1973

WESTERN AUSTRALIA

REPORT

of the

HONORARY ROYAL COMMISSION

appointed to inquire into

and report upon the

TREATMENT OF ALCOHOL AND DRUG DEPENDENTS

IN WESTERN AUSTRALIA

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HONORARY ROYAL COMMISSION TO ENQUIRE INTO

THE TREATMENT OF ALCOHOL AND DRUG DEPENDENTS IN WESTERN AUSTRALIA

INTRODUCTION

To His Excellency Major General Sir Douglas Kendrew, K.C.M.G., C.B., C.B.E., D.S.O., Governor in and over the State of Western Australia and its Dependencies in the Commonwealth of Australia.

May it please Your Excellency -

We, the members of the Honorary Royal Commission appointed to enquire into the treatment of alcohol and drug dependents, have the honour to present to Your Excellency, our report as follows:-

HISTORY:

On Wednesday, 3rd May, 1972, the Honourable R.J.L. Williams moved in the Legislative Council: -

> That a Select Committee be appointed to investigate and assess the present facilities and methods available, both Governmental and others, and to inquire into and report to the House on ways and means to develop, improve, and co-ordinate the treatment of alcohol and drug dependents.

On Tuesday, 30th May, 1972, the motion was debated and agreed to in amended form as follows:

> That a Select Committee be appointed to investigate and assess the present facilities and methods available, both Governmental and others, to inquire into and report to the House on ways and means to develop, improve, and co-ordinate the treatment of alcohol and drug dependents, and recommend ways to combat the initial incidence of such dependency.

The Legislative Council then appointed the Honourables Lyla Elliott, T.O. Perry, and the mover, as a Select Committee with

power to call for persons, papers and documents; to adjourn from place to place; to sit on days over which the Council stands adjourned, and to report on Thursday, 16th November, 1972.

The Select Committee at its initial meeting on Wednesday, 31st May, 1972, appointed the Honourable R.J.L. Williams Chairman.

On Thursday, 3rd August, 1972, the Honourable R.J.L. Williams was granted leave to move the following motion which was agreed to by the Legislative Council:

> That leave of the Council be granted under Standing Order 354 for the President to authorise the disclosure, to appropriate authorities, of documents or evidence received by the Select Committee enquiring into the Treatment of Alcohol and Drug Dependents.

On Wednesday, 15th November, 1972, the Honourable R.J.L. Williams was granted leave to make a progress report, pursuant to Standing Order No. 355 as follows:-

> That in view of the impending conclusion of the current session, and as the Select Committee has not completed its investigations to enable its report to be presented to Parliament, a respectful request had been forwarded to the Honourable Premier and approved by the Executive Council for the members of the Committee to be appointed an Honorary Royal Commission to continue and complete the enquiries commenced by them with the view to reporting to His Excellency the Governor prior to the next session of Parliament.

The members of the Committee were duly appointed as an Honorary Royal Commission on 15th November, 1972. The terms of the appointment as published in the Government Gazette on 17th November, 1972, were as follows:-

ROYAL COMMISSION

WESTERN AUSTRALIA)
To Wit:)

By His Excellency the Honourable Sir Albert Wolff, Knight Commander of the Most Distinguished Order of Saint Michael and Saint George, Lieutenant-Governor and Administrator in and over the State of Western

Australia and its Dependencies
in the Commonwealth of Australia.

A. WOLFE

Lieutenant-Governor
and Administrator.

To RICHARD JOHN LLOYD WILLIAMS,
LYLA DAPHNE ELLIOTT, and
THOMAS OSWALD PERRY,
members of the Legislative
Council:

(L.S.)

I, the said Lieutenant-Governor and Administrator, acting with the advice and consent of the Executive Council, do hereby appoint you, RICHARD JOHN LLOYD WILLIAMS, LYLA DAPHNE ELLIOTT, and THOMAS OSWALD PERRY, members of the Legislative Council, to be an honorary Royal Commission without payment of remuneration to do the following things, namely -

(a) To continue and complete the inquiries commenced by you, as a Select Committee of the Legislative Council, into the treatment of alcohol and drug dependents.

(b) Having completed those inquiries to make your report to me in writing, making such recommendations as to legislative and or other action as you may consider necessary.

AND I hereby appoint you the said RICHARD JOHN LLOYD WILLIAMS to be the Chairman of the said Royal Commission.

AND I hereby declare that by virtue of this Commission you may, in the execution of this Commission, do all such acts, matters and things and exercise all such powers as a Royal Commission or members of a Royal Commission may lawfully do and exercise whether under or pursuant to the Royal Commissions Act, 1968, or otherwise.

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GIVEN under my hand and the Public Seal of the said State, at Perth, this Fourteenth day of November, 1972.

By His Excellency's Command,

JOHN T. TONKIN

PREMIER

GOD SAVE THE QUEEN !!!

PROCEDURE:

Investigations -

Following its appointment, the Select Committee commenced taking of evidence, and during the course of its investigation visited Byford Rehabilitation Centre, Fremantle Gaol, Bunbury Gaol and Perth Central Lockup. At each of these establishments the Committee studied admittance, assessment and treatment procedures which are currently in use.

In addition, the Select Committee journeyed to South Australia to inspect and study the effectiveness of the Alcohol and Drug (treatment) Board. During the course of tour the Committee inspected 'Elura', St. Anthony's Hospital, Archway Rehabilitation Centre, Central Methodist Mission, Nazareth Crypt, Shaftesbury House, Kuipto Colony and Koster House.

The Honorary Royal Commission inspected Swanbourne Hospital, Graylands Hospital, Heathcote Hospital, Bandyup, Karnet, Wooroloo, and Bartons Mill. At each of these centres, the Commissioners spoke informally to people who were involved in the problem of Alcoholism or Drug Addiction.

EVIDENCE

Commencing on 3rd July, 1972, and on twenty four subsequent days, informal evidence was taken from 69 witnesses and formal evidence was taken from 80 witnesses listed hereunder - the last evidence was taken on 12th January, 1973, and the transcript of evidence from witnesses totalled 941 pages.

WITNESS	OCCUPATION	Transcript PAGE
A, Mr.		813
Adams, C.S.	Minister of Religion	480
Bailey, C.L.		383
Bamberger, E. von	Clinical Psychologist	171
Barlow, J.M.	Welfare Officer	612
Beaton, J.R.	Lecturer in English	519
Beazley, S.N.F.	Prison Officer	587
Bell, A.F.J.	Medical Practitioner - Claremont Hospital	137
Bell, L.J.		861
Blackmore, H.J.	Medical Practitioner - Claremont Hospital	104
Boulton, J.B.	Executive Director, National Safety Council	351
Bradley, J.		871
Brennan, T.G.	Social Worker	62
Campbell, C.W.	Director, Department of Corrections	407
Carr, J.T.	Health Educator, Health Education Council	360
Clayton, G.M.	Minister of Religion and Therapist	846
Colbung, K.		559
Currie, W.O.	Inspector of Women Police	537
Davidson, W.S.	Commissioner of Public Health	277
Davies, W.H.		712
Dunjey, M.V.	Medical Practitioner - Royal Perth Hospital	36
Dunn, D.W.		421
Edwards, E.J.	Professor of Law	695
Ellis, A.S.	Director, Mental Health Services	1
Ellison, R.M.	Physician - Heathcote Hospital	312
Fletcher, R.R.		623
Flood, J.B.	Education Officer, Health Education Council	884
Francis, C.		269
Fuering, E.		208
Goldstone, S.R.	Minister of Religion	480
Gray, W.B.C.	Medical Practitioner, Mental Health Services	(442 (590
Greenacre, S.E.		628
Haswell, D.H.	Crime Intelligence Bureau.	914
Hazlewood, J.	Anglican Dean of Perth	216
Hetherington, P.	Student Counsellor, University of Western Australia	239
Hickman, W.A.		595
Hunter, H.	Brigadier, Salvation Army	89
I. Mrs. Joyce		198
Jenkins, G.A.	W.A. Temperance Alliance	114
Jones, F.N.		707
Kerr, M.		900

WITNESS	OCCUPATION	Transcript PAGE
Lee, C.	Secretary, Inebriates Advisory Board	8
Lee, T.G.	Superintendent of Police, Liquor and Gaming Branch	48
Lefroy, R.B.	Professor of Medicine, Sunset Hospital	326
Louden, L.W.	Superintendent of Education	915
Lunney, E.L.		871
MacKay, J.R.	Executive Director, Y.M.C.A.	646
Maine, K.A.	Director, Community Welfare Department	723
McCall, M.G.	Professor of Medicine, Royal Perth Hospital	388
McGrath, P.W.	Detective Sergeant, C.I.B.	253
Mippy, A.J.		607
Moyes, P.M.	Headmaster, Christchurch Grammar School	288
O'Brien, M.L.		549
Parker, Arthur John	Superintendent of Police, C.I.B.	398
Parker, Arthur Joseph	Retired Customs Officer	833
Pickett, G.R.	Ex Commissioner of Prisons, Hong Kong	924
Pougher, J.C.E.	Medical Practitioner, Heathcote Hospital	448
Putnin, B.	Justices of the Peace Association	369
Rooney, J.R.	Medical Practitioner	501
Sanders, P.H.	Student Counsellor, W.A. Institute of Technology	669
Scrymgeour, O.		843
Simmonds, S.	Justices of the Peace Association	369
Simpson, F.H.G.	Liaison Officer, Byford Treatment Centre	230
Smart, V.A.		829
Smith, G.	Director, Christian Welfare Centre	77
Solomons, N.	Freelance Consultant in Creative Work and Communications	768
Standen, C.E.	Snr. Inspector of Police and Snr. Police Prosecutor	468
Stewart, D.W.		669
Straiton, T.	Prison Officer	582
Tatom, R.	Education Co-ordinator, Mental Health Services	296
Whale, H.E.	Psychiatric Social Worker, Heathcote Hospital	340
Wright Webster, C.R.	Chief Probation and Parole Officer	148
X, Mr.		789
Y, Miss		789

In addition to oral evidence received, written submissions were received from the following persons: -

	NAME	TITLE OF SUBMISSION
1.	Mr. George Smith, B.A., M.A.I.W.	(1) The scene in Western Australia. (2) The Winston Churchill Memorial Trust-A Fellowship Report.
2.	Seaforth Alcoholic Rehabilitation Centre.	(1) Biographical precis of the centre.
3.	Mr. J.M. Forrest, S.M.	(1) Alcoholism.
4.	Health Education Council of W.A.	(1) Alcohol and Alcoholism-paper used by the Police Academy.
5.	The Law Society of Western Australia.	(1) Opinions.
6.	Rev. G.A. Jenkins.	(1) Comments by a leading Hotelier in W.A.
7.	Mr. C. Wright-Webster.	(1) Information relating to the drug problem.
8.	Dr. Andrew Wiel. (submitted by Dr. D.J. Ryan)	(1) Altered States of Consciousness.
9.	Mr. B.F. Ryker.	(1) Personal Statement.
10.	Consulate-General of Japan.	(1) Drug and Alcoholism Control Laws in Japan.
11.	Mr. G.R. Pickett, J.P.	(1) Personal Experiences as Director of Hong Kong Prisons Department.
12.	Dr. M. Lugg.	(1) Discharges from W.A. Hospitals.

