted treatment places is capped at 1,200 places and there are tight eligibility criteria. An important but unintended outcome of the heroin assisted treatment program has been the widespread perception among youth that heroin is now considered a 'loser' drug to be provided to sick people by sterile clinics run by the state.

Mr Hosek indicated that prevention programs had developed enormously over the past 10 to 15 years and that health promotion approaches played an important role in prevention. The school based programs emphasised the development of life skills, the empowerment of children and the solving of conflict.

Professor Fiona Stanley gave a presentation titled *Early Causal Pathways and the Benefits and Limitations of Early Intervention* on Monday 13 August 2001. Professor Stanley initially described how the statistics indicated that the developmental health and well being of our young people was in crisis in Western Australia and in Australia in general. She pointed to one in four Australian children having significant mental health problems, the quadrupling of the rate of suicide among young males, and the doubling of the rate among young females over the past 40 years. She also referred to a range of other social indicators to demonstrate the crisis in the developmental health and well being of our youth.

Professor Stanley described the importance of identifying the causal pathways to developmental health and wellbeing problems among our youth. She indicated that through research there are opportunities to identify the causal pathways to poor outcomes for youth and develop early interventions to overcome these problems. Interventions that are early tend to be much more effective and cheaper than those that are later in the development of young people.

The success of the HIV-AIDS and road traffic trauma campaigns was identified as an Australian success story whereby research had been used to target early interventions to achieve very good outcomes. Professor Stanley indicated that the same level of political commitment and mobilisation of resources needed to be made to address drug related problems facing our youth.

2.4 RECOMMENDATIONS

Recommendation 1 Social Policy

> This Summit recognises that social and drug policies should take into account the diverse nature of the Western Australian community, in particular the exclusion and related disadvantage of Aboriginal communities caused by colonisation and its impacts and the special needs of other particular groups.

Therefore, this Summit recommends that the existing foundations of the current Western Australian drug strategy be affirmed. Building on those foundations, a genuine government and community partnership be used to inform, develop and implement drug policy within an integrated social policy. The development of a comprehensive drug policy should include consideration of the potentially problematic legal substances such as alcohol, tobacco, volatile substances and prescription medication.

Recommendation 2 Prevention and Social Capital

That Western Australia builds on and improves social capital as a primary means of reducing the impact of drug harm in society through deliberate linking of social policies and programs including welfare, education, employment, health, housing and justice; and therefore, government invest in the prevention and reduction of drug related harm through the early recognition of persons at risk and by encouraging full community participation in education and early intervention strategies.

Recommendation 3 Early Intervention

That Government invest in the prevention of drug related harm to the Western Australian community by providing early intervention programs that focus on broad based public and school education, preventive health and social services with emphasis on community participation and development.

Recommendation 4 Treatment

That government seriously consider all treatment options discussed at this Summit, either as trials or expansion of existing programs for people who experience problems associated with their drug use, acknowledging the need for adequate resourcing and the important role of family and community.

Recommendation 5 Judicial Discretion

In recognition of the need for judicial discretion for offences committed to support drug use, it is recommended that a full range of sentencing options be available to all courts in all places, including in appropriate cases, treatment in the community or treatment in a secure drug free institution as an alternative to conventional incarceration for adults and juveniles.

VOTING RESULTS FOR RECOMMENDATIONS 1-5			
	YES	**NO**	**ABSTAIN**
Recommendation 1	92	7	
Recommendation 2	96	3	
Recommendation 3	96	2	1
Recommendation 4	75	24	
Recommendation 5	97	2	
1 Delegate did not vote			

CHAPTER 3

YOUNG PEOPLE AND ILLICIT DRUG USE

3.1 WESTERN AUSTRALIAN CONTEXT

Issues Paper 1 addressed *Young People and Illicit Drug Use*. It identified that young people between the ages of 12 and 25 years constitute around one fifth of the total Western Australian population. At the last census in 1996, there were some 362,900 young people within this age range (Australian Bureau of Statistics, 1998).

Western Australia has the second highest overall rate of recent use (ie last 12 months) of any illicit drug. The relevant statistics for young people have been drawn from the Issues Paper, *Illicit Drug Use in WA: Facts and Figures*. As can be seen in the table below, young people aged 20-29 years have the highest levels of use in Australia, with levels of use higher than the national average.

RECENT DRUG USE OF PERSONS AGED 14 YEARS AND OVER BY JURISDICTION, 1998
(Percentage of the Cohort Population)

	NSW	VIC	QLD	**WA**	SA	TAS	ACT	NT	AUS
Any illicit drug									
14-19 years	39.4	41.1	33.2	**35.8**	47.8	39.2	36.9	41.1	38.9
20-29 years	37.5	42.3	43.7	**52.9**	43.1	43.9	40.0	49.4	42.1

The Issues Paper raised awareness of the common tendency for 'youth' to be 'lumped together' and considered as a single group. This age range was described as a time for significant life changes including physical, social and emotional change, as well as changes in economic dependence and legal status. The increasing levels of psychosocial problems, such as crime, depression and suicide, as well as problematic drug use are considered to be a call for action for all sectors of the community: parents and teachers, healthcare and welfare workers and community leaders.

The complex and diverse reasons why young people use drugs were highlighted, drawing attention to the necessity of an holistic approach that is integrated and inclusive. It was suggested that issues around young people and drug use should be considered within the context of the family, peer group, school and community, and not in isolation from these factors.

Young people have different patterns of drug use to adults, as well as different patterns of drug use within their cohort group. Levels of use vary and are seen to be reflective of the degree of disadvantage and marginalisation experienced by young people. It was also recognised that higher levels of drug use occur among high school students from families in

the highest 20% of family income. These differences were acknowledged to often require specific prevention and treatment frameworks and service provision models designed around the specific needs and issues of young people.

Childhood and adolescence were described as important years for health promotion initiatives because the decisions people make and the behaviours they adopt during these formative years can have a major impact on their health as adults. Drug education was considered to have the potential to equip children and adolescents with the knowledge, attitude and skills necessary to make informed decisions regarding their drug use behaviour. While schools were seen to provide a setting for curriculum based drug education, it was also noted that they play a significant role in the development of a child's knowledge, attitudes and skills regarding drug use.

School based, harm minimisation drug education has been effective both in terms of efficient dissemination of information and value for money (Department of Human Services, Victoria, 2000). The introduction in 1997 of the Western Australian School Drug Education Project was described as being instrumental to the development of the school drug curriculum. With an increased proportion of students coming from disrupted families, schools were often seen to be a student's main source of social support and in some cases their only stable influence.

Attention was drawn to the widespread support for the implementation of community focused and community based initiatives in recent years. Local Drug Action Groups and Community Drug Service Teams were described as two community focused initiatives addressing local drug related problems, albeit for the wider community, not specifically for young people. While some Community Drug Service Teams have specialist workers to engage with young people within the community, the teams have a mandate to work with all people in relation to drug use. The importance of building communities inclusive of youth has been identified as a way to make a significant difference to young people who feel alienated and devalued.

The issue of youth homelessness for metropolitan, regional and remote Western Australians is described as a very real one. For young people engaging in drug use, the problem is often more complex due to the lack of appropriate housing options. Gaps exist in the area of crisis, medium, and long term housing options for young drug users. Other options such as community housing and private rental are often inaccessible or difficult to access for young people.

A united, committed and strategic response was identified as the only feasible way to reduce the burden of harmful drug use on young people, their families and communities. Furthermore, it was deemed that this should include the promotion of young people's emotional health and wellbeing, with all responses and interventions centred on evidence based research and practice. The development of effective long term policy and services designed to prevent and reduce harmful drug use were considered dependent on the inclusion of young people in the decision making processes at all levels.

3.2 COMMUNITY CONSULTATION

Of the 25 submissions received the majority stated that young people have unique needs and they must be involved in the development of alcohol and other drug programs targeting young people. There was also support for the adoption of an holistic approach to meet the needs of youth using illicit drugs. Just over half of the submissions focussed on treatment related issues. There was strong support for increasing the number of youth specific treatment services, including youth detoxification centres, crisis and supported accommodation facilities and residential treatment programs. Other points made throughout the submissions included the need for cooperative inter-agency coordination, with limited support for coerced treatment of youth with drug related problems.

The Community Policing Safer WA Committee, Fremantle District (Submission No 163), recommended a community approach to youth detoxification services, employing a non-medical model, sharing resources within the local community including medical services, psychological and psychiatric services and counselling based on the Victorian youth friendly model. The focus would be on local communities taking responsibility and having input into establishment and management of services based on a shared care model.

The submission from WANADA Membership Forum (Submission No 237), indicated strong support for the development, implementation and evaluation of a consistent statewide, evidence based school drug education program. This program should be developed by young people, parents, alcohol and other drug workers and teachers and implemented by appropriately trained teachers/personnel. The submission strongly supports early intervention, promoting the need for protocols, programs and practices in schools and allowing for young people using drugs to remain in the education system. The submission supports the development of a non-medical detoxification service for people under 18 years of age, availability of crisis and other accommodation for those exiting drug treatment, with an emphasis on outreach and follow up services.

The submission from the community organisation Investing In Our Youth (Submission No 350), described a coordinated and collaborative program that involves a number of funding bodies and agencies from government, non-government and the community. The program aims to establish a community wide research and planning process to promote collaborative and strategic use of resources, using the *Communities That Care* approach to drug prevention planning.

The Trinity Youth Options submission (Submission No 445), noted that drug use does not occur in isolation and that it is functional in that it serves a purpose for users. Coercive treatment is not supported and is seen to be unjust and likely to be ineffective. There is a strong belief that drug use issues must be approached from a health and welfare perspective.

3.3 PRESENTATIONS TO THE SUMMIT

Mr Martin Hosek gave a presentation to the Summit on Monday 13 August 2001 titled *The Swiss Experience in Drug Strategies: An Evaluation of Practice.* He described the pragmatic

approach taken toward drugs by the Swiss Government. Mr Hosek made the following comments in relation to young people and relevant approaches to drug issues:

> Approaching the problem in a pragmatic way took away a lot of the mystical attraction of heroin that made it especially interesting for young people in search of a new alternative, or rebel lifestyle. Our evaluators confirmed that the image of heroin among young people has undergone a substantial change. Whereas, only 10 years ago, it was a 'rebel' drug, it is now considered the 'loser' drug… This is an unintended, but important, effect of the social aid and the medical measures, and has a great influence on the consumption habits of teenagers, who now rather tend to avoid heroin (Record of Proceedings, 13/08/2001, page 12).

Professor Sven Silburn's presentation to the Summit on Tuesday 14 August 2001 titled *Promoting Young People's Health and Wellbeing, Using Prevention and Early Intervention Strategies* focused on prevention and early intervention:

> It is true to say that there is little effective integration of current prevention that targets the range of associated youth problems…Our current efforts to deal with the drug issue are somewhat like providing expensive ambulances at the bottom of a cliff to pick up youngsters who fall off, rather than building a fence at the top to keep them from falling in the first place…Victoria has invested a substantial amount of money in the 'Communities That Care' model, which is one of the most promising models to come out of the United States….I urge this Summit to think about that as a possible option (Record of Proceedings, 14/08/2001, page 10).

Mr Bruno Faletti's presentation to the Summit on Tuesday 14 August 2001 titled *The WA Schools Drug Education Project* described the delivery of early intervention and prevention strategies in Western Australian schools. A number of key points were outlined in his presentation:

> Although it has been stated this morning that illicit drug use is almost normative in our schools, the latest surveys indicate that in fact 40 per cent of students in secondary schools have experimented with drugs while regular users of cannabis drops down to about 13 per cent…. School drug education sends out a clear non-use message about illicit drugs… The research shows that if drug education is to be effective, it must be an important part of a coordinated approach…What is said in the classroom should be reflected outside the school, in the home and by the community… We should also look at strengthening our regional capacities, enhancing drug education in the post-compulsory years where it becomes a real problem, examining our approaches to illicit drug use and involving parents in all aspects of drug education (Record of Proceedings, 14/08/2001, page 13).

Professor Tim Stockwell (Record of Proceedings, 14/08/2001, page 23), in response to questions about school education and evaluation, highlighted the importance of feedback about what engages and interests young people and what is important to them in developing school-based education. He said that not all schools dedicate time to drug education and indicated that all schools must make time.

3.4 RECOMMENDATIONS

Recommendation 6

The Community Drug Summit recommends that in the development of policy, funding priorities and models of service, the diversity of young people's needs be recognised with

respect to age, gender, sexuality; indigenous, socio-economic, cultural, linguistic and educational background; geographic location, and levels of risk and ability.

An effective response, which actively involves young people from a range of diverse groups, is needed to address the lack of services and facilities for them, particularly in relation to:

- support and treatment services;
- social and recreational needs; and
- rural, regional and remote communities.

Recommendation 7

The Community Drug Summit recommends adequate resources be targeted towards prevention programs that aid capacity building in local communities by:

- enhancing strategies to retain students in the education process;
- increasing access to alternative educational settings;
- ensuring continuing education of young offenders during and following involvement in the juvenile justice system;
- building supports around young people isolated from families;
- developing flexible and long term employment and training strategies that create real job opportunities;
- resourcing families in their parenting role;
- resourcing schools to provide professional development for school counsellors and teachers to:
  - identify the signs of drug abuse;
  - refer young people to appropriate services; and
  - develop supportive/therapeutic protocols to ensure best practice in addressing illicit and licit drug use in the school environment.

Recommendation 8

The Community Drug Summit recommends the establishment of holistic, accessible, supervised youth specific medical and non-medical detoxification, assessment, rehabilitation and respite services in metropolitan, rural, regional and remote areas that are linked to appropriate 'through' care options. There should be sufficient resourcing of youth specific treatment options to ensure a continuum of care and appropriate post treatment follow up.

Recommendation 9

The Community Drug Summit recommends the establishment of a framework for prevention and early intervention programs that is both positive and effective for young people, to inform policy and practice on a whole of government basis and throughout the community. This should target:

- continued support and further development for local community drug action groups;
- support to the community by professional human service providers;

- forming of partnerships, including general practitioners and other community health workers with key stakeholders, including drug users, police, members of the community, to ensure participation reflecting the diversity of rural, regional and remote populations, all levels of government, small business, education and community agencies;
- interactive and young person friendly information and 'marketing';
- education on four levels:
  - home;
  - community;
  - school; and
  - individual.

Recommendation 10

The Community Drug Summit recommends that recognition be given to the importance of accommodation as a protective life factor. We recommend a range of readily available internally and externally supported, as well as independent, accommodation options as essential for young people who:

- are single and/or under 18;
- are current drug users and/or have mental health issues;
- have high support needs;
- need access to pre and post drug treatment;
- live in rural and remote regions;
- are from culturally and linguistically diverse backgrounds, including refugees; and
- are from indigenous backgrounds.

These options should include a well resourced continuum of care and include the option of expanding support services to the private rental market for both tenants and landlords housing young people.

VOTING RESULTS FOR RECOMMENDATIONS 6-10			
	YES	**NO**	**ABSTAIN**
Recommendation 6	94	2	1
Recommendation 7	96	1	
Recommendation 8	96	1	
Recommendation 9	96	1	
Recommendation 10	95	2	
3 Delegates did not vote			

CHAPTER 4

SUPPORTING FAMILIES TO DEAL WITH ILLICIT DRUG ISSUES, PARTICULARLY REGARDING ISSUES FOR CHILDREN OF DRUG USERS AND PARENTS AND SIBLINGS OF DRUG USERS

4.1 WESTERN AUSTRALIAN CONTEXT

Issues Paper 2 titled *Supporting Families to Deal with Illicit Drug Issues, Particularly Regarding Issues for Children of Drug Users and Parents and Siblings of Drug Users* showed that illicit drug use by an individual within a family affects all members of that family. For many family members the cycle of drug abuse is insidious, in that relationships over a period of time become strained and tenuous because of the pressure of addiction and changing roles within family systems. The definition of family is important in that it can have different meanings for different cultural and social groups. For example indigenous families have a wider and more inclusive meaning which includes giving a special place to the extended family. Within certain social groups, like young drug users, there are people with whom they have special relationships and not just people who are related.