EXHIBITS

Apart from the evidence listed previously, the Commission admitted as exhibits the following documents:-

Exhibit No.	Name	Nature of Exhibit
1.	Dr. A.D. Ellis.	Opinions and Statistics on Alcoholism and Drug Addiction.
2.	Mr. C. Lee.	Medical Cards and Papers.
3.	Mr. C. Lee.	"Perhaps a Chance", the personal story of an alcoholic.
4.	Dr. M.V. Dunjey.	Testimony in support of oral evidence.
5.	Mrs. Joyce I.	Testimony in support of oral evidence.
6.	Mrs. R. Tatom.	Detailed papers in support of oral evidence.
7.	Mr. C.L. Bailey.	Testimony in support of oral evidence.
8.	Mr. D.W. Dunn.	Posters and pamphlet relating to marihuana smoking.
9.	Inspector Currie.	Acts relating to.
10.	Mr. R.R. Fletcher.	Diagram showing progression of drug addiction.
11.	Mr. F. Jones.	The Twelve Steps and Traditions of A.A.
12.	Mr. A.L. Parker.	"Scientific Investigation and Physical Evidence", by L.V. Jones.
13.	Mr. A.J. Parker.	List of Drugs.
14.	Mr. J. Flood.	"Policy and Program", - Employees with drinking problems.
15.	Mr. L.W. Louden.	"Health Education and Human Relationships", Teachers' Manual, Education Department.
16.	Mr. E. von Bamberger.	Detailed papers in support of oral evidence.
17.	Various.	Select Committee tour of inspection of South Australian treatment centres.

REFERENCES:

During the course of its inquiry the Commission read and examined many documents and reports, related to these fields from all parts of the world.

PREPARATION OF REPORT:

The Commission met on a further sixteen occasions, totalling 84½ hours for the purpose of discussion, analysing evidence and preparing the Commission's report.

SECTION 1: SYNTHESIS OF EVIDENCE ON DRUG DEPENDENCY.

1. 1. Extent of the Drug Problem.

1. 2. Drug Detection.

1. 3. Causes of Drug Abuse.

1. 4. Treatment.

1. 5. Escalation.

1. 6. Penalties and Legislation.

1. 7. Education.

1. 8. Community Planning.

SYNTHESIS OF THE EVIDENCE RELATING TO DRUG DEPENDENCY

1. 1. EXTENT OF THE DRUG PROBLEM:

The extent of the drug problem in Western Australia, as in any other part of the world, can never be accurately assessed owing mainly to the illegal implications of drug usage. Furthermore, lack of referral centres, "neutral houses" etc. tend to inhibit drug-users from seeking guidance or bringing their problems to surface and thus curtails another avenue for estimating the problem. Statistics on drug charges provide some recourse but such information must be interpreted tentatively as it is heavily reliant on detection techniques, the latter probably revealing only "the tip of the iceberg". Notwithstanding this caution the available facts present a fairly grim picture of this State's drug situation: 182 persons were charged over the last twelve months as opposed to 101 charged during the preceding twelve months which represents an increase of 85%. Of the 182 persons charged, 26 were under the age of 18 years and the bulk of their offences related to Cannabis smoking. In the 18 - 21 years age group, of the 81 persons charged, an alarmingly high proportion of offences concerned hard-drug usage. 75 offenders were over 21 years of age, Cannabis usage constituting the majority of their offences. From these above statistics it appears that 54% of the total offenders smoke Marihuana. There seems to be some consistency between this percentage and a witness's observation that at least 400 - 800 students are regular Marihuana users. It has been suggested that tertiary students perhaps have too much freedom to experiment and this is further accentuated by the availability of drugs on the campus. The Commission heard, with concern, that Opium and Heroin could be obtained; in fact, apart from an occasional dry period, any drug could be procured and "quite a deal of Australian-grown stuff, too". However, a strong distinction is apparently maintained between the use of soft and hard drugs (potheads and junkies) and

the predilection for Cannabis is interpreted by some to be a cult symbol for radical tendencies. Various lines of evidence sought to establish that the youth of Perth have now accepted drug-taking as a component of their sub-culture, in much the same way as "jeans" typically represent their current mode of dress. Evidence further suggested that it was inevitable that Marihuana usage would spread downwards from tertiary institutions to schools, the paradox of the problem being that drug-use is more prevalent with young people who have good education, than those who do not.

Other sources of evidence highlighted the fact that hypnotics, tranquillisers and barbiturates are the most highly abused drugs, which may as well lead to drug dependency. An Expert witness claimed that the high kidney-disease rate in Australia which was 50% above that of the U.S. was attributable to the abuse of analgesics in our peculiar climate. Figures for 1971 indicate that 16 men and 17 women treated for drug-dependency were hospitalised for a total of 283 bed-days, the mean age of patients being 42. It was constantly reiterated that in Western Australia, addiction to barbiturates and amphetamines is far more prevalent than figures indicate.

In view of the foregoing information, despite denials by some witnesses that Western Australia did have a drug-problem, the Commission formed the opinion that the drug scene is far more serious than had previously been imagined. While conceding that the Perth drug situation is far removed at present from the abysmal U.S. drug scene, (the latter requiring an addict to steal $10,000 p.a. in support of his habit) it must be acknowledged that there is an increasingly serious drug-problem in this State. The possibility of preventing drug-abuse from reaching epidemic proportions in Western Australia is enhanced by two factors: -

(a) Isolation of the State;

(b) A small enough population (to be administered).

In the final analysis, dependence on drugs, exclusive of the categorisation of dependents into age or sex, is significantly related to the ease with which each or other drug may be obtained and used, and the initial extent of the problem may be gauged to some degree by this availability.

CONCLUSIONS:

(1) Insufficient, categorised statistics are available to measure with accuracy the extent and nature of the drug problem in Western Australia.

(2) However, from the few reliable statistics available it would appear: -

(a) drug taking in all forms is increasing; and

(b) no particular age group can be categorised for drug dependency, but in broad terms, the illegally obtained drugs such as Cannabis, narcotics, hallucinogens, barbiturates and amphetamines seem to be used to a greater extent by the under 25 age group. Drug dependency amongst the over 25 group in the main seems to stem from prescribed and legally obtained drugs such as tranquillisers, hypnotics and analgesics.

RECOMMENDATION:

That one central co-ordinating agency be given the task of continuous collecting and collating of relevant statistics concerning drug use and abuse in the State of Western Australia. The type of statistics which should be readily available would include the following:

Type of drug;

Persons age, sex, occupation, race, religion,

family background, marital status, treatment success/failure rate;

Number of convictions for possession, trafficking, importing, etc.;

Total quantities of drug seized by authorities.

Any other information found necessary by the co-ordinating Agency.

1. 2. DRUG DETECTION:

In reviewing the current measures to counteract the import and cultivation of drugs, the Commission took cognisance of the vast areas of the State that are vulnerable as importing points. It is reasonable to expect that 4,350 miles of coastline apart from the interior cannot be constantly and effectively patrolled and acknowledgement of this limitation merely necessitates the implementation of other preventive measures to discount this vulnerability.

Evidence was given concerning the effective functioning of the Central Crime Intelligence Bureau, Drug Intelligence Section, situated at Canberra, which provides feedback to all States regarding the number of arrests made throughout Australia in connection with drug charges. This central processing agency facilitates State detection measures especially because drug-users tend to be nomadic.

In examining the need for increased detection services the Commission found some divergence in the evidence presented. Some witnesses suggested that the Customs Department do not and cannot recover a considerable percentage of drug imports. This view seems to be substantiated by the remarks of the former Minister for Customs in respect of the low detection rate for illegal drug importing. Other evidence argued that perhaps improved detection measures and not necessarily increasing drug-usage, may be

responsible for the increasing number of drug charges. A further line of evidence suggested that if the drug-squad was disbanded and replaced by a citizen's squad, more addicts were likely to seek treatment sooner, the fear of prosecution being removed. The Commission was pleased to learn of the initiative shown by the Y.M.C.A. (Perth) in providing detection training for youth workers which covers knowledge of drugs, effects and stages of dependency, and types of at-risk persons.

Considerable agreement amongst witnesses related to the urgent need for the training of selected personnel at overseas centres. It was shown that interchange of duty and reciprocal training at State levels throughout Australia did have beneficial effects.

Some witnesses pointed out the grave danger of a rapid increase in drug trafficking and abuse in this State as and when States and countries tighten up their laws in relation to this problem. Easier markets would be sought and it was felt that Western Australia may be particularly vulnerable.

CONCLUSIONS:

(1) The ease with which drugs can be concealed and disguised makes detection extremely difficult as indicated by the fact that it is estimated that no more than 10% of all illegally imported drugs are detected and seized.

(2) That there is a real danger of a sudden increase in drug trafficking in this State as a result of the harsher measures being adopted in other parts of the world. The drug detection agencies, i.e. Central Crime Intelligence Bureau, Narcotics Squad of Customs and Excise and W.A. Police Force Drug Squad are efficient in their operation, but require further refinements and improvements to increase their capacity in the whole field of illegal drug trafficking to enable

them to handle any sudden increase.

(3) The work done by voluntary organisations such as that outlined by the Y.M.C.A. of Perth could well be copied and extended to other voluntary youth organisations.

RECOMMENDATIONS:

(1) That the Drug Squad of the W.A. Police Force be immediately increased in size and that personnel be trained both at Interstate and Overseas centres. Training to be a continuous process, and interchange of personnel between the States to be encouraged.

(2) That as drug detection is a highly specialised field requiring increasingly sophisticated techniques and training, members of the Drug Squad be employed solely on duties related to drug detection without being required to perform other Police duties, unless absolutely necessary. Further, that the Drug Squad be detached from the C.I.B. and be placed under the command of a senior officer as presently applies to the Firearms and Liquor Branches.

(3) That the recommendation of the Senate Select Committee (1971) that urgent attention be given to the establishment of an Australian Coast Guard Service be supported.

1. 3. CAUSES OF DRUG ABUSE:

In attempting to identify and isolate the causes of drug-abuse, the Committee was aware of the danger of simplifying these causes, which in themselves stemmed from massive and complex interactions of basic social problems. The credibility of such statements as "the drug problem is a people problem" and "the drug problem cannot be isolated" is a clear acknowledgement of the intricate influences that lead to dependency.

However, in the interests of obtaining a clearer perspective

of the influences that the community, particularly its younger members, are exposed to, also in the interests of develcping preventive and treatment programmes, (see later) the causes of drug abuse have been delineated intc four categories:

(a) Availability of drugs (especially legally obtainable).

(b) Individual dependency potential: strong dependency - intrinsic instability: mild dependency - curiosity, etc.

(c) Internal (Nuclear) living environment - family relationships.

(d) External living environment - complex, adaptive social interaction.

Availability of drugs - some previous comments have been made in this respect. Apart from minor analgesics which may be obtained without prescription, statistics show a stupendous increase in drug-prescriptions over the last decade which in this State has resulted in 4,922,000 prescriptions being issued during 1971-72 which is almost double the amount issued during 1961-62. Expert witnesses admitted that Doctors, in their efforts to maintain tight visiting schedules, had been issuing prescriptions without adequately researching patients' problems. More recently, medical authorities have drawn attention to this neglect and some success in this sphere seems to have been achieved. It does appear however, that barbiturates may still be over-prescribed, although more caution with pain-killers and morphia derivatives is being exercised. Evidence also referred to the practical difficulties that would arise if certain persons with mild discomfort were forced to queue up at a doctor's surgery. To diminish the indiscriminate use of prescribed drugs it was proposed that a register of such

drugs be maintained by chemists, which could then be tabulated and regularly perused by some central agency. It was also suggested that information pertinent to the danger of excessive use be provided with every sale of the drug.