There has been a steady increase in the numbers of young people using illicit drugs, with nearly four in ten (38.3%) Western Australian school children identified as having used cannabis (*Illicit Drug Use in WA:Facts and Figures*, June 2001). It is estimated that over 2% of Australians have injected illicit drugs and close to 110,000 people have injected in the past year. It is still uncertain how many families are affected by drug use, but logically there would be the same numbers of families, as there are individuals, affected by drug use.

Families who are affected by illicit drugs often feel violated and hurt with the way in which the media portrays drug users and the negative view on drug use held by the wider community. Community attitudes towards drug users not only stigmatise the users but also the families of users. The combined effects of having to live with someone who is drug dependent and the negative community attitude to drug users, often results in families feeling overwhelmed and isolated. Families felt that the media needed to be more responsible given it has an influential role in shaping and determining community attitudes. As such it should be providing a balanced view, with representation from both sides of the debate.

Families are confronted with the conflicts between harm minimisation and zero tolerance views. Unfortunately, families are often caught in the middle between these two opposing positions, and feel powerless because they often sense that while the debate continues there is still a lack of appropriate treatment options available to users.

General practitioners are often the first point of contact for families and users, but they are often too busy to deal with users in an appropriate manner. In the event that a family member does receive treatment for drug use, immediate and extended family are usually not included in the recovery process. Client confidentiality is often cited as the reason for this exclusion by treating professionals.

Parental neglect due to drug use is a growing concern. There is an increasing number of Western Australian children being taken into care. There is significant evidence of the coexistence of the misuse of drugs and alcohol by parents and incidents of serious child abuse. This is substantiated by recent research conducted by the Department for Community Development which shows that between 65-70% of applications for care and protection orders for children, taken out in 1999/2000, state alcohol and/or substance abuse as an associated reason.

4.2 COMMUNITY CONSULTATION

Fourteen submissions were received; four from community members, nine from agencies and one unknown.

There were a number of submissions that strongly recommended alcohol and drug education for carers of drug users and for the general community. The submission from the Parent Drug Information Service, stated that carers of drug users need to have access to information and support in a simple and efficient way (Submission No 430). In addition, the Parent Drug Information Service identified the need to broaden the scope of the definition of carer. For example, in the event of grandparents being placed in the primary carer role for their grandchildren, there should be a formal recognition of this situation (Submission No 430).

A major concern raised in a number of the submissions was the current negative community attitudes toward drug use, which were often exacerbated by the media. According to WANADA stereotyped images about drug users are continually presented to the wider community by the media (Submission No 237). The reporting of drug matters by the media is often sensationalised adding to the myths which then further alienate families from the community. Statements like they deserved to die because they use drugs are heartbreaking for parents and carers of drug users (Submission No 430).

Many of the submissions claimed that there are limited services available to carers, whether they are parents, siblings or grandparents. In rural and remote locations, accessing services for families and users is difficult. The submission from the Department for Community Development Office in Mandurah indicated that even though this region is close to Perth, families there have difficulty in accessing services (Submission No 146).

WANADA raised a concern with interagency working relationships. It stated that some agencies are not effectively working together on behalf of their clients. It identified difficulties with the current shared care arrangements, which involve, two or more workers working with a client who is associated with more than one agency (Submission No 237).

Confidentiality and client privacy were raised in a number of submissions. It was felt that the rights of carers, parents, grandparents and others are not considered when the drug user is receiving treatment. Mrs Barbara Arthur, in her submission raised the matter of grandparents

having access to information about the welfare of grandchildren in the event of drug misuse in the family (Submission No 136). The submission from Palmerston suggested that the service sector needs to address confidentiality so that:

> … family members are able to overcome this sense of alienation and clients are able to maintain the sense of trust and security important in the client worker relationship (Submission No 326).

The Care for Children Advisory Committee, noted that neglect and physical abuse occurring in families is a major community concern, indicating that the incidence of drug misuse by young parents is resulting in an increased number of children being taken into care. It was stated that reports have shown that children who are taken into care at a young age often remain longer, with few returning to their biological family. Reunification between children and their parents should be the goal, but it should not be compromised and strategies that address parenting and lifestyle issues must be included in any intervention. Appropriate cultural and social assessment instruments assisting in the identification of the weaknesses and the strengths of families affected by drug misuse were needed (Submission No 447).

4.3 PRESENTATIONS TO THE SUMMIT

In her keynote address to the Summit, Professor Fiona Stanley described the links between drug misuse and the broader social problems that are currently being experienced by children in families identified as at risk. She stated that these risks could be identified along the causal pathways beginning at birth and following on into adulthood. In Australia, families are under enormous stress due to increasing societal pressures. These pressures are leading to divorce and separation and she suggested that if current trends continue, 48% of marriages will end in divorce in 2001. The increase in relationship conflicts/breakdowns, domestic violence, unemployment, drug and alcohol addiction, is pushing those families with the least resilience into critical situations. The impact of these and other socio-economic factors is leading to an expanding underclass of disadvantaged adults, families and communities (Record of Proceeding, 13/8/2001, page 5).

There was strong support for the introduction of early intervention and prevention programs into schools and support to families in an effort to minimise drug misuse. Many of the Summit speakers indicated that early intervention through community education was essential.

There were a number of comments made about the role of the media in its reporting of drug issues. Professor Tim Stockwell challenged the Summit by asking whether there was a need to introduce a code of conduct to be imposed upon the media on how they report drug issues (Record of Proceeding, 14/8/2001 page 9). Mr Graham Mabury, a 6PR Radio presenter, suggested that the Summit delegates consider the following two points in their deliberations:

> … that representatives from the community and the media work together to establish paradigms that identifies acceptable reporting standards and that representatives from the media and the community work together to present positive images on this issue (Record of Proceeding, 13/8/2001, page 23).

The issue of the lack of culturally appropriate and family sensitive services was raised by Ms Sandra Collard, an Aboriginal mother of a young ex drug user. She stated that her family was frustrated and felt excluded from the treatment services provided to her son because service providers did not recognise the family as part of his recovery process. She said that when she and her family were seeking information there was little available that was culturally appropriate (Record of Proceeding, 14/8/2001, page 16). Mr Francis Lynch stated 'families often do not know where to go to get information, and are unaware of what is available to them' (Record of Proceeding, 14/8/2001, page 49).

Ms Pam McKenna (Record of Proceeding, 14/8/2001, page 6) identified the need to address the gaps that currently exist between services. She indicated that agencies working across systems, should aim for greater integration of clients from the community to treatment and back into the community. She proposed that agencies improve on the way that they currently communicate to families on how their agencies can offer support.

The issue of drug misuse and parental neglect and its wider social impact was discussed. Mr Nathan Kurth recounted his experiences of being a child of a parent who abused drugs. He was taken into care soon after birth and has had limited contact with his mother since that time. Mr Kurth spoke of visiting his mother when she was in prison, and finding these experiences confusing and unsettling. He told the Summit that as he got older there were other occasions when they would arrange to meet, but she would not show up and he felt very disappointed. Mr Kurth concluded by making the comment 'I am allowing delegates to realise that my mother's substance abuse had more of a hold over her than she had over her son' (Record of Proceeding, 14/8/2001, page 19).

4.4 RECOMMENDATIONS

Recommendation 11

It is recommended that the Western Australian Government consult with media interests to facilitate the development of a mandatory Code of Practice which aims to minimise sensationalism in relation to the reporting and treatment of drug issues in the media and supports a positive image of young people and families.

Recommendation 12

It is recommended to the Government of Western Australia that families be supported in the goal of creating a safe and secure environment by the development of community capacities through:

- Adopting effective grassroots community development programs that enrich community cohesion, promote social inclusion, encourage and recognise cultural diversity; and
- the challenging of the stereotyping of those who are affected by drug use.

Recommendation 13

The Community Drug Summit recognises that there are significant numbers of children entering foster care or being cared for by extended family members due to drug use of their parents. It is recommended to the Western Australian Government that an appropriate range of Aboriginal and non-Aboriginal and culturally appropriate services be developed and funded to support the needs of these children; including support to their carers, relevant counselling and other services to the children and affected parents. Every attempt should be made to maximise the opportunities for safe return of children to the care of their parents, which includes the increased provision of whole of family residential treatment.

Recommendation 14

The Community Drug Summit recognises that family members of a drug user are often involved in helping the person access services and can be a key resource to assist their recovery, but can be marginalised in the process due to narrow interpretations of privacy and confidentiality considerations. It is recommended that the Western Australian Government engage all relevant stakeholders in a process that re-assesses privacy and confidentiality issues so as to maximise the involvement of family members and significant others in the service system whilst still acknowledging the rights of the individual.

Recommendation 15

It is recommended to the Western Australian Government that:

- it supports a wide ranging approach to service delivery, ensures that these services are funded according to need, widely publicised, regularly and appropriately reviewed and evaluated;
- information about all available services is presented in a wide range of ways (taking into account indigenous, CALD and gender identity and sexuality issues); and
- particular emphasis be placed on developing services that assist families dealing with a drug user, such as increased provision of crisis care, respite, compulsory rehabilitation (where appropriate), assisted detoxification services and bereavement support.

VOTING RESULTS FOR RECOMMENDATIONS 11-15			
	YES	**NO**	**ABSTAIN**
Recommendation 11	95	3	
Recommendation 12	96	1	1
Recommendation 13	96		1
Recommendation 14	85	10	3
Recommendation 15	84	13	1
1 Spoilt paper for Recommendation 13 2 Delegates did not vote			

CHAPTER 5

ADDRESSING ILLICIT DRUG USE AMONG ABORIGINAL PEOPLE, INCLUDING THE PROVISION OF TREATMENT PROGRAMS FOR DRUG DEPENDENT ABORIGINAL PEOPLE

5.1 WESTERN AUSTRALIAN CONTEXT

In Issues Paper 3 titled *Addressing Illicit Drug Use Among Aboriginal People, Including the Provision of Treatment Programs for Drug Dependent Aboriginal People* it was noted that indigenous people living in Western Australia are a diverse group particularly in regards to cultural practices. In addition the indigenous population is characterised by a larger number of young people with, 59% under the age of 25 compared to 37% in the non-indigenous population (Australian Bureau of Statistics 1998).

Patterns of drug use in the indigenous community are varied and there is concern about the widespread use of cannabis within the indigenous community becoming normalised practice. It was noted that the use of amphetamines is now an issue for indigenous people, particularly in regional areas. It was suggested that this was related to the proximity of activities like fishing, mining and tourism. Of concern were the unsafe practices of injecting drug users, particularly in prisons where indigenous people are disproportionately represented and at greater risk of contracting blood borne viruses.

The impact of illicit drug use on indigenous families is a source of multiple problems from violence to mental illness. Of concern is the incidence of inadequate child-care by parents with drug problems. Increasingly these children are being taken into care due to parental neglect. Because of the kinship systems present within indigenous communities this situation can have an impact across the extended family and communities. Community members are also particularly concerned with the growing incidence of indigenous drug dealing and the associated violence that accompanies this type of activity.

With regard to current services it was noted that there are limited treatment programs specifically for indigenous people, particularly those living in rural and remote areas. The services that are currently available are under resourced and there are few prevention strategies available to indigenous communities.

5.2 COMMUNITY CONSULTATION

On the 27 June 2001 an Aboriginal Community Drug Forum was held at the Derbarl Yerrigan Health Service in East Perth. Approximately 140 people attended, representing a broad cross section of both the indigenous and the non-indigenous community. Participants who attended came from locations across the state and the proceedings and outcomes are documented in Submission No 545. The key points from the Forum are summarised, and then reference is made to other submissions, of which there were seven.

Members of the indigenous community participated willingly in the Aboriginal Community Drug Summit Forum, but wished to express their disappointment that legal drugs like alcohol and tobacco, and the misuse of prescription drugs and volatile substances were not to be part of the debate at the Community Drug Summit. It was felt that these substances were more of an issue for indigenous communities than illicit drugs and they needed to be addressed in their own right (Submission No 545).

Concern was expressed about the 'normalising' of illicit drug use in the indigenous community, as was the increasing incidence of intergenerational drug use, with some parents introducing their children to illicit drugs. The increasing incidence of illicit drug related violence in indigenous communities, was also a major concern. There is a perception that there is a lack of police action in apprehending and prosecuting known drug traffickers. Parental neglect associated with illicit drug use is an increasing phenomenon with indigenous families. Often extended family, grandparents, uncles and aunts are required to assume primary responsibility for caring for the children of drug dependent parents. This is having a significant impact on community relationships, as is the increasing number of indigenous children being taken into care because of parental neglect due to illicit drug use (Submission No 545).

Indigenous people thought that there is a need to develop pathways for recovery from prison to the community for indigenous people affected by drug use. There is a need to shift the focus of illicit drug use from law enforcement to a health and social justice focus, and an urgent need to review drug diversion courts to assess their effectiveness for indigenous people. This was seen as critical because of the high incarceration rates of indigenous people in prisons within Western Australia. In this context there is an urgent need for harm minimisation activities in prison to reduce the risk of contracting blood borne viruses. Culturally appropriate harm reduction strategies are needed for indigenous people, however Forum participants expressed concern about the understanding of harm reduction in the indigenous community (Submission No 545).

There is a need to provide more indigenous specialist drug and alcohol services that are inclusive and allow for family and community participation. Many of the existing main stream services have no or few indigenous workers and therefore do not appeal to indigenous people.

The submission from Job Futures in Mandurah noted that young indigenous people normalise imprisonment, with the added complexity of it being seen as a 'rite of passage' (Submission No 520). Submissions from the Western Australian Substance Users' Association Inc (WASUA) and WANADA identified difficulties in relationships between indigenous people and the police. It was suggested that Aboriginality often means being stereotyped as a drug user or a criminal by police. WANADA and WASUA wanted this problem addressed (Submission Nos 229 and 237).

The submission from the Mawarnkarra Health Service in Roebourne identified an urgent need for culturally appropriate indigenous drug and alcohol services. The emphasis should be on engaging and working with local indigenous communities to develop strategies that are locally owned and controlled (Submission No 90).

5.3 PRESENTATIONS TO THE SUMMIT

Mr Ted Wilkes, the Director of Derbarl Yerrigan Health Service, provided the keynote address on indigenous matters at the Summit. He stated that:

> … being indigenous can mean living with drugs, be it from a distance or from within; more often than not it is from within. If indigenous people have not used drugs themselves, someone in their immediate or extended family has and continues to do so' (Record of Proceeding, 14/8/2001, page 36).

He further stated that there are many underlying issues that needed to be taken into consideration as they are contributing factors to drug misuse, namely poverty and the associated problems of poor housing, low self esteem, racism and other social disadvantages (Record of Proceeding, 13/8/2001, page 36).

Mr Wilkes said that there is an alarming increase in the incidence of indigenous people involved in the manufacture and trafficking of illicit drugs. He said that the indigenous community's confidence in the Police's ability or willingness to deal with illicit drug use is at a low ebb. With the acceptance and high use of cannabis in the indigenous community the current laws pertaining to cannabis use should be changed, to decriminalise its use (Record of Proceeding, 14/8/2001, page 38).

Professor Fiona Stanley in her keynote address, said that 20% of indigenous children are living in extreme poverty and this is a contributing factor to drug misuse. For indigenous children, she said the impact of colonisation and its consequences needs to be recognised as unique. It has an enormous bearing on developing intervention, programs when working with indigenous people. Professor Stanley indicated that appropriate intervention targeted at certain points along the pathways of human development for children and adolescents could improve their outcomes. She said 'interventions that are early tend to be more effective and cheaper than those that are late, where you are almost close to the outcome'. (Record of Proceeding, 13/8/2001, page 5).