Individual dependency potential - in considering the drug-dependency potential of individuals the Commission saw fit to further dichotomise this potential into strong and mild forms, recognising that, "dependency is really a reflection of an internal state of instability". Whilst it is not argued that inadequate personalities are most susceptible to dependency, it should be pointed out that the personality factor is not considered to be as crucial as some believe. The 'strong' dependency potential reveals itself in such personality variables as sensitivity, idealism, where conflict between the "materialistic hypocrisy" practised by the "establishment" and subjective idealism of the individual leads to consequent dissatisfaction with the "system" and a leaning (later, dependence) on artificial stimulants and solaces for meaningful living. Other 'strong' factors include the urge to release latent inhibitions or to maintain placebo effects. In some cases innate or complex personality disorders provide 'strong' potential for dependency. Mild causes of potential dependency have been identified as:

(a) curiosity to experiment;

(b) attraction to participate in illegal activities; and

(c) group and social pressures.

These factors tend to be more applicable to youth and students as potential drug abusers. Group pressure upon an individual, with the threat of stigmatisation and alienation has been shown to be a relatively powerful factor and will be considered more fully later.

Internal (Nuclear) Living Environment - the breakdown of

family relationships or disruptions to such has long been recognised as a contributing factor to dependency. The evidence presented confirmed this. Some witnesses observed that too much responsibility had been thrown onto the education system and while not denying the need for specialised staff in specific areas of education it was asserted that these supplementary services "cannot take the place of the home". The generation-gap is believed to have widened owing to the inability of parents, in many respects, to become receptive and adaptive to the many and constant changes of a progressive youth oriented environment. This deficiency was also shown to be evident in child-rearing practices, where conflict with parents and inflexible behaviour patterns, have awakened the desire to escape from stereotyped reality.

External (Social) Living Environment - survival, in an evolutionary context implies adaptability and where this function is lacking in social interaction, withdrawal and introversive tendencies may become prime targets for dependency. Other factors such as migration, unemployment, movement from country to metropolitan areas require an adjustment to changed circumstances, perhaps even a reappraisal of personal values, which, if they cannot be incorporated into the mainstream of daily activity may lead to frustration, disillusionment and consequent recourse to chemical crutches. Much evidence has emphasised that the sheer speed and change of modern living coupled with the complex, formal demands of 'civilisation' require additional personal resources if one is to cope successfully. This may account for the current interest shown by youth in seeking immediate spiritual experiences. Further evidence has suggested that the vicarious experiences of young people during their formative years has stifled their potential for creativity. These vicarious influences would include television, which is almost constantly available, motion pictures, newspaper

reports and all other means of giving information which simultaneously preclude opportunities for discovery learning. It has been alleged that the overthrow of traditional values without replacement has led to an "existential vacuum" for youth and adults alike and the lack of creative, conscious expression is substituted for by image-pushing, mind-expanding drugs.

CONCLUSIONS:

The causes of drug abuse are so many and so complex that it would be quite impossible to unravel all of them and say definitely that in a given set of circumstances drug dependency will arise. At best, they can only be taken as guidelines. However, from the evidence given, the Commission formed the opinion that some of the major causes are:

(a) An inability to cope with the social and economic pressures inherent in the increasing complexities of modern day society;

(b) Disillusionment of a section of youth with the "establishment" as represented by legislators, educational authorities, the churches and law enforcement agencies whom they charge with hypocrisy in their attitudes to such things as inconsistency in dealing with offences related to alcohol as against drugs, involvement in the Vietnam war and the materialistic society.

(c) Family breakdowns affecting all age groups, which could well have been avoided had people known about existing agencies established to help them in times of stress, e.g. Community Welfare, School Guidance, Marriage Guidance, etc.

Whilst the reasons given by witnesses were by no means exhaustive we highlight these as some of the recurring evidence given. Caution has been exercised in interpreting this evidence because it is realised that the whole situation requires ongoing research

to further investigate this field with greater accuracy.

RECOMMENDATION:

That ongoing research be conducted into the causes of all forms of drug use and abuse by the agency recommended under the section headed - "Research".

1. 4. TREATMENT:

The Committee was aware that no treatment programmes for drug addiction were effectively operative in the State and within its terms of reference sought to establish whether in fact a need for treatment centres could be shown; further, if there was such a need, what measures of therapy would be most beneficial. Some evidence supported the view that the establishment of a treatment centre was at present unnecessary, that it would be an uneconomical proposition and would possibly intensify the local problem by attracting interstate and overseas drug-users. It was also claimed that the value of therapeutic centres was dubious owing to their low success rates throughout the world. The Rockefeller programmes in the U.S. were typically singled out as ineffective measures, but it was pointed out that where manipulation and deception could be practised by patients, any such schemes would inevitably fail. Therapy initially helps the addict to recognise that he has a problem which must be removed, hence, "the problem of addiction lies with the person and not the habit."

There appeared to be firm agreement amongst witnesses that a treatment centre, if established, would have to be divorced from a prison setting. Apart from the fact that negligible treatment for addicts is offered in prisons, this contention became more valid when the Commission was informed that due to inadequate lock-up facilities, drug-offenders had been accommodated along with other offenders in prisons, thus

exposing impressionable youth to the palpably dangerous criminal element. There was less consistency in the evidence relating to the use of psychiatric facilities for drug addicts. Whilst it was claimed that drug-users do not see themselves as "mental" cases to be relegated to a mental institution, opposing considerations were that the addicts may be suitably classified as psychiatric patients as they tended to reveal personality disorders. It was however, commonly acknowledged that such a facility should be administered by mental health experts but should not become an isolated drug-clinic for adolescents.

Witnesses views varied with regard to staffing arrangements of a treatment centre. Some saw the need for fully trained personnel orientated towards progressive social psychiatry, whilst others saw the wisdom of using ex-addicts to assist in rehabilitation. This latter technique, allowing for suitable "screening" has apparently been effective elsewhere because, for the addict, there is substantial communication, strength and motivation to be gained from this type of identification. In the process of "getting down to levels", the amateur has been observed at times to be more valuable than the professional. In this context, the importance of motivation as a therapeutic variable may be noted. A Witness stated that different motivations may be involved in the use of the same drug. Elsewhere, it was asserted that drug-abuse can only be curtailed if something of value (motivation) is offered to replace drugs in addicts' lives. In the words of an ex-addict - "Heroin is still bigger than Texas".

In examining preventive measures the Commission was impressed with the evidence supporting the establishment of Referral and Information Centres. Many witnesses remarked that the fear of prosecution and sometimes sheer ignorance of drug-usage deterred young offenders and parents from seeking support. Consequently it was suggested that neutral offices

be set up in the city and far-flung suburbs to provide necessary information and advice to members of the community without fear of arrest. It was envisaged that Pre-Treatment or Referral Centres could be incorporated into such a system providing modified therapy where required. It was felt that non-governmental agencies would be better equipped to carry out these functions; also as these services would be mostly availed of by young people, a 'Mod-Squad' front and approach would be convincing.

The Commission having been acutely aware of the lack of co-ordination amongst services active in prevention of drug-abuse, also the fact that no single authority was responsible for dealing with the problem, resolved to investigate the feasibility of setting up a Government-sponsored authority to co-ordinate, and subsidise, the existing agencies which offered preventive and treatment services to combat the incidence of drug-abuse. Much evidence supported the realisation of such an authority, although fears were expressed that unless a broad, progressive approach was adopted, the authority could become a stumbling-block. This would hence necessitate a wise choice of administrative personnel. It was also observed that the provision of voluntary treatment and committal procedures could constitute a further function of the Authority. There was some suggestion that the necessary organisations do exist, albeit fragmented, whose directions could be focused appropriately by the Authority. There was also a risk that the Co-ordinating Authority itself could become a fragment.

CONCLUSIONS:

(1) That fragmented services are presently available to dependent persons.

(2) That there is a need for some comprehensive co-ordination of these facilities and this need will become more apparent

from the evidence given in respect to alcohol dependency. The majority of witnesses asked this question supported the idea of establishing a co-ordinating Authority.

(3) Certain safeguards would have to be observed in order to allow the Authority to function effectively and so as not to cause any overlap in certain areas where the field is well covered.

RECOMMENDATIONS:

(1) An autonomous authority be set up to administer, advise and direct the services required for the treatment of both drug and alcohol dependents.

(2) The Authority to be financed from the State Budget, e.g. Liquor Act 1970, section 168.

(3) The duties of the Authority will be:

(a) To establish:

(i) Information, Assessment and Referral Centres;

(ii) small (15-20 bed) detoxification units;

(iii) in-patient and out-patient treatment centres, (probably attached to general hospitals - not mental institutions);

(iv) after care hostels for all patients where necessary;

(v) rehabilitation programmes;

(vi) permanent residential centres for those people who do not wish to take part in any rehabilitation programme but who need a place they can regard as a permanent home;

(vii) two main centres for treatment and rehabilitation, these centres to be Byford (expanded as per plan) and Wooroloo. Both these premises to be transferred from the Department of Corrections to the new Authority.

(b) To ensure adequate trained staff are available for treatment programmes. (People presently employed in

this field in any Government Department to be transferred at their request to work for the new Authority with due safeguards being paid to conditions of service, long service leave, retirement pension funds, etc.)

(c) To co-ordinate the services and facilities available by voluntary agencies and to recommend to the Government the subsidies that should be paid to such agencies.

(d) To liaise on matters of alcohol and drug dependency with Government agencies or departments responsible for health, education, law enforcement, community welfare, and with Alcoholics Anonymous and other voluntary organisations in this field. This to be achieved by the establishment of an Advisory Committee consisting of one representative from each of the above Government agencies plus other members as the Authority deems fit. The Committee to meet not less than once in each three months.

(4) The Authority shall be comprised of the following personnel - Chairman (part-time) to be a prominent citizen with extensive public and community service experience.

A Medical Practitioner (part-time) who is currently practising in either of the fields of dependency.

A Senior Legal Practitioner (part-time).

Administrative Director (full-time) - a person employed at present by the Public Service with extensive current and practical knowledge of the alcohol and drug rehabilitation field.

1. 5. ESCALATION:

ESCALATION FROM SOFT TO HARD DRUGS:

The question of whether there is progression from soft to

hard drugs is an issue which may be keenly debated. As yet, insufficient research has been undertaken, especially in relation to individual longitudinal studies. This has however, not thwarted exclusive and extremist statements from being made, allegedly with the seal of scientific investigation. In view of the legislative implications of this Commission's findings it was imperative that each statement and statistic given in evidence be interpreted with utmost caution.

An initial attempt was made to determine the extent of addiction, if any, to Marihuana which is considered the most popular of the soft drugs. Much of the available evidence did not classify Cannabis as addictive in the strict sense, but some reports indicated that psychological addiction did take place, even to the extent of suggesting that at some ultimate stage no satisfaction is obtained. Witnesses have proposed that the euphoric experience gained, induces one to maintain or return as soon as possible to this state. Some have claimed that Marihuana does have a tolerance effect which results in progression to harder drugs whilst other sources believe that possibly a reverse tolerance is obtained whereby the user requires diminishing amounts to maintain a euphoric state. Although a recent medical publication states that there is little evidence that any inherent property in Marihuana is responsible for progression to hard drugs, the Commission was informed that a recent U.S. Government survey found Marihuana to be addictive. There appears to be considerable support for the view that personality and environmental factors are largely responsible for this habituation. In this respect, individual dependency potential, discussed earlier, (see P 19) bears relevance. Vulnerability of youth, pressure from peer group, sub-culture identification, maturational after-effects, comprise the environmental factor. The Wooten Report concluded that different personalities are attached to hard and soft drug usage.