Mrs Sandra Collard, an indigenous woman, spoke at the Summit as a parent of a drug user. She spoke of the difficulties and personal pain that she and her family experienced over a period of four years. As a family they wanted to work together, but were isolated from treatment options because 'mainstream organisations did not understand that they were not working with an individual but with a family. (Record of Proceeding, 14/8/2001, page 16).

Ms Wendy Casey the Coordinator, Kimberley Community Drug Service Team, (Record of Proceeding, 15/8/2001, page 4) presented the model that is currently operating in the Kimberley area. In her team, 50% of the staff are indigenous, and other indigenous people are employed in non-indigenous generic positions. Importantly, the agency's mental health, alcohol and drug policies reflect indigenous thinking. The services offered in this region are culturally appropriate and reflect best practice. She further stated that in a geographical area as large as the Kimberley community, development strategies had contributed to the success of their operations.

Mr Alex McIntosh, a Senior Project Officer for Youth located in Geraldton, stated that there is an increasing incidence of eight and 10 year old indigenous children using illicit drugs and an increasing number of indigenous women in these regions using illicit drugs, namely cannabis. He cited social and relationship reasons for this increase. The partners of these women abuse alcohol, and the women's response is to resort to cannabis, as a means of coping. This is leading to an increase in suicides or attempted suicides, parental neglect, and mental health problems (Record of Proceeding, 14/8/2001, page 40).

Ms Dawn Bessarab an indigenous woman currently working at Curtin University referred to ways of working which are culturally sensitive. She said that:

> … treatment programs need to be culturally designed so that they work with Aboriginal world views because, even though the effects of drug use are the same for Aboriginal families as they are for non-Aboriginal families, the way in which people respond is different because of cultural factors and historical difference (Record of Proceeding, 14/8/2001, page 41).

5.4 RECOMMENDATIONS

Recommendation 16 Aboriginal Social Exclusion and Drugs

That Government introduces urgent reform to public policy and social sector structures that enables Aboriginal families and communities to access the economic and cultural resources necessary to ensure that Aboriginal people are able to productively participate fairly and safely in Western Australian political and civil society. These resources must include:

- equitably distributed economic development; and
- improvements in family, kinship cultural and community support systems especially in times of crisis.

Recommendation 17 Aboriginal Life Course and Drugs

That Government give priority to the early introduction of coherent and comprehensive Aboriginal affairs social policy and programs, that specifically target the points and periods in the life course of Aboriginal people and communities when they are undergoing changes that are likely to have a long term effect on their socio economic status. These points and periods should include as a minimum infancy, entering school, moving from primary to secondary school, school leaving, entering the workforce or periods of long term unemployment, becoming parents or changes in family circumstances. The transitions of childhood and adolescence for Aboriginal people should be particularly targeted.

Recommendation 18 Prisons, Aboriginal Prisoners and Drugs

That Government should immediately introduce prison reforms that provide culturally secure drug detoxification and rehabilitation for Aboriginal prisoners including the introduction of an Aboriginal therapeutic community within major metropolitan prisons and regional prisons with significant Aboriginal populations. Such reforms should link culture, the family, community and personal services and supports and personal development programs and

could be usefully linked to an expanded Aboriginal involvement with the Western Australian Drug Court.

Recommendation 19 Lack of Resources to Serve Aboriginal Needs

That Government urgently and significantly increase the level of funding and establish a comprehensive resource base to support Aboriginal community drug action including:

- an expanded knowledge base with specific support for action based research that addresses Aboriginal communities questions and priorities;
- a significantly improved range of culturally secure treatment, rehabilitation and detoxification facilities and services either delivered by Aboriginal communities or in partnership with them; and
- a greatly expanded culturally and technically competent and compassionate workforce able to deliver services in the community and other settings.

It is especially important that Government ensures that such efforts, indeed all services are culturally secure. Aboriginal people may choose to use mainstream services and Aboriginal people must not be afforded a less favourable outcome simply because they hold a different cultural outlook.

Recommendation 20 Enforcement

That Government increases law enforcement efforts to target the networks supplying drugs to Aboriginal communities which destroy our internal capacity to build and maintain cultural, family and civic strength and fellowship. In order to complement these enforcement efforts, additional health sector efforts that better equip Aboriginal families and communities to educate their members about the impact of drug abuse are necessary.

VOTING RESULTS FOR RECOMMENDATIONS 16-20			
	YES	**NO**	**ABSTAIN**
Recommendation 16	93	5	1
Recommendation 17	96	3	
Recommendation 18	99		
Recommendation 19	97	2	
Recommendation 20	97	1	1
1 Delegate did not vote			

CHAPTER 6

PREVENTION AND EARLY INTERVENTION STRATEGIES, INCLUDING SCHOOL, PARENT AND PUBLIC EDUCATION AND ACTION IN LOCAL COMMUNITIES

6.1 WESTERN AUSTRALIAN CONTEXT

Issues Paper 5 *Prevention and Early Intervention Strategies, Including School, Parent and Public Education and Action in Local Communities* indicated that prevention strategies in Western Australia have focussed on education in schools, parents through public campaigns and community action and partnerships. These have been developed since the mid 1990s.

Drug education in schools has been through the School Drug Education Project established in 1997. This includes professional development for schools and teachers, drug education curriculum, drug policies in schools as well as strategies for parents and community involvement. The WA Police Service has also implemented a youth education strategy for late primary and early secondary school aged children known as the Youth Drug and Alcohol Education Program (GURD). This strategy also involves media advertising, and school and community education which is undertaken by trained police officers.

Illicit drug media campaigns began in 1996 under the *Drug Aware* banner and specifically targeted heroin, cannabis, psycho stimulants (amphetamines, LSD and ecstasy), drugs and driving. The campaigns have used youth press, radio, convenience advertising and posters for young people and mainstream press for parents. These campaigns have generally achieved high rates of awareness.

The primary strategy in local communities has been the development of about 80 Local Drug Action Groups (LDAGs). These groups are made up of local volunteers who assist with public education campaigns, supporting parents, providing activities for youth as well as working with local schools and police. There has also been a wide range of activities undertaken by these groups working within their own community and developing partnerships with local businesses, TAFE, universities, local governments and community pharmacies.

6.2 COMMUNITY CONSULTATION

There was a total of 33 submissions received in relation to prevention and early intervention. Of these 20 were from community members, 10 from agencies, two from community action groups and one unknown. There was strong support for education and early intervention.

Nineteen submissions supported the need for education on alcohol and other drugs for various target groups, including the general community, primary school children and parents. There was some support for specialist training for teachers. There was both support for the inclusion of harm reduction in drug education and some opposition to it.

Of note were submissions from WANADA (Submission No 237), WASUA (Submission No 229) and the LDAGs Inc (Submission No 407). These groups made submissions on behalf of their members through their own consultative processes.

WANADA suggested that school drug education needs to be flexible and comprehensive, and able to meet both the needs of students that do not use drugs, and those that do. It was also suggested drug education needs to involve students, parents, teachers and other drug experts in its development, implementation and evaluation. In relation to early intervention strategies, it recommended the development and implementation of programs for primary, secondary, government and private schools, which aim to address drug use issues as well as keeping the child within the school's system. The development and implementation of living and coping skills programs is also seen as an important part of primary and secondary school education. WANADA also advocated strategies to improve the wider community's knowledge of drug issues and available services.

WASUA indicated that parents need to be better informed about drugs and drug using and be able to participate in joint training systems in schools. Parents should also be encouraged and supported in discussing drug use and associated issues with their children from an early age. It also argued for programs which teach children life and coping skills, as well as drug programs that present accurate information rather than exaggeration and scare tactics. It was suggested that a specific program be implemented in Western Australian high schools that would enable a drug worker or counsellor (who understands drug use and has training in harm reduction strategies and treatment options) to be responsible for basic drug education.

The submission from the LDAGs Inc outlined their role in prevention projects within their local communities, engaging and supporting families and young people. They advocated for strengthening and supporting partnerships between themselves and government and non-government agencies. They also wanted acknowledgement and recognition of the work undertaken by volunteers who make up LDAGs.

6.3 PRESENTATIONS TO THE SUMMIT

Professor Fiona Stanley, the Director of the TVW Institute for Child Health Research, addressed the Summit on *Early Causal Pathways and the Benefits and Limitations of Early Intervention* (Record of Proceedings, 13/08/2001, page 4). Professor Stanley outlined the importance of early intervention and the potential to address and overcome problems early. This approach produces benefits in terms of greater effectiveness of the intervention and is more cost efficient than later interventions. The early identification of behavioural and learning problems presents an important opportunity for intervention.

Professor Stanley stressed the importance of identifying causal pathways, these are factors which impact upon children and lead to either positive or negative outcomes. Negative outcomes include, drug and alcohol use, drug dependency, depression, suicidal behaviour and crime. She indicated that good early interventions may simultaneously address a range of conditions, for example, a strategy that may address drug use in children may also improve educational outcomes, employability options, and help develop healthier adults and better parents.

The need for data and evidence was stressed. Evidence of effectiveness is paramount in the development of optimal early interventions. She emphasised the importance of the continued collection of data in relation to illicit drug use in young people, especially in relation to both positive and negative causal pathways. The identification of risk factors will assist in the development of intervention trials and subsequent evaluation processes.

Mr Martin Hosek, from the Swiss Federal Office of Public Health, addressed the Summit on *The Swiss Experience in Drug Strategies: An Evaluation of Practice* (Record of Proceedings 13/08/2001, page 12). Mr Hosek explained that in Switzerland health promotion approaches play an important role in prevention. This includes the promotion of life skills, empowerment of children and conflict resolution skills, all of which are considered essential. Schools strive to promote health and provide a nurturing environment for children. The Swiss Federal Office of Public Health works with schools and tries to involve families in addressing specific risk behaviour, rather than focusing on drug use.

A national early intervention research project has been implemented by the Swiss Government. This project supports children and young people who are having difficulties at school and who show signs of at risk behaviour. It is recognised that drug use is rarely the only problem. As such, this project has been designed to assist children and young people overcome underlying problems.

Dr Bill Saunders, a consultant, addressed the Summit on *Concepts, Models and Frameworks: An Overview in Relation to Western Australia* (Record of Proceedings, 13/08/2001, page 29). Dr Saunders argued that those people with 'less going for them' in terms of relationships, homes, jobs and a feeling of belonging are more likely to become dependent on drugs. With more social deprivation, more unemployment and more wretchedness there will be more drug use. Given that drugs are primarily used for psychological solace rather than recreation, he argued that in these circumstances, drug education will not stop people using. He believes that the ultimate solution is better childhoods.

Dr Saunders suggested that the best prevention approach is less about a drug specific intervention but ensuring safety and wellbeing in childhood. He advised the Summit that this approach had been taken in the Channel Islands where an investment was made in parenting programs and support for children who were not doing well at school. This was seen as the primary solution, rather than focussing on drug use specifically.

Professor Tim Stockwell, the Director of the National Drug Research Institute, addressed the Summit on *An Overview of Prevention* (Record of Proceedings, 14/08/2001, page 7). Professor Stockwell indicated that the precursors to drug use are very important especially in relation to early prevention in childhood. He suggested that there are clear indications of risk

factors in the lives of young people, in their family relations, as well as in their schooling. These indications predict a myriad of problem behaviours including aggression, conduct disorders, risky sex practices, smoking, excess alcohol use and drug use.

He outlined some encouraging results from intervention studies in which the incidence of these problems had been delayed or reduced by the targeting of these risk factors and by assisting children to develop skills to overcome these risks. He asserted that Australia urgently needs projects designed to investigate these issues further. He also noted that prevention approaches need to take into consideration the various layers of society and how they interact. Professor Stockwell stressed that teachers are demanding harm minimisation education to enable them to appropriately deal with students who are already using illicit drugs.

Professor Sven Silburn, of the TVW Telethon Institute of Child Health Research, addressed the Summit on *Promoting Young People's Health and Wellbeing, Using Prevention and Early Intervention Strategies* (Record of Proceedings, 14/08/2001, page 10). Professor Silburn argued for early intervention. He believes that not enough attention is paid to the early years of child development and advised that many problems could be identified in grades 1 or 2. He outlined the importance of identifying risk factors which arise during the course of child development and increase the chances of drug and alcohol abuse. He also emphasised the importance of protective factors, which decrease the likelihood of young people developing drug and alcohol abuse problems. He advised that programs addressing risk factors had shown positive results.

Professor Silburn described various risk factors affecting young people, at community, school and family levels. For example, cohesive communities in which people feel a stronger sense of affiliation and belonging generally have a lower rate of problems. Similarly, family dysfunction has a stronger correlation with problems that lead to higher risks of drug use. He stressed that understanding of protective factors as well as risk factors will assist in the development of broad social policies and targeted programs.

Professor Silburn also stressed the importance of effective parenting. He advised that a Canadian study indicated that with adequate parenting, there is a steady decline in behaviour problems. He supported for the Victorian 'Communities That Care' model (derived from the United States) which aims to promote positive attachments to family, school and community.

Professor Silburn also advocated for selective interventions for specific risk groups. For example, the United States program 'Preparing for Drug Free Years' is aimed at primary school children. He indicated that programs should be developed for other groups such as the children of drug users, and for adolescents at risk of depression. He also argued for broadly targeted universal prevention strategies and strengthening the links between clinical prevention and promotion services across government, in partnership with the non-government sector.

Mr Bruno Faletti, the Manager of the School Drug Education Project, addressed the Summit on *The WA Schools Drug Education Project* (Record of Proceedings, 14/08/2001, page 12). Mr Faletti advised that school drug education is part of the prevention and early intervention focus and sends out a clear non-use message. He identified a need for the development of a

program for students who experiment with or use drugs on a regular basis. The need for school drug education to be part of a coordinated approach including a range of other initiatives such as parent education, public education, health service reorientation and general community mobilisation was discussed. He emphasised the importance of coordinating drug education with other agencies such as the Police, Life Education Australia and the Health Department, proposing that drug education should be undertaken in the context of promoting health in schools and in the community.

Mr Faletti stressed the importance of early intervention and the need to connect students whose lives are affected by drug use, with appropriate services both within and beyond the school environment. Proper evaluation of existing programs was essential. He also proposed the expansion of drug education in the post-compulsory years, as well as the involvement of parents in the development of drug education programs.

Ms Sandra Spadanuda, speaking on behalf of the Youth Affairs Council of WA Forum, suggested that education is important and needs to be integrated into local communities, started at an early age, and be realistic, accurate, relevant and practical. She also indicated that there should be more information on why and how people are taking drugs and less on the drug they are taking. Rather than focussing on faults the positive aspects of young people needed to be encouraged (Record of Proceedings, 14/08/2001, page 27).

Ms Kamila Waihi, speaking on behalf of the Youth Advisory Council in Northampton, indicated that there is a need for education to help young people with poor self-esteem. She also stated that boredom is an issue for young people in rural areas, where there are less resources and entertainment for this group of people (Record of Proceedings, 14/08/2001, page 30).

Ms Johanna Somerville, a representative from the Office of Youth Affairs Drug Forum, argued that a supportive and encouraging family, which has clear values about drugs and other issues, is the most significant factor in preventing drug use, and helping young people achieve their goals. However, this type of parenting style needs to be supported. She also indicated that most young people believe that school drug education started too late and that it should be 'realistic and meaningful', focussing less on addiction and more on experimentation and how to handle this (Record of Proceedings, 14/08/2001, page 31).

Mr Ted Wilkes, the Director of the Derbal Yerrigan Health Service, outlined the damage done to children at an early age through seeing their parents and elders consuming alcohol and drugs. He also indicated that people who are homeless, living in poverty or inadequate, overcrowded housing, have fewer employment prospects or suffer from low self-esteem are extremely vulnerable to drug use and dependence (Record of Proceedings, 14/08/2001, page 36).