Although it was maintained that a sharp distinction existed

between soft and hard drug users with mutual despisal, there did not appear to be sufficient reason to suppose that escalation would not occur. It was shown that Marihuana and LSD were correlated both being representative of the same sub-culture. Further, that LSD provided a more intense, hallucinogenic experience, an individual's reaction to which could never be predicted. If Marihuana was unavailable, the swing would be towards other hallucinogenics, with a distinct possibility that an experimenter or one who craves for a drug-induced experience will not be too selective and thus sample the drug most freely obtainable at the time. The contrary argument advanced was that if Cannabis was legalised, its availability would reduce or even sever contact between Cannabis users and pushers of hard drugs. There would also probably be reduced LSD usage if Cannabis supplies were held constant.

Misinformation, sometimes deliberately contrived, about the ill-effects of drugs, especially Marihuana, has made many young people sceptical of "drug-propaganda", to the extent that authentic advice concerning the use of more serious drugs may be disregarded. Some witnesses recalled first-hand observations of this nature and explained the alleged ill-effects of some drugs and were thus not convinced of the dangers of more potent drugs.

CONCLUSIONS:

(1) The Commission has found that the disseminating of inaccurate information about Marihuana has created a dangerous credibility gap insofar as more harmful or addictive drugs are concerned.

(2) The Commission has also found that although the physically harmful or addictive properties of Marihuana have been inconclusively reported, one certain fact emerges from the evidence - that fact is that psychological and

environmental factors will lead some users of Marihuana to sample other more dangerous and/or addictive drugs, particularly other hallucinogens such as LSD.

The Commission regards this as a very real and distinct danger outweighing any other consideration.

RECOMMENDATION:

That Marihuana usage be not legalised until incontrovertible evidence has been produced to show that there is no possible danger of escalation.

1. 6. PENALTIES AND LEGISLATION:

The effects of various penalties for drug-abuse were reviewed in conjunction with judicial functions. Legislative proposals concerning inconsistencies in interpreting the law were also considered and are presented below.

It was generally observed that the maximum penalties imposable for drug-abuse were sufficient, but that there was need for differentiation between experimenters, users and dealers in applying these penalties. It was concluded that there would be some difficulty in devising exclusive categories for the three types. However, scaling of penalties could be instituted which could also be applicable to the various drugs being abused. Some of the evidence given showed that for experimenters, modified treatment and counselling were more effective than heavy fines or imprisonment. The inefficacy and danger of imprisonment has already been considered (P. 22, 23) and it remains now to reassert that punitive measures can be exploited by the criminal sub-culture in prisons and can lead to rebellion and bitterness on the part of the offender. One suggestion was that experimenters should be regarded as irresponsible and immature and should be treated for such without ignoring the areas where they may have shown good social adjustment. For regular users it was felt that severe penalties were inferior

to probation and parole measures, though it was readily admitted that high penalties discouraged interstate drug-users from visiting Western Australia. Probation seems to offer more control over offenders, additionally it forces them to accept responsibility for their actions, which in itself is a form of therapy. In this connection, a need was seen for more probation officers, preferably some with special training in supervising drug-offenders. The need is further accentuated because Courts are now most disposed to the use of pre-sentence reports, compiled by probation officers, which include the social history of the offender and his introduction to drugs. The Massachusetts, U.S.A. law relating to drug-abuse seems to maintain a distinction between experimentation and regular use and may deserve further consideration. In brief, it states that : -

(a) Any drug-dependent may apply for treatment and will receive psychiatric or medical evaluation of his chances of benefiting from such treatment;

(b) a first-offender, other than a trafficker, has a right to treatment in lieu of prosecution, Some evidence indicated that greater restraints may have to be imposed on 'confirmed' addicts during the interim of their being charged and sentenced, to prevent their causing further damage to themselves or to others, or property. It was envisaged that some type of adult remand and assessment centre should be suitable.

Other issues raised in evidence concerned the possibility of Cannabis and LSD usage being decriminalised if they were not associated with any other criminal offence. It was also proposed that charges for driving under the influence of drugs be made more specific. Some criticism was laid against the tactics and the approach adopted, at times, by the Police force. It was felt that some re-education would improve their understanding and manner in dealing with drug offenders. The Commission was also made aware of the difference between attitudes of the Police and State Welfare Agencies, the former preferring charges, the latter, neglect applications. Evidence showed that a growing number of 18-19 year old offenders were being charged whilst a relatively small number of 16-17 year olds were charged or referred to the appropriate welfare authority. It was contended that the drug problem would not be alleviated by shooting offenders

across State borders. Further that legislation in this respect needs to be more defined to restrict divergence in interpretation and practice.

The evidence concerning inconsistencies showed these to relate to : - (a) the formulation of State drug laws, per se, and -
(b) to sentencing procedures of magistrates.

In the first instance it was held that Western Australian law differs from that of other States in that the maximum penalty for possession of drugs is three years, as opposed to two years, in other States. Further a trafficking charge is triable summarily by a Magistrate thus denying the defendant a jury. The normal maximum penalty for conviction summarily is eighteen months; however, for trafficking, the maximum penalty is ten years. This discrepancy could be removed if trafficking was to be made an indictable offence - i.e.: - trial by jury. The Commission's attention was drawn to the range of penalties that had been applied to drug offences, especially for Marihuana usage, which seemed fairly disproportionate to the penalties imposable for other offences. As one witness remarked, "the massive imbalance that exists between the treatment of Cannabis - users and other offenders is a source of bewilderment and anger, when one can be seen to threaten and destroy both life and property and get more lenient treatment than another who indulges in a victimless crime." This leads to the second inconsistency, the sentences issued by Magistrates. It was suggested at the outset that perhaps a survey could be undertaken to determine the extent, if any, of this inconsistency in sentencing. The evidence, in this regard, supported the view that this vacillation could only be curbed by reducing the range of maximum penalties. Conversely, it was shown that mandatory penalties would fail to recognise motivational and environmental factors, which were included in pre-sentence reports. Flexibility of approach was seen to be imperative, especially in dealing with youth. It was also observed that publication of court proceedings relating to

drug charges seemed to have adverse effects on the public, and more so on youth. This is partly due to sensational reporting, partiality to one view point, which sometimes leads readers into drawing false premises.

It may be appropriate to conclude this section by considering the observation of one witness that we must be careful not to lose large numbers of young people who would otherwise be worthwhile citizens, and magnify our problems as they relate to those who know their friends are worthwhile human-beings, but who were caught up by unthinking legalisms.

CONCLUSIONS:

(1) There must be a distinct line drawn between users and traffickers for the purposes of the law.
(2) Rehabilitation of users must be paramount in any legislation to be enacted in the future.
(3) Legislation must be so framed as to minimise apparent inconsistency in dealing with offenders, but leaving the judiciary with sufficient flexibility and discretion in interpreting the law.
(4) That imprisonment of drug dependents without any attempt to rehabilitate or medically treat them serves no useful purpose but can only embitter and criminalise an erstwhile law-abiding citizen.
(5) There is an urgent need for more probation officers with special training in these fields of dependency.
(6) The mass media should exercise greater restraint in reporting Court cases related to drug usage.
(7) Penalties for traffickers in any illegal drug should be severe.

RECOMMENDATIONS:

(1) First user offenders should be released to the Probation Service for a period of not less than six months and

providing satisfactory reports are given at the expiration of this time, the offender should be discharged and no conviction recorded.

(2) That more probation officers be appointed with specialist training to enable them to combine supportive therapy with their present supervisory role.

(3) That in relation to alcohol and drug offenders appearing in Court for a second time and subsequent offences, the substantive provisions laid down in Part III of the Alcohol and Drug Addicts (Treatment) Act 1961-64 of South Australia be adopted as part of our legislation for their treatment.

(4) The relevant penalties provided for adult users in any other Act shall be repealed automatically upon proclamation of the new legislation.

(5) Juvenile offenders to be dealt with under the provisions of the Child Welfare Act, Section 4.

(6) That all cases of trafficking in illegal drugs be regarded as an indictable offence and be tried on committal by a Superior Court with a jury.

(7) Upon conviction for the offence of trafficking, the penalties shall be: -

(a) First offence: Liable to a term of imprisonment for 10 years.

(b) Second offence: Liable to a term of imprisonment for 15 years, shall be declared an habitual criminal, and section 664 of the Criminal Code of Western Australia shall apply.

1. 7. EDUCATION:

It was seen earlier that this State's vulnerability to drug-abuse is unquestionable and in view of this limitation it was considered imperative that preventive measures be introduced or consolidated at the earliest opportunity. Education has received universal

acclaim as a fundamental weapon to thwart, in the first instance, and combat, in the second instance, drug dependency. From the relevant evidence accumulated the Commission was able to discern three major areas in the sphere of education which were examined with a view to strengthen, where inadequate, these areas. They are presented as : -

(a) Education pertaining to drug-use.

(b) General education.

(c) Health education.

Education pertaining to drug-use: Controversial evidence was presented to the Commission in respect of the orientation of information to be disseminated amongst school-children. One line of evidence represented the responsibility of the Church to the present generation, which during more recent times had been shown to be lacking. Thus education programmes in connection with drug use would have to involve Churches and other affiliated organisations because of their regular contact with youth at various levels and the apparent advantage of presenting information at an informal level. It was further reasoned that the development of individual values and recognition of obligations would be enhanced if education was to be more aligned to Moral Studies rather than Social Studies. Other sources of evidence stressed the need for honest presentation of facts without moral judgment and attempted to show that the younger generation having immunised itself against indoctrination of traditional values would reject discussions and information services that sought to incorporate these values. A medical expert witness told the Commission that, from personal experience, he had found that young people appeared to be very receptive to and impressed by biochemically oriented information concerning drug use. A surprising amount of concern and attention seems to be devoted to the possible effects of drug abuse on the following generation, particularly amongst girls.

Although there is much to commend frank, factual dispersion of information, there was quick and wide acknowledgement of the danger of stimulating unhealthy interests in drugs by ingenuous education. The Commission was advised of the Human Relationships Workshops programmes that had been devised by the Mental Health Services Education Unit and introduced in the community and high schools to provide discussion forums on the use and abuse of drugs, whilst at the same time maintaining the primary perspective of 'prevention'. There was a possibility of these workshop programmes becoming didactic rather than providing stimulating discourse; this, it was felt, could be minimised by offering teachers and co-ordinators more access to psychologists. It was also considered that at-risk people could be better identified in groups than in sheer numbers. An informal group comprising of mental health experts and educationists had been formed to review the development of these programmes.

The success of drug-education schemes outside the class-room was seen to be dependent upon two major factors:

(a) the type of facility or "set-up", where information could be obtained;

(b) the type of personnel used for providing this information.