Mr Alex McIntosh, a Senior Project Officer for Youth with the Compari Midwest Community Drug Service Team, attributed early drug use in rural areas to the lack of support offered to youth within those areas, parental neglect and lack of prospects in relation to employment, education, housing and financial security. Isolation has a bearing on the wellbeing of a community and this needs to be taken into consideration when policies, procedures and programs are being developed (Record of Proceedings, 14/08/2001, page 39).

Mr Joe Collard, a Youth Liaison Officer for the City of Gosnells, indicated that disillusionment, depression, lack of purpose, financial problems, unemployment and poor parental examples all contribute to drug abuse (Record of Proceedings, 14/08/2001, page 42).

6.4 RECOMMENDATIONS

Prevention and Early Intervention Strategies

Recommendation 21

The Government create an overall coordinating body to:

- coordinate responses to drug related issues, identified needs, and program development;
- report directly to the relevant Minister;
- assist organisations to access funding for the prevention of problematic drug use and treatment;
- provide support to regional, remote and rural areas in ways designed by active consultation with these communities;
- support and fund a diverse range of prevention and treatment options; and
- to become an independently funded body.

Recommendation 22

Research has shown that causal pathways to problematic drug use, crime and suicide can be minimised by early intervention strategies commencing from early childhood. All government and non-government agencies must implement this research in their planning and report annually on their strategic approach.

Recommendation 23

That the State Government develop a common standardised regional boundary structure for all State service agencies to achieve integration across government strategic planning, reporting and service delivery. This structure to be used to address the key risk and protective factors related to licit and illicit drug use for individuals, families and communities throughout Western Australia.

Recommendation 24

There is strong support for comprehensive school based drug education that has an evidence base, however attention must be paid to:

- research and evaluation relating to behavioural outcomes and school implementation;
- enhanced student, family and community input into the development of school programs;

- increased government resourcing of drug education programs particularly targeting post-compulsory programs (years 11 and 12);
- compulsory inclusion of drug education in pre-service teacher training;
- enhanced provision for comprehensive parent and community education;

- cultural relevance of all interventions and materials; and
- all school administrators and councils consider the need for a comprehensive approach to school drug education.

Recommendation 25

Families are the cornerstone to building an ordered society. The Government needs to mobilise the community, to strive for caring and safe family environments by providing assistance to parents to develop positive parenting skills and provide the opportunity to engage children through a peer support and mentoring program.

To empower communities to mobilise it is recommended that additional funding be directed to enhance and promote the activities of Community Drug Service Teams, Local Drug Action Groups, Local Service Clubs, Police, Safer Western Australia, School Drugs Education Program (SDEP) regional organising committees, and Local Government.

VOTING RESULTS FOR RECOMMENDATIONS 21-25			
	YES	**NO**	**ABSTAIN**
Recommendation 21	86	13	1
Recommendation 22	83	17	
Recommendation 23	97	2	1
Recommendation 24	91	8	1
Recommendation 25	93	6	1
All Delegates voted			

CHAPTER 7

TREATMENT FOR DRUG USERS AND REINTEGRATION OF DRUG DEPENDENT PEOPLE INTO THE COMMUNITY

7.1 WESTERN AUSTRALIAN CONTEXT

Issues Paper 5 *Treatment for Drug Users and Reintegration of Drug Dependent People into the Community* defined the term treatment as being any intervention that has the potential of engaging problematic drug users into health enhancing behaviours or more direct clinical contact.

The concept of reintegration into the community, while a vital aspect of successful treatment, relies on the implicit assumption that most drug dependant people were integrated prior to becoming drug dependent and that their drug use caused their subsequent social exclusion. For many drug users, this is not the case. These people are often socially marginalised prior to using drugs. Their use of drugs can be seen as a way of coping with this exclusion. Therefore, for many people habilitation, as opposed to rehabilitation, should be the proper focus of intervention. The long term success of any treatment is dependent on a drug user's access to various assets such as housing, employment, financial stability, social relationships and personality resources such as resilience.

Treatment and rehabilitation 'givens' highlighted in Issues Paper 5 include:

- treatment 'works'. Consumers have better health, commit less crime and have reduced drug use than those consumers who do have treatment contact;
- treatment is cost effective in terms of health care and crime cost reductions;
- a diversity of treatment services is required to respond to the range of drug use problems faced by different individuals;
- different treatments, often of diverse ideological perspectives achieve similar outcomes. 'Non-specific' factors such as the degree of rapport with a counsellor appear to be important;
- longer treatment improves outcome. Three months of care, significantly improves outcome;
- effective treatment requires ready availability, easy accessibility and to be able to address the multiple needs of an individual;
- appropriate use of medications, together with counselling improves outcomes;
- detoxification is only the first step of treatment and is not, by itself, an effective treatment;
- treatment does not have to be voluntary to be effective; and
- recovery from addiction is a process not an event.

The previous State Government's reorganisation of drug treatment services included the introduction of 12 Community Drug Service Teams and the restructure of the then Alcohol and Drug Authority into a specialist drug agency called Next Step Specialist Alcohol and Drug Services. The strategy promoted making alcohol and drug problems everyone's business and involved improving responses by hospitals, involvement of general practitioners and capacity building in service agencies such as the Ministry of Justice and the Department of Family and Children's Services.

7.2 COMMUNITY CONSULTATION

A total of 36 submissions were received relating to this topic. Key agencies responding included Next Step Specialist Drug and Alcohol Services, WASUA, WANADA, Palmerston Association and Narcotics Anonymous. Responses were also received from users, medical practitioners, workers with pharmacotherapies and advocates of alternative therapies.

Most of the submissions identified gaps in services. Key gaps identified include the:

- need to extend withdrawal services with home based withdrawal;
- lack of adequate residential programs and the need to establish crisis accommodation;
- lack of adequate counselling and methadone services in rural areas;
- extension of the use of pharmacotherapies; and
- a facility to cater for at risk amphetamine users.

Comorbidity (people presenting with both addiction and mental health problems) was also a key issue identified in that there is a need to develop an integrated model of care using a shared care approach. The lack of recognition of the role that Attention Deficit Hyperactivity Disorder (ADHD) plays in the development of drug problems was identified as a significant issue in three submissions.

Roughly an equal number of submissions were for and against compulsory treatment. Agencies that were against the compulsory treatment of users indicated their support for 'time out' facilities for young amphetamine users who had become unstable.

There were 241 submissions (mainly from individuals) that recommended policies that promote 'a drug free society and zero tolerance to drugs'. Many of the submissions specified opposition to heroin on prescription and/or called for the adoption of the Swedish approach to dealing with drugs.

7.3 PRESENTATIONS TO THE SUMMIT

The first keynote speaker to the Summit was Professor Fiona Stanley. She spoke on *Early Causal Pathways and the Benefits and Limitations of Early Intervention*. Although treatment was not her topic area, she spoke as a researcher of the necessity to rigorously evaluate outcomes of programs by choosing effective indicators to measure change. With regard to a heroin prescription trial she stated:

> Do the research - find out and trial it. People forget the meaning of 'trial'. 'Trial' means an experiment to see whether something works. It does not mean that a heroin trial will be here forever. It is a trial: it will give an outcome and evidence. (Record of Proceedings, 13/08/2001, page 7).

Mr Torgny Peterson spoke at the Summit on *The Swedish Approach to Illicit Drugs: Benefits and Limitations*. He gave an overview of the Swedish Government's bipartisan drug policy as being one to create a society free of drugs. The history of the development of this policy was based on the Swedish experience with alcohol abuse. The use of illicit drugs is a criminal offence, however drug users are treated, not put in prison. Treatment may be compulsory, in which case it would continue for six months, but in practice was usually done on a voluntary basis, especially with adults. Mr Peterson indicated that voluntary treatment has a superior outcome. He commented that alcohol is a much bigger problem than illicit drugs in Sweden. Illicit drugs used in Sweden were mainly cannabis and amphetamines. He agreed with Professor Stanley's comments on the need for evaluation of planned interventions and warned that statistical information from Europe not be used unless it could be confirmed.

On Monday 13 August 2001, Mr Martin Hosek gave a presentation on the development of Switzerland's drug treatment policies since the mid 1980s which were implemented in response to the rapid spread of HIV and 'open' drug scenes in Swiss cities. Three national referenda were held from 1997 to 1999. The first referendum proposed abstinence based treatments and the second proposed the opposite policy, that is, the liberal availability of drugs. Both referenda were rejected. Heroin-assisted treatment was approved in the third referendum. In concluding, Mr Hosek stated:

> The drug problem cannot be solved, it can only be handled. …There is no single measure, activity or project that makes the difference; it is the package of them all. (Record of Proceedings, 13/08/2001, page 15).

Dr Bill Saunders addressed the Summit on *Concepts, Models and Frameworks: An Overview in Relation to Western Australia.* He commented on the expenditure by different countries in responding to drug problems and highlighted the high cost of the Swedish approach to dealing with illicit drugs. He raised the issue of how much the community is prepared to spend on drug related responses. In answer to a question on existing Western Australian services he stated:

> Gaps exist, but I do not think we need to tear down the fabric of what we already have to address them. (Record of Proceedings, 13/08/2001, page 41).

Dr George O'Neil, Director of the Perth Naltrexone Clinic gave a presentation on *Using Naltrexone: Strengths and Limitations* (Record of Proceedings, 16/08/2001, page 5). The presentation described the elements of the Physiology, Housing, Relations, Education, and Employment (PHREE) program as the necessary order of treatment for addicts. He argued that naltrexone implants provide a safer detoxification result than opiate maintenance programs, such as using methadone.

Dr Alison Ritter, Head of Research, Turning Point Alcohol and Drug Centre, Melbourne gave a presentation titled *An Overview of Treatment for Illicit Drug Problem, Including New Pharmacotherapies* (Record of Proceedings, 16/08/2001, page 7). She presented an overview

of treatments, including new pharmacotherapies and introduced the topic by commenting that treatment is a good investment. Dr Ritter summarised the three broad classes of treatments for illicit drug problems as:

- drug withdrawal/detoxification that can be either medicated or 'cold turkey';
- relapse prevention involving changing long term drug use behaviour, usually after detoxification; and
- substitution pharmacotherapies which are analogous to the use of nicotine patches while quitting smoking.

She said that withdrawal can be achieved using a number of medication options however it was emphasised there is a need for a calm and supportive atmosphere to achieve success. Although this is an important stage in treatment, it does not in itself, change behaviour.

Dr Ritter stated that relapse prevention requires both changing drug use behaviour and addressing emotional, practical and social needs. Research shows the best outcomes are from cognitive behaviour therapy which involves practical issues, such as dealing with cravings, high risk situations and life-coping skills. Length of treatment is the best indicator of treatment results, however there is a problem in getting people to stay in residential treatment. The minority who do stay for three months or more, do very well.

The aim of substitution pharmacotherapies is to achieve pharmacological stability while lifestyle issues are addressed. She stated that:

> The main objection that people have to substitution pharmacotherapies is that a drug is still being prescribed … the [research] work that has been done in Switzerland, notably on prescribed heroin has demonstrated that the treatment works…. The one essential ingredient that can make all the difference is a sense of connection. (Record of Proceedings, 16/08/2001, page 9).

Speaking as part of the Carers and Consumers Panel (Record of Proceedings, 16/08/2001, page 13) Mr Rosco Woods a former drug user, echoed a number of other speakers who presented a user's perspective, that drug use often reflects other problems in the lives of users. Drug use, while apparently illogical to others, can make sense to the user if it is deadening the pain of their lives. Only by the user addressing underlying issues in their own lives are they able to progress beyond dependency.

Mrs Geraldine Mullins of the Australian Parent Movement (Record of Proceedings, 16/08/2001, page 14) spoke against harm reduction and advocated a hard hitting drug free policy, similar to the Quit campaign.

Members of the Providers Panel (Record of Proceedings, 16/08/2001, page 18) spoke of the need to maintain a range of services, to involve families in treatment, to listen to consumers and 'coalface professionals' when making policy. They also argued for equity of pay between different agencies and to reduce waiting lists for treatment. Dr Allan Quigley, the Director of Clinical Services at Next Step commented on costs of treatment:

> In Western Australia we spend between $2,000 and $3,000 a year per person on pharmacotherapy treatment. Keynote speakers at the Summit have advised that in Switzerland around $20,000 per person a year is spent on providing heroin treatment, and that in Sweden the

> cost of compulsory residential treatment is up to $140,000… Although we need more information about the cost effectiveness of our treatment programs, our first priority should be to attract and retain people in treatment. We should set the goal of having more than 50 per cent of drug dependent people in treatment. (Record of Proceedings, 16/08/2001, page 21 and 22).

Ms Kathryn Kemp, Manager of the South Metropolitan Community Drug Service Team (Record of Proceedings, 16/08/2001, page 19) briefly described the cost and accessibility advantages of a non-medical detoxification facility that could possibly be run as a home-based detoxification service with nursing cover.

Dr Pat Cranley, representing the participating Divisions of General Practice Drug Focus Group (Record of Proceedings, 16/08/2001, page 22) spoke of the need for abstinence, not maintenance as the goal of doctors. He emphasised the need for rehabilitation rather than prison to help users while protecting the public. He spoke of the hindrance caused by the criminal record of recovered addicts and advocated for a clearance of records after two or three years to help their work prospects.

Associate Professor Richard Mattick (Record of Proceedings, 16/08/2001, page 28) commented on the difficulty of understanding the concept of harm reduction. He described it as keeping people alive and well while they become abstinent. He made the following comments in relation to a trial for heroin prescribing:

> … I want to point out that Martin Hosek comes from Switzerland which is a very conservative country. As a part of its response to the open drug scene and increasing heroin use, Switzerland has provided injectable prescribed heroin. I am not sure that I am in favour of this or against it. I used to be against it, and I am shifting gradually, but I am not sure. It is a minority option. By that, I mean that only a small proportion of really badly off injectors come into this treatment. It is not fun. They have to go to a clinic three times a day. They cannot even smoke in the clinic. They can inject drugs but they cannot smoke. It is not an attractive option. It is bait; it brings people into treatment. It is not a long term treatment. It is not legalisation; it is about bringing people into treatment. Heroin is now perceived as a loser's drug. It is something that old junkies do.
>
> The way in which the Swiss system is portrayed in Australia nationally is that prescribing heroin makes heroin available. The debate is very unsophisticated. When reading *The Sydney Morning Herald, The West Australian,* or *The Australian* it is very rare to get a good idea of what is being argued. If you take one thing from this Summit, take from Switzerland the fact that heroin prescribing does not mean free availability; it means dealing with people who have a lot of trouble in their lives because of their heroin use. In that context Switzerland has prevention, residential and outpatient care, harm reduction and supply control strategies. In controlling the supply of drugs, the Swiss get rid of the precursors. They take away the ways in which people can make drugs. They have trafficking control. They deal with organised crime and money laundering. They are not a soft society. Those who know anything about Switzerland know that it is, arguably, a very practical society. They are motivated by having an ordered society and they are very sophisticated. They made this decision carefully. Martin Hosek said that if the heroin trial were sold to the community in Switzerland – one of his colleagues also said this – in the way it was sold in Australia, it would never have been approved. I think you are being misled. (Record of Proceedings, 16/08/2001, page 29).

7.4 RECOMMENDATIONS

A lot of services are in place, however, there are not options that suit everybody, not all services provide immediate access when this is appropriate, waiting lists have developed and there are not enough services specifically for youth, Aboriginal, CALD and people with disabilities or in the regions. The following recommendations are made with this in mind and to ensure that a diversity of treatments is in place and continues to improve.

Recommendation 26 Development of current services

Develop and implement strategies for improved coordination of access to services, eg, by promotion of and linkage to key entry points (24 hour telephone services, community Drug Service Teams, general practitioners and others), including through the media, to make it easier for clients to access the most suitable service.