With regard to the first factor, it was considered important that the facility could be availed of without fear of repercussions and where Police and community sanctions would be subservient to the purposes of the services. It was also envisaged that instruction or advice could be offered to parents concerning a suitable approach to their children, whether or not drug involvement was suspected. As noted earlier, there was fair agreement that a non-Governmental facility would be more approachable. With respect to the second factor, it was felt as peer-identification was significant in social relation-

ships of young people, personnel with a 'Mod-Squad' image could be very appropriate to meet this requirement. Recovered addicts would be particularly suited to fulfil this function having regard for the fact that where direct 'inside' feedback concerning the drug-scene was available, the desire to experiment may be appreciably mitigated. Although there was some risk in using ex-addicts, it was contended that their expertise in 'drugs' could not be doubted and the fact that they are being successfully employed as Probation Officers in the U.S. further substantiates their case.

The question of whether or not drug-education should be introduced at primary-school level was raised in the evidence. Many witnesses seemed to favour the introduction of such a measure with the adage, "Give me a child up to the age of five and he is mine for life", offering sufficient justification. It was believed that even minimal education on drugs for pre-school children would cultivate "attitudes" which could subsequently be combated or reinforced by further education. An expert witness, however, in defending the lack of formal education at primary and secondary levels, offered the following explanation: - The Health Education Council, which guides the Education Departments health-education policy, has advised that the programmes currently available tend to stimulate undesired interest in drugs. Recent research has confirmed this. Further, teachers have not received any preparation for introducing drug-education; neither are there any programmes nor provisions to do so. Finally a nationwide approach to implement these measures is being considered by the Commonwealth Department for Education and Science and will include, if brought into effect, the introduction of a compulsory course on drugs at all teachers colleges.

The evidence continually showed that drug-education to achieve any success at all could not be treated as an isolated theme. The problem, in reality, is entangled with other social problems

and unless seen in this context, will be overestimated or vice-versa. A measure of this isolation is reflected in the dichotomous "we" and "they" reporting of the media which only accentuates the development of sub-culture and the generation gap.

General Education: Some emphasis was laid on the perceived relevance of various courses to "work-bound youth". It was claimed that if recognition of this relevance was found wanting, youth would be unprepared for work-situations and the dissillusionment that may accrue would be tantamount to being at-risk (see Exhibit No. 16 - Guidance Branch Report per E. von Bamberger).

Evidence was received concerning the communication breakdown between educational authorities and parents where it was seen that both parties were inclined to shift responsibility to the other. Children's home back-grounds tend to reflect the interest of their parents in their education, and where this is well developed, the teacher's task is made easier. One measure that could promote rapport between parents and teachers would be the introduction of after-hours playtime programmes for school children to combat idleness, curiosity and keep them constructively occupied until their parents returned from work.

One witness claimed that, "our educational system does not teach our children to relate at an emotional level". Earlier (Cf. Causes P.20, 21) it was suggested that current methods of learning appear to inhibit the creative potential of young people. It was proposed that each of these claims, i.e. - the inability to relate, and to create, could be resolved by introducing into school curricula, sessions of encounter therapy, the nucleus of which was creative drama. Another similar proposal suggested Psychodrama, where ideas regarding the development of personal resources were dramatised in a group situation.

Health Education: As was seen earlier in this section, the

Health Education Council is an advisory body to the State Education Department and fulfils a primary preventive role in relation to various forms of social abuse. Its programme of "modern social issues" which is used in schools and with parent-groups incorporates drug-education and from the evidence, appears to have had a mixed reception. Some witnesses in denying the adequacy of these programmes argue that "lectures en masse" are unable to convey the far-reaching consequences of social problems; also the lack of personal identification reduces the effect of this type of communication. Other evidence has contended that these programmes are profitable because of the emphasis on personal responsibility. Although a major proportion of expert evidence has commended the scheme, the Commission sees the need for continuous assessment of the scheme's efficacy. Evidence given by witnesses directly involved in health education indicates that the proper functioning of the Council is hampered by the lack of funds, hence staff, especially where endeavours are being made to extend these services to the industrial sector where a considerable percentage of absenteeism, inefficiency and accidents are attributable to social maladjustments. It was shown that the contribution of the Council in terms of Prevention could be significant if the central unit in the metropolitan area was to become a specialised support unit for local and regional units, all of which would require additional finance.

CONCLUSIONS:

The Commission feels that in education, lies the greatest potential for combating drug use or abuse, for perhaps the most important factor in determining the kind of society in which we live is the quality of education given to our children.

Although the role of parents in providing love and a life style for a child is of primary importance to and influence on that child, the State has a very powerful weapon in the education system whereby inadequacies or deprivation, suffered by a child in its home life, whether cultural or love, can to a large extent

be mitigated.

The excellent submissions presented to the Committee particularly by the psychologists from the Guidance and Special Branch of the Education Department, and the Co-ordinator of the Education Unit of Mental Health Services, we believe, provide the basis for the kind of formula needed in our schools to prepare children for living instead of just for the workforce.

Children must be taught how to relate to each other as human beings, how to communicate, to handle problems, to think for themsleves, to reason, to search for truth - in addition to the purely academic subjects.

The Senate Select Committee expressed it very well -

> "The Committee believes very strongly that it is the proper role of education to prepare young people to take their place and fully participate in the activities of the society in which they will live. It therefore supports the initiation of a major review of the existing school curriculum with its objective being to place proper emphasis on 'education for living' rather than on academic achievement. It believes that a revised curriculum should emphasise the development in the individual of both internal and external relationships. By internal the Committee means factors within the control of the individual including interpersonal relationships, physical and mental health, family and community responsibility, biology and the use of leisure. By the term external relationships it includes those in which group attitudes collectively can influence such matters as the environment, including pollution, preservation of the balance of nature, town planning practices, poverty and road safety."

RECOMMENDATIONS:

(1) That the proposals contained in the submissions of the Co-ordinator of the Education Unit of Mental Health Services and Psychologists from the Guidance Branch of the Special Education, and Guidance Branch of the Special Education and Guidance Division of the Education Department be accepted as a basis for education to improve the mental and emotional health of the community and that increased funds and personnel be made available to enable their implementation.

(2) The Health Education Council's work be expanded and that increased funds be made available in order that this Council can establish regional officers and offices where the Council feels the need is greatest.

(3) Liaison between the three above-mentioned bodies be part of the management functions of the autonomous authority established in recommendation (1) under the heading of "Treatment".

(4) Any educational programme must be complete and integrated into the everyday school curriculum.

(5) The Health Education Council shall be responsible for the production of programmes in conjunction with the Education Department, and Education Unit of Mental Health Services.

(6) The Teacher Education Authority should introduce into the various teaching colleges a syllabus devoted to training of students in Human Relations Workshops. This instruction at teacher colleges initially to be given by outside lecturers with experience in this field.

1. 8. COMMUNITY PLANNING:

The Commission's recognition of the need for Community Planning was guided by the assumption that local problems can best be resolved by people and agencies offering services from within the reference communities. For a problem to be successfully encountered, it will need to be first identified and researched in terms of its extent, its effects within the community, its origin and the factors that have promoted its escalation. However, as some expert witnesses observed, there was some danger firstly of planning projects to meet neat research designs rather than the needs and problems of people; secondly, a proportion of the information gathered by in-depth studies would become redundant owing to the changing social scene and would have to be accounted for in the planning of programmes. Thus it was important that feedback and communication be maintained with the community during research operations so

that the information gleaned would be authentic and have wide applicability.

It was envisaged that a close liaison between community health and welfare services could be achieved by the formation of monthly or bi-monthly committees consisting of representatives from health, police, education and welfare services, along with other community groups. The comparatively small population of the State (especially the metropolitan area) would facilitate constant communication between all available resources, though by the same token, the size of the State, (in relation to regional areas) would present some difficulties.

The need for community ventures can be seen from the fact that increasing hours of leisure are being made available to the working public, without increasing avenues of entertainment or recreation - it is in this sphere that community social programmes could be developed. Provisions could be made for securing premises which could include reading rooms, coffee-lounges, restaurants, games-rooms and dancing facilities. This type of social environment may be especially attractive for migrants or others suffering social deprivation. Staff could comprise of part-time volunteers, who, themselves may be in need of activation, and thus would welcome the opportunity to participate. A social worker could, perhaps, be available. There would certainly be no need for alcohol availability. In general terms, such centres could stimulate and stabilise interpersonal relationships and foster a spirit of altruism and community involvement. Other ventures could be directed towards expanding or improving child-minding facilities, the obvious effects of such schemes being to raise the economic levels of families, additionally, to relieve "housewife" monotony and frustration.

In realising the implications of a growing, drug-oriented, sub-culture, it has been suggested that the community should

endeavour to establish a peer group representing anti-drug culture. Programmes should be constructed so as to give youth the opportunity to try growth experience through awareness of others and shared experiences. This would surely provide expansion of consciousness, controlled, yet without the scars of physiological and psychological damage. As one witness put it:

> "There is no miracle cure or simple answer to these or other symptoms of serious social pathology. Sound applied social research projects can enable us to define the problems and plan a strategy for dealing with them.
>
> Government resources applied wisely to alleviate poverty and to remove disadvantage are likely to be most effective in dealing with this as with other social pathologies."

CONCLUSIONS:

The problem is of such magnitude that the Commission had neither the time nor the facilities to undertake a thorough and detailed investigation into all aspects of community planning. However, the Commission became increasingly aware of the complexities and association of alcohol and drug dependence with other sociological problems. It is apparent from the evidence that a multiplicity of factors involving community planning in all its aspects contribute in part to the problem of drug use and abuse. Concomitant with this is also the associated problem of alcohol dependency. Evidence confirms that no one single factor is responsible for these interrelated problems.

RECOMMENDATION:

That continuous and comprehensive research be carried out by the Government, in an attempt to identify the individual factors which contribute in part or as a whole to inadequate community planning and which give rise to these and associated problems.

Such planning to take into account the recommendations that may be made from time to time by the Co-ordinating Authority and the Alcohol and Drug Foundation referred to later under

Research P. 67, section 2. 9.

SECTION 2: SYNTHESIS EVIDENCE ON ALCOHOL DEPENDENCY.

2. 1. Extent and Effects of Alcohol Abuse.

2. 2. Causes.

2. 3. Facilities.

2. 4. Treatment and Rehabilitation.

2. 5. Inebriety as an Offence.

2. 6. Legislation.

2. 7. Aboriginal Alcohol Problem.

2. 8. Education.

2. 9. Research.

SYNTHESIS OF EVIDENCE ON ALCOHOL DEPENDENCY

2. 1. EXTENT AND EFFECTS OF ALCOHOL ABUSE:

Before commencing discussion on the Commission's findings in relation to the State alcohol problem, it may be appropriate, at the outset, to reach a definition for alcoholism which will be compatible with following sections of this report. As one witness remarked, definitions (of alcoholism) will vary according to their relevance or bias towards particular disciplines. Hence, a medical definition will state that alcoholism results from an excess protracted intake of alcohol leading to physiological damage, finally to disability; whereas, a sociological definition would imply that alcoholism results from intake over a period which causes disruption of work-performance, interrelationships and social activities. As the Commission's terms of reference have provided for an examination of the problem in its social perspective, the World Health Organisation's definition of alcoholism appears to be best suited for the present purposes. This states that "there is some form of alcoholism when alcohol interferes with any social, economic, employment, or personal requirements of a human being." Thus the problem is identified in terms of its effects upon an individual's proper functioning. Additionally, addiction (to alcohol) per se, is succinctly described in the Notification of Diseases (non-communicable) Regulations of Western Australia as "a state of periodic or chronic intoxication produced by the repeated consumption of a drug, which state is often characterised by a desire to continue taking the drug, a tendency to increase the dose and a psychic and physical dependence on the effect of the drug."