Recommendation 27

Build the capacity of existing services, with particular attention to attracting and meeting the needs of Aboriginal, CALD, people with disabilities and rural, regional and remote people and communities, to eliminate and prevent waiting lists and to enable immediate responses to people in need where that is appropriate.

Recommendation 28 Gaps in current services

Develop the following services to meet key gaps in the existing network of specialist alcohol and drug services:

- increased support for people after rehabilitation, including transition to housing, employment and education (reintegration), self help support networks, and where appropriate half way houses;
- a residential, low medical respite/detoxification centre, particularly for young people and able to accommodate people with amphetamine problems, providing immediate and easy access and a flexible program;
- a statewide network of home based withdrawal services using a shared care approach with general practitioners; and
- trials of a number of new and innovative services including acupuncture detox, herbal and nutritional medicine, meditation, traditional Chinese medicine and state funded group and individual psychotherapies.

Recommendation 29 New and innovative service

Provide a trial of heroin on prescription treatment that is subject to a detailed evaluation, involves full clinical and social support, and is targeted at people who have failed at other treatment and would not be likely to otherwise enter treatment.

Recommendation 30 Continuous improvement

Require and support specialist alcohol and drug agencies and services to continuously improve services, with attention to:

- family sensitivity of agencies and services (support for families and their involvement as part of the solution);
- strong community and agency linkages (to ensure responsiveness to trends and needs);
- independent evaluation (eg for naltrexone implants) and continuous outcome measurement (including consideration of the costs and benefits of accreditation for agencies);
- counselor skills and remuneration;
- integration with mental health and disability services; and
- using language that is friendly (eg avoiding terms such as comorbid people).

VOTING RESULTS FOR RECOMMENDATIONS 26-30			
	YES	**NO**	**ABSTAIN**
Recommendation 26	99	1	
Recommendation 27	97	3	
Recommendation 28	97	3	
Recommendation 29	61	37	2
Recommendation 30	99	1	
All Delegates voted			

CHAPTER 8

BROADENING THE PROVISION OF TREATMENT FOR DRUG USERS THROUGH OTHER HUMAN SERVICES, INCLUDING THE HEALTH, JUSTICE, WELFARE AND YOUTH SECTORS, AND ITS INTEGRATION WITH SPECIALIST ALCOHOL AND DRUG SERVICES

8.1 WESTERN AUSTRALIAN CONTEXT

According to Issues Paper 7 *Broadening the Provision of Treatment for Drug Users Through Other Human Services, Including the Health, Justice, Welfare and Youth Sectors, and its Integration with Specialist Alcohol and Drug Services* a wide range of professions and organisations are involved in responding to people affected by drug use. The provision of responses by human services, in addition to specialist drug services is fundamental in providing an integrated service to people affected by drug use.

While some people affected by drug use attend specialist drug services, it is not sufficient to respond to drug use and ignore housing, mental and physical health, finances, family relationships and employment. Effective responses are those that address all the needs of the person affected by drug use (National Institute on Drug Abuse, 2000). Specialist drug services have to collaborate with broader human services to ensure all the needs of people affected by drug use are addressed.

Drug related problems are relatively common, represent substantial cost (human and economic) to the community (Collins and Lapsley, 1996) and have relevance beyond the specialist drug services. Some people never use specialist drug services, but use broad human services. People working in health, welfare, law enforcement, education, family and corrective services regularly respond to people affected by drug use (Roche, 1998).

These services can have significant impact on the well being of people affected by drug use. Drug use has relevance for antenatal care, dietary problems, financial problems, relationship breakdowns, safety and shelter and legal concerns. Ignoring drug use can compromise care. For example, ignoring drug use in a client with mental health problems will reduce the effectiveness of mental health treatments.

Drug use has relevance for staff in a range of agencies. A growing concern for many agencies is the issue of drug related critical incidents for staff and clients. Effective occupational health and safety procedures demand that staff and agencies are well equipped to respond to such incidents.

Consequently, a wide range of professions and organisations need:

- knowledge about drug use and its relationship to other problems and needs;
- awareness of how a client's drug use is important when responding to health, welfare, social, legal and employment needs;
- recognition that they have a role in responding to people affected by drug use; and
- recognition that they can be effective in responding.

A wide range of human service staff are credible and effective agents of change.

Two local plans are relevant:

- the previous State Government's drug strategy (Together Against Drugs, 1997) stressed the need for a comprehensive and enhanced approach across the various human service providers. The implementation of this plan has been coordinated by the WA Drug Abuse Strategy Office (WADASO) supporting and encouraging practice development in a range of human services; and
- the Health Department of Western Australia's (HDWA) focus on drugs is described in the 'InterAction' strategy (Health Department of Western Australia, 1999). This emphasises a 'whole of organisation' response, coordinating services of a number of purchasing and provider units.

Other departments and organisations also coordinate responses to drug related harm (eg Department of Justice, Department of Community Development and the WA Police Service).

Education on understanding and responding to drug use is included in many post-secondary education programs, however, the subject is not a significant core curriculum item for any profession.

Next Step Specialist Drug and Alcohol Services, funded by the HDWA, provide a range of continuing education and training programs. Other organisations also provide a range of opportunities. Such programs serve important functions. However, they can be difficult for some staff to attend (eg due to time, geographical or staffing constraints) and are often reliant on staff self selecting to attend.

Other projects funded by the HDWA target key organisations. For example, one project specifically targets the education needs of GPs and another aims to disseminate 'brief interventions' across health services.

WADASO and the HDWA have committed funds to build the capacity of broad human services. Strategies include:

- practice development projects, supported by WADASO and relevant government departments, including the Department of Community Development, Department of Education and the Department of Justice;
- increasing the capacity and expertise of health services in drug service provision by placing key change facilitators in mainstream health services (eg Graylands Hospital

and Sir Charles Gairdner Hospital) and creating a specialist team in Next Step charged with expanding the capacity of the broader health services to manage drug withdrawal;
- funding Next Step to provide a Clinical Advisory Service to medical practitioners; and
- the establishment of a Joint Services Development Unit at Graylands Hospital to build the capacity of services to respond to clients with co-existing drug and mental health problems.

8.2 COMMUNITY CONSULTATION

Twelve submissions were received, including nine from organisations. The South West Metropolitan Mental Health Advisory Group (Submission No 223) identified 'dual diagnosis' or comorbidity as a major problem. It described its efforts to evaluate whether services within the South West Metropolitan corridor were equipped to deal effectively with clients with co-existing mental health and substance use issues. The results of a focus group with consumers, an agency survey and a workshop highlighted:

- the importance of appropriate and timely communication and liaison between agencies, consumers and their families and carers;
- a paucity of detoxification services;
- defects in the referral process from one agency to the next; and
- confusion with differing philosophies of different service providers.

WANADA (Submission No 237) recognised that because of the extent of illicit and licit drug use, many human service providers come into contact with drug users. In WANADA's view, conflicts between the differing policies and practices of various human service providers undermine the health and well being of illicit drug users. In addition the:

- attitudes of some human service providers;
- lack of appropriate alcohol and other drug training for human service workers; and
- organisational barriers to change result in the provision of services that are inconsistent, usually uninformed, at times discriminatory and often result in ineffective use of resources.

The Health System Development Forum (Submission No 324), described its efforts to progress the HDWA Drug Strategy 'InterAction' within and across the health system. Initiatives with GPs, helping health services to develop alcohol and other drug policies and the use of an Alcohol and Drug Project Officer at Sir Charles Gairdner Hospital (SCGH) have proved to be effective. It was pointed out that:

> There are approximately 25,000 nurses, 5,400 practicing medical officers and 2,000 GPs in Western Australia currently. If each of these health workers responded effectively to one person affected by drug use per year, they would have a significant impact on drug related harm in the State. (Submission No 324).

Mr Kevin Moran (Submission No 255) supported broadening the provision of treatment but believed it was very important to provide accurate statistics of service use to ensure that inflated client numbers are not used to compound the repeated calls for increased funding.

Overall, the main themes of the Community Consultations were:

- the need for all human service organisations to respond to drug use among their clients; and
- the need for the development of integrated care models including, cross agency training, clinical pathways and inter agency protocols.

8.3 PRESENTATIONS TO THE SUMMIT

Dr Moira Sim, a delegate at the Summit, (Record of Proceedings, 15/8/2001, page 51) described GPs as the most accessible of health care providers and as being an 'untapped resource'. She acknowledged that until about 10 years ago there was little education for GPs on drug use, but this was changing and GP initiatives were emerging. Ms Kathryn Kemp (Record of Proceedings 16/8/2001, page 19) made a plea for broadening the provision of treatment. She said that government services were often top heavy and over-medicalised. Services should be 'systemic' and that this had implications for how service providers would be trained and how priorities were defined.

Dr Pat Cranley (Record of Proceedings, 16/9/2001, page 22) emphasised the importance of GPs as primary caregivers and regretted the lack of interest in drug problems by some GPs. This was understandable, given Medicare rebates, the effect of addicts on a practice and the lack of education. He called for cooperation between GPs and service providers.

Mr Adam McLeod (Record of Proceedings, 16/8/2001, page 23) referred to his service, that of home-based withdrawal plus GP support, as a good example of a 'shared-care' model. Dr Allan Quigley (Record of Proceedings, 16/8/01, page 23) said detoxification services for people in Perth were very inadequate. He said 'we need to strengthen the capacity of GPs and community drug service teams to provide detoxification.'

8.4 RECOMMENDATIONS

Recommendation 31 Comorbidity

That Mental Health and Alcohol and Other Drugs (AOD) agencies, as a matter of urgency, be resourced to develop a workable partnership to deal with clients who present with both mental health and alcohol and other drug problems, to ensure that they receive immediate, accessible, accountable and culturally appropriate service with continuity of care.

It is recommended that such a strategy should include but not be limited to:

- a statewide network of comorbidity consultant/coordinators linking the community and both domains of AOD and Mental Health Services;

- ready access for clients of AOD services and general practitioners to psychiatric assessment and emergency treatment; and
- continuing professional development of Mental Health workers in AOD issues, and AOD workers in Mental Health issues.

Recommendation 32 Shared Care

There is a need to avoid duplication and fragmentation of services we need to develop and implement shared care models across human services (eg health, welfare, police, justice and housing) that ensure continuity of care. It is recommended that to make the most effective use of resources, funding models be developed that maintain shared care across sectors. These models should include agreed goals, communication, case management and continuity of care based on collaboration instead of competition. To allow maximum flexibility in providing local solutions to local issues:

- dedicated AOD funds should be pooled and managed with input from all key stakeholders, including but not limited to AOD agencies, general practitioners and other service providers in the community, indigenous organisations and other relevant government and non-government agencies;
- under this funding model there is a particular need to address the unique needs of indigenous people, remote, rural and regional areas; and
- at the same time, it is important to ensure that the mainstream government funding agencies involved maintain their efforts in the area.

Recommendation 33 Access

Acknowledging that access to, and availability of, information about AOD services is difficult for some populations (eg indigenous, remote, rural and regional, and CALD groups, gender identity and sexuality, high risk young people, people experiencing co-existing mental health and AOD problems and those from a low socio-economic environment), it is recommended giving priority to the development of systems and solutions to address this lack of access and availability in a manner that is responsive to local needs, such as:

- education and training of existing service providers;
- further developing the capacity of these services;
- use of innovative models of volunteering;
- community development initiatives that build capacity through empowerment;
- use of existing technologies (eg telehealth, telepsychiatry); and
- supporting models of voluntary treatment (as opposed to compulsory models).

Recommendation 34 Broadening Service Provision

That the government agencies (eg health, welfare, police, justice and housing) with an exposure to drug issues be directed to develop and adopt a set of common policy goals for working with people impacted by drug use, and that they be resourced to achieve these goals. That this be done in partnership with non-government service providers and include relevant peak bodies.

In addition, that government resource a whole of community approach to respond to AOD issues in a cohesive manner, ensuring the continuity of care for all those impacted by drug use through the development and continued support of such initiatives as:

- training and resourcing of general practitioners;
- government and non-government 'reintegration' agencies;
- prisons, corrections and justice AOD services;
- services in rural, remote and regional communities;
- services to clients with diverse cultural and linguistic backgrounds;
- indigenous specific services;
- agencies servicing difficult to target groups;
- linkages with Emergency Services; and
- will also include dialogue with Commonwealth Government agencies such as Centrelink.

Accepting that treatment works and acknowledging that the current level of those engaged in treatment is estimated to be less than 30% of the total population who could benefit from such treatment, it is recommended that the government address the need to increase this level of engagement in treatment to a minimum of 50% of the existing population of dependent people using drugs. This could include:

- expanding the availability of detoxification;
- the engagement of General Practitioners in the delivery of pharmacotherapies;
- expanding the availability of assessment, counselling and long term rehabilitation services; and
- urgently developing and expanding through-care services from prison to community.

Recommendation 35 Cultural Change

It is evident that the stigmatisation and prejudices that currently exist in respect of people using drugs are an impediment to disclosure and entry to treatment at all points. Furthermore, the negative attitude of service providers and the community at large does adversely impact on the physical, emotional, social and spiritual well being of individuals, families and significant others effected by drug use, thus delaying entry into treatment.

Therefore it is recommended that the government recognise its social responsibility and duty of care in the provision of services to the members of our community who use drugs by providing:

- continual professional education and training for all relevant workers;
- broad based community education;
- programs that enhance community development approaches;
- greater participation of people who use drugs in the development of policies and practices;

- cultural awareness training;
- culturally appropriate services; and
- the development of ethical behaviours in the delivery of services.

VOTING RESULTS FOR RECOMMENDATIONS 31-35			
	YES	**NO**	**ABSTAIN**
Recommendation 31	99	1	
Recommendation 32	99	1	
Recommendation 33	94	6	
Recommendation 34	96	4	
Recommendation 35	100		
All Delegates voted			

CHAPTER 9

DRUGS AND LAW ENFORCEMENT, INCLUDING CONSIDERATION OF THE MOST APPROPRIATE LEGAL FRAMEWORK FOR ILLICIT DRUGS, DIVERTING DRUG USERS INTO TREATMENT AND TREATING THE MOST SERIOUS OFFENDERS IN PRISONS

9.1 WESTERN AUSTRALIAN CONTEXT

Issues Paper 7 addressed *Drugs and Law Enforcement, Including Consideration of the Most Appropriate Legal Framework for Illicit Drugs, Diverting Drug Users into Treatment and Treating the Most Serious Offenders in Prisons.* It acknowledged that while police could be said to have a role in reducing drug related problems simply by limiting the supply of illicit drugs, more recent developments in drug policy and law enforcement recognise that there are other ways that law enforcement can contribute.

The relationship between drug use and crime is a complex one. Studies show that a high percentage of people arrested or detained for crimes have been using opiates or other drugs, with more than 60% of people in the criminal justice system having a history of drug use (Loxley and Bevan, 1999; Australian Institute of Criminology, 2001; Cant, Downie, and Mulholland, 2000). Evidence also suggests that incarceration does not appear to deter drug offenders (Makkai, 1998). The Paper highlights that the vast majority of drug offenders are charged with simple possession offences with the biggest proportion being charged with possession of cannabis.

New approaches to drug law enforcement that focus on enforcing laws in such a way that keep health, welfare and other harms to a minimum are in place (Hellawell, 1995; Sutton and James, 1996). However, if police are to be supported in reducing drug related harm in the community, it was suggested that they need organisational, procedural, legislative and community support to target law enforcement. The Issues Paper states that simply leaving the issue to police discretion leaves police vulnerable.

Within the Western Australian context, the existing legislation is problematic where possession, penalties and convictions are inconsistent in some areas, open to interpretation in others and have potentially life long consequences with regard to personal criminal records. Western Australia has developed a range of programs to divert eligible offenders into drug treatment and supervision at key points in the criminal justice process, including the Cannabis Cautioning and Mandatory Education System, the Court Diversion Service (CDS), and the Western Australian Drug Court.