Although an attempt was made to treat the extent of the alcohol problem and the effects of alcoholism as separate issues, it has proved to be not altogether successful as the evidence has often shown the two issues to be closely correlated and intractable. However, as the extent of the problem cannot be accurately assessed it has been proved advantageous to measure

this in terms of the effects and consequences, thus allowing the detrimental significance of alccholism to the community to be exposed.

One source of evidence claimed that there were approximately 50,000 alcoholics in the State, while conservative estimates suggested that fewer than 10% of excessive drinkers were alcoholics. Be the exact figure what it may, the undisputable fact remains that the ratio of alcoholics in proportion to the population of Western Australia is rather high and is supported by the following statistics: In 1971, general, public and private hospitals treated 446 males and 111 females for alcoholism and alcoholic psychosis. These patients, with an average age of 47 years, occupied a total of 4473 bed-days. In addition 467 males and 126 females were treated for diseases in the four metropolitan teaching hospitals which showed alcoholism as a secondary diagnosis. The average age of these patients was 45 years for males and 51 years for females. This second group occupied a total of 9250 bed-days. The Mental Health Services Hospitals also admitted during this period 451 males and 98 females for similar complaints for a total number of bed-days of 48,080 at a cost of $940,898. The overall cost of hospitalisation alone for the combined group of patients was known to be in excess of $1,000,000. Other evidence showed that expenditure on alcohol per day in Australia was close to $3,000,000.

In Western Australia, figures reveal the following:

IMPORTS OF WINES AND SPIRITS:	1969/70	1970/71
	$ 6,183,000	$ 7,872,000
RETAIL SALES - BEER, WINE, AND SPIRITS:	$92,900,000	$102,600,000

CONSUMPTION PER HEAD - BEER, WINE AND SPIRITS	1939 Gals.	1949 Gals.	1959 Gals.	1969/70 Gals.
Wine	.6	1.3	1.1	2.0
Spirits	.2	.3	.3	.4
Beer	11.7	16.9	22.7	27.1

Statistical information relating to the effects of the problem was also presented in evidence. Thus it was shown that 50% of

drivers killed in traffic-accidents have revealed significant blood alcohol levels at post-mortem. With regard to delinquency, it was alleged that 85% of offences dealt with in the Perth Police Court are alcohol-related and it was suggested that this percentage may be higher in country areas, especially the North and North-West. The remark of an expert witness that, "the highest content of court proceedings in any one day are people on drunken charges and crimes associated with drunkenness" aptly sums up the situation.

Other effects have been shown to include loneliness which more often is a result rather than a cause of alcoholism, and appears to be brought about by the disruption of established relationships due to the precedence given to alcohol. Apart from these effects on an alcoholic, aggressive and bitter feelings may emanate from family members towards the alcoholic member. Wives, in particular, appear to be prone to destructive self-pity, coupled with sheer embarrassment, reduced family-pride, and fear for the children's safety and development. In this respect the Commission is pleased to record the constructive efforts of Al-Anon in helping families in this plight to adjust to and accept their particular circumstances.

2. 2. CAUSES:

From the evidence, three major factors have emerged which can apparently lead to alcohol addiction:

(1) These are community sanctions for indulgence, which from the traditional point of view are reflected in such statements as "hold your liquor like a man"; from the commercial viewpoint these sanctions find expression in the form of glamorous advertising which associates sporting and public personalities with alcohol consumption, the obvious inference being that alcohol is essential to success; from the social viewpoint, alcohol appears to be the passport for solialising, such activities being

"geared to the massive ingestion of alcohol". The overall effect of these sanctions is that drunkenness, within limits, is socially approved of.

(2) Some of the evidence has indicated that addiction to alcohol can be "environmentally hereditary" - i.e.: the father who frequents a hotel serves as a model for the children. There was some statistical and evidential support for the belief that the majority of alcoholics learned to drink at home, although it was convincingly argued that other negative influences, from a person's occupational, social or sporting environment could contribute to alcohol abuse. The environmental factor seems to be especially significant in relation to the Aboriginal Alcohol problem which will be discussed later.

(3) Alcohol has been shown to be used to excess where psychological and psychiatric disorders exist in a person - solace from feelings of depression, insecurity and inferiority is allegedly sought and achieved in spite of alcohol being known, medically, as a depressant.

CONCLUSION:

The cost to this State of alcoholism in human and financial terms is high enough to warrant all possible preventive measures being taken to contain, control and combat it.
That as it has been shown conclusively that alcohol can have a seriously deleterious effect on the human body, it should be regarded in the same light as tobacco smoking.

RECOMMENDATIONS:

(1) That steps be taken to combat the glamorous image projected by alcohol advertising and promotion which has over the years been calculated to present alcohol as a necessary part of our culture.

(2) That an investigation be conducted into the feasibility of

reducing the percentage of alcohol by volume in all alcoholic beverages on sale in this State. (See comparative table following.)

SPIRIT STRENGTHS

MINIMUM PRESCRIBED BY STATE LEGISLATION

State	Whisky	Brandy	Rum	Gin	Legislation
Western Australia	43.0 P.A.V.	43.0 P.A.V.	43.0 P.A.V.	37.0 P.A.V.	Health Act W.A. and Food and Drug Regulations.
New South Wales	37.2 P.A.V.	37.2 P.A.V.	37.2 P.A.V.	37.2 P.A.V.	Pure Food Act No. 31 of 1908.
Victoria	37.2 P.A.V.	37.2 P.A.V.	37.2 P.A.V.	37.2 P.A.V.	Health Act and Regulations.
Queensland	38.9 P.A.V.	37.2 P.A.V.	37.2 P.A.V.	37.2 P.A.V.	Health Act 1937-1946 and Food and Drugs Regulations 1964.
Tasmania	37.2 P.A.V.	37.2 P.A.V.	37.2 P.A.V.	37.2 P.A.V.	Food and Drugs Act 1910 and Public Health Act 1935.
Northern Territory	37.2 P.A.V.	37.2 P.A.V.	37.2 P.A.V.	37.2 P.A.V.	Food and Drug Ordinance 1963.
South Australia	37.0 P.A.V.	37.0 P.A.V.	37.0 P.A.V.	37.0 P.A.V.	South Australian Food and Drugs Act 1908-1939.
A.C.T.	-	-	-	-	Has no minimum but uses that for N.S.W.

P.A.V. means Percentage Alcohol by Volume at 20° Celsius.

2. 3. FACILITIES:

The table set out hereunder lists the present facilities available to alcoholics in the metropolitan area. As this information has been extracted from the evidence given to the Commission, it may not be exhaustive, but is considered to be fairly representative.

Agency/Facility	Protection Only	Assessment & Treatment	Treatment Only
Police Department:			
East Perth Lock-up	*		
Corrections Department:			
Karnet		*	
Byford			*
Wooroloo			*
Fremantle		*	
Mental Health Services:			
Heathcote		*	*
Claremont		*	*
Selby		*	*
Havelock		*	*
Stirling		*	*
Royal Perth Hospital: Ward 9	*	*	
Sir Charles Gairdner Hospital Casualty	*	*	
Anglican Church: St. Bartholomew's	*		
Catholic Church: Camillus House	*		
Salvation Army:			
Seaforth			*
Tanderra	*		
St. Vincent de Paul Society	*		
Sunset	*		

In addition, Alcoholics Anonymous have 18 groups in the metro-

politan area, 16 in country areas and 5 in prisons.

The evidence revealed that treatment facilities were almost completely lacking in the North of the State with day-patient clinics situated only at Kalgoorlie and Geraldton. The need for regional facilities was shown to arise from various factors, the most obvious one being that a substantial proportion of alcoholics and potential alcoholics were located in regional areas, particularly the Northern and Goldfield areas of the State, where work for these people is generally easier to find. However, social life in these areas appears to be heavily reliant on alcohol consumption and this does little to enhance the progress of a recovering or well-intentioned alcoholic. Apart from this, the uneconomical transportation to Perth of persons seeking treatment, coupled with the consequences of impairing family relationships and support at a period when they are most needed as a source of motivation, provides further justification for the establishment of regional treatment centres.

2. 4. TREATMENT AND REHABILITATION:

On assimilating the evidence presented respecting the treatment and rehabilitation of alcoholics, it appeared to the Commission that some significant factors militated against the success of currently operating treatment and rehabilitative programmes. One such factor is the unwillingness on the part of many alcoholics, more so the older ones, to admit to or discard their disordered ways of life. A second factor is that, at present, there is no clearly superior or successful treatment method. Thirdly, there appear to be no means, statistical or otherwise, to properly assess the value of treatment administered, and fourthly, inadequate follow-up and after-care-facilities negate effective treatment, if at all provided. These factors along with other aspects of treatment raised in the evidence, are discussed more fully below.

Some importance was attached to the type of personnel employed at treatment centres. It was felt that a careful and thorough

selection of staff would have to be made on the primary basis of one's aptitude to relate with people who were relearning their responsibilities. Empathy and a practical approach were valuable qualities, which when possessed by some recovered alcoholics made such people, with due screening, suitable personnel. It was often emphasised that in treatment, some degree of feeling for the patient was necessary, more so when there was close, frequent, patient contact. Some reasonable criticism was levelled against the requirement at Byford, for staff officers to wear uniforms, as this was shown to detract from the personal communication that developed between patients and staff. Some expert witnesses indicated that there was a scarcity of trained personnel and if prison was to give way to rehabilitation, training programmes would have to be devised to fulfil staffing needs. It was also envisaged that such courses could provide medical students and police cadets with a broader orientation to alcoholism than that presently available. Lack of suitably qualified personnel extends to the professional ranks as well, notably, social workers and psychiatrists. This may be due to unattractive salaries, insufficient centres and the low success rate, often unpredictable, associated with alcoholism.

Whilst it was generally agreed that imprisonment was not the answer to alcoholism, contrary evidence was received concerning the proper location of treatment centres. Alcohol problems were seen by some to derive mainly from psychiatric disorders, thus treatment in the psychiatric ward of a hospital seemed appropriate. However, it was argued that both alcohol and drug addicts did not consider themselves to be suitably located if in a psychiatric ward, as did psychiatric patients as well. It was suggested that perhaps a medical environment, i.e.: an alcoholic unit attached to a general hospital, would be more suitable, although stigmatisation would inevitably follow. It was conceived that the establishment of more out-patient clinics would reduce stigma effects. On the other hand it was observed that irrespective

of the location of alcoholic facilities, stigma would develop as soon as the stereotype could be identified. Some evidence indicated that treatment for alcohol and drug dependents could not be conducted in the same place, the reason being that alcoholism is a disease whose symptoms, causes and methods of treatment are quite dissimilar to drug-addiction. However, the fact that both problems are treated for the common aim of terminating an undesired habit, has been offered as sufficient ground to conjoin treatment facilities. In like vein, it was suggested that males and females can be treated at one centre providing for communal dining and work rooms with integration of male and female nursing staff. Such effects could well be attractive and beneficial to the entire programme.

Some evidence was directed to the question of compulsory and voluntary admittance to treatment which was seen to be associated with levels of motivation. "Compulsion yields little success in the cure of alcoholism" was a remark that was well supported. However, it was shown that compulsion is needed for some people and the favourable percentage of such recoveries warrants some attention to coercive measures. It was proposed that both voluntary and committed patients could be treated at one centre provided the centre was free of prison control, in fact totally autonomised save the necessary connections with other Government departments. Some witnesses believed that there was not enough provision for voluntary admittance to treatment centres, whilst others held that adequate controls should be placed on voluntarily admitted patients. It was even suggested that the authority to detain be vested in the health services. Treatment was often ineffective for alcoholics in the geriatric class who may have been sentenced by courts, but had no inclination to dispense with the habit. For such cases, a separate facility could be provided. Motivation appears to be the fundamental therapeutic measure in treating alcoholism. It was contended by many witnesses, and substantiated by the methods of Alcoholics Anonymous, that until an alcoholic has reached the

depths of degradation and recognises this, little can be done to help his plight. Education, well-publicised information centres and family support were considered to be some means of inducing motivation or a willingness to seek treatment, and where this was achieved, efforts would have to be made to ensure that employment was not jeopardised. The success of treatment, (compulsory or voluntary) and punishment,(fines and sentences) was always largely due to the motivational factor. Thus it was felt that there should be provision for treatment experts to decide the suitability of various programmes for alcoholic persons and the need for coercion to be great before it is sanction by any agency.

The Commission also received evidence relating to the currently inadequate pre-treatment and post-treatment facilities. Detoxification and assessment centres were regarded as very necessary to proper diagnosis of alcoholic problems. However, as their primary function would be "drying out", their ultimate value would depend on there being sufficient provisions for further treatment. It was further observed that the establishment of such centres would alleviate the Police task of charging habitual drunkards. It was suggested that these centres would be ideally located within a general hospital. Evidence was given of the Swedish Royal Commission's (1968) proposals that, inebriates, rather than be punished, be sent to detoxification clinics attached to hospitals. Detention at these clinics could be for a minimum of six hours and a maximum of 48 hours, during which social and medical investigations could be conducted.

All major health and welfare schemes have shown that pretreatment and treatment programmes will not be effective unless supplemented by adequate after-care and supportive therapy to patients and their families. One expert witness claimed that initial after-care was more important than treatment itself. Other witnesses attributed a large proportion of Alcoholics Anonymous' success to the constructive support it provides to recovering members.

It was also alleged that the rate of recidivism was due more to poor after-care than treatment methods. One proposal was that more half-way houses subsidised by the Government should be made available to support those who have no home or family to go to. Another proposal was for a less-care or self-care facility to be established for patients going through adjusting periods with ultimate out-patient support administered by social workers. Ex-patients clubs could perform a valuable after-care function.

The Commission received proposals for the establishment of Alcoholics clinics within a general hospital complex as operating in Melbourne where medical, psychiatric and social workers could provide a team approach with an employment officer liaising with private welfare agencies and implementing after-care measures. It was felt that the poor medical attraction to treating alcoholic disorders could be counteracted if alcohol treatment was offered on a part-time basis, mixed with general medicine. Patients would be encouraged to remain in their normal environments where the support of family and friends would be direct and constant. This would necessitate out-patient treatment only, but if medical complications prevailed, facilities for in-patients care should be available.

Evidence was given of the Washington, U.S. programme for treating inebriates. Primarily, treatment precedes judgment. Treatment centres are located at all hospitals where patients are initially treated and then phased out to rural Government sponsored communities which have counselling facilities and group-therapy sessions. Finally, these patients return to society.

Much of the evidence presented stressed the need for treatment methods to be continually evaluated in statistical terms. Published recidivism and cure-rates are essential for assessing any programme. In this context, an expert witness suggested that as 10-18% of alcoholics on a total-abstinence treatment course become controlled social drinkers. It may be worthwhile to

orientate the entire programme to social drinking and thus obtain better results. It may provide some incentive to the patient as well.

CONCLUSION:

That inadequate and ineffective facilities for treatment and rehabilitation related to all aspects of alcohol dependency are available in this State.

RECOMMENDATION:

See recommendations under "Treatment" on page 22.

2. 5. INEBRIETY AS AN OFFENCE:

Some of the evidence presented earlier indicated that the reimprisonment rate for alcoholics prove that sentences are valueless as punishments, deterrents or cures, and that some benefit may be obtained if inebriety was to be treated as an illness rather than an offence. The Commission thus directed its investigation to the cleavage between inebriety as an offence and as an illness, seeking to identify the factors that allowed for this distinction and thence to discover measures to combat inebriety in both these forms. Three individual types have been postulated:

(a) The criminal using alcohol as an excuse - i.e.: commits offence, then gets drunk or gets drunk tc commit offence;

(b) the heavy drinker, who gets drunk and then commits an offence (usually disturbing the peace);

(c) the genuine alcoholic also commits offences, drunk or otherwise, to obtain supplies and maintain his dependency.

Divergent opinions were expressed in respect of whether drunkenness should be retained as an offence. Many witnesses argued in favour of inebriety, per se, being decriminalised, notwithstanding the degradation of human dignity and the impairment of family responsibilities. Official witnesses pointed out that drunkenness

as an offence was used by the police to prevent the possibility of an individual doing injury to himself and to others, by way of implication. Some advantages were seen for establishing a separate Police facility for dealing with inebriated persons, who were estimated to exceed 10,000 annually. Other sources however, indicated that drunkenness and offences germane to inebriety should be divorced from Police Courts, which were overburdened by the frequent appearances of old, confirmed inebriates who do not have any wish to be rehabilitated. It was proposed that in such cases, detoxification units may be more suitable and effective than Police investigation, more so, if decriminalisation replaced extant legislation. One line of evidence maintained that a drunken person should be held responsible for every act he commits. If an act is anti-social or unacceptable to community values, consequences must follow which will diminish the probability of such an act occurring again. In particular, stringent measures should be adopted in relation to driving a vehicle under the influence as this is potentially criminal. The Commission was advised of an anomaly that exists within present legal structures whereby a person on a drunk-driving charge could be committed for a shorter period than an alcoholic committed for treatment and rehabilitation. Four considerations arise from this;

(a) the drunk-driver may be an inebriate gone unnoticed due to inadequate investigation, thus:

(b) the sentence handed down will reflect punishment and not treatment;

(c) it appears unjust that an alcoholic (who may not have committed any other offences, save drunkenness) must serve more time to equip himself for a more useful role in the community while,

(d) a drunk driver may return to society as much a menace as before.

This possibility of an alcoholic not being detected is further strengthened by the fact that alcoholics have to drink more than

social drinkers to reach the indictable blood alcohol level of 0.08. Hence it was proposed that on loss of licence for drunk driving, a person should be required to produce medical evidence of sobriety having been maintained for a stipulated period, before the licence is re-issued. It is in this area of early detection and diagnosis that the fundamental value of detoxification units lie. A further proposal which the Commission considered pertained to the introduction of classification centres to which persons charged with inebriety could be committed for pre-sentence reports. The courts in turn could base their sentences on the recommendations contained in these reports. The defendant's co-operation would have to be enlisted for compiling details of the social case-history. Incrimination could be guarded against by providing for the defendant's right of legal representation. This provision, although unequivocal, would at times be unrealistic if there is adequate legal machinery to prevent abuse of authority, and if the financial and personnel resources of such centres were availed of without sufficient reason. Another requisite was that Judiciary and law-enforcement bodies be thoroughly acquainted with the symptoms of alcoholism and its various stages, before passing judgment on an alleged offence. Evidence suggested that this procedure was being increasingly followed. Finally, there was some support for the view that rejected coercive measures and instead placed the onus on the offender. Thus he is required to make a decision regarding his treatment and rehabilitation, which if unacceptable to him, must be followed by the normal course of law. In the event of recidivism, an offender should be denied the opportunity to decide. (See section 2. 6. LEGISLATION - for Conclusions and Recommendations.)

2. 6. <u>LEGISLATION</u>:

It has been said that social legislation invariably incorporates the contemporary attitudes of the community and if unanimity is lacking, such sanctions provide a framework within which

conventions find expression and to which the community ultimately adjusts. From this assumption that social values are guided by legislation, the Commission endeavoured: -

(a) to determine the effects of recently passed legislation concerning alcohol consumption; and -

(b) to entertain corrective proposals.

The evidence given suggested that recent legislation has been orientated towards the promotion of drinking. This is evident from the following legislative measures, allowing eighteen-year olds to drink, issuing gallon-licences, extending the closing hours of hotels to 10.00 p.m. and in some cases, 12.00 midnight, introducing Sunday sessions at hotels, giving permits to cheap wine-houses and sports clubs. If alcohol consumption is to be disparaged, it will necessitate some reversal of this popular legislation which will be difficult to repeal because of the currently developing social trends, especially amongst youth, which have received some impetus from these measures.

An official witness quoting relevant statistics confirmed that increased drunkenness has resulted from introduction of the Liquor Act, 1970. A discrepancy in this Act was also shown whereby a person who is subject to the provisions of the Act does not commit an offence if he receives liquor well away from licensed premises. Some evidence suggested that perhaps a separate Act for Alcoholics could be introduced which may to some degree, remove the stigma of mental health institutionalisation and rehabilitation.

Some expert evidence recommended the introduction of a Sobriety certificate after a drunk-driving conviction. It was envisaged that such a certificate could be issued by a registered medical practitioner, or more preferable, an independent medical body. Other expert witnesses presented a strong argument for alcoholism to be made a notifiable disease and for a central Case Register to be set up. It was contended that this type of legislation could well bring about a revaluation of community sanctions

respecting alcoholism; in point of fact, severe legal measures could force quick and effective changes in conventional thinking.

CONCLUSION:

The overwhelming weight of evidence points to the fact that fines and imprisonment for drunken persons have no desirable or beneficial effect whatsoever. Firstly it has no reformative or rehabilitative effect on the offender and secondly it places an undue strain on the Police, the Courts and the Department of Corrections facilities, thereby hindering them from performing far more valuable and appropriate work in the overall interests of the community.

RECOMMENDATIONS:

(1) That drunkenness per se be no longer regarded as an offence punishable by a fine or imprisonment, but rather as an illness.

(2) That the Police be given authority to take persons found inebriated in a public place to detoxification units or to their homes, rather than to lockups.

(3) Provision be made in any new legislation for committal procedures along the lines of those contained in Part III of the South Australian Act.

(4) That a person who loses his driver's licence for driving under the influence or drunken driving be required to produce evidence of sobriety issued by a medical panel before having the licence restored. A medical panel shall consist of not less than two doctors who are not in partnership.

(5) That the permitted level of Blood Alcohol Content for drivers of vehicles to be reduced from .08 to .05.

(6) The revision of all laws relating to inebriety be a priority task for the Crown Law Department and the proposed Authority, using as additional guidelines the South Australian Alcohol and Drug Addicts (Treatment) Act, 1961-1964, and the Washington U.S.A. State Uniform Alcoholism

and Intoxication Treatment Act, 1972.