The Western Australian Drug Court is being evaluated as part of a trial, and has only been in operation for six months. The main criticism to date is the very low number of Aboriginal clients referred, with only two progressing past the referral stage, with none completing the program.

Prisons hold both offenders convicted of drug related offences and many others with serious substance abuse problems. Western Australian prisons are currently very overcrowded and indigenous people are disproportionately represented. The major focus of drug programs in prisons has been to prepare prisoners for release, consequently most program input was in the last six to eight months of the designated sentence. There is no comprehensive methadone maintenance program in Western Australian prisons although current policy supports methadone maintenance and detoxification for newly received prisoners already undergoing treatment prior to their sentence. Treatment programs in Western Australian prisons are neither comprehensive nor intensive.

Issues for consideration included:

- the appropriateness of deemed supply offences and the onus of proof for drug offences;
- consideration of further steps to reduce the harms associated with illicit drug use by offenders in the criminal justice system; and
- reforms that would provide the best system for reducing cannabis related harm to the Western Australian community.
- the laws associated with used and unused drug injecting equipment;
- distinctions between drug users and drug dealers including small time user-dealers and large commercial dealers.

Law enforcement is seen to have a crucial role beyond supply reduction in reducing drug related problems. While there are a number of new initiatives being undertaken in Western Australia, clearly there is a need for further legislative and procedural changes to reduce drug related harm in the Western Australian community.

9.2 COMMUNITY CONSULTATION

Of the 44 submissions addressing Issues Paper 7, 34 were from individuals and 10 were submitted by groups and/or organisations.

The most common theme was the legalisation/decriminalisation of illicit drugs, with nine opposing and 10 supporting decriminalisation, of which seven were specific to decriminalising cannabis use. There was also support for the medicinal use of cannabis. The submission from the Criminal Lawyers Association of Western Australia (Submission No 219), provided an extensive analysis on criminal law and policy, with detailed recommendations for change centred on a harm reduction and health outcome focus.

The National Drug Research Institute (Submission No 208), submitted a comprehensive paper recommending a new legislative model for cannabis use in Western Australia. The model incorporates features of the cautioning and infringement notice schemes, aiming to shift the cannabis market away from large scale criminal suppliers toward small time user-growers through the application of civil penalties for the provision of small amounts of cannabis. The submission suggests that the recommended model would reduce social harms, and be unlikely to increase the number of heavy users.

Several submissions supported early intervention and education on drug use as a way of avoiding subsequent law enforcement problems. Some felt that more funding should be allocated to community development, treatment and support services rather than to law enforcement. In a number of submissions drug use was seen as a health issue rather than a legal or criminal issue.

Prisons were of interest with five submissions calling for inmates to have access to clean injecting equipment, bleach, and treatment including pharmacotherapies, counselling, support and blood borne virus services. The submission from the Australian Drug Law Reform Foundation (Submission No 438) highlighted the need to adapt community strategies for safe injecting in prisons, noting that community strategies are not always directly translatable. There was also support for the training of prison officers, police and justice staff in the area of harm reduction.

A submission from the Office of the Inspector of Custodial Services (Submission No 129), outlined a number of issues around drugs and the prison system, emphasising a need for prison based therapeutic drug programs. The submission pointed out that prisoners would be able to remain drug free only in a drug free environment, suggesting that the establishment of drug free units/environments within general prisons is unlikely to be effective. This premise was supported with examples from the United States and the United Kingdom. The submission describes an ideal setting for such a program to be a therapeutic prison, not merely a therapeutic community within a prison.

A submission from WANADA (Submission No 237) emphasised the need to ensure continuity of care for people with alcohol and other drug problems when they leave prison. Given that individuals are at a high risk of opiate related overdose when released from prison, the reassessment of post-release assistance was recommended.

Suggestions for change to legislation were the repeal of drug self administration laws, including the offence of possessing used drug implements and the regulation regarding the register of drug dependent people. The WANADA submission highlights that Western Australia is the only State in Australia with a register of drug dependent people. This was considered to be in conflict with other harm reduction strategies.

9.3 PRESENTATIONS TO THE SUMMIT

Mr Steve Jackson, the General Manager, Western Operations, Australian Federal Police (Record of Proceedings, 15/08/2001, page 13) described to the Summit the national and international dimension of law enforcement, and drug supply reduction. Mr Jackson described the new criminal environment surrounding illicit drugs and the need for flexibility of law enforcement:

> Most significantly, they [drug syndicates] can shift rapidly between commodities and modus operandi in search of profit and to avoid or mitigate the risk to which they are exposed… In a single word, they are flexible; therefore, law enforcement must be more flexible if we are to stay ahead of the game.

Ms Julie Wager, Stipendiary Magistrate, Perth Drug Court addressed the Summit on *Drug Courts in Western Australia* (Record of Proceedings, 15/08/2001, pages 15). She described the two year Western Australian Drug Court pilot program, highlighting differences between the Drug Court and the traditional adversarial court. She described the approach taken by the Drug Court, together with its aims and limitations.

> The Drug Court is different, in that it is not an adversarial court….It is a specialist team court, and it supports an offender to make a choice. That choice is to make lifestyle changes and to stop using drugs... It is not enough to lock up people in prison to detoxify them... A secure, drug free facility would be ideal for that purpose….Another concern is that the Drug Court presently does not have any legislation...We need legislation to make it clear that the funding of, and the Court's emphasis on, education, vocation, health and family are just as important as the emphasis on traditional justice methods… One of the advantages of a Drug Court is that we have a chance to see what may work.

Mr Simon Lenton gave a presentation to the Summit titled *Legislative and Regulatory Models for Drugs and their Evaluation* (Record of Proceedings, 15/08/2001, page 17). He summarised the six main models for drug laws and discussed the advantages and disadvantages of the different legislative models, commenting specifically on the law relating to cannabis control. Mr Lenton proposed a system that allows drug policy implementation to be responsive to local community needs, whilst separating the cannabis market from the market for other illicit substances. He drew attention to research showing that there is little difference between civil penalties and strict criminal penalties in deterring drug use. It was noted that the costs for securing criminal convictions are far greater than those for enforcing civil penalties. Finally, Mr Lenton drew attention to the submission from the National Drug Research Institute (Submission No 208), which proposes a new model for the control of cannabis in Western Australia.

Commissioner Barry Mathews, from the Western Australian Police Service, in responding to a question from a delegate commented that:

> Shifting drugs out of a criminal environment into a civil environment may resolve one side of the problem by taking the organised crime aspect out of it to some extent, but it may increase the level of harm through greater availability and so forth (Record of Proceedings, 15/08/2001, page 22).

Dr Alex Wodak, Director of Alcohol and Drug Services at St Vincent's Hospital, Sydney, gave a presentation to the Summit titled *Drugs are Here to Stay: How Best to Reduce Problems Drugs Cause.* (Record of Proceedings, 15/08/2001, page 24). The underlying theme in his presentation was that the reduction of drug related harm should be the paramount objective of drug policy. Dr Wodak emphasised that drug problems should be treated primarily as a health and social issue, with recognition for the importance of evidence based drug treatment, medical research and drug policy.

Dr Joe Santamaria gave a presentation to the Summit on *The Case for Sanctions* (Record of Proceedings, 15/08/2001, page 28). He presented the case for sanctions in the field of drug use, as a measure to protect the common good. He noted that sanctions establish social norms, and in the field of drug abuse, a lenient policy has always resulted in a blow out of drug users. However, Dr Santamaria pointed out that sanctions alone do not reduce the

problem, and there needs to be complementary measures such as education, and attention to other social and personal factors, treatment and community support.

Mr Nick Stafford spoke to the Summit on *A Drug User Perspective on our Current Laws* (Record of Proceedings, 15/08/2001, page 30). He discussed the issue of law enforcement from a drug user's perspective.

> …one could mistakenly believe that every person who uses those substances is addicted or will become addicted. That is not true. That belief masks the reality of what is going on in our culture. The people who do become dependent do not do so because of the drug; they become dependent because of what is going on inside of them… Interestingly, if delegates were to observe a drug treatment service for a month, they probably would not hear much about drug use. Those involved talk about the issues inside themselves; they talk about many other things… Another thing that really upsets me about the way we deal with drugs; say young people have some real trauma inside them from a family break up, abuse or whatever, why do they go and use a drug to deal with that? It is because they cannot seem to find another way… How do we respond to them when they grab the last straw to try to cope with life? We label them a criminal and we bust them and try to put them in jail if we can. To me that is barbaric.

One key point made during question time to the Panel of Young People was whether punitive action would deter users and dealers, that is, small time dealers who deal to support their habit. Mr Paul Dessauer responded that (Record of Proceedings, 14/08/2001, page 34):

> Nobody sets out to commit any criminal activity thinking they are going to get caught…. It doesn't matter how strong the penalties are. If the person does not believe that the consequence will be a result of engaging in that activity, they will do it anyway. Young people, in particular, are not scared of that sort of punishment. It is not something they think about.

Mr David Malcolm (Record of Proceedings, 15/08/2001, page 7), whilst addressing the delegates of the Summit, was quite clear about the deficiencies of the current prison system in dealing with drug related crime:

> At present we have no appropriate facilities for the secure treatment of drug addicts sentenced to a period of imprisonment. There is an important need for such a facility….The emphasis must shift to rehabilitation and treatment.

9.4 RECOMMENDATIONS

Recommendation 36

Parents and carers should have the right of audience in all juvenile justice issues (eg Children's Court; Diversion). Where appropriate, parents and carers should have formal rights to have influence on outcomes.

Recommendation 37

The range of diversionary options should be reviewed and significantly broadened, especially outside the metropolitan region and for Aboriginal communities. Courts/treatment/therapeutic services need to be adequately resourced (physical resources and staff expertise) to meet

these additional demands. There is a need for a specifically funded and legislated Drug Court.

It is recommended that diversion/treatment/referral options should recognise the diverse needs of people. While this diversity is influenced by pattern and type of drug use and so on, it is particularly important that diversion options meet the needs of culturally and linguistically diverse people and Aboriginal people. Clinical/support services must be developed to ensure effective interventions are readily accessible in terms of time, geographical location and acceptability to various groups.

Recommendation 38

Drug programs need to be determined at entry to the prison system by using quality assessment and matching interventions to individual needs. They should be comprehensive, evidence-based and continually monitored. There is a need to review and support programs at different levels:

- entry (eg withdrawal management);
- risk of drug use during imprisonment (eg pharmacotherapies);
- risk of harm while in prison (eg harm reduction strategies);
- drug free units within the prison system; and
- preparation for release (eg facilitating transition into the community, reduction of overdose risk).

These changes should be made in the context of and enhancing support for existing strategies to prevent drug use in prison and building the expertise of staff within the prison system.

Recommendation 39

For adults who possess and cultivate small amounts of cannabis the government should adopt legislation that is consistent with *prohibition with civil penalties,* with the option for cautioning and diversion. For those under 18 years old, the Government needs to take the best possible steps to avoid young people commencing cannabis use (eg prevention and other effective strategies). The same principles (as adults) of *prohibition with civil penalties* should be provided, with the expansion of options for cautioning and diversion to education or treatment programs and coercive treatment options should be available, that include the opportunity for parents and carers to influence outcomes. Implementation of these resolutions needs to be accompanied by:

- education for the public;
- this will include education on the implications of the legislation, education on the risks of cannabis use/misuse in general and in specific circumstances (eg for people who are vulnerable to mental health problems, for people who may be operating machinery, including vehicles) and education on available treatment options;
- the evaluation and monitoring of the impact of this legislation on patterns of cannabis use and related harms and coincidentally there should be routine monitoring of potency of available cannabis;

- the re-affirmation of relevant responsibilities and legislation (eg preventing intoxication while driving, preventing intoxication while at work); and
- to measure the overall impact of cannabis in the community, the Government should implement a comprehensive scheme to collect data through the Health and Justice systems.

Recommendation 40

Law enforcement measures need to be taken to address both supply and demand reduction priorities arising out of the Summit. This should take into account, the fact that the well being and safety of the broad community should be assured, including matters related to victims of crime. In addition, drug use should be reviewed primarily as a health and social issue. An extensive and urgent review of existing laws and consideration of new legislation relating to the misuse of illicit drugs be carried out to include, but not exclusively:

- *The Misuse of Drugs Act 1981*;
- *The Sentencing Act 1995*;
- The Mental Health Laws;
- *The Road Traffic Act 1974*;
- Confiscation of Profits and Assets Legislation; and
- Juvenile Justice Legislation.

New legislation needs to address issues such as the increasingly highly organised, mobile and professional drug suppliers.

Increased training in harm reduction methods, availability of treatment and rehabilitation services, and responding to drug users for police and other human service workers is recommended.

VOTING RESULTS FOR RECOMMENDATIONS 36-40			
	YES	**NO**	**ABSTAIN**
Recommendation 36	97	3	
Recommendation 37	98	2	
Recommendation 38	98	2	
Recommendation 39	72	27	1
Recommendation 40	89	11	
All Delegates voted			

CHAPTER 10

REDUCING HARM TO THE COMMUNITY AND INDIVIDUALS CAUSED BY CONTINUED DRUG USE

10.1 WESTERN AUSTRALIAN CONTEXT

Issues Paper 8 covered the topic *Reducing Harm to the Community and Individuals Caused by Continued Drug Use.* In this paper the stated aim of harm reduction is to reduce drug related harm by encouraging people who use drugs to do so more safely. A distinction is drawn from treatment in that it aims to reduce drug use and hence harm. In practice the distinction between harm reduction and treatment is less clear. Examples of the unclear distinction between harm reduction and treatment strategies are methadone maintenance and needle exchanges programs. Both programs could be equally argued as being harm reduction and treatment strategies.

Western Australia has the second highest rate of recent use (ie last 12 months) of any illicit drug. It was estimated from the National Drug Strategy Household Survey (NDSHS, 1998, WA results) that in Western Australia in 1998:

- 648,061 people had used an illegal drug in their lifetime;
- 228,039 people had used an illegal drug other than cannabis in their lifetime;
- 314,763 people had used an illegal drug in the past year; and
- 122,462 people had used an illegal drug other than cannabis in the last year.

Issues Paper 8 canvassed a number of significant issues for consideration including:

- whether narcan (naloxone hydrochloride) should be more widely available for administration to overdose victims by peers?
- whether there should be an expansion in programs to provide safe injecting equipment to rural areas and the metropolitan area (after hours)?
- the need for self injecting facilities in Western Australia;
- should free hepatitis A and B vaccinations be offered and promoted to drug users? and
- examination of ways to increase the adoption of harm reduction strategies by users.

The paper concluded by making the statement:

> Harm reduction strategies aim to save lives, enhance health and reduce the impact of drug use on the broader community. The strategies are part of an overall framework that includes prevention, education, treatment, care, law enforcement, research and strategies to integrate people who use drugs into the broader community. *(*Issues Paper 8, page 10).

10.2 COMMUNITY CONSULTATION

There were 18 submissions categorised under the topic *Reducing Harm to the Community and Individuals Caused by Continued Drug Use,* eight of which were from groups. Eight of the submissions supported harm reduction strategies, four stated their opposition to such strategies, three urged the Summit to support a drug free society, and three stated abstinence was the only means to reduce harm.

A submission was received from the Expert Clinical Advisory Group to the Health Department of Western Australia on naloxone hydrochloride (narcan) provision (Submission No 195). This expert committee was unanimous in its opposition to the increased availability of naloxone hydrochloride for peer and family administration on clinical, methodological, practical and legal grounds. It is feared that naloxone availability will be used as an exclusive first aid and that ambulances and health professionals such as the Opiate Overdose Prevention Strategy (OOPS) will not be contacted. This submission argued that the greater availability of naloxone hydrochloride could lead to more adverse consequences than the present situation.

A submission received from WASUA suggested that peer education interventions such as WASUA's drug treatment referral service, health clinic and syringe exchange program were best placed to sustain a change in the behaviour of users (Submission No 229). WASUA supports a trial of harm reduction strategies such as heroin on prescription, safe injecting facilities, peer administration of naloxone hydrochloride, the provision of safe injecting equipment for users in custodial environments, and expansion of needle and syringe programs. WASUA also recommended that the *Opiate Addition Register* held under the *Drugs of Addiction Notification Regulations 1980 of the Health Act 1911* be abolished.

WANADA made a submission arguing that the current needle and syringe program as a harm reduction strategy was not well understood by the public, rank and file police and many local governments (Submission No 237). In addition to improvements in needle and syringe programs, it suggested that dramatic improvements are required in pre and post test counselling associated with blood borne virus (BBV) testing. It was suggested that more user friendly health centres need to be provided for BBV testing and vaccination.

A detailed submission was received from the Safer WA Safe Disposal Sub Committee (Submission No 398). This committee suggested that needle and syringe programs need to be expanded in rural areas, in the metropolitan area after hours, through hospitals, pharmacies, and vending machines. It suggested that more effort was required to educate local governments and the public on the benefits of needle and syringe programs. The submission also called for amendments to legislation so that it would not be an offence for a user to be in possession of used injecting equipment.

The Safer WA Safe Disposal Sub Committee supported the introduction of safe injecting facilities as a means to referring drug users to treatment, and providing information and education about safe injecting practices and safe needle disposal practices.

Some 241 submissions were received and categorised under the category *Zero Tolerance/Drug Free Society*. Of this group of submissions, 113 specifically stated that harm

minimisation and drug law liberalisation would encourage drug use. Thirty of these submissions stated that harm minimisation and drug law liberalisation did not encourage abstinence.

Twenty-seven of this group of submissions suggested that school, media and police based prevention strategies, early intervention targeting first time users, and abstinence based treatment are solutions that should be tried. A further 65 called for a Swedish based zero tolerance approach that included compulsory treatment. Seventeen submissions recommended the United Kingdom approach of setting measurable targets for achieving a decline in drug use in the community.

Forty-six submissions called for more drug education specifically emphasising drug harms and 27 called for tougher laws in relation to illicit drugs.

10.3 PRESENTATIONS TO THE SUMMIT

Dr Alex Wodak gave a presentation to the Summit on Wednesday 15 August 2001 titled *Drugs are Here to Stay: How Best to Reduce Problems Drugs Cause.* In his presentation, Dr Wodak indicated that drug overdose deaths in Australia had increased from 6 deaths per year in 1964 to 958 in 1999. The spread of HIV infection is under control and should be seen as a harm reduction strategy triumph, however hepatitis C infection among injecting drug users is rising by almost 11,000 new infections per year.

Dr Wodak noted that Australia's national drug policy is harm minimisation consisting of supply, demand and harm reduction. Notwithstanding this policy, he indicated that based on 1992 estimates, some 84% of total Commonwealth and State expenditure in response to illicit drugs was allocated to drug law enforcement, 6% to drug treatment and 10% to prevention and research.

Dr Wodak indicated that based on the available evidence supply control is not cost effective but treatment is cost effective. He suggested that there is still a role for drug law enforcement but relying too heavily on supply control and not enough on health and social interventions has been a mistake. It was noted that research shows that drug education, although worthwhile, only achieves modest gains and the expectations from these strategies should be realistic.

Dr Ingrid van Beek, Medical Director of the Sydney Medically Supervised Injecting Centre, gave a presentation to the Summit on Wednesday 15 August 2001 titled *Injecting Rooms: Their Roles and Limitations.* In her presentation she noted that 47 injecting facilities had been established in four countries in Europe, in response to open drug scenes and the concentrated supply of drugs from the surrounding areas. She indicated that the establishment of the Kings Cross trial of a safe injecting facility was in response to a similar open drug scene. There have been a significant number of homeless, injecting drug users in the Kings Cross since the 1970s that led to the proliferation of illegal shooting galleries in the heart of Kings Cross in the 1990s.

Dr van Beek indicated that the aims of the Sydney medically supervised injecting centre include:

- the reduction of fatal and non-fatal overdoses;
- to reduce the transmission of blood borne viral infections;
- improve drug users' access to relevant health and social welfare drug treatment and rehabilitation services; and
- to reduce the public nuisance associated with street based injecting including discarded syringes.

With regard to the need for, or a location of a supervised injecting facility, Dr van Beek made the following comments:

> The most recent data about where drug overdoses occurred - unfortunately this data is quite old – shows that 10% of all overdose deaths in Australia were in Kings Cross. This is comparable to the total number of overdose deaths in Western Australia. … It is important to locate those facilities not only where there is a high prevalence of street based drug use associated with overdoses, but also where there is community support. We have very strong support in the Kings Cross area (Record of Proceedings, 15/08/2001, page 35).

Prior to the voting on recommendations associated with this topic, delegate Ms Charlotte Stockwell made the following comments on safe injecting facilities:

> We acknowledge that this is a very difficult issue for the Summit. I also acknowledge that it is one on which this group has been divided. I am representing a majority opinion, not a unanimous one… Our recommendation seeks to give guidance to the Government on how it should go about considering the issue. There appears to be general consensus that Perth does not have an open drug scene of a nature, intensity and size similar to those found in Kings Cross and in other parts of Europe. However, we ask that rather than simply ruling out safe injecting services, we take a middle path – a path of inquiry. We need better information about the European experience. We need the results of the Kings Cross trial. We need to know more about the how, when and where and the consequences and impacts of public injecting drug use in Western Australia. This information should be used to consider what might work to reduce overdoses, deaths, crime and public nuisances in the Western Australian context. Support from the community is an essential element in this consideration (Record of Proceedings, 17/08/2001, page 46).

10.4 RECOMMENDATIONS

Recommendation 41

Local communities, local governments, non-government organisations should be resourced, encouraged and funded by governments to develop locally appropriate responses to hazards arising out of illicit drug use. These include:

- education and support for families on strategies to minimise the risk of physical, emotional and social harm;
- practical assistance to families to minimise and/or prevent property loss or damage;
- increased community involvement in discussing and learning about drug use;
- user education on safer and responsible needle and syringe use and disposal;

- resourcing peer education, which targets harms arising from the use of a variety of illicit drugs, and provides information on treatment options and referral opportunities;
- needle and syringe provision and disposal facilities and services;
- education and support for the managers and staff of licensed premises and other venues and the implementation of appropriate harm reduction strategies; and
- education for doctors, nurses, teachers and all members of the community who have contact with drug users to have non-judgemental attitudes.

Recommendation 42

That law reform be undertaken which will enable:

- the undertaking of a trial for the provision of naloxone hydrochloride to peers by significant others. Participants in this trial should be given peer based resuscitation training, overdose prevention, narcan administration training as well as ambulance and hospital protocol training;
- the decriminalisation of the possession of implements containing traces of illicit substances; and
- the reduction of perceived and actual barriers to treatment arising out of the Drugs of Addiction Notification Regulations.

Recommendation 43

The Western Australian State Government work in partnership with key media organisations including the Australian Broadcasting Authority, the Federation of Commercial Television Stations, commercial radio broadcasters, the Press Council and the Australian Journalists Association to develop codes of practice or, when applicable, to incorporate in existing codes of practice, standards relating the portrayal, depiction, reporting or discussion of all matters related to the use of illicit drugs, including but not limited to:

- protecting the privacy of persons who use illicit drugs and their families and associates;
- avoiding stereotyping, misconceptions and myths about illicit drug use;
- portrayals that romanticise, sensationalise, or present as desirable the use of any harmful drugs and substances including alcohol and tobacco;
- portrayals or depictions that instruct in the use of illicit drugs;
- protecting the vulnerability to exploitation of drug dependent persons (eg from being offered payment to pose while injecting);
- accurately communicating harm reduction measures;
- avoiding polarising the public debate on drug policy wherever possible;
- using preferred self-descriptors for persons or organisations that represent a particular point of view on drug policy; and
- avoiding the use of terms which denigrate or degrade users of illicit drugs especially by identifying or characterising them solely by their drug use (eg. users of illicit drugs, intravenous drug users rather than ‘junkies’.

Recommendation 44

The Government, after consultation with employers and unions introduce industrial relations legislation and public health funding to further develop harm reduction strategies.

Workplace drug policies should be based on consultation and endorsement by the employees in the workplace. This should take into account:

- the health and wellbeing of affected workers; and
- the safety of other workers who may be put at risk by a person whose performance has been impaired by alcohol or other drugs and this will be;
  - solely related to safety at work;
  - applicable to both workers and management; and
  - rehabilitative not punitive.

Drug use and poly drug use policy promotional programs should include:

- printed drug information material;
- drug education integrated into existing training mechanisms; and
- drug specific training for all supervisors, occupational safety and health representatives and managers.

Regulations to reduce risk of drug use should include:

- provision of fatigue management training for individuals where the length of shift exceeds 8 hours; and
- consideration of the impact of shift/rostering structures, unrealistic deadlines and the general work culture that may encourage drug and poly drug use within the workplace, and especially in high risk industries.

There should be funding for public medical services, including counselling, to visit workers in remote worksites to facilitate confidential treatment for those struggling with work related drug use.

Further research is needed to investigate the prevalence of drug use in a range of industries, with a view to understanding the contribution of employment conditions to poly drug use.

Recommendation 45

The Western Australian Government consider the issue of supervised injecting services in the light of:

- the European experience of these services as a response to the problem of open drug scenes;
- the results of the Kings Cross 18 month trial when these are available;
- the different demographics and patterns of injecting drug use in Western Australia;
- the possibility of alternative models of supervised injecting services;

Community Drug Summit Submissions

Sub ID	F/Name	S/Name	Suburb
1	Tina	Hirst	Gosnells
2	Ian	McLennan	
3	Roger	Pratt	City Beach
4	Frank	Collins	Morley
5	Frank	Collins	Morley
6	Frank	Collins	Morley
7	Frank	Collins	Morley
8	Gail	Lee	Gidgegannup
9	M	Dixon	Marmion
10	Bill	O'Grady	Claremont
11	Betty	Young	Ardross
12	Janos	Paskandy	Mirrabooka
13	John	Carr MPS JP	Doubleview
14	Anne	McEvoy	Subiaco
15	Ian	Ashley	Dianella
16	Ken	Matheson	Scarborough
17	Wai Ling (Frank)	Rogerson	Wembley
18	T & E	Kenny	East Fremantle
19	J F	Calleja	Bassendean
20	Arthur	Olsen	Maddington
21	Leonie	Holloway	Medina
22	Robert	Fimmel	Como
23	F	Rozendaal	Thornlie
24	Mary	Mantle (B.Bu)	Ocean Reef
25	H	Laughton-Smith	Mundaring
26	D	Crogan	W. Leederville
27	Shane		
28	P	Nicholas	Geraldton
29	Jim	Ozich	
30	Meg	Godwin	
31	Wendy	Bryce	Ferndale
32	David	North	
33	Judith	Orr	Rossmoyne
34	Shirley	Wild	Glen Forrest
35	William	Connell	Churchlands
36	John	Grinceri	Edgewater
37	T	Beyer	Attadale
38	J	Elliott	Geraldton
39	Arthur	White	Doubleview
40	Karl	Berentzen	Mindarie
41	D	Beyer	Attadale
42	Barbara	Bourhill	Attadale
43	Geoff	Howarth	Denmark
44	Lorne	Ferster	Stirling
45	Jacqui	Ratiyczak	Morley
46	Tania & Miguel	Guerrers	Marangaroo

Community Drug Summit Submissions

47	Stephen	Sjpiteri	Duncraig
48	Tim	Clear	Beechboro
49	Barbara	Perry	Scarborough
50	C. A.	Burns	Scarborough
51	S. C.	Burns	Scarborough
52	James	Ledger	Wembley Downs
53	Mario	Borg	Greenwood
54	David	Jansen	Greenwood
55	S	Carricell	Scarborough
56	Steven	Crew	Churchlands
57	Gabrielle	Abel	Greenwood
58	David	Haydon	Woodlands
59	Kylie	Nichols	Glen Forrest
60	Laura	Bull	Wembley Downs
61	Monica	Romagnoli	Rockingham
62	J	van den Bogetti	Scarborough
63	Raymond	Cammock	Port Kennedy
64	Justin	McFinnity	City Beach
65	Susan	Carrick	Scarborough
66	Josh	Morris	Wembley Downs
67	Kathleen	Smith	Maida Vale
68	Amanda	Smith	Maida Vale
69	Justin	Carrick	Wembley Downs
70	Fiona	Smith	Wembley Downs
71	Errol	Wilkinson	Noranda
72	S F	Daniels	Greenwood
73	Antoinetta	Issa	Wembley Downs
74	Mary	Issa	Wembley Downs
75	B	McKinley	WODONGA
76	Anthony	van Dyke	Woodlands
77	S R	Gillespie	Osborne Park
78	Michaela	Hughes	Cottesloe
79	J	Peter	Duncraig
80	R	Firth	City Beach
81	Leah & John	Moir	Mirrabook
82	Allen	D'Silva	Lynwood
83	Francis	Hrubos	Glen Forrest
84	Allen	Stenhouse	Wembley
85	Janet	Brown	Sth Hedland
86	Kylie	Agale	Sth Hedland
87	Bob	Neville	Sth Hedland
88	Jackie	Bickendorf	Karratha
89	Alan	Habgood	Karratha
90	Joyce	Trust	Roebourne
91	Michelle	Adams	Karratha
92	Juha	Dyster	Cunderdin
93	Caroline	Gumede	Scarborough

Community Drug Summit Submissions

94	Mary	Newman-Martin	Joondanna
95	Bill	Burns	Doubleview
96	A	Nicholson	Kenwick
97	Diane	Niyati	Claremont
98	Joyce	Henderson	Rossmoyne
99	Geoff & Norah	Taylor	Armadale
100	Barry & Jean	Hicks	Edgewater
101	John	Hakesley	
102	Jack	Apgar	
103	Jonathan	Maile	Huntingdale
104	John	Sheppard	East Perth
105	Philip	Haydon	Woodlands
106	Allan	Frearson	Busselton
107	Cyrus	Adams	Girrawheen
108	Josef	Holzschuh	Annandale
109	Celine	Briffa	Woodlands
110	Maureen	Taylor	Dunsborough
111	Peter	Wieske	Canning Vale
112	M	Cencic	Karrinyup
113	Lucile	Yearwood	Woodlands
114	Julius	Re	Highgate
115	Mary	West	Katanning
116	Anne	Blackbourne-Kane	Katanning
117	Liz	Guidera	Katanning
118	Bryan	Gooley	East Perth
119	Kevin	Cleaver	Pingelly
120	B	Joyce	Morley
121	Peter & Yvonne	Clifford	Kelmscott
122	Jim	Bavin	Toodyay
123	Margaret	Wilcox	Dunsborough
124	Mrs….		Northam
125	No	Name	
126	Beryl	O'Hare	Manjimup
127	Brian	Flood	Melville
128	Heather	MacFarlane	Cottesloe
129	Richard	Harding	Perth
130	C	Early	Attadale
131	Melanie	Samuels	Lynwood
132	Dennis	Carrick	Scarborough
133	Joseph	D'Alessandro	City Beach
134	Lucy	Cammock	Port Kennedy
135	Linda	Andrews	Victor Harbour
136	Barbara	Arthur	Quinns Rocks
137	Greg	Brophy	Kalgoorlie
138	Robert	Swift	Kalgoorlie
139	Brian	Thompson	Kalgoorlie
140	Peter	Jacob	Kalgoorlie