2. 7. ABORIGINAL ALCOHOL PROBLEM:

The alcohol problem of the Aboriginal people has been shown from the evidence to be attributable to various factors which broadly fall into either social or historical perspectives. From the social viewpoint the Commission understands that a distinction may be drawn between problems accruing from an inadequate domestic environment, i.e.: housing; and problems in coping with the interactive social sphere. The latter type have been emphasised by official and expert witnesses who have seen the process of assimilation to be based on learned behaviour patterns. Unfortunately social behaviour in the general community is largely expressed through the medium of alcohol (as has been seen earlier) and many Aboriginals have readily adapted to the "liquid assimilator" as a major means of gaining access to, and the acceptance of, the community. In as much as they have learned that excessive intake of alcohol is frequently characterised by noise, abuse, vulgarity and fighting, they have learned to reflect the poor values that are associated with excessive drinking, such as loss of ambition and disregard of social disapproval. Historically, the alienation of the Australian Aboriginals from alcoholic brews have rendered them ill-equipped, socially and metabolically, to handle alcohol consumption. Their predilection for wine is attributed to the fact that it was the first type of spirit that was introduced and became available. They are more easily affected by liquor because of poor nutrition. Owing partly to their socio-cultural background and the aforementioned desire to assimilate and gain acceptance, many Aboriginals have developed into compulsive drinkers, enhanced by their susceptibility to the "power of suggestion" and peer influences. Thus it has been stated that, "many of them require radical re-arrangement of their entire social environment" to isolate them from detrimental group pressures.

Expert witnesses considered that the stigma attached to the

alcohol problem amongst Aboriginals largely arose from a gross misunderstanding of the cultural values of Aboriginals by the white community which could be removed by introducing Aboriginal culture and history into general education. This would provide Aboriginal people with a measure of self-respect and pride in their heritage, besides making the community more aware of the traditional influences on Aboriginal behaviour and their struggle to integrate.

The Committee was informed that some traces of discrimination against Aboriginals existed, one source being unsympathetic policemen. Although there was no evidence for palpable discrimination, it was held that over-protective measures were often interpreted as being discriminatory. Thus a proposal for brewing a special beer with lower alcoholic content for Aboriginals would have to be rejected on the grounds of partiality to one section of the community. The principle of equality before the law was generally acclaimed and although the equal drinking rights recently conferred on Aboriginals seemed to have adverse effects, this was to be expected because the learning process is invariably slow and painful. Experts agreed that since giving Aboriginals citizenship responsibilities, their over-all integration has progressed. Admittedly, on a gradual basis and not as fast as the public expects. Their dilemma is further extended by the pace at which the rest of the community is advancing in terms of affluence. This can be resolved by providing more opportunities for education and allowing for extra time in which they can adjust and make up lost ground. Encouraging improvements, however, have been noticed by those who have continuity in Aboriginal Welfare work. It was suggested that a socialisation course for Aboriginal men, analogous to the home-makers course for women, may facilitate social development.

Statistics made available to the Commission showed that in 1971, of the 446 males and 111 females hospitalised for alcoholism, 21 males and 24 females were Aboriginal. It is distressingly

significant that the proportion of alcoholics in the Aboriginal community is greater than the proportion of alcoholics in the remainder of the State population. It was further estimated that in women's prisons, 80% of the population are Aboriginal, of which, almost all would have an alcohol problem. Some witnesses indicated that the success rate of treatment or reform for Aboriginals was exceptionally low and perhaps warranted special facilities or programmes for these people if it was to be acknowledged that their life-style and intrinsic problems were different to those of the rest of the community. In particular, the irrelevance of present urban treatment programmes for Aboriginal people from the interior of the State, reveals itself in the recidivism rate. Some merit was seen in the proposal for using powerful tribal elders in conjunction with modern psychiatric techniques. Evidence from official and expert witnesses supported the view that Aboriginal inebriates could be treated separately by their own people, using superstitious methods where applicable, with professional back-up if necessary. Some witnesses favoured the establishment of a separate institution staffed mainly by Aboriginal people who could provide effective treatment by using their folk-lore. Another line of evidence rejected the above arguments and contended that Aboriginals could be effectively treated alongside white people if some selection was indulged in and the balance of power orientated towards the desired direction. Thus "in any institution the standard of the institution is only as high as the standard of the social structure of the persons who are in it." Lack of adequate after-care measures were seen by some witnesses to contribute to the poor success of treating Aboriginal alcoholics. Alcoholics Anonymous could play an important role in areas where the people have no strong religious background, but proper rehabilitation centres, as need in the Goldfields and Northern areas would have to be organised by experts.

Some evidence pointed to the effects that lack of education has

on the older members of the Aboriginal community. The present poor schooling levels of Aboriginal children have been blamed partly upon alcoholic parents. A need has thus been shown for the distribution of special educational material to combat ignorance and promote healthy, communal interests. In this context it was felt rationing supplies will not help Aboriginal families to learn to manage their domestic affairs, in fact it will lead to excessive reliance on Welfare bodies, as may have been encouraged in the past.

CONCLUSIONS:

The Commission concludes that the drinking problem among the Aboriginal community is symptomatic of deeper social ills, as are the associated problems of unemployment, poor health, lack of social skills, etc. The Aboriginal people have been caught in a gap between their former traditional way of life, and the highly competitive and fast moving modern society. Their difficulty in bridging the gap has resulted in a perpetual state of poverty and in their alienation from the wider community, in which they find it difficulty to cope through lack of education, job training, housing and motivation.

The problems are interacting in that lack of employment means inability to maintain a home which in turn affects the health and education of the children and the morale of the adults.

The multiplicity of problems, poor motivation and lack of self confidence lead the people concerned to seek an outlet in alcohol, which helps them to forget their problems, inadequacies and responsibilities. They have also learned that alcohol is used by the non-Aboriginal community as a social medium.

RECOMMENDATIONS:

(1) That efforts be stepped up by Government agencies to provide a comprehensive and co-ordinated programme of

education, housing, job training and training in social skills for Aboriginal people.

(2) That Aboriginal history and culture be taught in the schools to promote a fuller understanding and respect for the Aboriginal race.

(3) Separate treatment facilities be provided for Aborigines who may be described as unsophisticated or still having strong tribal ties e.g. those at present living in the Goldfields and North West.

2. 8. EDUCATION:

Most of the evidence on educational measures accentuated the preventive aspects of alcohol abuse as they applied to -

(a) adults in the community, and;

(b) children at schools.

As has been noted earlier a need was shown for the community to be prepared and educated to extract maximum benefit from the increasing hours of leisure that were becoming available. It was popularly expressed that alcohol if used in moderation, "is a very good social medium", which, however, was not to deny that provisions for an equal supply of soft beverages at all celebrations or functions should not be encouraged.

Adults in the community - one body of evidence held that factual information should be distributed respecting the mental, physical, spiritual and economic advantages of retaining one's sobriety, an illustration of which could be the heavy percentage of people in mental hospitals and prison due to alcoholism. It was felt that a large-scale public education programme incorporating negative publicity about alcohol would have to be supported by more education units and restricted liquor advertising to counteract the propaganda of the liquor trade. Other sources presented the view that the public was generally aware of the consequences of intemperance with alcohol, but were in need of finer details on safe drinking. To this purpose, guides to safe drinking could be prepared, indicating how much alcohol

one could consume and be able to drive.

Children at schools - some witnesses seemed to favour the implementation of alcohol education at the primary school level which would be especially relevant for children who may have an alcoholic parent. Official witnesses disagreed with this view, citing research which had proved ineffective. Other evidence pointed to the need for these programmes to be presented by people with a conviction. In particular, teachers should be aware that as models to school-children, the attitudes (to the problem) which they convey can be more important than instruction or advice. Some advantages were seen to be gained by availing of outside, responsible, organisations to assist with alcohol-education in schools. It was observed that education is often effective by means of identification. Hence, invitations to sporting and other prominent personalities to attend school discussions or to address groups in connection with misuse may have salutary, novel and awesome effects upon children. It was further suggested that documentary films and cartoons could supplement such measures. Some expert witnesses contended that the efficacy of alcohol-education at secondary levels was due more to Human Relations workshops than to specifically designed lectures on the issue, as prepared by the Health Education Council. It was considered important that discussions revolving around individual responses to peer-group and social pressures be encouraged and thus educate young people to realise that social acceptance is not and should not be governed by external stimulants. (See Conclusions and Recommendations pages 38 - 40.)

2. 9. RESEARCH:

The Commission has been led to believe from the various submissions presented that the establishment or consolidation of therapeutic facilities, without prior or concurrent research, will not alleviate the problem of dependency.

It was indicated in an earlier section (of Treatment) that

the success of treatment measures could best be evaluated in terms of statistical evidence, and it seems appropriate here to record the view of an expert witness that, "no project for treating alcoholics should be given public money unless it is able to assess its results over time and compare this with other forms of treatment".

Experimental evidence cited before the Commission revealed a correlation between latent personality problems and dependency and was a further indicant that therapy and preventive measures should be developed on sound instances. Lack of previous investigation or controversial findings could force the application of experimental designs to practical, but not necessarily therapeutic situations. One witness expressed the desire for every Governmental facility to be extended, if called upon, to support various researches. The value of operating a separate Research Unit which could coordinate social research in the State and distribute information to interested and functional bodies, was acknowledged by many witnesses.

CONCLUSIONS:

Ongoing and meaningful research by some authority is vitally necessary for all the preceding recommendations to have any real measurable success. It needs the best of staff, facilities and funds to play its proper role. Its duties must include checking on the efficacy of present treatment and approach, research world-wide, recommending new methods to be adopted and introduced, collecting, collating and disseminating its findings to appropriate institutions and reporting its conclusions and recommendations at regular intervals to the Parliament of this State.

RECOMMENDATION:

That an Alcohol and Drug Research Foundation be established in this State as soon as possible.

ACKNOWLEDGEMENTS:

The Commission wishes to place on record its appreciation to all those witnesses who voluntarily contributed either oral evidence or written submissions during the course of the enquiry. The knowledge gained from this source was of great assistance to the Commission in the preparation of this report. We are grateful to the officers and staff of Government Departments, the United States Consul and the Attorney Generals office of Washington, U.S., who co-operated so readily with advice and assisted the Commission greatly in its investigation. The Commission would especially like to place on record its appreciation for the co-operation it received whilst inspecting rehabilitation facilities in South Australia, in particular, The Chief Secretary and Minister for Health, the Honourable A.J. Shard, M.L.C., Alderman W. Bridgeland, Chairman of the Alcohol and Drug (Treatment) Board, and the Central Methodist Mission. The Secretary of the Commission, Mr. D.J. Stephens, carried out his duties with courtesy and diligence and spared no effort in the completion of his task, also Mr. L.D. Jobe, whose assistance in preparing a digest of evidence received, was of great assistance to the Commission in its final deliberations. The Chief Hansard Reporter Mr. J.A. Cox and his staff are to be thanked also for their speed and efficiency which contributed greatly towards the successful conclusion of the Commission's enquiry.

CONCLUSION:

The Commission is more than aware that its enquiries were not exhaustive because of the limitation of time imposed upon its Members by other Parliamentary duties. Its recommendations have been framed with only one object in mind and that is to commence a complete and integrated programme to combat and control alcohol and drug dependency.

The Commission does not pretend that it has found the total solution to these social problems, but genuinely believes that an approach along the lines recommended would benefit the State in the long run.

Our grateful thanks go to all those who have assisted us in our enquiries.

Dated this 1st day of May, One Thousand Nine Hundred and Seventy Three.

R.J.L. Williams
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R.J.L. WILLIAMS (CHAIRMAN)

L. Elliott
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L.D. ELLIOTT (MEMBER)

T.O. Perry
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T.O. PERRY (MEMBER)

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