Community Drug Summit Submissions

141	Rose	Lawrence	Mt Lawley
142	Rhonda	Haynes	Willagee
143	Rosemary	Chandler	Palmyra
144	Karolyn	Bromwell	Mt Pleasant
145	Frank & Pat	Hackett	
146	Barry	Chatel	Mandurah
147			
148	Nyanda	McBride	Karrinyup
149	Julie	Begley	Armadale
150	Tess	Connelly	Pemberton
151	Marilyn	Overhue	Esperance
152	Mary	Ambrose	Lathlain
153	Roma	Lewis	Duncraig
154	V	Wardman	Applecross
155	George	de Vos	Dianella
156	Stanislaw	Harasymow	Yokine
157	Neri	Vekeman	
158	No Name		
159	CWA		West Perth
160	No Name		
161	Kevin	Kennedy	Nedlands
162	D	Hagan	Wembley Downs
163	Laurie	Humphreys	Coolbellup
164	Peter	Conroy	Kewdale
165	National Civic Council		West Perth
166	Gerard	Quesnel	Sorrento
167	S	Mitchell	Inglewood
168	Donald	Mitchell	Inglewood
169	M	Gosling	Como
170	Maddalena	G, M, A S	Attadale
171	Thomas More Centre		Perth
172	J	Mewburn	Thornlie
173	Robert	Adams	Thornlie
174	E	Symcox	Carlisle
175	B	Masino	
176	John	Wieske	Byford
177	M	Webb	Dianella
178	J	Scott	Attadale
179	R	Kents	Bruce Rock
180	Margaret	Preshaw	Scarborough
181	D	Barich	Ardross
182	Mary	Daly	Parkwood
183	Joe	Santamaria	
184	Denis	Conlan	Albany
185	Mr & Mrs	Hawkins	Thornlie
186	Patricia	Halligan	Riverside Gardens
187	Andrew	Reedy	

Community Drug Summit Submissions

188	Peter	Kossen	Australind
189	Gerard	Spoelstra	Riverton
190	Helena	Bolhuis	Mt Nasura
191	David	Cleal	Langford
192	Geoff	Westlake	
193	John	Smith	
194	Mr & Mrs	Jackson	Albany
195	HDWA		East Perth
196	V	McQuade	Parkwood
197	Mr & Mrs	Holder	Thornlie
198	Robert	Dextor	Edgewater
199	Joan	McArthur	Riverton
200	Rodney	White	Mosman
201	Hazel	Bothe	Corrow
202	Edith	McCourt	Rossmoyne
203	Dorothy	Boyle	Rossmoyne
204	Adele	Chapman	Cannington
205	Jan	Chapman	Lesmurdie
206	Keith	Anderson	Orelia
207	Beverley	Jefferies	Karratha
208	Simon	Lenton	Perth
209	Denis	Whitely	Perth
210	Mr & Mrs	O'Connor	Booragoon
211		Next Step	
212	The Catholic Women's		Mt Lawley
213	Joyce	Crouchley	Boya
214	Di	Davies	
215	Joseph	McSevich	E Fremantle
216			
217	B J	Low	Salter Point
218	C J	Hopkins	Craigie
219	Ben	Clarke	
220	Shane	Shenton	Embleton
221	Bridget	Curran	
222	Laurie	Eastwood	Wembley
223	Angela	Corry	
224	Mrs W	Herbert	
225	Sharyn	Martin	Heathridge
226	Carmen	Sferco	
227	Victor	Patrick	West Perth
228	Mrs B	Siloeski	
229	WASUA		Northbridge
230	Watchmen	In god's Service	North Beach
231	Michael	Kronenberg	Forrestfield
232	Chris	Barker	Mandurah
233	Barri	Norton	Broome
234	Sister Leone	Collins	Broome

Community Drug Summit Submissions

235	Elizabeth	Rosenberg	Broome
236	WA Police Svce		
237	Jill	Rundle	West Perth
238	Neil	Horner	Busselton
239	Tina	Frost	Meadow Springs
240	Susan	Slack	Scarborough
241	J	Laver	Cuballing
242	Brian	Morcombe	Albany
243	C M	Smith	Albany
244	Mrs	Tremain	Maylands
245	Trina	Michailidis	Currambine
246	David	Bensley	Koondoola
247	Mr T	Devitt	Gwelup
248	James	Richardson	
249	R	Studham	Inglewood
250	V	Studham	Inglewood
251	C & H	Vanderstoep	Kenwick
252	J	Gillham	Bull Crrek
253	M	Griffiths	Parkerville
254	J	Hussey	Innaloo City
255	Kevin	Moran	Hillarys
256	Fiona	Farringdon	Samson
257	Marion	Ivanic	Bassendean
258	Pauline	Zani	Ashfield
259	Woman's Temperance		West Perth
260	T D	McMullen	West Leederville
261	Lesley	Gilroy	Ardross
262	Damir	Lendich	
263	John & Barbara	Notte	Midland
264	S	Craig	Crawley
265	Peter	Hackett	Waterford
266	Jan	Hudson	Alfred Cove
267	Simon	Lenton	duplicate
268	Noel	Sharp	Geraldton
269	Norma	O'Hara	Kewdale
270	L	Shervington	Floreat
271	A & B	Yensch	Attadale
272	Barbara	Whilldin	Albany
273	J	Cozijnsen	Yangebup
274	Sylvester	Lane	Attadale
275	J	Schotte	Willetton
276	Ken	Ogier	Booragoon
277	Liz	Atkinson	Shelley
278	Len	Wakeman	Carlisle
279	A R	Hugh	Chidlow
280	Maurice	Bland	Rossmoyne
281	G & E	Helsby	Rossmoyne

Community Drug Summit Submissions

282	Youth Legal Svce		Perth
283	E P	McLennan	Quairading
284	J M	Weare	Shenton Park
285	Irene	Byron	Kalamunda
286	David	Egan	Ferndale
287	Rupert	Sherlock	Midland
288	Judith	Gleeson	Meadow Springs
289	A W	Sutton	Embleton
290	Natalie	Thomas	Eden Hill
291	Elizabeth	Leahy	Dalkeith
292	Enid & Ian	Conochie	Denmark
293	M H	Dale	Albany
294	Moora	Baptist Church	Moora
295	C D	Hawkins	Moora
296	Claire	Roberts	Perth
297	Rodney	White	Mosman Park
298	Nicky	Bath	Woden ACT
299	Allan	Frearson	Busselton
300	Elizabeth	Ford	Busselton
301	Candice	Conrington	Cowaramup
302	David	Naughton	Busselton
303	David	Naughton	Busselton
304	Sharon	Perry	Busselton
305	No Name		
306	Steph	Casadio	Bunbury
307	No Name		
308	Brian	Wray	Innaloo
309	Patricia	Langdon	
310	M & M	Rose	Sorrento
311	Paul	Hotchkin	Greenwood
312	P & T	Baker	Kingsley
313	Anita	Matthews	Denmark
314	Steve	Heini	Wanneroo
315	Imelda	Aslett	Lower King
316	Mike	Aslett	Lower King
317	Eastern Perth Public	& Comm Health Unit	
318	Eastern Perth Public	& Comm. Health Unit	
319	Simon	Rose	Duncraig
320	Paul	Entwistle	
321	WA Police Svce		
322	Leanne	Hancock	
323	Brian	McComish	Albany
324	Paige	Sullivan	East Perth
325	Palmerston Assoc		
326	Palmerston Assoc		
327	Palmerston Assoc		
328	Palmerston Assoc		

Community Drug Summit Submissions

329	Jeff	Fullelove	Merriwa
330	Anthony	Murphy	Marangaroo
331	Anthony	Murphy	Marangaroo
332	Anthony	Murphy	Marangaroo
333	Murray	Gomm	
334	Tony	O'Donnell	
335	No Name		
336	Angela	Corry	
337	Welfare Rights	& Advocacy Svce	
338	Welfare Rights	& Advocacy Svce	
339	Harold	Luxton	Rockingham
340	Darryl	Burnside	Rivervale
341	Rev George	Davies	West leederville
342	David	Moyses	
343	Louise	Hinds	Denmark
344	Perth Womens Centre		Northbridge
345	Chris	Hall	Carnarvon
346	Heinrich	Benz	6054
347	Kim	Hargreaves	Perth
348	East. Perth	Public & Comm Health Unit	
349	Nick	Suess	Bayswater
350	Colleen	Carlon	Bunbury
351	Moira	Sim	Mt Lawley
352	John	Lavers	Koondoola
353	Derek	Marsh	Bunbury
354	Jon	Rose	
355	Vern	Stannard	East Vic Park
356	Chris	Settle	
357	Families & Friends	Drug Law Reform	
358	Les	Johnson	Lower Kalgan
359	J	Wann	Leeman
360	Joshua	Bowen	Stoneville
361	L	Kuhne	
362	Heidi	Ross	Carlisle
363	H	de Jong	Gosnells
364	Robert	Elliott	
365	R & E	Haeusler	Three Springs
366	R	Stoker	Kewdale
367	J	McMullan	6022
368	Margaret	Ker	Mt Lawley
369	Deidre	Lyra	Forrestfield
370	Lucia	Musgrave	Stirling
371	D C	Fairs	Dianella
372	Yolande	Watkins	Mt Pleasant
373	Gary	Bromwell	E. Vic Park
374	Graham	Malthouse	Ferndale
375	Lana	Debono	

Community Drug Summit Submissions

376	Wendy & David	Craven	Moora
377	Michelle	Shave	Hamilton Hill
378	B & J	Chapman	
379	Linda	Martinskis	
380	R & C	Evans	Brookton
381	Aus Family Assoc		Lower King
382	Trevor	harvey	Yangebup
383	G	Mullins	
384	J	Barich	Perth
385	Terry	O'Neill	Maida Vale
386	Madeleine	Goiran	Thornlie
387	Joseph	Scicluna	
388	Francis	Donohoe	
389	Josephine	Stone	Ardross
390	Isabel	Postmus	
391	Gail	Gifford	Vasse
392	Peter	Abetz	Willetton
393	Gordon	Hudson	
394	J M	Wallace	Riverton
395	Terry	Ryan	thornlie
396	DR Pat	Cranley	
397	K	Martinovich	
398	Peter	Osborne	
399	Serena	Ryan	Claremont
400	J	Underwood	Attadale
401	Tracey	Foster	Perth
402	David	Wray	
403	Cheryl	Lyra	Forrestfield
404	Peter	Sloan	Wanneroo
405	Bert	Dolin	Applecross
406	Suzanne	Helfott	Mt Lawley
407	Jessica	Gray	
408	Etza	Peers	Hospital Ave
409	Anne-Marie	Pike	Padbury
410	P J	Marsh	
411	Calvary Youth Svce		
412	George	Smith	South Perth
413	R	Steineck	
414	S	Taylor	
415	Dr C	D'Cruz	Leederville
416	Kathleen	Courtney	Kensington
417	Keith	Mcencroe	Joondanna
418	Grant	Gorddard	Como
419	Fay	Jones	Bicton
420	Sandy	Moran	City Beach
421	Damien	Shiel	Bunbury
422	Mary	George	Midland

Community Drug Summit Submissions

423	Peter	Dent	Karrinyup
424	M	Gonzalez	Willetton
425	B	Silveski	
426	No Name		
427	Martine	Chapman	
428	John	White	Calista
429	Gillian	Gonzalez	West Perth
430	Next Step		Mt Lawley
431	R	Steineck	Manning
432	Mission	Australia	East Perth
433	Bruno	Faletti	East Perth
434	Stirling Coastal	Group LDAG	
435	Narcotics Annonymous		Newtown
436	Debbie	Terelinck	West Perth
437	Neil	Bennett	Bibra Lake
438	Jason	Meotti	
439	Jude	Bevan	Perth Bus. Centre
440	Anne	Griffiths	East Perth
441	No Name		
442	David	Wray	East Perth
443	Jane	Pike	Padbury
444	Clare	Pike	Padbury
445	Chris	Trinity Youth Options	Perth
446	Youth Affairs		West Leederville
447	Patrick	Mahoney	
448	B	Silveski	
449	Neil	Beck	Victoria Park
450	Keith	Shilkin	Hospital Av Nedlands
451	Adam	McLeod	Subiaco
452	Petition		
453	Juha		
454	B	Silvesti	
455	Keith	Jones	Balga
456	Amber	Pasco	Augusta
457	Lynda	O'shea	Wanneroo
458	Phillip	Moran	Beckenham
459	N	Moylan	Kellerberrin
460	C Roger	Pratt	City Beach
461	S & I	Cenin	Denmark
462	Kevin	Moran	
463	M	Reid	Booragoon
464	Betty	O'Gorman	Chidlow
465	Jeff	Moss	Kingsley
466	Maureen	Grierson	
467	Jill	Martignoli	Edgewater
468	Brian	Pearce	Esperance
469	John	Walker	Esperance

Community Drug Summit Submissions

470	Alva	Courtis	Esperance
471	David	Meer	Boulder
472	Catherine	Bishop	Kalgoorlie
473	Janet	Brown	Sth Hedland
474	Michael	Woods	Scarborough
475	Joe	Santamaria	
476	Barry	Morgan	Samson
477	Vilmos	Laczo	North Perth
478	M	Gosling	Como
479	John	Walker	Esperance
480	Wayne	Scheggia	West Perth
481	D.E.S.	Main	Albany
482	School Drug Educ.	Task Force	East Perth
483	No Name		Rockingham
484	No Name		Rockingham
485	Sarah	Atkinson	
486	Sarah	Atkinson	Rockingham
487	R & H	Gent	Mandurah
488	Deidre	Noon	North Perth
489	No Name		Geraldton
490	Graham	Clarke	Geraldton
491	Kelly	Sorenson	Geraldton
492	Tracy	McCagh	Geraldton
493	Alex	Hewson	Geraldton
494	Gay		Geraldton
495	Anthony		Gerealdton
496	Denis	Lidington	Carnarvon
497	Judy	Trend	Carnarvon
498	Chris	Hall	Carnarvon
499	Janice	Baines	Carnarvon
500	Annie	Campbell	Carnarvon
501	Kate	Rickerby	Geraldton
502	Karl	Sisson	Geraldon
503	Aboriginal	Drug Forum	Derbil Yerrigan
504	No Name		
505	No Name		Carnarvon
506	Sarah		Geraldton
507	Steve	Fletcher	Geraldton
508	Mac		Geraldton
509	Rosemaree	Magro	Geraldton
510	Pat	Morton	Geraldton
511	No Name		Geraldton
512	No Name		Geraldton
513	K	Brosnan	Geraldton
514	Shane	Hill	Geraldton
515	No Name		Geraldton
516	No Name		Geraldton

Community Drug Summit Submissions

517	Shane	Foreman	Geraldton
518	Alex	McIntosh	
519			
520	Janet	Mathieson	Mandurah
521	No Name		
522	AleX	McIntosh	Geraldton
523	Jacquie		Geraldton
524	Nick		Geraldton
525	Nichola	Hamilton	Geraldton
526	Jame	Forman	Geraldton
527	Jim	Eftos	Perth
528	Judy	Hughes	Girrawheen
529	WA Police	Service	
530	Valeraie		Geraldton
531	Phil	Tuffin	Geraldton
532	Social Worker		Mandurah
533	ArthurhARRIS		Peel
534	Trish	McGowan	Peel
535	Kathy	Coulson	Mt Lawley
536	Ian	Bodill	Margaret River
537	David	Gallagher	South Fremantle
538	WAAMH	Ann White	West Perth
539	Mal	Osborne	Kalgoorlie
540	Recreation WA		
541	Harry	Clarke	Melbourne
542	John	Raven	Nedlands
543	Alex	Wodak	Sydney
544	Prof Charles	Watson	Bentley
545	Aboriginal Comm. Drug		East Perth

- the impact such services would have on the unsafe disposal of injecting equipment, overdose, blood borne virus transmission, the public nuisance associated with drug use and the encouragement of users to enter treatment services; and
- this should be done only with the support of local community opinion.

VOTING RESULTS FOR RECOMMENDATIONS 41-45			
	YES	**NO**	**ABSTAIN**
Recommendation 41	90	9	
Recommendation 42	75	24	
Recommendation 43	91	8	
Recommendation 44	92	7	
Recommendation 45	63	35	1
1 Delegate did not vote			